



## General Studies-2; Topic: Issues relating to development and management of Social Sector/Services relating to Health, Education, Human Resources.

### Strengthening Critical Care Governance in India

#### Introduction

- The **Supreme Court (SC)** recently reprimanded senior health officials of **28 States and Union Territories** for adopting a "casual approach" towards framing **uniform guidelines for ICUs and CCUs** in hospitals.
- The issue dates back to **2016**, when the SC recognized the **need for nationwide guidelines** for ICU and CCU treatment standards.
- A **Central Committee** under the **Directorate General of Health Services (DGHS)** prepared **model guidelines in 2023**, but these required **state-specific recommendations** since *health is a State subject* under the Constitution.
- Despite repeated directions, **most States failed to respond**, forcing judicial intervention.

#### Why ICU/CCU Guidelines are Critical

- Absence of national standards leads to wide disparities in critical-care treatment, increasing risks of negligence and mortality.
- Clear admission, treatment, and discharge norms protect patients' rights and doctors from unnecessary litigation.
- Standard criteria prevent misuse of ICU beds and ensure better allocation of limited medical resources.
- Consistent protocols reinforce citizens' faith in public health institutions.
- Ensures similar quality of care across states, towns, and villages, reducing health inequity.

#### Constitutional and Governance Dimensions

- Health falls under the **State List (Seventh Schedule)**, making States primarily responsible for health infrastructure.
- The SC's directive reflects **judicial activism** to uphold the *right to quality healthcare* as part of **Article 21**.

- The case underscores the need for cooperation between the Centre and States to harmonise standards in a decentralised health system.
- Personal affidavits ensure that senior bureaucrats bear **direct responsibility** for compliance.

## Challenges in Implementation

- Many districts lack basic critical-care facilities or even **Level 1 trauma centres**.
- Deficit of intensivists, anaesthesiologists, and critical-care nurses hampers effective implementation.
- Around 60% of ICU beds are in private hospitals, where enforcement of uniform norms is difficult.
- Smaller States struggle to invest in advanced ICUs due to limited health budgets.
- Delays in forming committees, inter-departmental coordination issues, and lack of urgency among State health departments.
- Weak inspection mechanisms and absence of real-time data systems to track ICU outcomes.

## Broader Multi-Dimensional Implications

- Strengthened ICU systems directly enhance **emergency and disaster response capacity**—vital during pandemics or mass-casualty events.
- Reduces mortality from **road accidents, sepsis, and non-communicable diseases** requiring intensive care.
- Judicial oversight ensures the **enforceability of health rights**.
- Establishes a precedent that **healthcare standards are justiciable**, not merely policy goals.
- Rational use of ICUs can lower **catastrophic out-of-pocket expenditures** for families.
- Promotes cost-effective healthcare delivery by preventing unnecessary ICU admissions.
- Ensures equitable access to life-saving care, irrespective of income or geography.
- Addresses ethical dilemmas on life support and withdrawal decisions through standardised protocols.
- Encourages data-driven governance through audit systems, performance metrics, and hospital grading.
- Promotes **transparency** and **accountability** in health management.

## The Role of the Judiciary

- The SC's intervention highlights its role as **guardian of constitutional rights** when executive inaction affects public welfare.
- Such judicial activism aligns with earlier health-related rulings—on oxygen supply during COVID-19, medical negligence, and pollution control.
- The directive strengthens **citizen-centric governance** and signals zero tolerance for neglect in life-saving sectors.

## Way Forward

- States must conduct consultations with hospitals, doctors, and public health experts to localise the central template.
- Expand training of intensivists and ICU nurses through medical colleges and digital courses.
- Use **PM-ABHIM** and **NHM** funds to upgrade district hospitals with modular ICUs.
- Offer viability-gap funding or CSR incentives for private hospitals adhering to national norms.
- Create **national ICU dashboards** for real-time data on bed occupancy, mortality rates, and compliance.
- Independent quality certification by NABH/NQAS to ensure periodic evaluation.
- Empower patients and families to know their rights regarding ICU admissions and treatment.
- Guidelines must evolve with medical technology and periodic peer reviews.

## Conclusion

- The SC's stern stance reaffirms that **quality healthcare is integral to the Right to Life**.
- The judgment is a reminder that **policy without implementation is injustice**, especially in healthcare where delays cost lives.