ALL INDIA LAWYERS UNION (DELHI UNIT)
Petitioner

v.

GOVT. OF NCT OF DELHI & OTHERS
Respondents

Delhi High Court

+ WP(C) No.5410/1997

22nd September, 2009

CORAM:

HON'BLE THE CHIEF JUSTICE
HON'BLE MR.JUSTICE MANMOHAN

Ajit Prakash Shah, Chief Justice (Oral)

1. The present public interest litigation has been filed by All India Lawyers' Union seeking directions for ensuring free medical treatment in terms of the lease agreement dated 16 th March, 1994 entered into between the Govt. of National Capital Territory of Delhi (hereinafter referred to as the GNCTD) and respondent No.2, i.e. Indraprastha Medical Corporation Ltd./ Indraprastha Apollo Hospital (hereinafter referred to as the IMCL) to establish a multi-disciplinary super specialty hospital. The petition is, inter alia, directed against the inaction of the GNCTD and IMCL to provide free treatment and medicines to the poor and needy citizens at the respondent No.2 hospital. It is contended inter alia that such inaction of both the respondents is adversely affecting the mandates of Articles 21, 39(e), 41, and 47 of Constitution of India. In course of proceedings, the Union of India and the Delhi Development Authority were also impleaded as party respondents. Before appreciating the issues under consideration in the present petition, a brief historical background is essential.

THE BACKGROUND FACTS

2. In 1986, the Delhi Administration (now the Government of NCT of Delhi), in order to utilize the then incomplete Players' Building near IP Stadium, lying vacant with its Medical Department, initiated the decision to open a multi-disciplinary super specialty hospital on 'no profit no loss' basis, after inviting offers from private institutions. A notice was issued in this regard which has been placed on record and accordingly, building along with the land was to be made available free of cost provided the hospital is, on the whole, run on a 'no profit no loss' basis providing free medical and other facilities to at least 1/3 rd of its indoor patients and 40% of its outdoor patients without any discrimination. The hospital was also required to participate in National Health programmes and Delhi Administration was to have due representation in the Management Committee of the upcoming hospital.

3. Pursuant to this notice, in all 25 offers were received and a High Powered Committee, under the Chairmanship of the Lt. Governor and other senior officers of the Central Government and the GNCTD as its members, short-listed four names suitable for the proposed hospital. The Laxmipat Singhania Medical Foundation in association and collaboration with Apollo Hospital Group was one of the offerers. The foundation was agreeable to run the hospital on 'no profit no loss' basis and to provide free medical and other facilities to 1/3 of indoor patients and 40% of outdoor patients in terms of notice issued by Delhi Administration.

4. Dr. Pratap C. Reddy, Chairman, Apollo Hospital also submitted a separate proposal, where he had given his own terms and conditions stating that the hospital, when completed, should treat nearly 10000 in-patients and over 30000 out-patients every year. As a commitment to serve various cross-sections of people, the hospital would offer: (a) 10% of the facilities, free of cost, (b) 10% of the facilities where patients pay only for the medicines and disposables and (c) 10% of the facilities at subsidized rates. Subsequently, after due deliberations, the aforesaid high power committee considered all the short listed cases and finally it was decided that Apollo Hospital Enterprises Ltd. will be the principal partner with the GNCTD on the same terms as offered by the Singhania Foundation in collaboration with Apollo Hospital. Thereafter, the President of India through Lt. Governor of Delhi entered into a Joint Venture Agreement dated 11th March, 1988 with Apollo Hospital Enterprises Ltd., specifically mentioning that the Administrator has decided to establish a project regarding multi-disciplinary specialty hospital in the building next to Indira Gandhi Indoor Stadium. The Administrator and Apollo Hospital also agreed to jointly promote and get registered public limited company under the name of IMCL as envisaged in the agreement, wherein 26% of the equity share capital of the proposed company was that of the Administrator. In the agreement it was clearly stipulated that the proposed company shall provide to Administrator the free facilities of medical diagnostic and other necessary care to not less than 1/3rd of the total capacity of 600 beds in the multi specialty hospital. It further provided that the hospital will also provide free of cost full medical diagnostic and other necessary facilities to 40% of the patients attending OPD of the hospital. The relevant clauses of the Joint Venture Agreement are as follows:

23. The proposed company shall soon after its registration as a public company enter into the lease/licence agreement with the Administrator in the form approved by him, for occupying the building situated next to Indira Gandhi Indoor Stadium which is in possession of Medical Department of the Delhi Administration. The proposed company shall provide to the administrator the free facilities of medical, diagnostic and other necessary care through not less than one-third of the total capacity of 600 beds in the multi-specialty hospital as contemplated in this agreement or any part thereof which may be commissioned for the time. The hospital will also provide free of cost full medical, diagnostic and other necessary facilities to 40% of patient attending the out-patient department of the hospital. The terms and conditions for admission to the one third free beds as aforesaid (which may be located in the general wards) shall be clearly laid down in the lease/licence agreement to be entered into between the proposed company and the Administrator.

24. The multi-specialty hospital to be established as contemplated in this Agreement shall be named 'Indraprastha Apollo Hospital' or such other name as may be agreed upon between the parties thereto.

25. The balance two third of the total capacity of 600 beds in the multi-specialty hospital shall be run on a commercial basis. The matter relating to the day-to-day management of these beds including the matters relating to admission and treatment on these beds shall be vested in the Managing Director of the (WP(C) 5410-1997) Page 5 of 70 proposed company subject to the superintendence direction and control of the Board of Directors. Neither the Administrator nor the Apollo shall at any time influence or attempt the hospital authorities (including the Board of Directors of the proposed company) in the matter relating to admission of patients to the commercial beds (being two third of the total capacity or the capacity which may be commissioned for the time) or any remission or concession on these commercial beds. Provided, however, that the Administrator shall have an option to utilise on principal to principal basis any commercial beds in the hospital on payment of usual fees and charges for the treatment of patients which the Administrator may recommend and the proposed company shall provide on a preferential basis, admission, treatment and care to the patients so recommended. (emphasis supplied)

5. These terms were in conformity with the notice inviting tender where it was specifically mentioned that the hospital has to run on 'no profit no loss' basis and 1/3rd of the hospital services will be provided free of cost which includes full medical diagnostic and other necessary facilities and 40% to the OPD patients. Pursuant to the offer and as per the agreement between the GNCTD and the company, lease deed qua the hospital building was executed between the President of India through Lt. Governor and IMCL at a nominal rate of Re.1 per month. The granted lease deed dated 21.04.1988 included the term stipulating that the lessee shall provide the diet, medical (WP(C) 5410-1997) Page 6 of 70 diagnostic and such other facilities to the agreed proportion of indoor and out door patients.

6. However, subsequently the Players' Building (where the establishment of hospital was initially planned) could not be used as the land was requisitioned by Sports Authority of India (SAI). Thus, a fresh agreement was entered into being the lease deed dated 16.03.1994 and an alternative area of 15 acres of land on Delhi-Mathura road, Jasola Village, Delhi (where the hospital at present located and functional) was leased out at a nominal rate of Re. 1 per month to the IMCL. The fresh lease deed amongst other terms and conditions, provided that a sum of Rs.14.83 crores out of Rs.15.478 crores received from SAI by way of compensation would be deposited in an interest bearing account in a Nationalized bank for the construction of the hospital building at a new site. Apart from Rs.14.83 crores plus interest, a further sum of Rs. 23.83 crores was paid by way of equity capital by the GNCTD to the joint venture. Thus, a total sum of Rs.38.66 crores (plus interest on Rs.14.83 crores) along with 15 acres of prime land on Delhi-Mathura road was leased out at the rate of Rupee 1 per month to the joint venture, IMCL. Like the earlier lease deed, the fresh lease deed contained provisions for providing free diet, medical diagnostic and such other facilities.

7. The Indraprastha Apollo Hospital was partially commissioned in July 1996. The GNCTD, right from the inception, was requesting IMCL to formulate suitable scheme for providing free treatment to indoor and outdoor patients as set out in the agreement and lease deed. Even in the Board of Directors' meeting held on 24th January, 1997 the then Chairman mentioned that the hospital should consider commencing free patient facility and a Committee of Directors was also constituted to consider the issue. The management of company took stand raising two issues that Clause 23 of the Joint Venture Agreement and Clauses 6(1) and 6(2) of the lease deed did not place any obligation upon the company to provide free medical or free consumables. Next, they wanted the definition of poor patients with guidelines on the nature of authorization for such patient referral and monitoring of admission. In the Board

Meetings held on 31st March, 1997 and 28th June, 1997, the government reiterated that free beds would include consultation, bed, diet, investigation, nursing, medicines and consumables. In the Board Meeting dated 20.8.1997 the government director moved a fresh resolution that all victims of the road accidents brought to Indraprastha Apollo Hospital be provided free treatment at the cost of the hospital. However, no decision could be arrived at and consideration of the same was deferred. Thus, the issue of free treatment mostly remained on paper and nothing conclusive and effective came to the help of the needy citizens. In this background, All India Lawyers' Union (Delhi) filed this petition on 10th December, 1997 impleading the GNCTD through its Chief Secretary and management of IMCL through its Chairman as respondent parties.

RESPONSE OF IMCL

8. The company in its affidavit of 21st January, 1998 filed as reply of respondent No.2 in the above case have submitted before the Court their response to the above which is essentially the stand of the other promoter. The respondent No.2 in its affidavit dated 21st January, 1998 filed with the 'limited object of opposing the admission of the writ petition' attempted to trivialize the issues by submitting that the matter involved questions of interpretation of an agreement and contractual obligations arising therefrom which could not be made subject matter of a writ petition. It described IMCL as a commercial venture jointly undertaken inter alia by the GNCTD, Apollo Group of Hospital and Schroder Capital Partners (Asia) Ltd., through another company providing Foreign Direct Investment (FDI), for establishing a modern multi-speciality hospital. It contended that the hospital was meant to be a 'self-generating project' wherein cost of free services, if any to be rendered to the poor and needy, would have to be generated from the revenue earned commercially, keeping a balance between the two activities, to be viable. While submitting that the hospital could not be equated with facilities run by the government with the help of grants to provide free medical aid, IMCL pleaded that its obligations were well defined and clearly set out in the two basic documents namely, the Joint Venture Agreement dated 11th March, 1988 and the lease deed dated 16 th March, 1994 executed by the Lt. Governor of GNCTD, neither of which required it to provide free medicines or consumables.

9. In above context it referred to Clause 7 of the Joint Venture Agreement which reads as under:

'Neither party shall transfer to sell his or its respective equity participation as aforesaid or any part thereof until the proposed company

has fully commissioned the multi-speciality hospital as contemplated in this Agreement. For the purpose of this Agreement, the full commissioning of the hospital shall mean that the hospital has attained an average bed occupancy ratio of ....% of the total capacity of 600 beds for a continuous period of not less than six months.' (emphasis supplied)

10. IMCL further placed reliance on Clauses 6(1), 6(2) and 6(3) of the lease deed to claim that its liability to provide free treatment facility would not arise till the hospital had been fully commissioned which event, in its submission, was yet to occur.

The clauses read as under:

‘6(i)That after the hospital is fully commissioned the lessee shall admit free of charge such patients as may be recommended by the Lt. Governor of the National Capital Territory of Delhi or any officer duly authorised by him in writing in this behalf upto 1/3rd (one third) of the bed strength consisting of 600 beds or such number of beds as near thereto as may be commissioned for the time being earmarked for such purpose by the Lessee subject to such emergent and contingent cases as may be required for direct and immediate admission of the patients taking advantage of the Hospital. Such emergent and contingent cases shall not exceed five in number at any given time and ex post-facto approval of the Lt. Governor of the National Capital Territory of Delhi or any officer duly authorised by him in writing shall in every case be obtained by the Lessee. The Lessee shall provide free diet, medical diagnostic and such other facilities to the patients aforesaid as are required by the patients for indoor treatment.

(2) That the Lessee shall also provide free medical diagnostic and other facilities for not less than 40% (Forty percent) of its out-door patients. Separate records shall be maintained by the Lease for the purposes aforesaid and such records shall be open to inspection by the Lessor or any representative authorized by him for the purpose.

(3) For the purposes of this Deed the full commissioning of the hospital shall mean that the hospital has attained an average bed occupancy ratio of 65% of the total capacity of 600 beds for a continuous period of not less than six months.’ (emphasis supplied)

11. Disowning any responsibility to provide free medical aid to poor and needy, IMCL set out in affidavit dated 21 st January, 1998, the following defences:-

1. The hospital was yet not ‘fully commissioned’, inasmuch as only 350 beds had become operational wherein average daily occupancy for the preceding six months was only 262.

2. The expression ‘medical and diagnostic facilities’ as used in the lease deed does not include the cost of medicines and medical consumables, inasmuch as the qualifying word ‘free’ had been consciously omitted from the stipulations in this context.

3. Unlike government hospitals and charitable institutions, IMCL, a public limited company, was answerable to the investors and the financial institutions supporting the venture through loans, the agreements in which regard carried no such obligations. Instead IMCL, providing medicare services through huge investments for establishing proper infrastructure, was required to ensure profitable and efficient working of the corporate hospitals run by it.

4. Though GNCTD is a major shareholder of IMCL, it can neither claim nor is entitled to any special rights over and above those of other shareholders of the company.

12. While seeking strict construction of the terms of the lease agreement and the Joint Venture Agreement so as to support its claim of not being obliged to provide free medicare till the hospital is fully commissioned, IMCL attempted to shift the blame for the ‘stalemate’ by attributing it to ‘unreasonable attitude’ on the part of the GNCTD. It submitted that as a ‘humanitarian gesture’, it had offered to commence free treatment facility for poor patients sponsored by the latter ‘on a pro rata basis’, but the same had not worked out for the following reasons, all attributable to the GNCTD:-

1. The ‘guidelines’ on the subject had not been finalised.

2. Procedure for payment for medicines and medical consumables to the hospital had not been set out.

3. The category ‘poor and deserving’ had not been defined.

4. The procedure for administering admission etc., had not been laid out.

13. In his affidavit dated 11th February, 1998, the Vice Chairman of IMCL submitted that Indian Hospital Corporation Limited (part of Apollo Group) had entered into a management agreement with IMCL to provide managerial services at nominal annual management fee of Re.1, forgoing the management fee ordinarily charged (Rs.2 to 5 crores) only to support it in its commitment to perform social obligations.

14. In the additional affidavit of 18th February, 1998, Mr. V.J. Chacko, Managing Director of R-2, inter alia, referred to the change in site of the hospital to mention that the cost overruns to the extent of 1.91 times had accrued essentially on account of the need to raise a superstructure instead of completing a semi-finished building which was offered initially. He reiterated the argument of the hospital still not being ‘fully commissioned’, also mentioning in this context the loss of Rs.3.87 crores incurred for the period ending 31st March, 1997. He set out at length various steps taken for rendering free treatment facilities. He stated that the company had constructed ‘a separate block’ measuring 8334.28 sq.mtrs. to accommodate 200 beds (including ICU beds) and a special operation theatre besides provision of five consultant rooms with at least ten consultants to attend OPD on all working days covering at least 21 clinical specialities with routine radiological, pathological investigative facilities, with arrangement for complicated surgeries in the main hospital. He also referred to arrangements negotiated with eminent consultants to provide free professional consultancy services and decisions taken not to charge for registration and admission, bed, treatment, surgeries and investigations (excluding medicines and medical consumables), nursing, food, housekeeping services, maintenance and preservation of records etc. While insisting that ‘medicines’ and ‘medical consumables’ cannot be covered under the freeship, he described these expressions as follows:-

‘Medicines:

Medicines include all items of medicines, drugs and pharmaceutical items including oral drugs, intravenous and intramuscular injectibles, intravenous fluids, vaccines for immunisation, dye and other contrast media, all dermatalogicals preparations for external use, ENT drops, disposables and such other items.

Medical consumables:

Materials include all consumables and disposable items used in the operation theatre, cath lab, cine angro film,DSA lab, lithotripsy theatre, etc including catheters, oxygenators, customs pack, cannulae, balloons, stents, pacemakers, valves, GDC and other coils used in DSA lab; endotracheal tubes, electrodes, surgical implants and consumables including sutures, aneurysm clips; ophthalmic consumables including intraocular lens and others; dialyser, blood tubings, dentures and (WP(C) 5410-1997) Page 15 of 70 dental implants, helium, medical gases, and such other items.’

STAND OF THE GNCTD

15. The GNCTD in its response pointed out that the terms and conditions on which the Indraprastha Apollo Hospital was constituted are different from the terms and conditions on which land had been allotted to other institutions to run hospitals. It referred to the Public Notice issued at the outset inviting applications from interested parties for opening multi-speciality modern hospital wherein it was specifically provided that the building along with land would be made available free of cost provided the hospital is run on 'no profit no loss' basis and made available free treatment to poor patients to the extent indicated above. Pointing out that IMCL did not want to provide free facilities in terms of the agreement, it was submitted that it had instead been raising issues of reference, eligibility criteria, possibility of floating a trust etc., only to sidetrack the issues and avoid its obligations. It submitted that the arrangement provided by the hospital for free treatment to patients sponsored by the GNCTD, without medicines and consumables in terms of interim orders of the Court, was also very unsatisfactory due to lack of sincerity on the part of the hospital. It is submitted that if the hospital had a genuine concern for the poor patients, then at least they should have provided free treatment totally inclusive of medicines, consumables etc. It is preposterous to expect them to pay. Ultimately, it was the poor public at large which are deprived of availing this state-of-the-art hospital involving public land and funds in violation of their constitutional rights. Then GNCTD supported the petitioner's prayer and requested this Court to direct IMCL to provide 1/3rd beds free of cost including free consultation, diet, tests, investigation, nursing, medicines and consumables and any other facility relating to the treatment of the patients.

LOST OPPORTUNITIES TO MAKE AMENDS

16. In March 1998, the counsel for the IMCL put forth a suggestion to sit down with the counsel for the GNCTD and the petitioner to prepare a table of ailments and the medicines required for, which cannot be provided free, and which should be paid for by the patients and the medicines which can be provided free of cost, or on payment of charges and possibility of subsidizing such medicines. This Court passed an interim order dated 30th April, 1998 recording these suggestions and proposed consultations and a report was to be filed by the IMCL. The proposed mutual consultations between the IMCL and the GNCTD never materialized. The IMCL, in letter written to the petitioner and the GNCTD and report submitted to this Court, reiterated its stand that medicines and medical consumables cannot be provided as it is neither provided in the agreement between the parties nor it is possible for the hospital to provide the same free of cost.

17. The Principal Secretary (Health), GNCTD had appointed a committee on 4th July, 1998 to visit the hospital to see the arrangements made regarding free treatment in terms of directions of this Court. The committee comprising of the Director, GB Pant Hospital, Medical Superintendent, LNJP Hospital and Medical Superintendent, GTB Hospital in its report dated 13th July, 1998 stated that there was a provision to examine only 50 patients per day in OPD with arrangements for 75 indoor beds (including 11 in ICU) for patients referred to by the hospitals under the GNCTD, as against 200 beds required to be made available under court directions. These arrangements were found by this committee to be highly unsatisfactory, in that:

a) OPD patients were allowed only two visits on production of first referral card;

b) All investigations were generally on payments, except routine blood/urine examination;

c) The patients were required to make deposits of Rs.2,000/- for admission in medical ward and

(WP(C) 5410-1997) Page 18 of 70 Rs.5,000/- in surgical ward as contingency expenditure.

18. The GNCTD issued a public notice for the information of general public that as per agreement between the IMCL and the GNCTD, the hospital will provide free treatment to the poor patients. The hospitals authorized to refer the patients were also indicated and patients were informed that patients admitted in free beds will not be charged for beds, nursing care, consultation, basic investigation, diet and for various surgical procedure. However, as per interim order of the High Court dated 29 th May, 1988, the patients had to pay for such medicines actually consumed and medical consumables like syringes, tubing solution etc.

THE REPORTS OF THE HIGH COURT COMMITTEE

19. This Court vide order dated 12th July, 2002 constituted a Committee comprising Dr. S.K. Sarin as the Chairman, Mr. Amrendra Sharan, Senior Advocate and Mr. Akshay Kumar Jain, Architect as the members, to verify the parity status of facilities being provided to the free and paid patients by the hospital, status of referral system by the Government for free treatment and number of commissioned free beds. The hospital failed to provide certain material information which had been called for by the Committee including on the following aspects:- (WP(C) 5410-1997) Page 19 of 70 a) Cost to the hospital per free bed in proportion to the food, medicines and consumables.

b) The criteria adopted to identify a ‘free patient’.

c) Speciality-wise break up of expenses on free patients.

d) Data about emergency admissions.

e) Speciality-wise break up for ICU patients on paid and free sides.

20. The Committee having met with reluctance on the part of the hospital authorities in sharing material information felt constrained to submit its report on the basis of scrutiny of some documents provided by the hospital and observations made during inspection carried out on 24th February, 2003. In its report dated 5th March, 2003 the Committee brought out certain glaring deficiencies in the arrangements and discriminatory treatment qua poor patients referred for free treatment, including the following:

a) The space norms, specification and services for poor patients are of much lower standards when compared with paid patients.

b) No procedure had been established for identifying patients entitled to freeship.

The area made available (2935 sq.mtrs.) for poor patients out of the total built up area (38580 sq.mtrs) works out only 7.6%.

d) Free patients are entitled only to general wards, each accommodating about 50 beds with common toilets, as against paid patients having provision for luxury suites, single rooms, double rooms, general wards (with 5 to 6 beds only), all with attached toilets.

e) Each paid patient on an average has available to him 72.45 sq.mtrs of space as against a space of 20.67 sq.mtrs per bed for free patient.

f) The areas meant for free patients are non-air- conditioned whereas all areas for paid patients are fully air-conditioned.

g) No records were found maintained for free patients, the statistics gathered indicating the number of admissions towards free side has been virtually negligible when compared to the paid patients.

h) On physical count only 117 beds out of the total 634 commissioned were found allocated to 'free patients', constituting 18.45% only.

i) The average occupancy of the commercial beds over the last one year was 338 (69.26%) as against meagre 23 (15.97%) for free beds.

j) Attempts had been made to inappropriately categorise patients from whom payments could not

 be recovered as free patients, which was actually an attempt to write off 'bad debt'.

k) Patients categorised as free patients were made to pay for the medicines and all consumables which formed a substantial portion of the total expenditure during hospital stay.

l) OPD treatment had been provided only to the extent of .0091%, .0017% and .0015% patients respectively during the financial years 2000-01, 2001-02 and 2002-03 respectively as against the obligation to provide free OPD services to 40% of the patients.

m)In spite of specific requirement of clause-6(2) of the lease agreement, no separate records were maintained for outdoor patients.

n) No separate records for emergency admissions or speciality-wise break up were maintained.

o) In ICU the share of free beds was only 12 out of 110 beds (constituting 9.83% against the requisite 33%), with actual occupancy allowed being only 7 out of 10 beds, as compared to 100% occupancy on the paid side.

p) The diagnostic facilities were not provided as free of cost to the poor patients.

21. The Committee reported that the hospital authorities had tried to shift the blame on to the GNCTD for non-utilisation of the commissioned free beds, inter alia, for the reason that government hospitals were not referring adequate number of patients for such purposes.

22. The Committee submitted another report dated 8th April, 2009 in compliance with further direction of this Court vide order dated 12th November, 2008 on the subject of corrective measures taken in respect of issues highlighted in its first report. The Committee took a random sample for the months of March, August and December for the previous five years and as per the details submitted it was found that out of a total of 38,120 number of paid indoor patients, only 939 were free indoor patients, which comes to 2.46% of the paid indoor patients, which needless to say, was much smaller than the agreed ratio of 1/3rd indoor patients entitled for free treatment. There was not much improvement in the infrastructure and facilities available for the free patients except that the air cooling system was made functional.

23. On the issue of space per bed, it was observed that floor area norms for a standard hospital bed were not complied with and beds were placed almost abutting each other without any proper circulation space. The Committee noted that there was no improvement in the hospital facilities for free indoor patients. Though the hospital was specifically asked to furnish specific details regarding various categories of patients recommended by the GNCTD, no details were provided. It was found that almost all the recommendation letters were written by the Health Minister. It was pointed out by the hospital authorities that a large number of hospitals were also entitled to refer patients for free treatment, but they were not availing all the facilities and the hospitals were not referring the patients for free treatment. The hospital authorities informed that they could not treat any patient free except those referred by the GNCTD. The procedure for referral as suggested in earlier report was not implemented. The information furnished by the hospital regarding cost to the hospital on free - in proportion to food, medicines and consumables for the last three financial years was unsatisfactory and no specialty wise break up was provided at all.

24. With respect to OPD patients it was observed that the number of free OPD patients out of a total of 1,29,145 only 358 patients were treated free, which comes to be only 0.27% of the paid outdoor patients, which certainly is miniscule in comparison to the agreed ratio of 40%. The Committee pointed out that the treatment of outdoor patients entails three steps: (a) outdoor registration and doctor's consultation, (b) diagnostic modalities and (c) medicines. No information was provided with regard to the aforesaid requirements which should be made available free of cost to the patients. The Committee opined that it was the duty of the hospital to comply and respect the clauses of the lease deed. The hospital authorities denied their liability of treating patients free on their own and restated that they have to be referred by the GNCTD. It was mentioned by the Committee that the agreement does not require any referral for outdoor free patients and the hospital is duty bound to provide free treatment to a minimum of 40% of patients, attending its clinics. It was further observed that no space was earmarked for free patients in the outpatient department. In fact, there were no directions or signages to this effect so that a common man can avail free services provided by the hospital. It appeared intentional to the Committee on the part of the hospital authorities not to advertise such facilities. There was no mechanism in existence of categorizing patients as free in outpatient services. The Committee reiterated its recommendations made in the earlier report and made further suggestions. Among other valuable suggestions, it was suggested that the hospital must announce that it will provide free emergency services within a radius of five kilometers. Instructions in this regard should be issued by the GNCTD to government hospitals and dispensaries to refer such patients for free treatment to Apollo. The police and traffic authorities should be instructed to take patients within defined radius to Apollo hospital in case of road accidents and emergency. The referral system should be transparent

and all the state machinery involved in health sector should be authorized to refer any patient, which they deem fit for specialized treatment irrespective of the recommendations.

REPORT OF JUSTICE QURESHI COMMITTEE

25. The GNCTD (Health & Family Welfare Deptt.,) vide Notification No.F.13/36/99-DHS/NH/pet.File/340 dated 12th June, 2000 constituted a Committee headed by Justice A.S.Qureshi (Retd) and some official and non-official members. The terms of reference of the Committee were set out in the said order as follows:

a) To review the existing free treatment facilities extended by the Charitable and other Hospitals who have been allotted land on concessional terms/rates by the Government. b) To suggest suitable policy guidelines for free treatment facilities for needy and deserving patients uniformly in the beneficiary institutions in particular to specify the diagnostic, treatment, lodging, surgery, medicines and other facilities that will be given free or partially free. c) To suggest a proper referral system for the optimum utilization of free treatment by deserving and needy patients.

d) To suggest a suitable enforcement and monitoring mechanism for the above including a legal framework.

26. The Qureshi Committee has noted about the working of the Indraprastha Apollo Hospital thus:

'The Apollo hospital was allotted 15 acres of prime land in South Delhi by the Delhi Government under the agreement dated 11.3.1988 and the lease deed dated 21.4.1988 for a token rent of Re.1/- per month. The hospital was commissioned in 1996. It was stipulated in the aforesaid two documents that one third of the total number of beds will be reserved for giving free treatment to the poor and deserving patients. It was agreed that 200 beds out of the projected total number of 600 beds would be available for free treatment. This stipulation of providing free treatment to the patients for whom the free beds were earmarked has never been fulfilled. The answer given in the questionnaire shows that 150 beds (i.e. 127 in wards and 13 beds in ICU) are kept as free beds and 510 are paying beds. Thus making the total number of beds 650. The one-third of total of 650 would be about 217. Therefore, 140 beds reserved for free treatment is considerably less than one-third stipulated. Out of these 140 beds meant for free treatment only a very small number are used by the so-called free patients. The average is said to be around 20 beds at any given time. The main reason for this large non-use of the free beds is the fact that the hospital insists that the free bed patients must pay for medicines and medical consumables. The cost of medicines and medical consumables may run into thousands of rupees and in some cases such as Chemotherapy etc., into lacs or more, which a poor or indigent patient cannot afford to pay. Therefore, the stipulation of free treatment has been violated right from the beginning till this date. The Delhi Govt. is grappling with this question in the High Court without a clue as to how to find a solution.

The government has four nominees on the Board of Directors of the public limited company (I.M.C.L) including its Chief Secretary and three other high officials. They are rendered ineffective and are not able to get even the legally valid and constructive proposals approved by the Board on the question of free treatment to the poor. They are out-voted by other Directors who have made a common cause to defeat any attempt

to provide a truly free treatment to genuinely poor patients. The dominant profit motive of the company has made other Directors totally indifferent and callous regarding free treatment to the poor in flagrant violation of the terms and conditions of the aforesaid agreement and the lease deed. The public limited company, has described itself as 'purely commercial' enterprise. Therefore, profit motive is inherent in its activities, which is quite understandable. But the profit motive should not be in defiant violation of the firm commitment in respect of free treatment to the poor patients.

The incorporation of the IMCL and the establishment of the Indraprastha Apollo Hospital has so far been a bad bargain as an investment for the Delhi Government. The only perceivable achievement is the setting up of State-of the-Art Super Specialty Hospital in Delhi for those who can afford to pay for its services, which is beyond most citizens of Delhi. The Delhi Government is holding 26% of the equity shares amounting to about Rs.23 crores. It has given 15 acres of prime land in South Delhi purchased from the DDA at an approximate cost of Rs.4 crores and has been leased out to the Company for 30 years at an annual token rent of Re.1/-. Over and above this, the Delhi Government has investment nearly Rs.15 crores for the construction of the building. The position of Delhi government is that of a person who has invested large amounts in cash and kind to buy an expensive cow, of which it is holding the horns while others are milking it and the Government is watching it helplessly. The Government has to find a solution to this intolerable situation and salvage its honour, investment and commitment to the poor, needy and deserving patients.

THE CONTENTIONS

27. Mr. Ashok Aggarwal, learned counsel appearing for the petitioner submitted that the right to health is a fundamental right flowing from Article 21 of the Constitution of India. The land belonging to the people has been given to the hospital with a positive obligation on the part of the hospital to provide free treatment to a certain percentage of poor patients as stipulated in the agreement. The breach of the clause relating to free treatment amounts to violation of the fundamental and human right to health of a vast majority of people. Mr. Aggarwal submitted that providing facilities for medical treatment is one of the primary duties of the Government and the arrangement with IMCL was in furtherance of this obligation and, therefore, the hospital has a public duty to perform. Inaction on the part of the State in securing implementation of the clauses of agreement is serious infringement of right to health provided under Article 21 of the Constitution of India. He submitted that the petitioner is seeking enforcement of the rights of the people of this city where the majority is poor, downtrodden and in need of free medical treatment. Larger public interest would be served by securing implementation of these conditions as they are meant for the benefit of the poor and needy who are in need of medical care and are not in a position to afford medical expenses. Learned counsel further submitted that by this arrangement a public element has been created and, therefore, the petitioner can seek mandamus both against the government and the hospital. In the present case, interpretation of the clauses of the agreement is involved. No factual dispute is involved. Therefore this Court in exercise of the powers under Article 226 can interpret the agreement and issue mandamus against both the government and the hospital to render free treatment to the poor and needy as per the agreement.

28. Mrs. Avnish Ahlawat, learned standing counsel appearing for the GNCTD submitted that in the agreement it was clearly provided that that the company shall provide to the Administrator the free facilities of medical diagnostic and other necessary care to not less than 1/3 of the total capacity of 600 beds in the multi-speciality hospital. These terms were in

conformity with the notice inviting tender where it was specifically mentioned that hospital has to run on no profit no loss basis and 1/3 of the hospital services will be provided free of cost which includes full medical diagnostic and other necessary facilities apart from 40% free treatment to OPD patients. 'Free bed' would include consultation, bed, investigation, nursing, medicines and consumables. Learned counsel submitted that the hospital somehow or the other does not want to provide free facilities as per the terms of the agreement and is raising issues of reference and eligibility criteria of the patients referred to the hospital which in any case is not its concern. If the hospital has genuine concern for the poor patients, then at least, it should have provided free treatment, inclusive of medicines and consumables as envisaged in the agreement. It is preposterous to expect a person belonging to the poor and vulnerable section of the society to pay for diagnostics and consumables. According to learned counsel the entire project is based on 'no profit no loss' basis with clear stipulation that 1/3 beds are for free treatment along with 40% OPD. The citizens of Delhi are deprived of the use of super specialty facilities provided by the hospital which was brought into existence with the public exchequer money.

29. Mr. Lalit Bhasin, learned counsel appearing for the respondent No.2-IMCL submitted that the present petition is not maintainable against IMCL as IMCL is not 'State' or its 'instrumentality'. Indraprastha Apollo Hospital is purely a commercial venture jointly undertaken by the GNCTD and IMCL and some NRIs. There is no public function involved in a commercial transaction between the two parties even if it relates to healthcare and IMCL is not performing any public function or public duty or is engaged in any public law activity. The fact that Delhi Government has also made substantial contribution for the construction of the building for the hospital does not confer any special status on the State Government. As there is dispute between the parties on the interpretation of certain terms of the agreement, the agreement provides for arbitration between the parties. The writ petition as pro bono publico litigation is a blatant attempt to circumvent the law and to deny the remedies available to the IMCL. Mr. Bhasin further submitted that the matter involves questions of contractual obligations and construction or interpretation of an agreement cannot be subject matter of a writ petition. In any event, according to him there is no obligation on the hospital to provide free medicines and consumables. The fact that the two terms 'medicines' and 'consumables' do not find any reference in the whole of the lease deed shows that they were never intended to be included in the facilities to be provided free of charge. If any free services are to be provided by the hospital the cost of these would have to be generated from the revenue earned by the hospital, that is to say that the paying patients will have to pay for the free medicines and consumables. This would result in costlier treatment to the paying patients and the hospital would become out of reach and overpriced. IMCL has obligations towards the investors, banks and financial institutions who have granted loans and has to be commercially viable. Mr. Bhasin finally urged that to provide free medical care is the obligation of the State and as such court cannot direct private parties to discharge public function in PILs against them. This is only an effort to circumvent State's obligation with a view to fastening the liability on a private party.

RIGHT TO HEALTH

30. By questioning the maintainability of the Writ Petition at hand, inter alia, on the grounds that IMCL is not 'State' or 'State instrumentality' or that it is essentially a commercial venture, the hospital has tried to trivialize the issues. The subject matter of the controversy is not as mundane as made out to be. As we shall presently demonstrate, the case presents a situation where 'right to health' of the public at large, recognized the world over, (sufficiently

delineated in India through Constitutional provisions, as interpreted by the superior courts) itself is at stake. By agreeing to be a partner with the State in the matter of health care, with stipulations about free health care to the specified extent, IMCL had taken onto itself the mantle of State instrumentality. The discourse on 'right to health' would show that it hardly lies in the mouth of the private player to turn around and abdicate its responsibility, after having offered its services for establishing a multi-disciplinary super-speciality hospital on the terms inclusive of benevolent arrangements for the poor and indigent and in the bargain having secured State largesse in the form of prime parcel of public land and monetary contribution.

31. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. Henry Sigerist, a prominent medicine historian, says that health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health to all, free of charge; medicine like education is then no longer a trade - it becomes a public function of the State.

International Perspective:

32. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: ' Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.' The International Convention on Economic, Social and Cultural Rights (ICESCR) provides the most comprehensive article on the right to health in international human rights law. While Article 12(1) of the Convention referred to the 'right to health' in aspirational terms, Article 12(2) mandated specific measures on part of the State parties to the Covenant. Its language reads as follows:

'1. The State parties to the present covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the State parties to the present covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;

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

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

(d) The creation of conditions which would assure to all medical service and medical attention in the even to sickness.'

33. There are provisions relating to protection and advancement of health in several conventions formulated under the aegis of the United Nations. The right to health is recognized, inter alia, in article 5(e)(iv) of the International Convention on the Elimination of

All Forms of Discrimination of 1965, in articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognise the right to health, such as the European Social Charter of 1961 as revised (art.11), the African Charter of Human and Peoples' Rights of 1981 (art.16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic , Social and Cultural Rights of 1988 (art.10). Similarly, the right to health has been proclaimed by the Commission on Human Rights as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments.

34. ICESCR calls upon State parties to 'respect, protect and fulfil' their citizens right to health. 'Respecting' the right to health means that the Government must refrain from taking actions that inhibit or interfere with people's ability to enjoy their right. 'Protecting' the right to health means that the State must seek to protect the people from having their rights infringed by third parties, such as healthcare providers, private industry, pharmaceutical companies, researchers or vendors. 'Fulfilling' the right to health means that the Government is required to take positive action to implement the right to health by adopting policies which allocate public resources to correct deficiencies in health facilities, goods and services (Patricia C. Kuszler, 'Global health and the Human Rights Imperative', Asian Journal of WTO and International Health Law and Policy Vo.2(1) March 2007). In this regard, General Comment 14 issued by the UN Committee on Economic, Social and Cultural Rights in 2000 states:

'The notion of the 'highest attainable standard of health' in Article 12(1) of ICESCR takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There is a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.'

The Committee further states in paragraph 12 that the right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

'(a) Availability. Functioning public health and health- care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

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

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. ‘

Mandate of Indian Constitution & Supreme Court:

35. The right to health or the right to health care is recognized in at least 115 constitutions. At least six other constitutions set out duties in relation to health, such as the duty on the State to develop health services or to allocate a specific budget to them. Part IV of our Constitution deals with the Directive Principles of State Policy. Among several provisions that touch on the subject of health, reference can be made to Articles 39(e), (f), 42 and 47 of the Constitution. These Articles read as follows:

‘39(e) that the health and strength of works, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength;

(f) that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment.

42. Provision for just and humane conditions of work and maternity relief :- The State shall make provision for securing just and humane conditions of work and for maternity relief.

47. Duty of the State to raise the level of nutrition and the standard of living and to improve public health - The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consuming, except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

36. The Supreme Court in several judgments recognized that right to health is implicit in Article 21 of the Constitution. In Pt. Parmanand Katara v. Union of India, (1989) 4 SCC 286 the Court was confronted with a situation where hospitals were refusing to admit accident victims and were directing them to specific hospitals designated to admit 'medico legal cases'. The Court ruled that while medical authorities were free to draw up administrative rules to tackle cases based on medical considerations, no medical authority could refuse immediate medical attention to a patient in need. Such refusal amounted to violation of universally accepted norms of medical ethics and the provisions of 'right to life' guaranteed under Article 21.

37. In CESC Ltd. v. Subhash Chandra Bose, (1992) 1 SCC 441 the Court held that the right to health of a worker is covered by Article 21 of the Constitution. It was also indicated that health does not mean mere absence of sickness but would mean complete physical, mental and social well being. Facilities of health and medical care generate devotion and dedication to give the workers' best, physically as well as mentally, in productivity. It enables the worker to enjoy the fruit of his labour, to keep him physically fit and mentally alert for leading a successful economic, social and cultural life. The medical facilities are, therefore, part of social security and like gift-edged security, it would yield immediate return in the increased production or at any rate reduce absenteeism on the ground of sickness.

38. In a subsequent judgment in Consumer Education & Research Center v. Union of India, (1995) 3 SCC 42 the Court dealt with the problem of occupational health hazards and diseases sustained by the workmen employed in asbestos industries. It was held that right to health and medical aid of workers during service and thereafter, is a fundamental right of workers. According to the Court, it can issue directions in an appropriate case to the State or its instrumentalities or even private employers to make the right to life meaningful and to pay compensation to affected workmen. It also held that the defence of 'sovereign immunity' would not be available to the State or its instrumentalities where fundamental rights are sought to be enforced. Relying on several previous judgments, the Court held that right to life would mean meaningful and real right to life. It would include right to livelihood, better standard of living in hygienic conditions at the work place and leisure.

39. In Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 SCC 37 the case related to failure on the part of the government hospitals to provide timely emergency medical treatment to persons in serious conditions. The Court observed:

'It is no doubt true that financial resources are needed for providing these facilities. But at the same time it cannot be ignored that it is the Constitutional obligation of the State to provide adequate medical services to the people.

Whatever is necessary for this purpose has to be done. In the context of the constitutional obligation to provide free legal aid to a poor accused, this Court has held that the State cannot avoid its constitutional obligation in that regard on account of financial constraints. (See : Khatri (II) v. State of Bihar (1981) 1 SCC 627). The said observations would apply with equal, if not greater, force in the matter of discharge of constitutional obligation of the State to provide medical aid to preserve human life. In the matter of allocation of funds for medical services the said constitutional obligation of the State has to be kept in view. It is necessary that a time-bound plan for providing these services should be chalked out keeping in view the recommendations of the Committee as well as the requirements for ensuring availability of proper medical services in this regard as indicated by us and steps should be taken to implement the same. The State of West Bengal alone is a party to these proceedings. Other States, though not parties, should also take necessary steps in the light of the recommendations made by the Committee, the directions contained in the Memorandum of the Government of West Bengal dated August 22, 1995 and the further directions given herein.'

40. In Vincent Panikulangara v. Union of India, (1987) 2 SCC 165 where the issue related to manufacturing, selling and distributing approved standard of drugs and banning of injurious and harmful medicines. In the background of that question, the Court held right to maintenance and improvement of public health as one of the fundamental rights falling under Article 21 of the Constitution. Quoting a well known adage 'Sharirmadhyam Khalu Dharma shadhanam' (healthy body is the very foundation of all human activities) the Court observed:

'...maintenance and improvement of public health have to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends the building of the society of which the Constitution makers envisaged. Attending to public health, in our opinion, therefore, is of high priority--perhaps the one at the top.'

41. We may also quote the illuminating words of Justice P.N.Bhagawati, as his Lordship then was, in Bandhua Mukti Morcha v. Union of India, (1984) 3 SCC 161:

'It is the fundamental right of every one in this country, assured under the interpretation given to Article 21 by this Court in Francis Mullen's case, to live with human dignity, free from exploitation. This right to live with human dignity enshrined in Article 21 derives its life breath from the Directive Principles of State Policy and particularly Clauses (e) and (f) of Article 39 and Articles 41 and 42 and at the least, therefore, it must include protection of the health and strength of workers men and women, and of the tender age of children against abuse, opportunities and facilities for children to develop in a healthy manner and in conditions of freedom and dignity, educational facilities, just and humane conditions of work and maternity relief. These are the minimum requirements which must exist in order to enable a person to live with human dignity and no State neither the Central Government nor any State Government- has the right to take any action which will deprive a person of the enjoyment of these basic essentials. Since the Directive Principles of State Policy contained in Clauses (e) and (f) of Article 39, Article 41 and 42 are not enforceable in a court of law, it may not be possible to compel the State through the judicial process to make provision by statutory enactment or executive fiat for ensuring these basic essentials which go to make up a life of human dignity but where legislation is already enacted by the State providing these basic requirements to the workmen and thus investing their right to live with basic human dignity, with concrete reality and content, the State can certainly be obligated to ensure observance of such legislation for inaction on the part of the State in securing implementation

of such legislation would amount to denial of the right to live with human dignity enshrined in Article 21, more so in the context of Article 256 which provides that the executive power of every State shall be so exercised as to ensure compliance with the laws made by Parliament and any existing laws which apply in that State.'

42. Mr.Bhasin sought to contend that the law relating to the right to health as envisaged under Article 21 is diluted to some extent in later decisions of the Supreme Court in State of Punjab v. Ram Lubhaya Bagga, (1998) 4 SCC 117 and Confederation of Ex-Servicemen Association v. Union of India, AIR 2006 Supreme Court 2945. The contention is without any merit. In Ram Lubhaya's case the Court had occasion to consider the question of change of policy in regard to reimbursement of medical expenses to its employees. Referring to earlier decisions, the Bench took note of ground reality that no State has unlimited resources to spend on any of its projects. Therefore, such facilities must necessarily be made limited to the extent finances permit. No right can be absolute in a welfare State. An individual right has to be subservient to the right of public at large. In the second judgment in Confederation of Ex- servicemen Association' case the Court in fact reiterated that the right to life also covers the right to health. In this regard the Court observed in paragraph 60, thus:

'It cannot be gainsaid that right to life guaranteed under Article 21 of the Constitution embraces within its sweep not only physical existence but the quality of life. If any statutory provision runs counter to such a right, it must be held unconstitutional and ultra vires Part III of the Constitution. Before more than hundred years, in Munn v. Illinois (1876) 94 US 113 : 24 Law Ed 77, Field, J. explained the scope of the words 'life' and 'liberty' in 5th and 14th Amendments to the U.S. Constitution and proclaimed;

'By the term 'life' as here used something more is meant than mere animal existence. The inhibition against its deprivation extends to all these limits and faculties by which life is enjoyed. The provision equally prohibits the mutilation of the body or amputation of an arm or leg or the putting out of an eye or the destruction of any other organ of the body through which the soul communicates with the outer world...by the term liberty, as used in the provision something more is meant than mere freedom from physical restraint or the bonds of a prison. The Court however came to the conclusion that the contributory scheme which was framed by the State in that case cannot be held to be illegal, unlawful or unconstitutional.

ROLE OF NON-STATE ACTORS

43. Health care is an essential concomitant to quality of life. Its demand and supply cannot therefore be left to be regulated solely by the invisible hands of the market. The State must strive to move towards a system where every citizen has assured access to basic health care, irrespective of capacity to pay. In an article by Shri R.Srinivasan 'Health Care In India - Vision 2020 - Issues and Prospects' the author suggested four criteria for establishing a just health care system - (i) universal access, and access to an adequate level, and access without excessive burden (ii) fair distribution of financial costs for access and fair distribution of burden in rationing care and capacity and a constant search for improvement to a more just system, (iii) training providers for competence empathy and accountability, pursuit of quality care and cost effective use of the results of relevant research and (iv) special attention to vulnerable groups such a children, women, disabled and the aged.

44. Prof. Amartya Sen, in his Prof. Hiren Mukherjee Memorial Parliamentary Lecture delivered at the Central Hall of Parliament House said:

‘A Government in a democratic country has to respond to ongoing priorities in public criticism and political reproach, and to the threats to survival it has to face. The removal of long-standing deprivations of the disadvantaged people of our country may, in effect, be hampered by the biases in political pressure, in particular when the bulk of the social agitation is dominated by new problems that generate immediate and vocal discontent.

If the politically active threats are concentrated only on some specific new issues (no matter how important they may appear), rather than on the terrible general inheritance of India of acute deprivation, deficient schooling, lack of medical attention for the poor, and extraordinary undernourishment (especially of children and also of young women), then the pressure on democratic governance acts relentlessly towards giving priority to only those particular new issues, rather than to the gigantic persistent deprivations that are at the root of so much inequity and injustice in India. The perspective of realization of justice is central not only for the theory of justice, but also for the practice of democracy.’

45. With regard to obligations of actors other than State parties, CESCR Comment 14 stipulates:

‘While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realisation of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.’ A.Yamin in his article ‘Protecting and Promoting the Right to Health in Latin America’ published in Health and Human Rights 2000 5(1); 134 observed:

‘...decision-makers in governments, international financial institutions and even multinational corporations must come to view health and health care as non-negotiable entitlements, not as matters of governmental largesse or productivity.’

Judith Asher, an activist, in her book ‘The Right to Health: A Resource Manual for NGOs’ says that within a human rights framework, the private sector and non-governmental bodies are expected to carry out their activities with full regard for the fundamental health rights of individuals and groups. Although not in a direct sense legally bound by the relevant obligations, they are expected to comply with the accepted health and human rights standards and norms by giving due attention to protecting, promoting, and realizing the right to health, both in the work that they carry out (for example, advocacy or service delivery) and in the conduct of their internal processes and administration.

MAINTAINABILITY OF WRIT PETITION

46. Article 226 of the Constitution of India states that every High Court has jurisdiction to issue appropriate writs to any person or authority for the enforcement of any fundamental right and for any other purpose. The expressions ‘any person’ and ‘for any other purpose’ have been explained and elucidated upon by the Supreme Court. The words ‘any person or authority’ used in Article 226 are not to be confined only to statutory authorities and instrumentalities of the State. They may cover any other person or body performing the public function. In Shri Anadi Mukta Sadguru SMVSJM Smarak Trust & Ors v. V.R.Rudani

& Ors., AIR 1989 SC 1607 the Court held that the law relating to mandamus has made the most spectacular advance. Article 226 confers wide powers on the High Courts to issue writs in the nature of prerogative writs. This is a striking departure from the English law. Under Article 226, writs can be issued to 'any person or authority'. It can be issued 'for the enforcement of any of the fundamental rights and for any other purpose'. The term 'authority' used in Article 226, in the context, must receive a liberal meaning unlike the term in Article 12. Article 12 is relevant only for the purpose of enforcement of fundamental rights under Art.32. Article 226 confers power on the High Courts to issue writs for enforcement of the fundamental (WP(C) 5410-1997) Page 49 of 70 rights as well as non-fundamental rights. The words 'any person or authority' used in Article 226 are, therefore, not to be confined only to statutory authorities and instrumentalities of the State. They may cover any other person or body performing public duty. The form of the body concerned is not very much relevant. What is relevant is the nature of the duty imposed on the body. The duty must be judged in the light of the positive obligation owed by the person or authority to the affected party. No matter by what means the duty is imposed, if a positive obligation exists mandamus cannot be denied. It may be pointed out that mandamus cannot be denied on the ground that the duty to be enforced is not imposed by the statute. The judicial control over the fast expanding maze of bodies affecting the rights of the people should not be put into watertight compartment. It should remain flexible to meet the requirements of variable circumstances. Mandamus is a very wide remedy which must be easily available 'to reach injustice wherever it is found'. Technicalities should not come in the way of granting that relief under Article 226. We also quote paragraphs 20 and 21 of the judgment:

'20. In Praga Tools Corporation v. Shri C.A Imanual and Ors., (1969) 3 SCR 773 : (AIR 1969 Supreme Court 1306) , this Court said that a mandamus can issue against a person or body to carry out the duties placed on them by the Statutes even though they are not (WP(C) 5410-1997) Page 50 of 70 public officials or statutory body. It was observed (at 778) ;

'It is however not necessary that the person or the authority on whom the statutory duty is imposed need be a public official or an official body, A mandamus can issue, for instance, to an official or a society to compel him to carry out the terms of the statute under or by which the society is constituted or governed and also to companies or corporations to carry out duties placed on them by the statutes authorising their undertakings. A mandamus would also lie against a company constituted by a statute for the purpose of fulfilling public responsibilities. (See Halsbury's Laws of England (3rd Ed. Vol. II p. 52 and onwards).'

21. Here again we may point out that mandamus cannot be denied on the ground that the duty to be enforced is not imposed by the statute Commenting on the development of this law, Professor De Smith states : 'To be enforceable by mandamus a public duty does not necessarily have to be one imposed by statute. It may be sufficient for the duty to have been imposed by charter, common law, custom or even contract.' (Judicial Review of administrative Act 4th Ed. p.540). We share this view. The judicial control over the fast expanding maze of bodies affecting the rights of the people should not be put into water-tight compartment. It should remain flexible to meet the requirements of variable circumstances. Mandamus is a very wide remedy which must be easily available 'to reach injustice whenever it is found'. Technicalities should not come in the way of granting that relief under Article 226. We, therefore, reject the contention urged for the appellants on the maintainability of the writ petition.'

47. In Binny Ltd. & Anr. v. V.V. Sadasivan, 2005 (6) SCC 657, elucidating upon the issue as to when a private body can be said to be performing public function, the Court observed:

‘Judicial review is designed to prevent the cases of abuse of power and neglect of duty by public (WP(C) 5410-1997) Page 51 of 70 authorities. However, under our Constitution, Article 226 is couched in such a way that a writ of mandamus could be issued even against a private authority. However, such private authority must be discharging a public function and that the decision sought to be corrected or enforced must be in discharge of a public function. The role of the State expanded enormously and attempts have been made to create various agencies to perform the governmental functions. Several corporations and companies have also been formed by the government to run industries and to carry on trading activities. These have come to be known as Public Sector Undertakings. However, in the interpretation given to Article 12 of the Constitution, this Court took the view that many of these companies and corporations could come within the sweep of Article 12 of the Constitution. At the same time, there are private bodies also which may be discharging public functions. It is difficult to draw a line between the public functions and private functions when it is being discharged by a purely private authority. A body is performing a ‘public function’ when it seeks to achieve some collective benefit for the public or a section of the public and is accepted by the public or that section of the public as having authority to do so. Bodies therefore exercise public functions when they intervene or participate in social or economic affairs in the public interest. In a book on Judicial Review of Administrative Action (Fifth Edn.) by de Smith, Woolf & Jowell in Chapter 3 para 0.24, it is stated thus:

‘A body is performing a ‘public function’ when it seeks to achieve some collective benefit for the public or a section of the public and is accepted by the public or that section of the public as having authority to do so. Bodies therefore exercise public functions when they intervene or participate in social or economic affairs in the public interest. This may happen in a wide variety of ways. For instance, a body is performing a public function when it provides ‘public goods’ or other collective services, such as health care, education and personal social services, from funds raised by taxation. A body may perform public functions in the form of adjudicatory services (such as those of the criminal and civil courts and tribunal system). They also do so if they regulate commercial and professional activities to ensure compliance with proper standards. For all these purposes, a range of legal and administrative techniques may be deployed, including: rule-making, adjudication (and other forms of dispute resolution); inspection; and licensing.

Public functions need not be the exclusive domain of the state. Charities, self-regulatory organizations and other nominally private institutions (such as universities, the Stock Exchange, Lloyd's of London, churches) may in reality also perform some types of public function. As Sir John Donaldson M.R. urged, it is important for the courts to ‘recognize the realities of executive power’ and not allow ‘their vision to be clouded by the subtlety and sometimes complexity of the way in which it can be exerted’. Non-governmental bodies such as these are just as capable of abusing their powers as is government.’

48. In Kulchhinder Singh and Others v. Hardayal Singh Brar and Others, (1976) 3 SCC 828, Krishna Iyer, J speaking for the Bench, observed:

‘In such situations what is immediately relevant is not whether the respondent is State or public authority but whether what is enforced is a statutory duty or sovereign obligation or public function of a public authority. Private law may involve a State, a statutory body, or a

public body in contractual or tortuous actions. But they cannot be siphoned off into the writ jurisdiction.'

49. In G.Bassi Reddy v. International Crops Research Institute and Another, (2003) 4 SCC 225 the Court observed:

'It is true that a writ under Article 226 also lies against a person' for 'any other purpose'. The power of the High Court to issue such a writ to 'any person' can only mean the power to issue such a writ to any person to whom, according to well-established principles, a writ lay. That a writ may issue to an appropriate person for the enforcement of any of the rights conferred by Part III is clear enough from the language used. But the words 'and for any other purpose' must mean 'for any other purpose for which any of the writs mentioned would, according to well established principles issued.

A writ under Article 226 can lie against a 'person' if it is a statutory body or performs a public function or discharges a public or statutory duty.'

50. It is now well settled that there is no absolute bar for entertaining a writ petition even if the same arises out of a contractual obligation or involves some disputed question of facts. Rejecting the argument that the High Court should not have entertained writ petition in relation to a contractual term, which conferred discretion upon the LIC in regard to issuing insurance policies, the Supreme Court observed in LIC of India v. Consumer Education & Research Centre, (1995) 5 SCC 482, thus:

'Every action of the public authority or the person acting in public interest or its acts give rise to public element, should be guided by public interest. It is the exercise of the public power or action ' hedged with public element becomes open to challenge. If it is (WP(C) 5410-1997) Page 54 of 70 shown that the exercise of the power is arbitrary unjust and unfair, it should be no answer for the State its instrumentality, public authority or person whose acts have the insignia of public element to say that their actions are in the field of private law and they are free to prescribe any conditions or limitations in their actions as private citizens, simplicitor, do in the field of private law. Its actions must be based on some rational and relevant principles. It must not be guided by irrational or irrelevant considerations. Every administrative decision must be hedged by reasons. xxxx xxxx xxxx The actions of the State, its instrumentality, any public authority or person whose actions bear insignia of public law element or public character are amenable to judicial review and the validity of such an action would be tested on the anvil of Article 14. While exercising the power under Article 226 the Court would be circumspect to adjudicate the disputes arising out of the contract depending on the facts and circumstances in a given case. The distinction between the public law remedy and private law field cannot be demarcated with precision. Each case has to be examined on its own facts and circumstances to find out the nature of the activity or scope and nature of the controversy. The distinction between public law and private law remedy is now narrowed down. The actions of the appellants bear public character with an imprint of public interest element in their offers regarding terms and conditions mentioned in the appropriate table inviting the public to enter into contract of life insurance. It is not a pure and simple private law dispute without any insignia of public element. Therefore, we have no hesitation to hold that the writ petition is maintainable to test the validity of the conditions laid in Table 58 terms policy and the party need not be relegated to a civil action.....'

51. In Kumari Srilekha Vidyarthi and Others v. State of UP, 1991 (1) SCC 212, Justice J.S.Verma, as his Lordship then was, speaking for the Bench observed thus:

(WP(C) 5410-1997) Page 55 of 70 '.......It is significant to note that emphasis now is on review ability of every State action because it stems not from the nature of function, but from the public nature of the body exercising that function; and all powers possessed by a public authority, howsoever conferred, are possessed 'solely in order that it may use them for the public good'. The only exception limiting the same is to be found in specific cases where such exclusion may be desirable for strong reasons of public policy. This, however, does not justify exclusion of reviewability in the contractual field involving the State since it is no longer a mere private activity to be excluded from public view or scrutiny.

27. Unlike a private party whose acts uninformed by reason and influenced by personal predilections in contractual matters may result in adverse consequences to it alone without affecting the public interest, any such act of the State or a public body even in this field would adversely affect the public interest. Every holder of a public office by virtue of which he acts on behalf of the State or public body is ultimately accountable to the people in whom the sovereignty vests. As such, all powers so vested in him are meant to be exercised for public good and promoting the public interest. This is equally true of all actions even in the field of contract. Thus, every holder of a public office is a trustee whose highest duty is to the people of the country and, therefore, every act of the holder of a public office, irrespective of the label classifying that act, is in discharge of public duty meant ultimately for public good. With the diversification of State activity in a Welfare State requiring the State to discharge its wide-ranging functions even through its several instrumentalities, which requires entering into contracts also, it would be unreal and not pragmatic, apart from being unjustified to exclude contractual matters from the sphere of State actions required to be non-arbitrary and justified on the touchstone of Article 14.

28. Even assuming that it is necessary to import the concept of presence of some public element in a State action to attract Article 14 and permit judicial review, we have no hesitation in saying that the ultimate impact of all actions of the State or a public body (WP(C) 5410-1997) Page 56 of 70 being undoubtedly on public interest, the requisite public element for this purpose is present also in contractual matters. We, therefore, find it difficult and unrealistic to exclude the State actions in contractual matters, after the contract has been made, from the purview of judicial review to test its validity on the anvil of Article 14.'

52. In a recent decision in United India Insurance Company Ltd v. Manubhai Dharmasinhbhai Gajera, (2008) 10 SCC 404 the Court held as follows:

'The action was brought by private individuals. The writ petition, however, had wider ramification. They not only would affect the writ petitions, but also others who would be similarly situated. Such cases may not be dealt with as individual cases. In appropriate case, such litigation may be regarded as public interest litigation. Even if it not so regarded, the High Court may consider the same to be `Public Law Litigation'

While determining a lis having public law domain, the courts would be entitled to take a broader view. It would not consider to be case involving contract-qua- contract question only. Even cases involving contracts may be determined by the High Court in exercise of its jurisdiction under Article 226 of the Constitution of India. (see: LIC of India and Anr. v.

Consumer Education & Research Centre and Ors. AIR1995 Supreme Court 1811, Sanjana M. Wig (Ms) v.

Hindustan Petroleum Corporation Ltd. AIR 2005 Supreme Court 3454 , ABL International Ltd and Anr. v. Export Credit Guarantee Corporation of India Ltd and Ors. (2004) 3 SCC 553 , The D.F.O, South Kheri and Ors. v. Ram Sanehi Singh : AIR 1973 Supreme Court 205 , Noble Resources Ltd. v. State of Orissa and Anr. AIR 2007 Supreme Court 119. We, however, do not think that facts involved in each case and the law laid down therein need not be discussed as there does not exist any basic principles therefor. These cases do not involve serious disputed question of fact. Basic facts are admitted. The High Court was concerned with the interpretation of statute and interpretation of the (WP(C) 5410-1997) Page 57 of 70 contract. Judicial Review of the impugned action on the part of the appellant was, therefore, permissible'.

53. In ABL International Ltd., v. Export Credit Guarantee Corporation of India, (2004) 3 SCC 553 the Court held that a writ petition involving serious disputed questions of facts which requires consideration of evidence which is not on record, will not normally be entertained by a court in the exercise of its jurisdiction under Article 226 of the Constitution, but there is no absolute rule that in all cases involving disputed questions of fact the parties should be relegated to a civil suit. It has even been held that in the writ petition, if the facts require, oral evidence can be taken. This clearly shows that in an appropriate case, the writ court has the jurisdiction to entertain a writ petition involving disputed questions of fact and there is no absolute bar for entertaining a writ petition even if the same arises out of a contractual obligation and/or involves some disputed questions of fact. Merely because the first respondent wants to dispute the meaning of a clause of the insurance contract it does not become a disputed fact. However, if such an objection as to disputed questions or interpretations is raised in a writ petition the courts can very well go into the same and decide that objection if facts permit. In the light of these decided cases, the objection to the maintainability of the writ petition has to be rejected.

54. In Harbanslal Sahania v. Indian Oil Corporation Ltd., (2003) 2 SCC 107 where a petroleum dealership termination was challenged in writ proceedings, despite existence of an arbitration clause that covered such matters, the Supreme Court held:

7. So far as the view taken by the High Court that the remedy by way of recourse to arbitration clause was available to the appellants and therefore the writ petition filed by the appellants was liable to be dismissed, suffice it to observe that the rule of exclusion of writ jurisdiction by availability of an alternative remedy is a rule of discretion and not one of compulsion. In an appropriate case in spite of availability of the alternative remedy, the High Court may still exercise its writ jurisdiction in at least three contingencies: (i) where the writ petition seeks enforcement of any of the Fundamental Rights; (ii) where there is failure of principles of natural justice or, (iii) where the orders or proceedings are wholly without jurisdiction or the vires of an Act and is challenged [See: Whirlpool Corporation v. Registrar of Trade Marks, Mumbai and Ors., AIR 1999 Supreme Court 22. The present case attracts applicability of first two contingencies. Moreover, as noted, the petitioners' dealership, which is their bread and butter came to be terminated for an irrelevant and non-existent cause. In such circumstances, we feel that the appellants should have been allowed relief by the High Court itself instead of driving them to the need of initiating arbitration proceedings.

55. In the present case, the venture of the GNCTD with the Apollo hospital was not a commercial venture. It was to provide super specialty facilities to the poor and the needy citizens. The hospital is obliged to provide free treatment to the indoor and outdoor patients to the extent indicated in the agreement. Even if the IMCL cannot be said to be State or its instrumentality, it is (WP(C) 5410-1997) Page 59 of 70 certainly entrusted with the public duties to provide free treatment to 1/3rd of indoor patients and 40% of OPD. It is expected to fulfill this public responsibility for the citizens of Delhi. We, therefore, reject the contention urged for the respondent No.2 on the maintainability of the writ petition.

INTERPRETATION OF CLAUSES IN AGREEMENT

56. Coming then to the question of interpretation of the clauses in the agreement we may reproduce the exact words of the Joint Venture Agreement as well as the lease deed:

Joint Venture Agreement:

'....The proposed company shall provide to the administrator the free facilities of medical, diagnostic and other necessary care through not less than one- third of the total capacity of 600 beds in the multi- specialty hospital as contemplated in this agreement or any part thereof which may be commissioned for the time. The hospital will also provide free of cost full medical, diagnostic and other necessary facilities to 40% of patient attending the out-patient department of the hospital.

Lease Deed

'6(i)...The Lessee shall provide free diet, medical diagnostic and such other facilities to the patients aforesaid as are required by the patients for indoor treatment.

(ii) That the Lessee shall also provide free medical diagnostic and other facilities for not less than 40% (Forty percent) of its out-door patients.'

57. In our opinion, the words in the agreement are of wide import and cannot be read in a narrow and pedantic manner. The words 'free of cost full medical diagnostic and other necessary facilities' would cover all the facilities including medicines and consumables. The words used in the agreement apart, the purpose underlying the setting of the hospital was that the prescribed percentage of patients from the poor and vulnerable sections of the society would receive free treatment in the hospital. The hospital was set up by the GNCTD with the intention to cater to the poor and vulnerable classes of the citizens of Delhi to the extent of 1/3rd of the indoor patients and 40% of OPD. It has been made clear in the Notice Inviting Tender that the hospital was to run on 'no profit no loss' basis. The GNCTD has provided a total of Rs.38.66 crores of capital investment along with 15 acres of prime land on Delhi-Mathura road on a notional rent of Re.1/- per month. These investments were made by the GNCTD to discharge its constitutional obligations to provide free medical treatment facilities to needy and deserving citizens. The intention of the State could never be that those who fall in that category would be required to fetch their own medicines or pay for the consumables. The terms of the agreement must, therefore, be interpreted rationally in order to ensure that the object underling the same is advanced. The hospital by taking the stand that such free patients are required to pay for consumables and medicines has made complete mockery of the scheme for providing free treatment to the poor and needy citizens. Viewed thus, the expression 'free medical diagnostic and other facilities' must be interpreted to mean

treatment not only in the nature of providing admission and accommodation to the hospital, diagnosis and investigation but free medicines and consumables also.

58. Our view is also supported by a decision of the Karnataka High Court in the case of Medical Relief Society of Karnataka v. Union of India, 1999 (111) ELT 327 (Kar). In that case the question primarily related to the interpretation of the notification No.64/88-Cus dated 1st March, 1988 issued by the Central Government in exercise of its powers under Section 25 of the Customs Act, 1962 and the eligibility of the petitioners for grant of exemption from payment of customs duty on the import of medical equipments from outside the country. The relevant portion of the notification reads as follows:

‘2. All such hospitals which may be certified by the said Ministry of Health and Family Welfare, in each case, to be run for providing medical, surgical or diagnostic treatment not only without any distinction of caste, creed, race, religion or language but also,- (a) Free, on an average, to at least 40 per cent of all their outdoor patients; and

(WP(C) 5410-1997) Page 62 of 70 (b) Free, to all indoor patients belonging to families with an income of less than rupees five hundred per month, and keeping for this purpose at least 10 per cent of all the hospital beds reserved for such patients; and

(c) At reasonable charges, either on the basis of the income of the patients concerned or otherwise, to patients other than those specified in clauses (a) and (b).’

One of the reasons, which the respondents have while refusing the benefit of the notification cited against to the petitioner was that they were not providing free treatment to indoor patients with family income with less than Rs.500/- per month. It was pointed out that what is provided by the hospital to such patients is not treatment but only free consultation and waiver of registration and ward charges. Insofar as consumables are concerned whether the same are in the form of medicines, injectibles or otherwise the patient is asked to purchase the same from the market for use in the hospital. The hospitals, on the other hand, contended that the notification did not envisage providing free medicines and other consumable articles to the indoor patients admitted to the hospital or to the outdoor patient treated free. Any interpretation making supply of medicines, it was contended, would make the entire scheme underlying the exemption unworkable and economically unviable for the hospitals. Rejecting the argument of the petitioner the Court held:

‘The question therefore is as to what exactly do the words ‘medical, surgical or diagnostic treatment’ appearing in para 2 of the notification mean. Stated differently does the term ‘treatment’ include application of remedies whether medical, surgical or diagnostic or would it be limited only to consultation and advice tendered to be patients. In the absence of any definition of the term treatment either in the exemption notification or the Customs Act, there is no option but to give the word its ordinary meaning as understood in common parlance....

.....

15. The words used in the notification apart, the purpose underlying the exemption unquestionably was to grant exemption only to hospitals, where the prescribed percentage of patients from the poorest of the poor sections of the Society with a family income of no more than Rs.500/- per month could get free treatment. It was contended by Mr. Shevgoor and perhaps rightly that in the current economic scenario with the purchasing power of the rupee

on the decline a family income of Rs.500/- is the barest minimum for survival. One can even say that those with that kind of income for an entire family are living on the edge and may be a vanishing special specie. What however is evident from the limit on the income placed by the authority issuing the notification is that it had in mind the poorest of the poor sections of the Society when a provision for exemption of duty on import of equipment was made. The intention of the authority issuing the notification could never be that those, who fall in the category should be satisfied with free advice of a Doctor in the hospitals getting exemption and should even as indoor patients fetch their own medicines or pay for the consumables. To attribute that intention to the Government would amount to frustrating the very purposes behind the grant of exemption. If a patient who, falls in the eligible category is also required to pay for the medicines and other consumable items used by the hospital in his/their treatment, it would render any such treatment in the hospital a luxury which he can ill afford. The notification has, therefore, to be interpreted rationally in order to ensure that the object (WP(C) 5410-1997) Page 64 of 70 underlying the same is advanced. The predominant object behind the grant of an exemption, which ran into hundreds of crores if not thousands was to ensure that the poorest in the society have an advantage of being treated free in such hospitals. The colossal amount of duty involved in the exemption could not conceivably be waived or given up by the Government only for purposes of providing free consultation to such patients. Viewed thus, the expression medical, surgical or diagnostic treatment in the exemption notification must be interpreted to mean treatment not only in the nature of providing admission and accommodation to the hospital, diagnosis and investigation, but free medicines and consumables also.'

59. A disturbing feature which we noticed is as per the figures submitted by the hospital itself the expenditure on consumables and medicines is Rs.186 crores out of the total hospital revenue of Rs.391.19 crores. It was pointed out by the counsel for the State that G.B. Pant Hospital, a super specialty hospital having 600 beds run by the GNCTD, spent only around Rs.23 crores in the year 2008 on consumables and medicines. Learned counsel appearing for the petitioner contended that the promoters have set up front companies from whom consumables and medicines are bought at a very high rate. This is vehemently disputed by the counsel for the hospital. We do not wish to express any opinion on this aspect except that the government will enquire into this aspect and ascertain whether such high expenditure is justified.

60. In our opinion, clauses of the agreement are absolutely clear in their meaning and the free treatment would also include consumables and medicines. However, the hospital has managed to avoid its responsibility to serve to the interest of the citizens for more than fifteen years by raising one or other frivolous objection. The land was given to the hospital at a token rent of Re.1 per month. In addition to the land, the GNCTD contributed substantially to the equity capital as well as to the construction of the hospital. Total investment of the GNCTD is more than Rs.38 crores. It is not permissible for the hospital to turn around and avoid the responsibility undertaken by it under the agreement. In this regard, the following observations of Justice B.P.Jeevan Reddy in Union of India and Another v. Jain Sabha, New Delhi and Another, (1997) 1 SCC 164, though made in the context of educational institutions, are pertinent :

'Where the public property is being given to such institutions practically free, stringent conditions have to be attached with respect to the user of the land and the manner in which schools or other institutions established thereon shall function. The conditions imposed should be consistent with public interest and should always stipulate that in case of violation

of any of those conditions, the land shall be resumed by the government. Not only such conditions should be stipulated but constant monitoring should be done to ensure that those conditions are being observed in practice. While we cannot say anything about the particular school run by the respondent, it is common knowledge that some of the schools are being run on totally commercial lines. Huge amounts are being (WP(C) 5410-1997) Page 66 of 70 charged by way of donations and fees. The question is whether there is any justification for allotting land at throw-away prices to such institutions. The allotment of land belonging to the people at practically no price is meant for serving the public interest, i.e., spread of education or other charitable purposes; it is not meant to enable the allottees to make money or profiteer with the aid of public property.'

DIRECTIONS

61. Despite lapse of more than 15 years there has been hardly any implementation of the conditions of the agreement providing for free treatment to indoor and outdoor patients. The Committee has submitted two reports which clearly show that the IMCL has flouted the conditions with impunity. It is in these circumstances necessary to issue the following directions in order to ensure implementation of the clauses in the agreement regarding free treatment:

(i) The respondents are directed to provide 1/3 of the free beds i.e. 200 beds with adequate space and necessary facilities to the indoor patients and also to make necessary arrangement for free facilities to 40% of the outdoor patients;

(ii) All government hospitals having speciality or super-speciality and even if it is general hospital shall and establish Special Referral Centres (Counters/Rooms). These centres shall be part of the casualty as well as regular OPDs of the Hospital.

The patients in critical condition, brought to the casualty of the hospital, if necessary, be referred by the Medical Superintendent/Director of the hospital for immediate treatment to the Indraprastha Apollo Hospital;

(iii) At the time of making reference records in triplicate shall be prepared. One copy of the same shall be given to the patient; second copy to the Director General Health Services and the third copy would be maintained by the hospital. The Indraprastha Apollo Hospital shall admit such patients and treat them free of any expenses in relation to admission, bed, treatment, surgery etc., including consumables and medicines. In other words, such patients would not be required to pay any expenses for their treatment in the Indraprastha Apollo Hospital;

(iv) When the patient is treated and discharged from the hospital, the hospital shall submit a report to the referral hospital with a copy to the DGHS indicating complete details of the treatment and the expenditure incurred thereon;

(v) Person entitled to free treatment as indoor patients (33% of the total beds) should be properly identified and classified.

Priority norms for such classification shall be as follows:

a) Person of below poverty line, identified on the basis of ration card;

b) Person referred by the hospital of the GNCTD; c) Class-III and Class-IV employees of the GNCTD; (WP(C) 5410-1997) Page 68 of 70 d) Any other poor or needy person on the recommendation of the Secretary (Health).

vi) Emergency patients upto a total of five per day, irrespective of any referral shall be admitted.

vii) Outpatient (OPD) facilities need to reach to the people and for this, the IMCL is directed to prominently display within its compound, as well as through advertisements, that 40% of OPD patients are entitled for free treatment.

viii) IMCL shall scrupulously maintain records about free treatment and paid treatment, which shall be open to inspection at all time by the DGHS, the GNCTD or his nominee.

ix) IMCL shall submit quarterly reports about free treatment provided to indoor and outdoor patients in the format to be devised/specified by the Principal Secretary (Health)/DGHS within four weeks from today indicating complete details of treatment and expenditure incurred thereon and such other information/material as considered necessary.

x) Records of the hospital and the information sent in the prescribed format to the concerned authority from time to time shall be subjected to half-yearly audit by the Principal Secretary (Health)/DGHS with the help of a Chartered Accountant/officers from the office of Comptroller General of Accounts and report thereof shall be submitted to the special committee comprising Chief Secretary and others, set up by the GNCTD for the purpose of this matter.

62. In our opinion, this is a fit case for imposing exemplary cost on IMCL which has contested the matter and raised several frivolous objections to avoid its responsibility to give free treatment to the citizens as envisaged under the agreement. IMCL shall pay Rs.2 lacs as costs, to be paid in equal shares to the petitioner and the GNCTD.

63. The writ petition stands disposed of in the above terms.

CHIEF JUSTICE

SEPTEMBER 22, 2009 MANMOHAN, J ‘v’