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BHARAT: THE WELLNESS VISHWAGURU OF THE WORLD - A COMPREHENSIVE ANALYSIS OF HEALTHCARE LAWS AND POLICIES IN INDIA

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Abstract

India's healthcare system must balance its goal of being a worldwide leader in medical tourism with the goal of achieving Universal Health Coverage (UHC). This is a challenging task. This paper examines how well India's legal frameworks from 2014 to 2024 ensure that all residents have fair access to healthcare and promote ethical conduct in the medical tourism industry. Using an exploratory and doctrinal method of research, the study examines pertinent policy papers, case laws, and legislation.

It looks at the legal underpinnings of UHC, including as the Indian Constitution's guarantee of the right to health. This analysis delves into key legislation enacted between 2014 and 2024 governing UHC schemes and medical tourism activities. Additionally, the research explores potential areas of overlap and conflict within these legal frameworks. The central hypothesis posits that gaps and inconsistencies within India's legal frameworks may hinder optimal healthcare access for citizens and ethical practices within medical tourism.

The goal of the study is to pinpoint these flaws and add to the current conversations on healthcare reform in India. In the end, the research aims to determine if India's legal system can successfully negotiate the difficulties of striking a balance between UHC and medical tourism, advancing the country toward its ambitions of being a leader in healthcare.

Introduction

In law, the term "health" is frequently used in conjunction with a characteristic such as "public health", "physical health", "mental health", "human health", or "animal health", which denotes the presence of "individual health". Thus, all these matters pertaining to health are covered under health legislations. There are other approaches to health besides the legal one, including health

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anthropology, health economics, health sociology, health philosophy, and health ethics.[1]

However, legal regulations offer a structure in this regard. They oversee health systems and function as a guide for health activity. For this reason, they are essential to any civilization. It, thus, becomes important for academicians as well as practitioners to evaluate the effectiveness of these legislations time to time.[2] "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This is the definition to health given in the preamble to the constitution of the "World Health Organization (WHO)" and forms the basis for the jurisprudence on "right to health" as a human right.[3]

The enumeration of "health as a human right" implied the necessity of establishing participation, "equality and non-discrimination", and legal accountability. Since social and ethical considerations are ingrained in the fundamental values of all "international human rights", the notion of a "right to health as a human right" places emphasis on these elements of health care and health status. When rights terminology is used to social purposes, it gives those objectives a unique significance.[4]

As Ronald Dworking puts it, if anything is categorized as a "right", it takes precedence over many "other claims" or commodities. Now that the legal basis for the right to health has been established, it is critical to comprehend how these principles are implemented in practical ways.

The Right to Health: A Global Priority

As of today, "each and every State" has accepted at least one international convention on "human rights" that upholds the "right to health".[5] Every right, in Salmond's view, has a duty that goes in tandem with it, and, must be accomplished. A right cannot exist without a corresponding obligation.[6] Likewise, the "right to health" has both "positive and negative" enforceable

[1] Anuska Kalita and others, 'The Barriers to Universal Health Coverage in India and the Strategies to Address Them: A Key Informant Study' 89 Annals of Global Health 69.
[2] Michel Bélanger, *Global Health Law: An Introduction* (Archives contemporaries 2011).
[3] Constitution of the World Health Organization 1946.
[4] Anne F Bayefsky, 'Office of the United Nations High Commissioner for Human Rights' in Anne Bayefsky (ed), *The UN Human Rights Treaty System in the 21 Century* (Brill | Nijhoff 2000) <https://brill.com/view/book/edcoll/9789004502758/B9789004502758_s044.xml> accessed 19 January 2024.
[5] 'The Right to Health as a Human Right', *Colloques/Workshop Series* (Brill 1979) <https://referenceworks.brillonline.com/entries/colloques-workshop-series/the-right-to-health-as-a-human-right-ej.9789028610286.14_500#> accessed 13 February 2024.
[6] 'Right to Justice & Its Interference with Rights and Duties' <https://articles.manupatra.com/article-details?id=undefined&ifile=undefined> accessed 6 February 2024.

components. These include the requirement that the state provide each person with equal access to health care and the primary duty to establish ideal circumstances that allow attainment of the right to health.[7]

A large chunk of the present literature on this subject cites "globalization of public health" as a major contributing element to the function of “international law” in “global public health”. The term "globalization of public health" describes how the globe is becoming more linked and how commerce and travel may quickly transmit illnesses across national boundaries. Because of this interdependence, certain nations may not have the infrastructure or resources necessary to adequately address threats to public health that come from other countries.[8]

Thus, the role of inter-governmental institutions such as World Health Organization became more significant in seeking global cooperation in recognizing “health as a Human Right”. However, it must also be noted that even after nearly six decades of adoption of one of the most important documents on the subject- ICESCR. States continue to be grappled with political, legal and institutional challenges that affect delivery of accessible and affordable healthcare. [9]

It is believed that this is caused, at least in part, by uncertainty over the “normative definition” of the "Right to Health" and discussion around the nature and extent of States' duties under "International Human Rights Law". One could also argue that the present global system of supervision over the "Right to Health", which is primarily focused on evaluating reports that States submit on a regular basis, is inadequate to “promote the effective implementation of this right”.[10]

This is partly because many States fail to comply with the reporting requirements, the bodies designated to monitor State compliance with international obligations are not adequately equipped, and methodological capabilities—possibly even expertise—are lacking. While many believe that States simply ratify human rights agreements in order to win over other States, not because they plan to carry out its provisions. Some contend that states ratify "human rights

[7] Allyn L Taylor, ‘Global Health Law: International Law and Public Health Policy’ [2017] International Encyclopedia of Public Health 268.

[8] Virginia A Leary, ‘The Right to Health in International Human Rights Law’ (1994) 1 Health and Human Rights 24.

[9] Aart Hendriks, ‘the Right to Health in National and International Jurisprudence’ (1998) 5 European Journal of Health Law 389.

[10] 677 Huntington Avenue Boston and Ma 02115, ‘Introduction’ (*Health and Human Rights Resource Guide*, 20 February 2014) <https://www.hhrguide.org/introduction/> accessed 1 February 2024.

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treaties" to bind themselves to their responsibilities as a safeguard against future violations, when they switch from authoritarian to democratic government.[11]

India's Contributions on the World Stage

At such instances of uncertainty, India consistently initiated efforts at international forum to advocate accessible and affordable healthcare. India successfully introduced and aided in the resolution on digital health's unanimous acceptance at the 71st "World Health Assembly" that was convened Geneva, Switzerland. Wherein, ministers and other government representatives from more than 35 nations pledged to expedite and carry out the necessary digital health initiatives to enhance population health at the national and local levels by 2023.[12]

The Delhi Declaration emphasizes that achieving sustainable development objectives and enhancing individuals' health and well-being depend on digital health. [13] The recently concluded G20 Summit also shed light on the current global needs safeguarding Right to health which includes implementing the One Health approach, strengthening primary healthcare and healthcare workforce. It also highlighted the need for conclusion of a “legally binding WHO convention”, “agreement or other international instruments” on “pandemic prevention, preparedness, and response”.

The New Delhi Leaders’ Declaration called for recognizing the “potential role” of “evidence-based Traditional and Complementary Medicine” in health and improving “access to mental health services and psychosocial support” in an “inclusive” manner.[14] India's population health indices itself have improved significantly: between 1992 and 2020, the country's new-born death rate dropped from 79 to 35 and its maternal mortality rate dropped from 437 to 97.[15]

Physical access to services has improved dramatically in the nation: 84% of children are completely vaccinated in "2020" compared to 35% in "1992", over 96% of individuals use

[11] United Nations, ‘Half a Century of a Right to Health?’ (*United Nations*) <https://www.un.org/en/chronicle/article/half-century-right-health> accessed 2 February 2024.

[12] ABP News Bureau, ‘India Will Become World Leader And Symbol Of Global Health Care In The Coming Years: Mansukh Mandaviya’ (26 August 2022) <https://news.abplive.com/business/india-will-become-world-leader-and-symbol-of-global-health-care-in-the-coming-years-mansukh-mandaviya-1550250> accessed 18 March 2024.

[13] ‘Global Health Leaders Adopt Delhi Declaration on Digital Health’ <https://www.who.int/southeastasia/news/detail/27-02-2019-global-health-leaders-adopt-delhi-declaration-on-digital-health> accessed 8 February 2024.

[14] ‘G20 New Delhi Leaders’ Declaration’ <https://www.mea.gov.in/bilateral-documents.htm?dtl/37084/G20_New_Delhi_Leaders_Declaration> accessed 8 February 2024.

[15] Anuska Kalita and others, ‘The Barriers to Universal Health Coverage in India and the Strategies to Address Them: A Key Informant Study’ 89 Annals of Global Health 69.

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healthcare when unwell, and the number of institutional births has increased by 63 percentage points between 1992 and 2020.[16]

Navigating Healthcare Access in India: Legal Landscape and Challenges

The "Indian Constitution's Preamble" seeks to ensure justice and equality for all of its citizens, which means that it upholds the Alma Ata Declaration's provisions of healthcare availability, accessibility, and affordability.[17] Article 21 has been construed to recognize the "right to health" as a fundamental right, under which the state is required to furnish its citizens with essential healthcare services.[18] The "provisions" pertaining to "health" are included under the "Directive Principle of State Policy" in Articles 39, 41, 42, and 47.

Article 47 accords on the state, the primary responsibility for "improving public health" and maintaining the "standard of life" and "nutrition of its citizens". [19] Hospitals and dispensaries, as well as public health and sanitation, are included in "Entry 6 of List II (State List)". The Indian Supreme Court plays a significant role in safeguarding the "general public's health". The "Apex Court" has stated time and again that the term "life" in "Article 21" refers to a "human life", not only an "animal's survival".[20]

At the same time, the legal framework in India suffers from many predicaments. One of the major challenges being- fragmented legal framework and out-dated laws. India's current healthcare system is extremely regimented and functions in silos having different organizations in charge of providing "primary, secondary, and tertiary healthcare". For instance, early detection is the responsibility of the "Integrated Disease Surveillance Programme (IDSP)" units in India's medical framework.[21]

In order to prevent and limit disease outbreaks, the "medical officer" stationed in the "primary

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[16] Ibid.

[17] *Consumer Education and Research center and Ors vs. Union of India (UOI) and Ors* [1995] 3 SCC 42 (Supreme Court of India).

[18] JSA, 'Right to Health as a Fundamental Right Guaranteed by the Constitution of India' (*JSA*, 22 March 2020) <https://www.jsalaw.com/covid-19/right-to-health-as-a-fundamental-right-guaranteed-by-the-constitution-of-india/> accessed 13 February 2024.

[19] Saroj Kant Choudhary, 'Judicial Approach in Realising Health Rights: Indian Perspective' [2014] SSRN Electronic Journal <http://www.ssrn.com/abstract=2467601> accessed 6 February 2024.

[20] *Francis Coralie Mullin vs. The Administrator, Union Territory Of Delhi & Ors* [1981] AIR 746 (Supreme Court of India).

[21] Global Legal Group, 'International Comparative Legal Guides' (*International Comparative Legal Guides International Business Reports*) <https://iclg.com/practice-areas/digital-health-laws-and-regulations> accessed 7 March 2024.

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health center", "community health workers, and field workers" collaborate closely with the "District Chief Medical Officer" and the assigned "District Level Teams".[22] Thus, barriers like inter-sectoral convergence, governance concerns, public-private partnerships, and guaranteeing additional outlays during the mission time continue to grapple implementation strategies.[23] Despite achieving the doctor-to-population ratio of 1:1000 as recommended by the "WHO" in 2018, India's distribution of health personnel remains unequal between rural and urban areas.[24] As opposed to industrialized countries, health insurance has become a less well-established funding alternative in India for dealing with out-of-pocket issues.[25]

Nonetheless, just 37% of Indians as a whole have health insurance. India's public health spending, including that of both the "central and state governments", was kept steady between 2008 and 2015 at around 1.3% of GDP, and then rose slightly to 1.4% in 2016–17. By 2025, the NHP-2017 suggested raising this percentage to 2.5%.

The state of Rajasthan in western India became the "first" in the nation to enact a legislation guaranteeing its citizens' access to health care on March 21, 2023.[26] Ensuring access to healthcare may appear like a "relatively uncontroversial" move for civil society, but private hospitals and physicians in Rajasthan swiftly and vehemently opposed the bill, calling it "draconian." They said that there was a lack of clarity on the definition of a medical emergency, and that this "ambiguity" would open the door to a deluge of claims that would overburden the already overwhelmed health care system.[27]

In public health facilities, the "Healthcare Act" outlines a number of patient rights, including the access to free consultations, medications, tests, and emergency care. Significantly, the law formalizes the obligation of private health providers to offer emergency care without discrimination. Although it hasn't always been followed or enforced, this stance is in accordance with the requirements that the Supreme Court ruled to be in place back in the 1980s.[28]

[22] Manish Tewari, 'India's Fight Against Health Emergencies: In Search of a Legal Architecture' [2020] Observer Research Foundation.
[23] Deoki Nandan, 'National Rural Health Mission: Turning into Reality' (2010) 35 Indian Journal of Community Medicine : Official Publication of Indian Association of Preventive & Social Medicine 453.
[24] Canna Ghia and Gautam Rambhad, 'Implementation of Equity and Access in Indian Healthcare: Current Scenario and Way Forward' 11 Journal of Market Access & Health Policy 2194507.
[25] Ibid.
[26] 'Crisis and Contestation over India's First Health Care Rights Law' (3 August 2023) <https://www.thebody.com/article/crisis-contestation-india-first-health-care-rights-law> accessed 22 March 2024.
[27] Ibid.
[28] Ibid.

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In India, the health sector might be owned by the government, the private sector, or individuals. Healthcare providers in the private sector are either individually or collectively owned and operated, and they are registered under the "CEA". These include clinics, hospitals, nursing homes, and dispensaries that may use Unani, Homeopathic, Ayurvedic, or Allopathic medicinal systems. In contrast the "MoHFW" oversees the public sector. They also include pharmacies, clinics, assisted living facilities, and hospitals that use different medical systems.[29]

The next section examines these issues and suggests some possible fixes to guarantee that everyone has access to reasonably priced healthcare.

The Road to Universal Health Coverage: A Review of India's Initiatives

India has introduced major initiatives like “Ayushman Bharat”. The “National Health Protection Scheme”, or “Ayushman Bharat”, provides coverage for "secondary" and "tertiary care" hospitalization up to “5 lakh rupees” per household annually for about 10 crore “poor and vulnerable families” (around “50 crore” beneficiaries). "Rashtriya Swasthya Bima Yojana (RSBY)" and the "Senior Citizen Health Insurance Scheme (SCHIS)", two preceding centrally funded programs, were merged into “Ayushman Bharat”, the “National Health Protection Mission”. [30]

A beneficiary covered by the program may collect "cashless benefits" from any “public or private” hospital in the nation. The benefits are transferable throughout the nation. The “National Health Protection Mission”, or “Ayushman Bharat”, is an “entitlement-based” program whose eligibility is determined by the “SECC” database's deprivation criteria. Benefits are available to the recipients in both empanelled private and public institutions. The Mission, places a strong emphasis on cooperative federalism and state autonomy.[31]

It establishes the "Ayushman Bharat National Health Protection Mission Council (AB-NHPMC)" at the highest level, with the “Union Health and Family Welfare Minister” serving as its chair, to provide “policy direction” and promote “cooperation” between the Center and States.

[29] Aakriti Grover and RB Singh, ‘Health Policy, Programmes and Initiatives’ [2019] Urban Health and Wellbeing 251.
[30] ‘Ayushman Bharat - National Health Protection Mission| National Portal of India’ <https://www.india.gov.in/spotlight/ayushman-bharat-national-health-protection-mission> accessed 8 March 2024.
[31] Ibid.

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The goal of attaining the best possible degree of health without experiencing financial hardship is outlined in the "National Health Policy" of 2017. Comprehensive primary care is now more widely available thanks to the more than 1.33 lakh "Ayushman Bharat - Health and Wellness Centres (AB-HWCs)" that serves as “teleconsultation hubs”. [32]

With e-Sanjeevani, telemedicine has become more popular and saves a large amount of money and kilometres every health visit. India's dedication to preventative and high-quality healthcare is further evidenced by the government's focus on "universal screening" of prevalent non-communicable illnesses and the effort for improving the quality of labour rooms. [33]

The second part is the “Pradhan Mantri Jan Arogya Yojana (PM-JAY)”, which covers over 10 crore poor and vulnerable households for secondary and tertiary treatment with an annual health insurance benefit of Rs. 5 lakhs. Beyond providing care for mothers and children, Ayushman Arogya Mandirs are intended to offer a wider range of services, such as treatment for “non-communicable diseases, palliative and rehabilitative care, oral, eye, and ENT care, mental health, and first-rate care for emergencies and trauma”.

These services will also include free necessary medications and diagnostic services. The services' growth has been planned step-by-step. At Ayushman Arogya Mandir, screening, prevention, control, and management of "non-communicable" illnesses as well as “chronic communicable diseases” including leprosy and tuberculosis have been implemented as a first step.[34] The “National Health Policy, 2017” highlights how the context of health sector has evolved in four major ways: First, priorities in health are shifting.

Despite the sharp drop in infant and maternal mortality, the burden of “non-communicable diseases” and some "infectious diseases" is increasing. The development of a strong health care sector, which is predicted to grow at a “double-digit rate”, is the second significant shift. The third shift is an increase in the frequency of “catastrophic expenses” brought on by health care expenditures, which are currently thought to be one of the “main causes” of poverty. [35] Fourth, increased “fiscal capacity” is made possible by growing “economic growth”.

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[32] ‘High Level Expert Group : National Health Mission’ <https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1244&lid=270> accessed 8 March 2024.

[33] ‘India’s Strides toward Universal Health Coverage | DD News’ <https://ddnews.gov.in/health/indias-strides-toward-universal-health-coverage> accessed 8 March 2024.

[34] ‘Ayushman Arogya Mandir’ (*Ministry of Health and Family Welfare*) <https://ab-hwc.nhp.gov.in/> accessed 8 March 2024.

[35] ‘National Health Policy, 2017’ (Ministry of Health and Family Welfare) <https://main.mohfw.gov.in/sites/default/files/9147562941489753121.pdf> Accessed: 08 March 2024.

In order to maximize health results, the strategy outlines the establishment of inter-sectoral coordination at the "national and sub-national levels" through the creation of organizations with representation from pertinent “non-health ministries”. This is consistent with the newly developed global "Health in All" strategy, which is meant to supplement Health for All.[36]

Urgent and significant reforms are required for the “Ministry of Health and Family Welfare's” regulatory role, which covers the regulation of “clinical establishments, professional and technical education, food safety, medical technologies, medical products, clinical trials, research”, and the application of other laws pertaining to health.

The "Missing Middle" Challenges of Health Insurance Coverage

Launched in September 2018, the “Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)” together with “State Government” extension plans provide hospitalization coverage to about 70 crore people, who make up the lowest 50% of the population. About 25 crore people, or 20% of the population, are covered by private voluntary “health insurance” and “social health insurance”. Thirty per cent of people still do not have health insurance.[37]

Due to overlap across plans and current coverage gaps in “PMJAY”, the real number of uninsured people is larger. We refer to this undiscovered group as the "missing middle".[38] The missing middle is not a single group; rather, it is made up of several groups from each quintile of spending. Although they are concentrated in the "top two quintiles" of rural regions and the “top three quintiles” of urban areas, the “missing middle” is dispersed among all spending quintiles in both urban and rural locations.

The “self-employed” (agricultural and non-agricultural) “informal sector” in rural regions and a wide range of jobs (formal, semi-formal, and informal) in urban areas make up the “missing middle”. Even with the ability to pay nominal charges, the missing middle remains uninsured in the absence of a "low-cost health insurance" product.

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[36] Rajiv Kumar Gupta and Rashmi Kumari, ‘National Health Policy 2017: An Overview’.
[37] S Manju Priya, ‘A Critical Analysis of National Health Policy 2017 with Specific Reference to Ayushman Bharat Pradhan Mantri Yojana and the Path to Universal Health Coverage’ [2023] International Journal of Law and Social Sciences 79.
[38] Rakesh Sarwal and Anurag Kumar, ‘Health Insurance for India’s Missing Middle’ (Open Science Framework 2021) preprint <https://osf.io/s2x8r> accessed 8 March 2024.

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Weaknesses in the Healthcare System's Infrastructure and Regulation

The CAG Report further pointed to various fallacies in implementation of the scheme. The online beneficiary registration system's "match confidence score", which is produced by comparing a beneficiary's documents with the SECC list of eligible beneficiaries, is no longer useful because registration requests were accepted or denied regardless of the match confidence score.[39] Errors were found in the beneficiary database due to insufficient validation procedures.

These included incorrect names, erroneous dates of birth, duplicate "PMJAY" IDs, and erroneous household sizes. Additionally, NHA failed to furnish any information or documentation about a thorough IEC strategy or the state of its execution at the Central level. Without which, the audit was unable to confirm if IEC operations were conducted centrally. Additionally, it lacked information on the central monitoring process for IEC activities throughout all Indian states, therefore the audit was unable to confirm if NHA had kept an eye on the IEC activities.[40]

The union government has a limited mandate to offer health care to the states under the present constitutional requirements. The "National Health Mission (NHM)", formerly known as the "National Rural Health Mission", has done a great job of supporting state governments financially and developing infrastructure. But as it lacks a constitutional mandate, NHM can only provide states with limited financial and logistical support rather than taking on the role of an implementation authority like to the "National Health System (NHS)" of the "United Kingdom".[41]

In cooperation with the state governments, the NHM must be given the constitutional status of guardian of the health care of the people of India.[42] In India's past, traditional knowledge systems have been crucial to public health because of their focus on preventative care and overall well-being. According to the "World Intellectual Property Office (WIPO)", "Traditional Knowledge" encompasses knowledge related to "agricultural, medicinal, and biodiversity-related fields", as

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[39] James Blanchard and others, *Vision 2035 Public Health Surveillance in India - A White Paper* ([NITI Aayog] 2021) <https://figshare.com/articles/book/Vision_2035_Public_Health_Surveillance_in_India_-_A_White_Paper/14093323> accessed 8 March 2024.

[40] 'Audit Reports | Comptroller and Auditor General of India' <https://cag.gov.in/en/audit-report/details/119060> accessed 8 March 2024.

[41] Jaison Joseph, Hari Sankar D and Devaki Nambiar, 'Empanelment of Health Care Facilities under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) in India' (2021) 16 PLOS ONE e0251814.

[42] Raman Kumar and Pritam Roy, 'India in Search of Right Universal Health Coverage (UHC) Model: The Risks of Implementing UHC in the Absence of Political Demand by the Citizen' (2016) 5 Journal of Family Medicine and Primary Care 515.

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well as folklore expressed through “music, dance, song, handicrafts, designs, stories, and artwork”.

It’s possible that the steps leading to the development of TK were not properly recorded in the same manner as a lot of scientific and technological data.[43] Concern over the acceptance of "traditional knowledge" as previous art has been voiced in recent years.

The Growing Appeal of Traditional Medicine

The responsibilities and contributions of indigenous knowledge sources, such as "traditional and complementary medicine systems", are receiving increased attention in the effort to develop stronger and more resilient global health systems. The WHO estimates that traditional medicine is practiced in 88% of all nations and those natural materials represent the basis for 40% of currently available pharmaceutical formulations.[44] In terms of health, this idea of "population self-reliance" is known as the fourth-tier.

All six of the “AYUSH systems” are recognized by the Indian government, and their knowledge and application are deeply embedded in society to the point that some of the interventions from the “antiquated medical systems” are essential to customs of “home care”. For instance, many households routinely massage their new-borns with oil, as recommended by the Traditional Medicine systems, despite current medical recommendations.[45]

Nonetheless, the design for UHC must take into account the various demands of the surrounding communities, which are segregated by gender, caste, and class and have uneven access to resources. Acknowledging this will guarantee that local resources are used effectively and the medical systems are suitably integrated into UHC planning.[46] As the potential of traditional medicine (TM) in healthcare systems becomes more widely acknowledged, there has been a push to create a strong legal framework for TM regulation and integration.

India is actively attempting to create a legislative framework that promotes innovation,

[43] ‘Traditional Knowledge- the Changing Scenario in India’, *Safeguarding Traditional Knowledge in India* (2008) <https://highcourtchd.gov.in/sub_pages/top_menu/about/events_files/apjaspeech.pdf> accessed 9 March 2024.
[44] SK Tripathi, ‘Traditional Knowledge: Its Significance and Implications’ (2003) 2 Indian Journal of Traditional Knowledge 99.
[45] Kaushik Chattopadhyay, ‘The Position of Drugs Used in Traditional Medicine within the Indian Healthcare System’ (2008) 6 Zeszyty Naukowe Ochrony Zdrowia, Zdrowie Publiczne i Zarządzanie 59.
[46] Sarika Chaturvedi and others, ‘India and Its Pluralistic Health System – a New Philosophy for Universal Health Coverage’ (2022) 10 The Lancet Regional Health - Southeast Asia 100136.

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safeguards traditional knowledge, and guarantees the efficacy and safety of TM practices. The medical tourism sector in India will be significantly impacted by this increased understanding of TM's potential.[47] For medical travellers looking for alternatives to traditional medicine, India's traditional medicine (TM) systems provide a distinctive and varied selection of treatment choices.

Unveiling India's Potential: A Look at the Future of Medical Tourism

India is a popular destination for patients seeking innovative and life-saving treatment, alternative medicine, cosmetic surgery, and wellness tourism. Furthermore, India has to become a major player in offering the traditional medical system's treatment.[48] However, the COVID-19 epidemic has damaged India's reputation owing to the health system's subpar performance, which might affect medical tourism's ability to compete internationally.

The bulk of medical tourists visiting India come mostly from the Middle East (35%) and Africa (51%). Orthopaedic operations (15%) and cardiac therapies (30%) are the most sought procedures. Reduced treatment wait times, home country connection, and high-quality clinical resources—including physicians, protocols, and infrastructure—all contribute to competitive advantage. [49] India's advantages as a location for medical value travel are Top-notch medical and diagnostic tools, excellent medical education, affordable, high-quality medical treatments and services, and no waiting.[50]

How to standardize the services is one of the largest issues facing the wellness sector. What kind of minimal level of service should foreign visitors to India reasonably expect? As of right now, the Indian government has started the accreditation procedure. Currently, the AYUSH ministry

[47] Shambhavi Shivani, Aparna Aparna and Srijan Mishra, 'Traditional Knowledge: Much More than What Meets the Eyes' (2022) 6 International journal of health sciences 1570.
[48] www.ETHealthworld.com, 'India Is Going to Play a Vital Role in Treating Lifestyle Disorders through Integrated Wellness: Dr Narendra Shetty, Kshemavana - ET HealthWorld' (*ETHealthworld.com*) <https://health.economictimes.indiatimes.com/news/industry/india-is-going-to-play-a-vital-role-in-treating-lifestyle-disorders-through-integrated-wellness-dr-narendra-shetty-kshemavana/105761524> accessed 20 March 2024.
[49] Manjula Chaudhary, Monica Prakash and Nanita Tyagi, 'A Study of Problems and Challenges Faced by Medical Tourists Visiting India' (Indian Institute of Tourism and Travel Management 2011) Study <https://tourism.gov.in/sites/default/files/2020-04/Med.pdf> accessed 08 March 2024.
[50] 'National Strategy and Roadmap for Medical and Wellness Tourism.Pdf' <https://tourism.gov.in/sites/default/files/2022-05/National%20Strategy%20and%20Roadmap%20for%20Medical%20and%20Wellness%20Tourism.pdf> accessed 01 March 2024.

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oversees it, but a shift is underway to shift "wellness" from "AYUSH" to the tourism sector. Additionally, there are no consistent regulations governing the use of medical devices and treatments by healthcare practitioners.

The most notable instances of inconsistent regulation are those pertaining to surrogacy. Every nation has a different set of laws according to its own culture, customs, and religious beliefs. India's tourist sector has enormous potential, but there are obstacles that must be overcome.

Conclusion

India's healthcare system is at a turning point. Even if there is a ton of promise, there has to be a clear plan in place to navigate the route towards a better future. The HWCs offer a chance to monitor problems linked to occupational health, non-communicable diseases, infectious diseases, and injury-associated disorders at the individual, family, and primary care levels. Following the passage of the "Clinical Establishments Act (Registration and Regulation)", 2010, several states are now able to establish directories of “clinical establishments” and use the data to improve and expand the notification of births, deaths, and diseases, particularly in the private sector. [51]

Likewise, the implementation of the "Health Management Information System" across the country can facilitate the timely and appropriate deployment of “human resources”, particularly for specialized services like pathologists and microbiologists at the block/district level. As the government embarks on the path of universal health care (UHC), India requires a national healthcare authority. In order to mainstream AYUSH as integrated healthcare, the “National Health Policy 2017” places a strong emphasis on "One Nation, One Health System" by creating guidelines.

Policymakers in India must deliberately choose the market sector to focus on and then market the nation as a destination for medical tourism.[52] The magnificent symphony of India's healthcare environment is periodically broken up by dissonant notes of struggle. India can turn this into a symphony of advancement that will benefit both its own people and medical tourists by taking a "strategic approach, embracing technology and integration", and cultivating an excellence culture

[51] Rajesh Kamath and Helmut Brand, ‘A Critical Analysis of the World’s Largest Publicly Funded Health Insurance Program: India’s Ayushman Bharat’ (2023) 14 International Journal of Preventive Medicine 20.
[52] Varun Sheth, ‘5 Reasons India’s “Missing Middle” Is Struggling to Access Quality Healthcare’ *The Times of India* https://timesofindia.indiatimes.com/blogs/voices/5 reasons-indias-missing-middle-is-struggling-to-access-quality healthcare/?source=app&frmapp=yes accessed 12 March 2024.

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in the public healthcare system.

This dedication to cooperation and innovation will guarantee that India leads the world in healthcare for many years to come.