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# Editorial Note

## Contrasting the Various Approaches of the Implementation of the 'Right to Health': Understanding the Models of Colombia, Cuba & South Africa.

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### I. Introduction

The notion of public health and access has increasingly gained more prominence in the past few decades.[1] This prominence has coincided with the transformation of the role of the state machinery or the government.[2] The current conception of government includes an element of social welfare, which is the culmination of decades of progress.[3] Ideas of social welfare have vaulted discussions about public health to the forefront of the queue and the international

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1 Gabriel Scally and Justine Womack, 'The Importance of Past in Public Health' (2003) 9 Journal of Epidemiology & Community Health 58.

2 Peter Blolan, Patricia Simone, Brent Burkholder, Laurence Slutsker and Kevin M. De Cock, 'The Role of Public Health Institutions in Global Health System Strengthening Efforts: The US CDC's Perspective' (2012) 4 PLoS Med 9.

3 Stanford Encyclopedia of Philosophy, 'Social Institutions' <https://plato.stanford.edu/entries/social-institutions/> accessed 8 November 2020.

community as a whole has had a myriad of discussions in this regard.[4] This has resulted in various conceptions of public health, from an idealistic universal idea of public health[5] to even a bare minimum standard of public health.[6] This idea has also found mention in many of the constitutions across the world.[7] Some countries have chosen to enact it as a justiciable right,[8] while others have made it aspirational.[9] That being said, it is crucial to keep in mind that the notion of health is not as bipolar as it may appear initially.[10]

Countries across the world have formulated different systems that are suitable to the needs of the respective countries.[11] Even in a country such as India, we can see that the healthcare framework can vastly differ from state to state. The framework in the state of Kerala in nothing like that of Bihar.[12] The focus of the paper is not to discuss the Indian scenario but to analyse certain popular healthcare systems across the world. The Indian system is fraught with problems,[13] and the author hopes that analysing healthcare systems across the world may provide India with certain benchmarks and aspirations by which it may improve its system.

The paper will focus on three healthcare systems, namely that of Colombia, South-Africa and Cuba. These countries have been selected, keeping in mind the vastly different schemes that have been implemented. An analysis of these countries would provide a good cross-section of the various healthcare models that are prevalent across the world. The paper will substantially engage with all the three

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4 World Health Organization, 'Public Health in the 21st Century: Optimism in the Midst of Unprecedented Challenges' <https://www.who.int/director-general/speeches/detail/public-health-in-the-21st-century-optimism-in-the-midst-of-unprecedented-challenges> accessed 8 November 2020; Brigit Toebes, 'International health law: an emerging field of public international law' (2015) 55 Indian Journal of International Law 299.

5 The Constitution of the World Health Organization 1946, Preamble; The International Covenant on Economic Social and Cultural Rights 1966, arts 2, 12.

6 Universal Declaration of Human Rights 1948, art 25

7 United Nations Office of the High Commissioner for Human Rights, 'The Right to Health: Fact Sheet No. 31' <https://www.refworld.org/docid/48625a742.html> accessed 8 November 2020.

8 Larry Gostin, Global Health Law (Harvard University Press 2014).

9 ibid; See also, Deepu P, 'Right to Health as a Constitutional Mandate in India' <http://3.108.39.227/wp-content/uploads/2021/08/RIGHT-TO-HEALTH-AS-A-CONSTITUTIONAL-MANDATE-IN-INDIA.pdf> accessed 8 November 2020.

10 Anna Svalastog, Doncho Donev, Nina Jahren Kristoffersen and Srecko Gajovic, 'Concepts and Definitions of Health and Health-Related Values in the Knowledge Landscapes of the Digital Society' (2017) 58(6) Croat Med J 431-435.

11 Lawrence O. Gostin and Larry Gostin, Public Health law: Power, Duty, Restraint (University of California Press 2000).

12 V. Raman Kutty, 'Historical Analysis of the Development of Health Care Facilities in Kerala State, India' (2000) 15(1) Health Policy & Planning 103-109; Himani Chandna, 'How Kerala Beat UP and all the others on NITI Aayog Health Index' (The Print, 27 June 2019) <https://theprint.in/health/how-kerala-beat-up-and-all-others-on-niti-aayog-health-index/254854/> accessed 8 November 2020.

13 Arvind Kasthuri, 'Challenges to Healthcare in India - The Five A's' (2018) 43(3) Indian J. Community Med 141-143.

models and derive themes, lessons and failures of these models. While this will provide a benchmark for India, comprehensive solutions for the Indian system, possible legislative amendments and reforms will remain outside the scope of the paper. This is primarily because the author feels that if the focus of the paper is too broad, then the discussion will become scattered.

The paper will primarily revolve around the following themes. First, what are the different healthcare models of Colombia, South-Africa and Cuba. Second, the various advantages and disadvantages of the system would be explored. Third, there would be a brief discussion on the Indian healthcare system and the author would also suggest starting points for how the Indian system can be further developed.

Parts II, III and IV of the paper will deal with the healthcare systems of various countries. Through this, the paper will break down the system to the readers and show the advantages and drawbacks of each of the systems. The countries were picked keeping in mind the varied approaches so that a wide spectrum of healthcare systems across the globe could be analysed. Part V of the paper indulges in a comparative analysis so as to point to what systems fare better when compared with one another. It also pinpoints the drawbacks of the system and uses the example of the HIV/AIDS pandemic to show how the various systems responded to the same. Part VI of the paper deals with the Indian healthcare system. The paper would show the unique nature of the Indian system and looks at various data points to demonstrate how exactly the system is different. The Part would also show the India specific drawbacks and provide a suggestion on how the system can be improved, keeping in mind the lessons from the various healthcare systems that have already been discussed in the paper. Part VII deals with the concluding remarks.

## II. Analyzing the Colombian Healthcare System

### A. Development of the Healthcare model

The Colombian system of healthcare envisages an active role of individual litigation which is built upon a constitutional guarantee of health.[14] These individual actions are popularly known as Tutela(s). Tutela is an action that can be brought by any individual for enforcement of their fundamental rights under the constitution.[15] Tutela has been enshrined as a constitutional mechanism and has

[14] Everaldo Lamprea, 'Colombia's Right-to-Health Litigation in a Context of Health Care Reform' in Colleen M. Flood and Aeyal Gross (eds), The Right to Health at the Public/Private Divide: A Global Comparative Study (Cambridge University Press 2014).

[15] Margarat Hagan, 'A Journey through Colombia's Constitutional Court's Tutela Design Challenge' (Legal Design and Innovation, 7 May 2019) <https://medium.com/legal-design-and-innovation/a-journey-through-colombias-constitutional-court-s-tutela-design-challenge-c3f4d20d73bd> accessed 8 November 2020.

been laid down in Article 86 of the Constitution.[16] The Colombian Courts have expanded the ambit of tutela to cover a wide variety of human rights issues as well, giving the citizens a direct line of approach to the courts.[17] As it stands, a tutela can be presented to any judge in the judicial system for the protection of a fundamental right. The concept is similar to what is popularly known in India as writs. The right to health has been constitutionally mandated in Article 49 of the Colombian Constitution. The nature of the guarantee is such that it is an institutional guarantee which is enforced and made justiciable by the action of the Colombian Courts. An institutional guarantee is a guarantee that is considered so inviolable that even a legislature by its action cannot alter it.[18] The inviolable nature of these institutional guarantees flows from the fact that many international instruments guarantee a right to health. In Colombia, the notions of health in these international instruments are seen as a part of the constitution, due to the theory of "constitutional block". [19] The constitutional block is an interpretative theory that mandates that certain international human right treaties are part of the constitution, and this theory has found wide acceptance in the Colombian Courts.[20] This theory essentially states that the constitution would not only include the text but also certain principles of international law.[21] The origin of this concept can be traced back to French constitutional jurisprudence.[22] In the Colombian constitution, this principle has been solidified in Article 93. Article 93 goes to the extent of stating that international treaties and agreements ratified by the Congress will "have priority" in the domestic legal system. It also states all duties and obligations in the constitution will have to be interpreted in light of the international human rights treaties ratified by the Congress. Essentially, these ratified principles become part of the constitutional block since they are essential for the interpretation of the constitution.[23] In addition to the treaties ratified by the Congress, customary norms relating to international humanitarian law as well as general principles of international law are treated as part of this constitutional block.[24]

Tutela actions were traditionally conceived for the enforcement of civil and political actions.[25] It was considered necessary since the state was seen as a vehicle

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16 The Political Constitution of Colombia 1991, art 86.

17 Katherine Young and Julieta Lemaitre, 'The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South Africa' (2013)26 Harvard Human Rights Journal 179 at 183-185.

18 Robert Alexyand Julian Rivers, A Theory of Constitutional Rights (OUP 2002) at 324.

19 Jorge Contesse, 'The Final Word? Constitutional Dialogue and the Inter-American Court of Human Rights' (2017) 15(2) International Journal of Constitutional Law 414.

20 Katherine Young and Julieta Lemaitre (n 17).

21 Manuel Jose Cepeda Espinosa and David Landau, Colombian Constitutional law book: Leading Cases (OUP 2017) at 42-45.

22 John Bell, French Constitutional Law (Oxford Press Scholarship Online 1992) 64–73.

23 ibid.

24 Decision C-291 of 2007 (per Justice Manuel José Cepeda Espinosa).

25 Patrick Delaney, 'Legislating for Equality in Colombia: Constitutional Jurisprudence, Tutelas, and Social Reform' (Equal Rights Review, 2008) <https://www.equalrightstrust.org/ertdocumentbank/Legislating%20colombia.pdf> accessed 8 November2020.

of social welfare. Tutela actions were slowly expanded to encompass healthcare in them. The introduction of the tutela enabled increased access to the justice system as a whole, with respect to fundamental rights.[26] Tutela actions do not contain much of the procedural limitations such as locus standi, nexus etc. Any person can bring forth a tutela action claiming infringement of fundamental rights and this can even be done on behalf of a group or on behalf of vulnerable individuals such as elders or children.[27] Under these actions, judges are specifically empowered to order government officials to carry out specific actions. Additionally, tutela orders have strict timelines and contempt of these orders can even lead to jail time for non-compliant persons.[28]

Initially, tutela actions were only granted when a clear link to right to life was established, i.e., when there was a situation that gravely threatened the life of the person. The Colombian Courts eventually expanded the scope of these actions by interpreting right to life to mean right to live with dignity.[29] For instance, the Colombian Courts ordered an eye operation to be conducted to save the eyesight of a man because the loss of eyesight would mean the reduction of quality and dignity of the life of the person, even though there was no threat to the life of the person.[30]

The Courts were also bestowed with broad powers not only to enforce tutela actions but also to provide the best healthcare, so as to close the gap between private-public healthcare systems.[31]

## B. Tutelas in Practice

Tutela actions have a lot of advantages,[32] and this led to a record rise in tutela actions year after year.

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[26] ibid.

[27] Manuel Jose Cepeda Espinosa, 'Readings on the Colombian Constitutional Court' (13 February 2012) <https://law.utexas.edu/colloquia/archive/papers-public/2011-2012/02-13-12_Espinosa_Opinions%20of%20Colombian%20Constitutional%20Court_post.pdf> accessed 8 November 2020.

[28] Allan Brewer-Car´ Ias, Constitutional Protection of Human Rights In Latin America: A Comparative Study of Amparo Proceedings (2008) Cambridge University Press at 182.

[29] Katharine G. Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) 33 Yale J Int'l L 113.

[30] Corte Constitucional [CC] [Constitutional Court], 23 de septiembre de 1992, Sentencia T-533/92, Gaceta de la Corte

[31] Chris Thornhill, 'Global Constitutionalism and Democracy: The Case of Colombia' (2020) 2(2) Jus Cogens 155-183.

[32] Manuel José Cepeda-Espinosa, 'Judicial Activism in a Violent Context: The Origin, Role, and Impact of the Colombian Constitutional Court' (2004) 3 Wash U Global Stud L Rev 529.

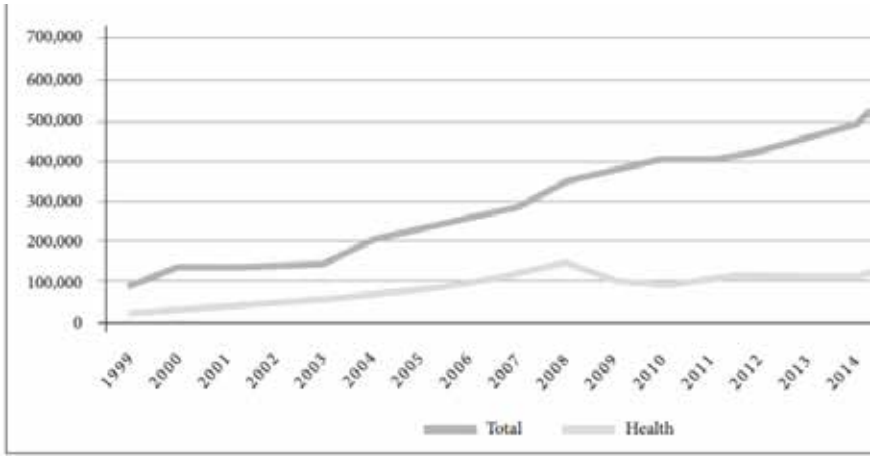


Figure 1.1[33]

The above figure illustrates the numerical quantity of tutela actions. We can observe that there is a steady rise in tutela actions relating to health from 1999-2008 and health actions also formed a significant proportion of the overall tutela actions.

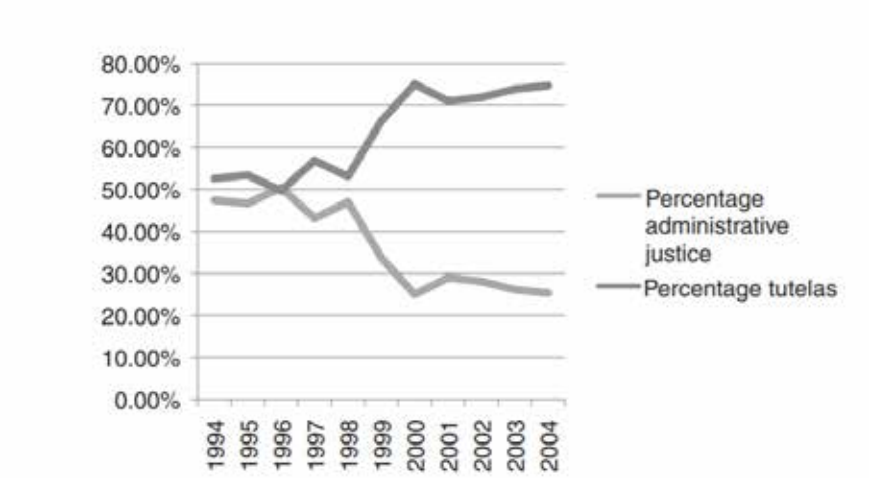


Figure 1.2[34]

[33] Aquiles Ignacio Arrieta-Gómez, 'Realizing the Fundamental Right to Health through Litigation: The Colombian Case' (Health and Human Rights Journal, 20 June 2018) <https://www.hhrjournal.org/2018/06/realizing-the-fundamental-right-to-health-through-litigation-the-colombian-case/> accessed 8 November 2020.

[34] Manuel José Cepeda, Polémicas Constitucionales (2007).

Initially, to fund the system of healthcare, all citizens were required to contribute a fixed portion of their income for healthcare.[35] This system was a public contributory system of "insurance" where the private players were also involved in providing the care.[36] An independent agency was set up, which monitored the costs of providing the insurance, and the government would fund any difference in the premium and the contribution of the individual.[37] The private players also received funds from the government for providing healthcare. Much of the tutela actions during this period were to force private players to provide healthcare because there was a growing animosity among private players against people who were beneficiaries of the government scheme.[38] Private players started accepting a lesser amount of government insurance beneficiaries because they felt that the compensation provided by the government was inadequate.[39] This forced the Courts to step in through tutela actions, but the chasm between private-public healthcare kept growing.[40]

Post-2000 onwards, we can see that the burden of the tutela actions finally caught up with the judicial system. The Courts also started reviewing a significantly reduced number of tutela actions. This was done by restricting the scope of tutela actions by bringing out increasingly complex rules for maintaining such actions. The Court stated that for the actions to succeed the situation had to be exceptional, especially when there was no direct threat to life involved.[41] The Courts also believed that the private healthcare system was more accessible to the general public so there was no need for excessive judicial intervention.[42]

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35 Aquiles Ignacio Arrieta-Gomez, 'Realizing the Fundamental Right to Health through Litigation The Colombian Case' (2018) 20(1) Health Hum Rights 133-145.

36 ibid.

37 Ursula Giedion and Manuela Villar Uribe, 'Colombia's Universal Health Insurance System' (2008) 28(3) Health Affairs 853-863.

38 ibid.

39 Oscar Bernal and Diana C Zamora, 'A Better Understanding of Reasons for the Failure of the Healthcare Reform in Colombia' (2014) 6(21) Health 2918.

40 Giedion and Uribe (n 37).

41 Corte Constitucional [CC] [Constitutional Court], 25 de septiembre de 1997, Sentencia SU-480, Gaceta de la Corte Constitucional [GCC] <http://www.corteconstitucional.gov.co/relatoria/1997/SU480-97.htm> accessed 8 November 2020.

42 Alicia Ely Yamin, Oscar Parra-Veramand Camila Gianella, 'Colombia: Judicial Protection of the Right to Health: An Elusive Promise?' in Yamin, Alicia Ely and Siri Gloppen (eds), Litigating Health Rights: Can Courts Bring More Justice to Health (Harvard University Press 2011) at 110-115.

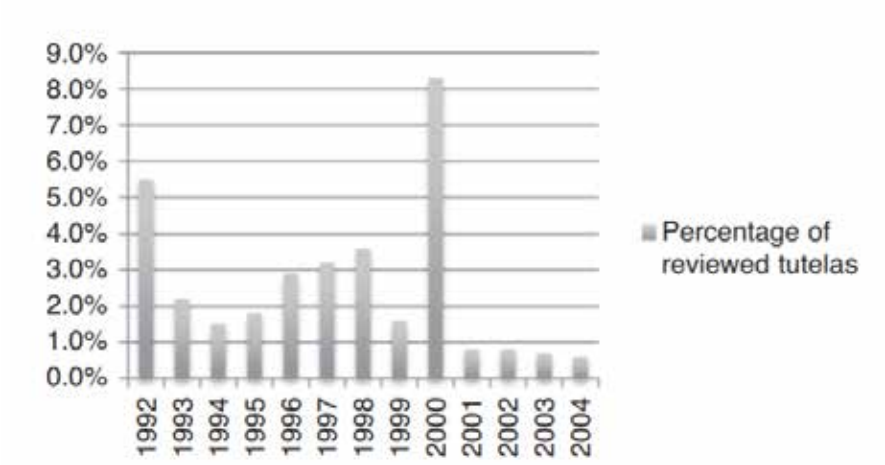


Figure 1.3[43]

Some commentators argued that the reduced actions by the Courts were due to the increasing economic strain on the private players.[44]

The economic crisis in 2008, growing bankruptcies in hospitals, breakdown of government public health machinery and refusal of private players to engage in the healthcare ecosystem threatened a complete breakdown of the system.[45] Taking cognisance of the issue, the Colombian Court significantly modified the basis of health tutela actions by the Decision T-760.[46] The effect of this case is apparent in Fig. 1.1, where there is a marked decrease in health tutela actions. The policy on health also completely shifted, with the government allowing private players to get involved in the insurance domain.[47] The 1990 ideas of healthcare underwent a drastic shift, and the government adopted the "ten decrees" plan.[48] The scope of healthcare provided was severely restricted, the notable ones being that a physician's ability to order treatment and medicines was severely curtailed. Access to specialist doctors from the private sector was reduced since the government was unable to pay for it.[49] It was clear that the tutela model of the 1990s failed, and that the government was forced to accept the divide between private-public

[43] Consejo Superior de la Judicatura, Estadísticas Judiciales (2007).
[44] Bernal and Zamora (n 39).
[45] Katherine Young and Julieta Lemaitre (n 17) at 188-192.
[46] Decision T-760, Colombian Constitutional Court <http://www.corteconstitucional.gov.co/relatoria/2007/T-016-07.htm> accessed 8 November 2020.
[47] C. Prada and S. Chaves, 'Health System Structure and Transformations in Colombia Between 1990 and 2013: A Socio-Historical Study' (2009) 29(3) Critical Public Health at 2-5.
[48] ibid.
[49] ibid.

healthcare. Universal and equal access to healthcare remains a pipe dream in Colombia, to this day.[50]

## III. Examining The South African healthcare System

Even though there were some significant public health movements in South Africa, it refused to commit to a complete overhaul of the existing system.[51] Instead, it opted to go for systemic and consistent changes which would improve the overall quality of healthcare over a more extended period.[52] South Africa was fraught with diseases, especially with the HIV/AIDS pandemic that brought a lot of issues to the forefront.[53] Commentators have also pointed that there were huge institutional inefficiencies that contributed a lot to the problem.[54] Although South Africa spent more than any other African country on healthcare (as a percentage of GDP), it was one of the few countries in the entire world where child mortality was increasing since the establishment of the Millennium Development Goals.[55]

Prior to the reforms, there was no centralised health policy or progressive public health legislations. The population was unable to afford various health treatments. There was also a severe lack of primary health infrastructure in the country.[56] To combat these inadequacies, the government introduced specific measures such as National Health Insurance (to provide universal health coverage),[57] establishment of public health entities such as the South African Health Products Regulatory Authority to provide a uniform and standardised form of

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[50] Nicolas Vargas, Hector Castro, Fredy Rodriguez-Paez, Diana Tellez and Ricardo Salazar-Arias, 'Colombian Health System on its Way to Improve Allocation Efficiency -Transition from a Health Sector Reform to the Settlement of an HTA Agency' (2012) 1(2) Value in Health Regional Issues.

[51] Yach D and Tollman SM, 'Public Health Initiatives in South Africa in the 1940s and 1950s: Lessons for a Post-Apartheid Era' (1993) 83 American Journal of Public Health 1043.

[52] Hoosen Coovadia, Rachel Jewkes, Peter Barron, David Sanders and Diane McIntyre, 'The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges' (The Lancet, 25 August 2009) <https://depts.washington.edu/sphnet/wp-content/uploads/2013/01/Coovadia.pdf> accessed 8 November 2020.

[53] Bongani M. Mayosi and Solomon R. Benatar, 'Health and Health Care in South Africa – 20 Years after Mandela' (N Engl J Med, 2 October 2014) <https://www.nejm.org/doi/full/10.1056/nejmsr1405012> accessed 10 November 2020.

[54] Brian Ruff, Mandi Mzimba, Simon Hendrie and Jonathan Broomberg, 'Reflections on healthcare reforms in South Africa' (2011) 32 Journal of Public Health Policy 184-192.

[55] Chopra, M, Lawn, JE, et al, 'Achieving the Health Millennium Development Goals for South Africa: Challenges and Priorities' (The Lancet, 19 September 2009) <https://www.thelancet.com/journals/lancet/article/PIIS0140673609611223/fulltext> accessed 20 December 2021.

[56] Obinna O Oleribe, Jenny Momoh, et al, 'Identifying Key Challenges Facing Healthcare Systems in Africa and Potential Solutions' (Int J Gen Med, 6 November 2019) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6844097/> accessed 20 December 2021.

[57] South African Government, 'National Health Insurance' <https://www.gov.za/about-government/government-programmes/national-health-insurance-0#:~:text=The%20National%20Health%20Insurance%20(NHI,of%20their%20socio%2Deconomic%20status.&text=This%20will%20be%20done%20using%20an%20NHI%20card> accessed 20 December 2021.

care.[58] There was also a lot of focus on providing and improving the primary health infrastructure with a focus on providing community based or district based solutions.[59] As part of the community based solutions, there would also be focus on disease prevention and community participation in bringing the overall level of diseases down in the country. Social determinants of health would also be monitored.

It is also important to note that South Africa has allowed limited levels of judicial intervention to tackle extraordinary healthcare situations. South Africa has recognised health as a justiciable right but restricted the scope of the right, varying the burdens on the economy and the judiciary.[60] The focus on providing healthcare is primarily on the executive branch of the government, and the government has been consistently ramping up public spending on health as can been seen in Figures 2.1 and 2.2.


Figure 2.1[61]

[58] South African Health Products Regulatory Authority, <https://www.sahpra.org.za/> accessed 20 December 2021.

[59] Nikki Schaay, Prof David Sanders and Vanessa Kruger, 'Overview of Health Sector Reforms in South Africa' (DFID Human Development Resource Centre, December 2011) <https://assets.publishing.service.gov.uk/media/57a08abc40f0b64974000740/overview_of_health_sector_reforms_in_south_africa.pdf> accessed 21 December 2021.

[60] Winnie T Maphumulo and Busisiwe Bhengu, 'Challenges of Quality Improvement in the Healthcare of South Africa Post-apartheid: A Critical Review' (Curationis, 29 May 2019) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6556866/> accessed 21 December 2021.

[61] South Africa Data Portal, 'South Africa Health Expenditure: Total vs Private' <https://southafrica.opendataforafrica.org/rtwhibg/south-africa-health-expenditure-total-vs-private> accessed 8 November 2020.

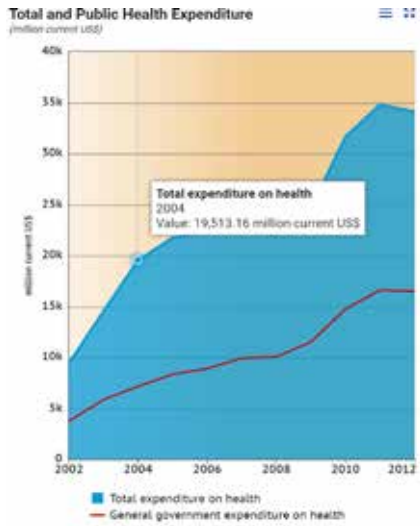


Figure 2.2[62]

South African healthcare model is a private-public insurance model.[63] About 14% of the total population avails private healthcare, while about 64% solely relies on the government for insurance. The rest of the population relies on a combination of both.[64] South Africans recognises the difference in the quality of healthcare between private and public. They have taken the pragmatic approach of conceding that the level of care across both sectors can never be truly equal.[65] However, they do take efforts to reduce the gap, and in pursuance of this, they introduced a quasi-judicial standard of "reasonableness" to ensure that the quality of healthcare provided in the public sector is reasonably comparable to that of the private sector.[66] Commentators have criticised that this standard provides too much flexibility to the healthcare sector and may stand as an impediment to achieving equality.[67] There is some truth to this criticism since the quality of private healthcare is considerably better than the public healthcare system, as is

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62 ibid.

63 Adam Fusheiniand John Eyles, 'Achieving Universal Health Coverage in South Africa through a District Health System Approach: Conflicting Ideologies of Health Care Provision' (2016) 16(7) BMC Health Service.

64 Coovadia (n 52) at 827.

65 B Malakoane, JC Heunis, P Chiobvu, NG Kigozi and WH Kruger, 'Public Health System Challenges in the Free State, South Africa: A Situation Appraisal to Inform Health System Strengthening' (2020) 20(58) BMC Health Service.

66 Lisa Forman, 'Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy' (2005) 5(1) Journal of Law, Medicine & Ethics711.

67 ibid; Sabrina Germain, 'Taking 'Health' as a Socio-Economic Right Seriously: Is the South African Constitutional Dialogue a Remedy for the American Healthcare System?' (2013) 21(2) African Journal of International and Comparative Law 145.

evidenced by the Medical Practitioners/Population ratio in Figure 2.3.[68] South Africa also has a racial history and those of colour getting substantially worse care.[69] The government is taking active steps to bring about racial equality in this regard.[70]

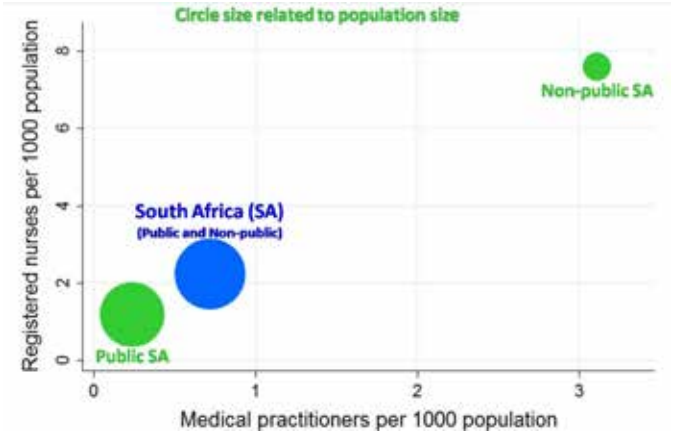


Figure 2.3[71]

On a superficial analysis, it may seem as if the South-African system is inequitable and unreasonable, but the strength of the system is also vastly under-appreciated as is discussed subsequently.[72]

## IV. Evaluating the Cuban Healthcare System

The Cuban system has increasingly gotten more attention in the past few decades.[73] Prior to the Castro government, Cuba was embroiled in much of the problems that the other impoverished countries faced. However, since then, things have turned around with Cuba getting recognition for its world-class

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[68] There are many other indicators as well, but a proper analysis of these factors would take considerably more space, time and expertise with handling data. See, World Health Organisation, Health System Metrics: Report of Technical Meeting <https://www.who.int/healthinfo/health_system_metrics_glion_report.pdf> accessed 8 November 2020.

[69] See Harriet Deacon, 'Racism and Medical Science in South Africa's Cape Colony in the Mid- to Late Nineteenth Century' (2000) 15(1) The University of Chicago Press Journal.

[70] ibid.

[71] Public and Non-Public Sector Nurses and Physicians in SA, <https://commons.wikimedia.org/wiki/File:Public_and_non-public_sector_nurses_and_physicians_in_SA.jpg> accessed 8 November 2020.

[72] For a more detailed discussion, See pt IV(B) of the paper.

[73] World Health Organization, 'Cuba's Primary Health Care Revolution: 30 Years On' <https://www.who.int/bulletin/volumes/86/5/08-030508/en/> accessed 8 November 2020.

healthcare facilities.[74] Cuba's healthcare statistics are among the best in the world. For instance, its child mortality is on par with that of New Zealand;[75] it was one of the first countries to eliminate mother-child HIV transmission;[76] and has even developed vaccines for cancer,[77] and Meningitis B.[78]. Its healthcare metrics matchup with that of the United States despite the fact that it spent decades under an economic embargo, and it also spent much less than the United States, as can be seen in Figure 3.1.

| | Cuba | United States |
|---|---|---|
| Life expectancy at birth (in years)[c] | 79.1 | 79.3 |
| Infant mortality rate (probability in dying by age 1 per 1,000 live births)[b] | 5 | 5.9 |
| Maternal mortality rate (per 100,000 live births)[c] | 39 | 14 |
| Mortality due to cancer, cardiovascular disease, diabetes, or chronic respiratory diseases (percent of population ages 30–70)[a] | 16.5% | 14.3% |
| Total spending on health as percent of GDP[a] | 8.6% | 17% |
| Per capita total expenditure on health at average exchange rate (US dollars)[a] | $558 | $8,845 |

Figure 3.1[79]

Though values of healthcare and universal access were enshrined in the constitution, the Cuban government understood its limitations. It started by setting out a Universal Healthcare Policy in 1976, something it knew would take decades to come to fruition.[80] As a part of this new policy, the Cuban government decided to nationalise healthcare training.[81] It also decided to involve more of the work-

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74 Ronn Pineo, 'Cuban Public Healthcare: A Model of Success for Developing Nations' 35(1) Journal of Developing Societies 16.

75 United Nations Children's Fund, Levels & Trends in Child Mortality: Report 2020 <http://pubdocs.worldbank.org/en/988751599654139713/UNICEF-2020-Child-Mortality-Report.pdf> accessed 8 November 2020.

76 World Health Organization, 'WHO Validates Elimination of Mother-to-Child Transmission of HIV and Syphilis in Cuba' <https://www.who.int/mediacentre/news/releases/2015/mtct-hiv-cuba/en/> accessed 8 November 2020.

77 Laurie McGinley, 'In a First, U.S. Trial to Test Cuban Lung-Cancer Vaccine' (The Washington Post, 27 October 2016) <https://www.washingtonpost.com/news/to-your-health/wp/2016/10/27/in-a-first-u-s-trial-to-test-cuban-lung-cancer-vaccine/> accessed 8 November 2020.

78 British Broadcasting Corporation, 'Americas Cuba Vaccine Deal Breaks Embargo' <http://news.bbc.co.uk/2/hi/americas/406780.stm#:~:text=The%20vaccine%20%2D%20the%20only%20one,vaccine%20virtually%20eliminated%20the%20disease> accessed 8 November 2020.

79 World Health Organization, 'World Health Statistics: 2015' <https://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf> accessed 8 November 2020.

80 William C. Keck, 'The Curious Case of Cuba' (2012) 102(8) American Journal of Public Health.

81 I.D.R Morales, Jose A. Fernandez and Francisco Duran, 'Cuban Medical Education: Aiming for the Six-Star Doctor' (2008) 10(4) Medicc Rev. 5-9.

force in the healthcare industry and to provide medical training in rural areas.[82] Education was heavily subsidised and was dependent on merit.[83] Even with this, the government understood that it would not be enough. There was a push to identify and rectify social, economic and environmental factors that contributed to a decrease of public health.[84] The government recognised that it was economically unfeasible to keep treating the symptom when the underlying cause was not being rectified. These factors were termed as social determinants of health,[85] and the medical workforce was also educated regarding these factors.[86] The government also started dedicating more funds to the research, prevention and specialisation workforce.[87]

To improve the social determinants of health, the government came out with the Family Physician Program.[88] A group of doctors and medical assistants were tasked with taking care of family or a group of families. They were not only responsible for primary healthcare facilities but were also charged with improving the various social determinants of health.

The policies do reap its benefits currently, with Cuba being one of the best in terms of preventive medical care.[89] There is also a marked improvement in various healthcare parameters as the years went on, as can be seen in Figure 3.2.

| | Cuba | | | | | | |
|---|---|---|---|---|---|---|---|
| Health Status Indicator | 1960 | 1970 | 1980 | 1990 | 2000 | 2010 | United States |
| Infant mortality (per 1000 live births)[24] | 37.3[a] | 38.7 | 19.8 | 10.7 | 7.2 | 4.5 | 6.42[b] (2009) |
| Infant mortality < 5 (per 1000 live births)[24] | ...[c] | 43.7 | 24.2 | 13.2 | 9.1 | 6.0 | 8.0[b] (2010) |
| Life expectancy,[24] y | ... | 70.04 | 73.55 | 74.70 | 76.15 | 77.97 | 78.2[b] (2009) |
| Low birth weight rate,[25] % | ... | 10.4[a] | 8.2 | 7.6 | 6.1 | 5.4 | 8.15[b] (2010) |
| Sustained access to improved sources of drinking water,[26] % | ... | ... | ... | 78.2 | 90.3 | 94.5[d] | ... |
| Older adults (% of population ≥ 60 y)[27] | ... | 9.0 | ... | 11.9 | 12.9 | 17.6 | ... |
| Infectious and parasitic disease mortality including AIDS deaths (per 100 000 inhabitants)[28] | ... | 45.4 | 10.1 | 9.6 | 6.6 | 8.0 | ... |
| Patient to doctor ratio/ (inhabitants per physician)[29] | ... | 1393[b] | 641 | 274 | 170 | 147 | 390[c] (2007) |

Figure 3.2[90]

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82 Neil Squires, Sussannah E. Colville, Kalipso Chalkidou and Shah Ebrahim, 'Medical Training for Universal Health Coverage: A Review of Cuba–South Africa Collaboration' (2020) 18(1) Human Resources for Health.

83 Julie M. Feinsilver, Healing the Masses: Cuban Health Politics at Home and Abroad(University of California Press 1993) at 124.

84 ibid.

85 World Health Organization, 'Social Determinants of Health' <https://www.who.int/teams/social-determinants-of-health> accessed 8 November 2020.

86 Don Fitz, Cuban Health Care: The Ongoing Revolution (2020) at 52.

87 ibid.

88 Mauro Castelló González, Reinaldo Pons Vásquez, et al, 'International Medical Collaboration: Lessons from Cuba' <https://www.mdpi.com/2227-9067/3/4/20/htm> accessed 8 November 2020.

89 Katherine Young and Julieta Lemaitre (n 17).

90 William C. Keck, 'The Curious Case of Cuba' (2012) 102(8) American Journal of Public Health.

## V. Comparative Analysis of the Various Systems

### A. General Comparison

Out of the three countries, it seems as though Colombia has fared the worst even though it may be the most idealistic one on paper. Colombian healthcare model primarily failed because it refused to take into account the economic considerations and the concerns of the private players. The author would also generally agree with the premise that the Colombian system is the worst due to its proclivity to a breakdown which is brought about by external shocks. Colombian system also fares poorly in terms of developments in the medical sector.[91]

Even though the Colombian system is prone to shocks, on comparing statistics, we can see that Colombia does fare better than South Africa on essential metrics such as the Human Development Index. There is also a strong correlation between performance and the fact that Colombia enjoys the highest Gross National Income per capita (Adjusted with purchasing power) ("GNI"),[92] among the three countries. On the other hand, it is disheartening to note that even with this amount of purchasing power, the country is vulnerable to economic shocks which can destabilise the whole system. Cuba fares as the best in almost all metrics and is regarded as a country with high human development. This feat is more impressive, considering the fact that Cuba has the least GNI per capita (Adjusted with Purchasing power) among the three countries. Cuban systems enjoy the highest life expectancy, higher mean and expected years of school, and the highest rank in the Human Development Index ("HDI"), all while having the least GNI. Therefore, it is no surprise that Cuba ranks the highest in the HDI (72nd), followed by Colombia (79th) and then South Africa (113th).[93] The following figures will illustrate the various metrics in the countries.

| | Life expectancy at birth | Expected years of schooling | Mean years of schooling | GNI per capita (2011 PPP$) | HDI value |
|---|---|---|---|---|---|
| 1990 | 74.6 | 12.3 | 8.5 | 4,920 | 0.676 |
| 1995 | 75.4 | 11.3 | 9.2 | 3,308 | 0.654 |
| 2000 | 76.7 | 12.3 | 9.6 | 4,047 | 0.686 |
| 2005 | 77.7 | 14.6 | 9.9 | 5,138 | 0.730 |
| 2010 | 78.3 | 16.4 | 11.0 | 6,601 | 0.776 |
| 2015 | 78.6 | 14.0 | 11.4 | 7,567 | 0.768 |
| 2016 | 78.6 | 14.1 | 11.6 | 7,597 | 0.771 |
| 2017 | 78.7 | 14.4 | 11.8 | 7,726 | 0.777 |
| 2018 | 78.7 | 14.4 | 11.8 | 7,811 | 0.778 |

Figure 4.1[94] - Metrics of Cuba

[91] Bernal and Zamora (n 39).

[92] World Health Organization, 'The Global Health Observatory' <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/94#:~:text=GNI%20is%20the%20sum%20of,and%20property%20income)%20from%20abroad> accessed 8 November 2020.

[93] United Nations Development Program, 'Human Development Index Ranking' <http://hdr.undp.org/en/content/2019-human-development-index-ranking> accessed8 November 2020.

[94] United Nations Development Program, 'Inequalities in Human Development in the 21st Century – Cuba' <http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/CUB.pdf> accessed 8 November 2020.

| | Life expectancy at birth | Expected years of schooling | Mean years of schooling | GNI per capita (2011 PPP$) | HDI value |
|---|---|---|---|---|---|
| 1990 | 69.8 | 9.0 | 5.5 | 7,392 | 0.600 |
| 1995 | 71.1 | 10.0 | 6.1 | 8,613 | 0.633 |
| 2000 | 72.9 | 11.4 | 6.5 | 8,254 | 0.662 |
| 2005 | 74.3 | 12.9 | 6.8 | 9,131 | 0.693 |
| 2010 | 75.4 | 14.3 | 7.4 | 10,567 | 0.729 |
| 2015 | 76.5 | 14.4 | 8.1 | 12,951 | 0.753 |
| 2016 | 76.7 | 14.6 | 8.3 | 13,087 | 0.759 |
| 2017 | 76.9 | 14.6 | 8.3 | 12,963 | 0.760 |
| 2018 | 77.1 | 14.6 | 8.3 | 12,896 | 0.761 |

Figure 4.2[95] - Metrics of Colombia

| | Life expectancy at birth | Expected years of schooling | Mean years of schooling | GNI per capita (2011 PPP$) | HDI value |
|---|---|---|---|---|---|
| 1990 | 63.3 | 11.4 | 6.5 | 9,588 | 0.625 |
| 1995 | 61.6 | 13.0 | 8.2 | 9,023 | 0.652 |
| 2000 | 56.0 | 13.0 | 8.8 | 9,498 | 0.629 |
| 2005 | 53.4 | 12.9 | 8.9 | 10,798 | 0.620 |
| 2010 | 57.7 | 12.8 | 10.2 | 11,723 | 0.662 |
| 2015 | 62.6 | 13.8 | 10.1 | 12,052 | 0.699 |
| 2016 | 63.2 | 13.7 | 10.2 | 11,908 | 0.702 |
| 2017 | 63.5 | 13.7 | 10.2 | 11,864 | 0.704 |
| 2018 | 63.9 | 13.7 | 10.2 | 11,756 | 0.705 |

Figure 4.3[96] – Metrics of South Africa

Even in various social determinants of health such as drinking water, sanitation, the incidence of preventable diseases, Cuba fares the best.[97]

## B. Hiv/Aids Pandemic

To analyse the stability of each system, it is beneficial to test it against an externality.[98] The HIV/AIDS pandemic in the 2000s provided a litmus test to the various healthcare systems. It is in this aspect that the Colombian system suffered the most. A public health crisis meant that the medical machinery was sent into override, but Colombia simply did not have the resources to deal with the crisis.[99] Usually, in such scenarios, both the public and the private machinery come

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[95] United Nations Development Program, 'Inequalities in Human Development in the 21st Century – Colombia' <http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/COL.pdf> accessed 8 November 2020.

[96] United Nations Development Program, 'Inequalities in Human Development in the 21st Century – South Africa' <http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/ZAF.pdf> accessed 8 November 2020.

[97] Pan American Health Organization, 'Country Report: Cuba' <https://www.paho.org/salud-en-las-americas-2017/?page_id=111&lang=es> accessed 8 November 2020; Pan American Health Organization, 'Country Report: Colombia' <https://www.paho.org/salud-en-las-americas-2017/?page_id=107> accessed 10 November 2020.

[98] Peter Howitt and Preston McAfee, 'Stability of Equilibria with Externalities' (1988) 13(2) The Quarterly Journal of Economic261.

[99] Bernal and Zamora (n 39).

together to deal with the crisis, but the healthcare policies of the government had already heavily damaged the private medical industry.[100]

On the other hand, the South African system displayed an enormous amount of resiliency and stability.[101] Due to the vagueness of the "reasonableness" standard, the Courts and the government could scale up the healthcare provided during the health crisis. Indeed, this put more strain on the private sector as well, but it was only for that specific crisis and for a short period of time.[102] The private health industry was willing to shoulder this burden in exchange for non-interference from the government during non-crisis times, as was the practice before this.[103]

The Cuban system, once again persevered and tackled the crisis quite well.[104] This was due to the fruits of their long-term healthcare planning.

Across all the three systems, one thing is clear: healthcare costs, particularly in the pharmaceutical sector, has been consistently rising. Commentators have blamed the statutes such as the Agreement on the Trade-Related Aspects of Intellectual Property ('"TRIPS') for the same.[105] TRIPS essentially regulate a private right from the perspective of international law, without taking into account international law considerations.[106] It also contradicts healthcare goals in many international instruments such as the Sustainable Development Goals.[107]

## VI. Lessons for India

### A. Background Information

Traditionally, during the time of Indian independence, healthcare was not in the forefront of the issues gripping the young nation. However, there were important reports such as the Bhore Committee Report produced in 1946,[108] that forms the basis of the Indian Healthcare system. The First National Health Policy was formulated in 1951, with subsequent revisions coming in 1983 that focused

[100] Luz Stella Alvarez, J Warren Salmon and Dan Swartzman, 'The Colombian Health Insurance System and its Effect on Access to Health Care' (2011) 41(2) International Journal of Health Services 355.

[101] Katherine Young and Julieta Lemaitre (n 18).

[102] Graham Bresick, Robert Mashand Klaus Von Pressentin, 'Evaluating the Performance of South African Primary Care: A Cross-sectional Descriptive Survey' (2019) 61(3) South African Family Practice 109.

[103] ibid.

[104] E J Pérez-Stable, 'Cuba's Response to the HIV Epidemic' (1991) 81(5) American Journal of Public Health 563.

[105] The Agreement on Trade-Related Aspects of Intellectual Property Rights 1995.

[106] Wenwei Guan, 'IPRs, Public Health, and International Trade: An International Law Perspective on the TRIPS Amendment' (2016) 29(2) Leiden Journal of International Law 411.

[107] ibid.

[108] Sai Ma and Neeraj Sood, A Comparison of the Health Systems in China and India (2008) RAND, Centre for Asia Pacific Policy.

on the idea of providing universal primary healthcare to all.[109] The Health Policy was once again revised in 2002 to decentralise healthcare and leverage private sector capabilities to provide more primary coverage.[110]

Indian governance system is federal in nature. In this federal structure, healthcare falls under the ambit of the state. As a result, the healthcare framework can vary largely from state to state. NITI Aayog has provided comprehensive breakdowns as to the various factors on which healthcare indexes can be monitored and improved.[111] States like Kerala have performed very well on the healthcare index, while states like Uttar Pradesh and Bihar have suffered.[112] The difference in quality between the states is such that the top-ranking state (Kerala) has two and half times the score of the least performing state (Uttar Pradesh).[113] Factors measured for the preparation of the index includes neonatal mortality index, total fertility rate, healthcare provider facilities, healthcare professionals etc.[114]

## B. Problems in the Indian Healthcare System

### 1. *Lack of Public infrastructure*

Though India has committed to developing public health infrastructure along with private health infrastructure, the fact remains that Indian public spending on healthcare has remained woefully inadequate. Developed countries such as United States have committed to spending around 17% of their GDP for public health infrastructure while Indian spending (as a proportion of GDP) has remained historically low.[115] Recent ten-year estimates point to the fact that India has spent a measly 1.3% of its GDP towards public healthcare.[116]

An inevitable consequence of abysmal public spending is that the burden falls on the population at large to take the brunt of the medical expenses. Looking at figures from the WTO, we can see that the Out-of-pocket expenditure

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[109] Govt of India, Ministry of Health and Family Welfare, 'National Health Policy 1983' <http://www.nhp.gov.in/sites/default/files/pdf/nhp_1983.pdf> accessed 2 April 2021.

[110] M Chokshi, B Patil, et al, 'Health systems in India' (Journal of Perinatology, 2016) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5144115/> accessed 20 November 2020.

[111] NITI Aayog, Government of India, 'Health Index', <http://social.niti.gov.in/health-index> accessed 20 December 2021.

[112] NITI Aayog, Government of India, 'Overall Performance', <http://www.social.niti.gov.in/hlt-ranking/hlt-overall-performance> accessed 20 December 2021.

[113] Ministry of Health and Family Welfare, Healthy States Progressive India: Report on the Ranks of States and Union Territories (June 2019) <http://social.niti.gov.in/uploads/sample/health_index_report.pdf> accessed 21 December 2021.

[114] ibid.

[115] Sumathi Bala, 'India's Covid Crisis Exposes Deep-rooted Problems in Public Health After Years of Neglect' (CNBC, 17 May 2021) <https://www.cnbc.com/2021/05/18/india-covid-crisis-shows-public-health-neglect-problems-underinvestment.html> accessed 17 May 2021.

[116] <https://www.statista.com/statistics/953163/india-public-expenditure-on-health-as-a-share-of-gdp/>

(as a percentage of the total health expenditure) for an individual in India is almost 63%, while developed countries such as United States and United Kingdom have these figures at 10.81% and 16.71% respectively.[117] It is also important to note that the world average for the same period for Out-of-pocket expenditure is around 19%.[118] Such a massive Out-of-pocket expenditure can have a drastic impact of the healthcare of the population, especially when India suffers from a low per-capita income anyway.[119]

We can also see that India has a high level of dependence on private healthcare providers. Data estimates show that almost 72% of the total health expenditure in India flows to the private sector, while the world average hovers around 40.25%. Developed countries such as the United Kingdom spend around 21.38% while the Untied States spends around 48%.[120]

## 2. *Urban-Rural Divide*

India primarily suffers from a severe problem of resource constraint, and this is especially apparent in the rural setting.[121] The resource constraint largely presents itself as a large gap between the provider's knowledge and the care provided, with the gap largely being attributed to the latter.[122] The low quality of care can be attributed to lack of economic incentive, lack of accountability and even a perceived lack of interest from the side of the government.

One of the major problems contributing to the low quality of care is the human resource problem. There is a shortage of medically trained professionals available in the rural areas of India. Rural areas face a tall task in training or recruiting medical professions, primari because there is little to no incentives, economic or otherwise.[123] Consequently, in rural India (which hosts a vast majority of the Indian population), personnel who do not have formal medical training

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[117] World Health Organization Global Health Expenditure Database, <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?end=2018&start=2000> accessed 20 November 2020.

[118] ibid.

[119] Sanjeeb Mukherjee, 'India's Low Per Capita Income Worrying, Needs to be Looked at: Sitharaman' (Business Standard, 12 August 2020) <https://www.business-standard.com/article/economy-policy/india-s-low-per-capita-income-worrying-needs-to-be-looked-at-sitharaman-120081201518_1.html> accessed 20 December 2021.

[120] WHO (n 117).

[121] Jishnu Das and Jeffrie Hammer, 'Quality of Primary Care in Low-income Countries: Facts and Economics' (2014) 6 Annual Review of Economics 525-553.

[122] Ada Kwan, Benjamin Daniels, Srinath Satyanarayana, et al, 'Use of Standardized Patients to Assess Quality of Tuberculosis Care: a Pilot, Cross Sectional Study' (The Lancet Infectious Diseases, 1 November 2016) <https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(16)30215-8/fulltext> accessed 21 December 2021.

[123] Mohan Rao, Krishna D Rao, et al, 'Human Resources for Health in India' (The Lancet, 12 February 2011) <https://pubmed.ncbi.nlm.nih.gov/21227499/> accessed 21 December 2021.

provide healthcare.[124] Merely providing formal medical training in rural areas might not help since there is also the problem of retaining talent.

Another problem plaguing the rural sector is the lack of sufficient public health infrastructure in India as a whole. This skewed dependence on the private sector for providing healthcare would mean that rural areas would suffer the brunt of the problem since private-sector establishments would not have any incentives to set up costly medical infrastructure in rural areas.[125] India also suffers from an unusually high percentage of out-of-pocket spending for medical infrastructure, which would also complicate matters.

## C. Way Forward for Improving the Indian System

The Indian situation is unique to the extent that none of the approaches discussed above would entirely solve the problem. It would have to develop a suitable health ecosystem that is accommodative of the Indian problems.

The Colombian approach of involving the judiciary would be a mistake since Colombia itself had to scale back the judicial intervention as discussed above. Moreover, the population and the marginalised sections of the population would present their own sets of challenges. Access to justice in India remains a problem.[126] Additionally, the judicial system in India is understaffed and overburdened,[127] so tacking on the additional task of regulating health would not be ideal. Due to the judiciary being overburdened, legal aid as a whole receives far less attention than it should.[128] Legal aid would be absolutely imperative in the event the rural community needs to access the judicial system. Rural areas suffer from lack of access to the judicial system as it is,[129] so it would be not wise to adopt the Colombian system.

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[124] Jishnu Das, Aakash Mohpal, et al, 'Socioeconomic Status and Quality of Care in Rural India: New Evidence From Provider and Household Surveys' (2016) 35(10) Health Aff (Millwood) 1764–73.

[125] Manoj Mohanan, Katherine Hay and Nachiket Mor, 'Quality of Health Care in India: Challenges, Priorities, And The Road Ahead' (2016) 35(10) Health Affairs1753–1758.

[126] Indian Express, 'Access to Justice Still a Challenge for Millions: Justice Ramana' (23 March 2021) <https://indianexpress.com/article/india/access-to-justice-still-a-challenge-for-millions-justice-ramana-7240561/> accessed 21 December 2021.

[127] Sourya Banerjee, 'The Problem of Access to Justice in India' (30 May 2018) <http://www.onefuturecollective.org/the-problem-of-access-to-justice-in-india/> accessed 20 November 2020.

[128] Shruti Naik, 'Indian Judges are Overburdened, Looking After Legal Aid Shouldn't Be on their Plate Too' (The Print, 26 December 2020) <https://theprint.in/opinion/indian-judges-overburdened-looking-after-legal-aid-shouldnt-be-on-plate/573300/#:~:text=The%20Indian%20judiciary%20is%20handling%20more%20than%2030%20million%20pending%20cases.&text=An%20overburdened%20Indian%20judiciary%2C%20with,to%20massive%20delays%20in%20adjudication> accessed 20 December 2021.

[129] Gagan Sethi, 'Rural Experience: Fewer Legal Aid Clinics, Police Personnel' (Hindustan Times, 22 February 2021) <https://www.hindustantimes.com/india-news/rural-experience-fewer-legal-aid-clinics-police-personnel-101613956331610.html> accessed 20 December 2021.

The South African approach of scaling the judicial response according to the health situation would also not be ideal due to the reasons mentioned above. Moreover, India suffers from a huge disease burden,[130] hence, waiting for a more dire situation to arise cannot be the solution.

The Cuban approach of long-term health planning, increase of trained health personnel especially in the rural areas do provide starting points of how India can build its own system. The Cuban system would not exactly be applicable due to the scale of the population and the vast income disparity that exists in India. As mentioned above, India clearly suffers from a problem of retaining talent in the rural areas as well. Though providing a comprehensive scheme for India lies outside the scope of the paper, a possible approach for India could be to improve the quality of the existing informal healthcare sector in the rural areas. This can be done by providing them with better infrastructure and training, from the side of the government.[131] A problem based on this idea was launched in West Bengal in 2013, where experts provided training to informal-sector caregivers. The data from the program showed a significant increase in the quality of the care provided.[132]

## VII. Conclusion

The aim of this paper was to provide a varied perspective on healthcare. While the Cuban system undoubtedly appears to be the best, it is essential to keep in mind that Cuba is a socialist country, so a lot of their industries are nationalised. This made it easier for Cuba to enact such a comprehensive health plan which is focused on social goals. Many countries of this world, including India, have a capitalistic outlook. Additionally, the requirements of each country differ, so it is vital to adapt any system to the needs of a particular country. Even if India takes inspiration from these countries, it is important to focus on this adaptation. With regard to India, it is also doubtful whether a national policy is pragmatic, considering the vastly different conditions of the people from state to state. The Colombian example teaches us to take into account economic considerations, while the South African system teaches us the importance of flexibility in the policy. For India, the problem is that there is simply not enough political consciousness with regard to health. It does not hold significant sway in electoral considerations. Political consciousness in India is necessary for large-scale modifications to the system. The effects of a growing political consciousness can be observed in countries such as the United States, where healthcare became a major issue post-2016 after Presidential candidates such as Sen. Bernie Sanders brought

[130] Geetha R Menon, Lucky Singh, et al, 'National Burden Estimates of Healthy Life Lost in India, 2017: An Analysis Using Direct Mortality Data and Indirect Disability Data' (The Lancet Global Health, December 2019) <https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(19)30451-6/fulltext> accessed 21 December 2021.

[131] Sourya Banerjee (n 127).

[132] (n 125) at 1755.

it to the forefront. In this post-COVID era, healthcare is poised to take up a broader focus from governments across the world.