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HUMAN RIGHTS CRISIS OF PUBLIC HEALTH POLICY: COMPARATIVE PERSPECTIVES ON THE PROTECTION AND PROMOTION OF ECONOMIC AND SOCIAL RIGHTS

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Abstract

The right to health is a fundamental right and to ensure its implementation, public health policy needs to be critically examined from a human rights standpoint. This article examines the right to health as an essential right in the economic and social rights discourse. A strict distinction between civil and political rights on the one hand, and social and economic rights on the other hand, is no longer valid in modern human rights discourse, and the state has an obligation to ensure the enforcement of both these categories of rights. Indian constitutional law, international human rights law and the jurisprudence developed by courts in India have underscored the importance of recognizing economic and social rights. This article explores how the right to health can be developed and promoted as a fundamental right falling within the umbrella of economic and social rights. It also examines the role of national human rights institutions in implementing economic and social rights, including the right to health. The article examines the healthcare situation in India and highlights the inadequacies of law and public policy to deal with issues relating to public health. The article argues for the constitutionalization of economic and social rights in India, focusing on the right to health. While the jurisprudence around the right to education has been very robust, the same has not been the case for the right to health. The article proposes a constitutional amendment to entrench the right to health as a fundamental right in the Indian Constitution and addresses how the right should be so entrenched. The article also explores the public health challenge in Hong Kong and Mainland China during the SARS crisis and uses this as a case study to develop an argument around the implementation of right to health as a social and economic right in India.

I. INTRODUCTION

Human rights have acquired a powerful language of empowerment. They have created opportunities for people and societies to galvanise social consciousness with a view to seeking rights and creating remedies to be provided by governments and power holders. They have embraced the new realities of transparency and accountability in every exercise of power. One of the remarkable achievements of contemporary human rights movement has been its ability to create a meaningful integration between civil and political rights and economic, social and cultural rights.

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While this integration is challenged and met with stiff resistance at times by governments themselves, there is a growing need for such recognition in different aspects of public policy.

Public health policy is a critical area, which deserves a deeper examination from a human rights standpoint. Public health is a significantly neglected aspect of public policy and no society can legitimately ignore public health without violating basic human rights of its people. The policy aspect of public health is central to formulating and implementing health policy of a society, the normative recognition of the right to health and its implementation through institutions and processes will be essential to create frameworks of accountability.

The article provides for a critical examination of the right to health as an essential right in the economic and social rights discourse. The article is expected to highlight the inadequacies of law and public policy to deal with health issues. Health is fundamental to one's existence. Public health crisis demonstrates that without a sound system of dealing with heath care, unnecessary sufferings and deaths could be caused.

There is a need to recognize that there is a solemn duty on the part of the government to protect one's fundamental right to health as part of economic and social rights. The SARS crisis in Hong Kong and Mainland China that happened a few years back and the continuing public health crisis in India clearly demonstrate that all progress and development can come to a standstill unless the government and its machinery work under a system of transparency and accountability. There is a need to pay attention on the following issues: a. the relevance of the fundamental right to health and its implications for formulating rights-based approaches to promoting good public health practices; b. the availability and scope of tortious remedies for victims; c. the need for greater transparency and accountability in governmental conduct in matters relating to public health.

While tort law deals with the question of health from the standpoint of compensating individual victims, it does not come to play until certain relationships are established between the victim and the perpetrator of the wrong. Moreover, as the SARS crisis in Hong Kong demonstrated, the law relating to liability of public authorities[1] and health care institutions is in state of flux.[2] Traditional principles of common law, which distinguish between policy and operational decisions, may not be helpful.

More importantly, the SARS crisis should also be seen as having significant implications for human rights and governance. Human rights in all its ramifications has acquired much importance in the contemporary world by the increasing tendency

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1 *SARS: How A Global Epidemic Was Stopped* (WHO, Geneva, 2006), available at <http://whqlibdoc.who. int/wpro/2006/9290612134_eng.pdf> (last visited on December 27, 2012); and D. P. Fidler, *SARS, Governance and the Globalization of Diseases* (Palgrave Macmillan, New York, 2004).

2 Yanjhong Huang, *The SARS Epidemic and it's Aftermath in China: A Political Perspective,* Stetson Hall University, available at <http://www.ncbi.nlm.nih.gov/books /NBK92479/> (last visited on December 27, 2012).

of national governments to include these rights in their respective laws. Courts in different jurisdictions are interpreting human rights, including economic and social rights, which cover the fundamental right to health.[3] The commitment to implement the economic and social rights is largely due to the influence of the global movement towards recognizing human rights and fundamental freedoms. The Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) have acquired greater legitimacy in the last few decades as more and more nations have realized the importance of these human rights instruments for better governance.

The right to health as a part of the international human rights law has been recognized by the ICESCR. In 2000, the UN Committee on Economic, Social and Cultural Rights stated that, "The right to health is not to be understood as a right to be healthy". It is "an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation".[4] Further, the right to health encompasses freedoms such as the right to be free from non-consensual medical treatment, and entitlements and the right to a system of health protection.[5] At the same time it has long been recognized that the protection of civil and political rights in a free society where health issues are freely reported and discussed is vital to the right to health.

This article will explore how right to health can be developed and promoted as a fundamental right falling within the umbrella of economic and social rights. Part II of the article will discuss the importance of economic and social rights and how access to justice is significant in promoting these rights. It will also examine the role of national human rights institutions in implementing economic and social rights including the right to health. Part III will discuss the constitutionalization of economic and social rights in India, focusing on the right to education and right to health. The article argues that while the jurisprudence around the right to education has been very robust, the same has not been the case for right to health. This part will also examine the healthcare situation prevailing in India. The final part will examine the public health challenge in Hong Kong during the SARS crisis. The article uses this as a case study to develop an argument around the implementation of right to health as a social and economic right.

II. IMPLEMENTING ECONOMIC AND SOCIAL RIGHTS THROUGH ACCESS TO JUSTICE

Human rights discourse has come to accept economic, social and cultural rights (ESCR) as important as civil and political rights (CPR). Human rights are universal,

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3 See *infra* 138 at para. 67.

4 Committee on Economic, Social and Cultural Rights, *General Comment No. 14 (2000) on the Right to the Highest Attainable Standard of Health,* UN Doc. E/C.12/2000/4, 4 July 2000 (hereafter "General Comment No. 14").

5 John Tobin, *The Right to Health in International Law* (2011), p. 211.

indivisible and interdependent and hence, it is no longer a persuasive argument to say that a society needs to wait for a while before they can have CPR or for that matter ESCR.[6] But the recognition of ESCR to be the same as CPR does not ensure the existence of an enforcement mechanism. Article 2 of the ICESCR describes the type of legal obligations that arise under the Covenant.[7] The states are required to take steps to the maximum of their available resources so that the ICESCR are progressively realized through all available means.[8] It is also useful to note that the *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights* also require states to use "all appropriate means, including legislative, administrative, judicial, economic, social and educational measures," to fulfill their obligations under the Covenant.[9]

In the same vein, the *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* noted that, "Like civil and political rights, economic, social and cultural rights impose three different types of obligations on States: the obligations to respect, protect and fulfill. Failure to perform any one of these three obligations constitutes a violation of such rights. The obligation to respect requires States to refrain from interfering with the enjoyment of economic, social and cultural rights…The obligation to protect requires States to prevent violations of such rights by third parties…The obligation to fulfill requires States to take appropriate legislative, administrative, budgetary, judicial and other measures towards the full realization of such rights…"[10]

The Human Development Reports of the United Nations Development Programme (UNDP) further demonstrate the growing importance of ESCR by assessing countries on the basis of Human Development Index (HDI), which takes into consideration a number of factors to assess the state of development, rather than the much narrower Gross Domestic Product (GDP) which takes into account

6 For an important article on the incorporation of international human rights in a few selected Constitutions of certain countries, see Yash P. Ghai, "Universalism and Relativism: Human Rights as a Framework for Negotiating Interethnic Claims", *Cardozo Law Review*, vol. 21 (2000), p. 1095.

7 "Human Rights Commissions and Economic and Social Rights", *Research Paper, Policy and Education Branch*, Ontrario Human Rights Commission (OHRC), Canada, p.8, available at <http://www.ohrc.on.ca/english/consultations/economic-social-rights-paper.pdf> (last visited on January 1, 2013).

8 *Ibid.*

9 See The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN doc. E/CN.4/1987/17, Annex; and *Human Rights Quarterly*, vol. 9 (1987), pp. 122–135, available at <http://www.abo.fi/instut/imr/ESC-files/Kap1/The%20Limburg%20principles%20on%20the%20Implementation%20of% 20the% 20ICESCR.doc> (last visited on January 1, 2013).

10 See The Maastricht Guidelines on Violation of Economic, Social and Cultural Rights, *Human Rights Quarterly*, vol. 20 (1998), pp. 691–705, available at <http://www.abo.fi/instut/imr/ESC-files/Kap1/The%20Maastricht%20Guidelines%20on% 20Violations%20of% 20Economic, %20Social%20and%20Cultural%20Rights.doc> (last visited January 1, 2013).

only the economic growth of the country.[11] The Millennium Development Goals (MDG)[12] and the Millennium Declaration[13] have reiterated the need for responding to serious human deprivations in the third world.

Many of the challenges facing the third world are indeed violations of ESCR. To focus on ESCR does not imply undermining the CPR or the achievements that we have gained in CPR.[14] Rather, it means that historically there has been far too much emphasis on CPR and it is time now to correct this anomaly and to give ESCR the same status as CPR. The international human rights framework has provided an Optional Protocol (OP)[15] to the ICCPR by creating a UN Human Rights Committee that is an institutional system for monitoring CPR violations. While as of now, there is no similar body as far the ICESCR is concerned, CESCR adopted an OP[16] that can ultimately help in creating such an institution, but the OP is not yet in force. But the mere absence of international institutional machinery should not discourage anybody to give the same importance to ESCR as they give to CPR.

The difference between CPR and ESCR is artificial and this has been proved time and again when it comes to actual enforcement of human rights. A notable example is the work of the Supreme Court of India[17] in expanding the "right to life" provision in the Constitution of India to include "right to education"[18] and a number of other provisions.[19] The activist judiciary was willing to overcome the barriers to

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11 See Human Development Reports, available at <http://hdr.undp.org/en/reports/> (last visited on December 31, 2012).

12 Millennium Development Goals, available at <http://www.undp.org/content/undp /en/home/mdgoverview.html> (last visited on December 31, 2012).

13 United Nations Millennium Declaration, 2000, available at <http://www.un.org/ millennium/declaration/ares552e.htm> (last visited on December 31, 2012).

14 See generally Marten Kjorem, "The Role of National Human Rights Institutions in Implementing Economic, Social and Cultural Rights", *EU-China Dialogue on Human Rights*, Beijing, 30-31 May 2002, available at <http://www.humanrights.dk/upload/application/54e00b7c/1cpdf.pdf> (last visited on January 1, 2013).

15 Optional Protocol to the International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966) [hereinafter Optional Protocol] (establishing a committee with authority to review alleged human rights violations). See generally Henry Steiner & Philip Alston, *International Human Rights in Context* (Oxford University Press, Oxford, 2nd edn., 2000), pp. 705-78 (analyzing the functions of the U.N. Human Rights Committee under the ICCPR Optional Protocol).

16 Optional Protocol to the International Covenant Economic, Social and Cultural Rights, A/RES/63/117 (2008).

17 See Vijayashri Sripati, "Toward Fifty Years of Constitutionalism and Fundamental Rights in India: Looking Back to See Ahead (1950-2000)", *American University International Law Review*, no. 14 (1998), pp. 413, 458.

18 See generally Vijayashri Sripati & Arun K. Thiruvengadam, "India: Constitutional Amendment Making the Right to Education a Fundamental Right", *International Journal of Constitutional Law*, vol. 2 (2004), pp. 148-58.

19 For further reading, see C. Raj Kumar, "International Human Rights Perspectives on the Fundamental Right to Education: Integration of Human Rights and Human Development in the Indian Constitution", *Tulane Journal of International and Comparative Law*, no. 12 (2004), p. 237.

justiciability of ESCR, and understand the context in which some rights were made justiciable by their presence in the chapter on Fundamental Rights and others being non-justiciable by their presence in the chapter on Directive Principles.[20]

It may be argued that "right to life" in its narrow conception is a negative civil and political right whereby the state cannot take away the life of a person without proper procedures and the right to education is a positive economic and social right.[21] But in reality, the so-called dichotomy prevailing between these two sets of rights are one of reinforcement and integral recognition so that social justice is achieved.[22] Even the criticism that ESCR are merely policy objectives and cannot provide a legal basis for enforcement has been overcome in the South African constitutional law.[23] The South African Constitution[24] has a broad range of ESCR such as access to adequate housing,[25] health care services, including reproductive health care,[26] sufficient food and water[27] and social security,[28] including suitable social assistance.[29] Article 27(2) requires the state to "take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights".[30]

According to Indian political analyst Mahesh Rangarajan, "the idea of political rights is more established in India than social rights". This is one of the reasons

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20 For an important and excellent article on integration of fundamental rights and directive principles of state policy in India, see Mahendra P. Singh, "The Statics and the Dynamics of the Fundamental Rights and the Directive Principles—A Human Rights Perspective", *Journal Section, Supreme Court Cases (SCC)*, (2003) 5 SCC (1), 1-14 (India); available at <http://www.ebc-india.com/lawyer/articles/2003v5a4.htm> (last visited on January 2, 2013).

21 For further reading, see Cecil Fabre, *Constitutionalising Social Rights*, *Journal of Political Philosophy*, vol. 6(3) (1998), p. 263; Henry Shue, *Basic Rights: Subsistence, Affluence and Foreign U.S. Policy* (1980), who argues that although ordinarily rights are classified as positive rights and negative rights, all rights impose duties which can be classified into positive duties and negative duties.

22 See Seattle Journal for Social Justice, Social Justice is the Will of the People: An Interview with Noam Chomsky, Transforming Social Justice, (Spring/Summer 2005), WL 3 SEAJSJ 471.

23 For further reading on the constitutionalization of right to education in South Africa, see Eric Berger, "Note, The Right to Education under the South African Constitution", *Columbia Law Review*, no. 103 (2003), p. 614.

24 See generally Shedrack C. Agbakwa, "Reclaiming Humanity: Economic, Social, and Cultural Rights as the Cornerstone of African Human Rights", *Yale Human Rights & Development Law Journal*, no. 5 (2002), pp. 177, 203.

25 South African Constitution, Article 26, available at <http://www.polity.org.za/html /govdocs/constitution/saconst02.html?rebookmark=1#27> (last visited on January 2, 2013).

26 *Ibid.*, Article 27(1)(a).

27 *Ibid.*, Article 27(1)(b).

28 *Ibid.*, Article 27(1)(c).

29 See generally Makau wa Mutua, "Hope And Despair For A New South Africa: The Limits Of Rights Discourse", *Harvard Human Rights Journal*, no. 10 (1997), p. 63.

30 *Note* 25, Article 27(2).

affecting universal public health coverage in India.[31] However, this idea of dichotomy between CPR and ESCR is slowly disappearing. Notably, in southern and western India, reformists took up health and education as key priorities, such that these social movements started impacting the politics in the region leading to policies on these ESCR rights.[32]

An overtly legalistic approach to human rights[33] has unfortunately failed to recognize the significance of access to justice in third world legal and justice systems,[34] concerning the capability of people to approach the courts of law or other governance institutions for enforcement of their rights. ESCR, if properly enforced, serve as empowering tools that will enable the protection of access to justice as a human right.[35] The citizenry of a state will be able to access the civil and criminal justice systems for the protection of their CPR better, if their ESCR are protected, promoted and fulfilled.

Rule of law in its modern sense encompasses a number of things, including the supremacy of the law, a concept of justice, restrictions on the exercise of discretionary powers, the need for an independent judiciary, and also includes the protection and promotion of human rights.[36] While scholars continue to debate over the exact meaning of the rule of law, countries worldwide have recognized the need for the protection of the rule of law as a fundamental fabric of their society.[37]

The goal of development is the enrichment of lives and freedoms of people worldwide.[38] Development policies have been subject to criticism due to the negative impact of globalization and the consequent marginalization of people.[39] While human rights discourse is continuously challenging the contemporary development paradigm,[40] the rule of law initiative can provide an important basis for understanding

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31 Patralekha Chatterjee, "Seeing Health Care as a Human Right in India", *The Lancet*, p. 377 (January 15, 2011), available at <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673611600317 .pdf> (last visited on January 17, 2013).

32 *Ibid.*

33 See Laurence R. Helfer, "Overlegalizing Human Rights: International Relations Theory and the Commonwealth Caribbean Backlash against Human Rights Regimes", *Columbia Law Review*, vol. 102 (2002), p. 1832.

34 See Upendra Baxi, "Voices of Suffering and the Future of Human Rights", *Transnational Law and Contemporary Problem*, vol. 8 (1998), p. 125.

35 Jeanne M. Woods, "Justiciable Social Rights as a Critique of the Liberal Paradigm", *Texas International Law Journal*, vol. 38 (2003), pp. 763 and 792.

36 See generally Richard H. Fallon, Jr., "The "Rule of Law" as a Concept in Constitutional Discourse", *Columbia Law Review*, vol. 97 (1997), p. 1.

37 See William C. Whitford, "The Rule of Law", *Wisconsin Law Review*, (2000), p. 723.

38 See Amartya Sen, *Development as Freedom* (1999).

39 Richard Klein, "Cultural Relativism, Economic Development and International Human Rights in the Asian Context", *Touro International Law Review*, vol. 9 (2001), pp. 1, 6-7, 25.

40 J. Oloka-Onyango, "Reinforcing Marginalized Rights in an Age of Globalization: International Mechanisms, Non-State Actors, and the Struggle for Peoples' Rights in Africa", *American University International Law Review*, 18 (2003), pp. 851, 852.

key development issues in parts of Asia and Africa.[41] Further, the implementation of ESCR will help in the protection of the rule of law. There is a need to understand the meaning of the rule of law in the development context for giving due recognition to the ESCR rights.[42] What this means is that realization of the ESCR rights is looked at under a broader context that will:

a. help in the protection of the rule of law and result in promoting development resulting in social change and social engineering;
b. help understand the policies and practices of developing countries with a view to promoting good governance;
c. help understand the role and limitations of judiciaries and the extent to which legal and judicial reform initiatives have responded to ESCR violations and helped promoting sound development policies; and
d. help understand as to how the relationship between rule of law and development is relevant for understanding issues relating to poverty and human rights,[43] trade and development, corruption and good governance and also health and human security.

A. Role of National Human Rights Institutions

Developmentalization of human rights is about recognizing the integral understanding of CPR and ESCR. The Declaration on the Right to Development is a first step in that direction where human rights based approaches to development becomes the part of the governance process.[44] The National Human Rights Institutions (NHRIs) should be key players domestically in the process of developmentalization of human rights. It is useful to refer to the work of South African Human Rights Commission, which is explicitly mandated to monitor economic, social and cultural rights.[45] The Commission is required to investigate, report and carry out research so as to ensure the conformity to economic and social rights.[46] It is supposed to take steps to redress if and when violations occur. On an

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41 See generally Jeremy Sarkin, "The Drafting of South Africa's Final Constitution from a Human Rights Perspective", *American Journal of Comparative Law*, vol. 47 (1999), p. 67.

42 See Ronald J. Daniels and Michael Trebilcock, "The Political Economy of Rule of Law Reform in Developing Countries", *Michigan Journal of International Law*, (Fall 2004), p. 99.

43 See generally Jeremy Cooper, "Poverty and Constitutional Justice: The Indian Experience", *Mercer Law Review*, vol. 44 (1993), pp. 611, 611-12.

44 Declaration on the Right to Development, A/RES/41/128 (1986).

45 See "About the SAHRC; available at <http://www.sahrc.org.za/home/index.php?ipkContentID=1&ipkMenuID=28> (last visited on January 2, 2013).

46 Marten Kjorem, "The Role of National Human Rights Institutions in Implementing Economic, Social and Cultural Rights", *EU-China Dialogue on Human Rights*, Beijing, 30-31 May 2002, available at <http://www.humanrights.dk/upload/application/54e00b7c/1cpdf.pdf> (last visited on January 2, 2013).

annual basis, the commission is supposed to request the concerned instrumentalities of the state to provide it with information measures towards the realization of ESCR.[47]

Many NHRIs are already performing the role of upholding CPR. Post 9/11, a number of countries have passed various legislations in the form of anti-terrorism laws[48] with a view to protecting national security. These laws have on numerous occasions violated domestic and international human rights norms and indeed intruded into civil liberties.[49] The NHRIs are ideally suited to intervene on these matters when they can engage with the government to ensure that the laws that are being passed with respect to national security do not violate civil liberties.

The NHRIs ought to be playing a pioneering leadership role in developing the human rights discourse domestically. This will involve being abreast with important discussions that are taking place worldwide in the field of human rights and to take steps to determine as to how to integrate these matters into the domestic legal, constitutional and institutional framework. National security will remain a key human rights issue in a number of countries worldwide and its potential consequence for human rights and civil liberties is obvious.[50] The UN Secretary General's recent report "In Larger Freedom" has focused on the relationship between security, development and human rights in the international context.[51] The NHRIs should be bringing this debate in the domestic context and address terrorism and human rights issues more holistically. Moreover, narrow perceptions of security fail to recognize the threats due to infectious diseases like SARS within the governance agenda. NHRIs are best suited to understand the relationship between CPR and ESCR, not only from a legal standpoint, but also from a practical implementation standpoint.

The NHRIs worldwide need to develop a focus on ESCR. This focus can be developed on the basis of adopting an international and comparative approach to the work of the NHRIs. There are few NHRIs, which have started to take cognizance of ESCR violations. The many other NHRIs need to develop capacities and jurisprudence relating to economic and social rights. Transnational conversations among NHRIs in a region or among other regions of the world are helpful to understand how ESCR issues have been dealt with by other NHRIs.

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47 *Ibid*.

48 For an extensive discussion of the question as to what constitutes terrorism, see Emanuel Gross, "Legal Aspects of Tackling Terrorism: The Balance Between the Right of a Democracy to Defend Itself and the Protection of Human Rights", *U. C. L. A. Journal of International Law & Foreign Affairs,* vol. 6 (2001), p.89.

49 For an interesting read on the impact of these acts on human rights, see Philip B. Heymann, "Civil Liberties and Human Rights in the Aftermath of September 11", *Harvard Journal of Law and Public Policy*, vol. 25 (2002).

50 See C. Raj Kumar, "Human Rights Implications of National Security Laws in India: Combating Terrorism while Preserving Civil Liberties", *Denver Journal of International Law and Policy*, (Spring 2005), p. 195.

51 Report of the U.N. Secretary General, *In Larger Freedom: Towards Development, Security and Human Rights for All*, (New York, USA, March 2005), available at <http://www.un.org/largerfreedom/contents.htm> (last visited on January 2, 2013) [hereinafter In Larger Freedom].

III. CONSTITUTIONALISATION OF ECONOMIC AND SOCIAL RIGHTS IN INDIA

A. Right to Education

Education as an economic and social right has been on the central stage since the adoption of the Indian Constitution.[52] To realize this ESCR, government of India appointed the Education Commission (1964-66) which recommended the 'common school approach'[53].[54] This was followed by another recommendation by the National Policy in 1968[55] which mooted for a free and compulsory education.[56] Further, the National Policy for Education (NPE) of 1986 aimed at a comprehensive policy framework for the development of education.[57] Another follow up in the spate of activities was opening up of Department of Primary Education under the Ministry of Human Resource Development (HRD) in New Delhi.[58]

The primary education policy[59] was launched under the scheme of Sarva Shiksha Abhiyan in 2001 at district level across the country.[60] These efforts proved to be soft and lacked precision.[61] The real impetus was created by the judicial process through a number of public interest litigations, which carved the future of education in India.[62] Judgments in *Mohini Jain v. State of Karnataka*[63] and *Unnikrishnan J.P. v. State of A.P.*[64] set the movement of recognizing right to education as fundamental right in motion.

In *Mohini Jain's case*, the court held that the state has an obligation to discharge

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52 T.N. Siqueira, *The Education of India* (Oxford University Press, Bombay, 1952).

53 Right to Education under Indian Constitution, available at <http://www.law-essays-uk.com/resources/sample-essays/indian-law/right-to-education-under-indian-constitution.php> (last visited on December 29, 2012).

54 K. G. Siayidian, et. al., Compulsory Education in India (Universal Book and Stationery Co., Delhi, 1966).

55 National Policy on Education, 1968, available at <http://www.indg.in/primary-education/policiesandschemes/national_policy_on_education_1968.pdf> (last visited on 14 January 2013).

56 Madhav Godbole, "Elementary Education as a Fundamental Rights: The Issues", *Economic and Political Weekly*, vol. 36, no. 50 (December 15-21, 2001).

57 S Evans, "Improving Human Rights Analysis in the Legislative and Policy Processes", *Melbourne Law School Legal Studies*, Research Paper No. 124, July 2005, available at <http://ssrn.com/abstract=771225> (last visited on December 30, 2012).

58 J P Naik, *Equality, Quality and Quantity, The Elusive Triangle in Indian Education* (Allied Publisher, New Delhi, 1975).

59 See "Elementary and Adult Education in India – Historical Perspective", Report of National Development Council Committee on Literacy, Planning Commission, 1993, available at <http://education.nic.in/cd50years/y/3P/45/3P450401.htm> (last visited on December 30, 2012).

60 Ramchandra Padma and Vasantha Ramkumar, *Education in India*, (National Book Trust, India, 2005).

61 See K Halvorsen, "Notes on the Realisation of the Human Right to Education", *Human Rights Quarterly*, vol. 12(3), (1990), p. 341.

62 *Infra* at 63 and 64.

63 AIR 1992 SC 1858.

64 AIR 1993 SC 2178.

its duty of providing educational institutions so that the citizens can enjoy their right to education.[65] The court further held that the state can discharge its duty either by establishing state educational institutions or by recognising private education institutions.[66]

This was followed by *Unnikrishnan's case* immediately next year. The court not only reprimanded the government institutions for being reluctant in enforcing Article 45, which directs the state to provide free and compulsory education for all children up to age of fourteen years, but also held that every child who is deprived of the right to education can get issued a writ of mandamus against the appropriate authority for the enforcement of their deprived right.[67] Court in *Unnikrishnan's case* not only gave primacy to Article 41, 45 and 46 of DPSP but also emphatically recognized India's obligation and commitment to make right to education as a fundamental right under the International Covenant for Economic Social and Cultural Rights.[68] Article 13[69] and 14[70] of ICESCR exerted pressure on

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65 *Note* 63.

66 *Note* 63.

67 *Note 64* at para. 15-20.

68 *Note* 19.

69 Article 13 (1)- The States Parties to the present Covenant recognize the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms. They further agree that education shall enable all persons to participate effectively in a free society, promote understanding, tolerance and friendship among all nations and all racial, ethnic or religious groups, and further the activities of the United Nations for the maintenance of peace.
(2) The States Parties to the present Covenant recognize that, with a view to achieving the full realization of this right:
(a) Primary education shall be compulsory and available free to all;
(b) Secondary education in its different forms, including technical and vocational secondary education, shall be made generally available and accessible to all by every appropriate means, and in particular by the progressive introduction of free education;
(c) Higher education shall be made equally accessible to all, on the basis of capacity, by every appropriate means, and in particular by the progressive introduction of free education;
(d) Fundamental education shall be encouraged or intensified as far as possible for those persons who have not received or completed the whole period of their primary education;
(e) The development of a system of schools at all levels shall be actively pursued, an adequate fellowship system shall be established, and the material conditions of teaching staff shall be continuously improved.
(3) The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to choose for their children schools, other than those established by the public authorities, which conform to such minimum educational standards as may be laid down or approved by the State and to ensure the religious and moral education of their children in conformity with their own convictions.
(4) No part of this article shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principles set forth in paragraph I of this article and to the requirement that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

India to make education *compulsory and free to all*, which again propelled initiatives directed towards having a robust legislative framework securing the same.[71] Further, UNESCO's Convention against Discrimination in Education demanded the principle of equality of educational opportunity towards education system.[72] International organizations tremendously contributed in creating pressure on India to abolish child labour and provide free and compulsory education to all children. Efforts of South Asian Coalition on Child Servitude (SACCS)[73] and Campaign Against Child Labour (CACL) are amongst them.[74]

This culminated in making the right to education a fundamental right through the 83rd Amendment Bill in 1997 but due to change of government this had to be dropped. International obligations and pressure riveted with internal movement led the Bill to be reintroduced as 93rd Amendment Bill in 2001 during National Democratic Alliance regime. This was passed in 2002, finally assuming the form of 86th Amendment[75] to the Indian Constitution by inserting Article 21A[76], paving the way for free and compulsory education to all children between the age group of 6 to 14,[77] and making right to education a fundamental right.[78] Article 45 was altered to accommodate the obligation of state to provide early childhood care and education to all children until they complete six years of age. The final change was in the form of insertion of clause (k) after Article 51A (j) which cast a responsibility on the parents and guardians to provide opportunity for the education of their children

70 Article 14- Each State Party to the present Covenant which, at the time of becoming a Party, has not been able to secure in its metropolitan territory or other territories under its jurisdiction compulsory primary education, free of charge, undertakes, within two years, to work out and adopt a detailed plan of action for the progressive implementation, within a reasonable number of years, to be fixed in the plan, of the principle of compulsory education free of charge for all.

71 Amartya Sen, "Human Rights and the Limits of Law", *Cardozo Law Review*, vol. 27 (2006), p. 2913.

72 Kishore Singh, "Right to Education and International Law: UNESCO's Normative Action", *Indian Journal of International Law*, vol. 44 (2004).

73 See also M Weiner, *The Child and the State in India*, *Child Labour and Education Policy in Comparative Perspective* (OUP, Oxford, 1994).

74 Manoj Kumar Sinha, "Right to Education: National and International Perspective", *Indian Journal of International Law*, vol. 48 (2008).

75 The Constitution (Eighty Sixth Amendment) Act, 2002, available at <http://indiacode.nic.in/coiweb/amend/amend86.htm> on (last visited on December 29, 2012).

76 Article 21A: "The State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine."

77 A. Mehendale, "*Right to Education and Constitutional Amendment: A Case of India",* Revised Final Project Report, Global Development Network's Bridging Research and Policy Programme, August 2005, available at <http://www.gdnet.org/middle.php?oid=203>, (last visited on December 30, 2012).

78 Dr Niranjanaradhya and Aruna Kashyap, "The Fundamental of the Fundamental Right to Education in India", available at <http://www.ncpcr.gov.in/Acts/Fundamental_Right_to _Education_ Dr_Niranjan_Aradhya_ArunaKashyap.pdf> (last visited on December 30, 2012).

between the age of six to fourteen years.[79] Now, right to free and compulsory education meticulously demanded a structured framework for its precise enforcement, else it would have surfaced as a hollow commitment by the state. This necessitated a legislation implementing the spirit of Article 21A in pith and substance.

Thus, the cumulative efforts of government and various organizations led to the enactment of the Right to Free and Compulsory Education Act, 2009 which came into force on 1st April 2010.[80] This legislation is truly revolutionary, in the sense that it mandates that 25% of the classes from 1st to 8th standard shall be reserved for socially deprived and disadvantageous section in schools established, owned or controlled by the appropriate Government or a local authority.[81] It is noteworthy that S. 12(1) (c) of the legislation provided for the similar arrangement to be followed by unaided minority schools, which was challenged in *Society for Un-aided Schools of Rajasthan v. Union of India*[82] on the grounds of being repugnant to Article 30(1) of the Constitution and was held to be unconstitutional.

However, what was provided as an ESCR at the time of commencement of the Constitution, by the contribution of the Supreme Court and pressure by the international community to oblige commitments under ICESCR led to finally offering a concrete shape to right to education in India.

B. Making the Right to Health as a Fundamental Right

Healthcare in India

The Bhore Committee's Report (1946) provided for a comprehensive and universal health care system for the Indian masses, which was not adequately taken

79 Vijayasri Sripati and Arun K. Thiruvengadam, "India: Constitutional Amendment making the Right to Education a Fundamental Right", *International Journal of Constitutional Law*, vol. 2 (148).

80 Right to Education Act, 2009, available at <http://www.indg.in/primary-education/policiesandschemes/primary-education/policiesandschemes/right-to-education-bill> (last visited on December 29, 2012).

81 Section 12(1)(c), Right to Education Act. The Supreme Court upheld the constitutional validity of this provision in April, 2012. Dhananjay Mahapatra, "Supreme Court upholds RTE, 25% Quota for Poor", *The Times of India*, (April 13, 2012), available at <http://articles.timesofindia.indiatimes.com /2012-04-13/india/31337167_1_unaided-minority-schools-free-education-86th-constitutional-amendment>.

82 AIR 2012 SC 3445.

into account in the early planning process.[83] Government had the option of correcting it in the five year plans by allocating sufficient funds to cater to the medical requirements of urban and especially rural people.[84] But to its detriment, government has not allocated even 3% of its expenditure on health care sector in all five year plans with an exception of first two five year plans where a little over 3% was allocated.[85] India ranks 153 out of 193 countries with respect to total expenditure on health per capita.[86] Further, affordability was a critical issue in health care as the

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83 Bhore Committee Report, National Institute of Health and Family Welfare, available at <http://www.nihfw.org/NDC/DocumentationServices/Committe_and_commission.html> (last updated Dec. 30th, 2012); The Bhore Committee: The Health Survey and Development Committee under the chairmanship of Sir Joseph Bhore and Secretary Dr. KCKE Raja, one of the joint secretaries Dr. K.T. Jungalwala and some of well-known members including Dr. J. B. Grant, Dr. B. C. Roy, Pandit P.N. Sapru and Dr. A. L. Mudaliar spent nearly three years in studying the health situation of the country and formulation of a national healthcare plan. The terms of reference of this committee, popularly referred to as the Bhore Committee, were simple: (a) broad survey of the present position in regard to health conditions and health organization in British India, and (b) recommendations for future development (Bhore, 1946, I.1). In formulating its plan for a National Health Service the Bhore Committee set itself the following objectives:
1. The services should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health;
2. These services should be placed as close to the people as possible, in order to ensure their maximum use by the community, which they are meant to serve;
3. The health organization should provide for the widest possible basis of cooperation between the health personnel and the people;
4. In order to promote the development of the health programme on sound lines the support of the medical and auxiliary professions, such as those of dentists, pharmacists and nurses, is essential; provisions should, therefore, be made for enabling the representatives of these professions to influence the health policy of the country;
5. In view of the complexity of modern medical practice, from the standpoint of diagnosis and treatment, consultant, laboratory and institutional facilities of a varied character, which together constitute "group" practice, should be made available;
6. Special provision will be required for certain sections of the population, e.g. mothers, children, the mentally deficient etc.,
7. No individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it and
8. The creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement recreation, are essential (Bhore, 1946: II.17).

84 United Nations Development Programme, *Human Development Report 2003*. Available at <http://hdr.undp.org/statistics/data/cty/cty_f_IND.html> (last visited on December 30, 2012).

85 Planning Commission, *Indian Planning Experience - A Statistical Profile* (Government of India, New Delhi, 2000).

86 "Litigating the Right to Heath in India: Can Litigation Fix a Health System in Crisis?", *CMI Brief*, (vol. 11(4) (May 2012), available at <http://www.cmi.no/publications/file/4475-litigating-the-right-to-heath-in-india.pdf> (last visited on January 17, 2013).

rich had access to good health care services[87] while poor continued to struggle for fulfilling their basic needs[88], which was even worse in the rural parts.[89] Five year plans have been merely reckoning the problem[90] without offering effective solutions to it.[91] The grass root reality could be gauged from the fact that first National Health Policy[92] was christened only in 1983 and not before.[93] Inchoate structure and lack of resources led to the foil of 1983 Policy.[94] This was again aimed to be corrected in the 10th five-year plan[95], which proposed attention not only in improving health care,[96] but also on the measuring and monitoring of the health care delivery systems[97] and the health status of the population.[98] This led to the creation of National Health Policy of 2001.[99] NHP of 2001 acknowledged that:

> "…..the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of

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87 Randall Alam Ellis, Moneer and Indrani Gupta, "2000: Health Insurance in India – Prognosis and Prospectus", *Economic and Political Weekly*, (January 22, 2000).

88 Abhay Shukla, *2001: Right to Health Care* (Health Action, May 2001).

89 Clear evidence that as early as the beginning of the 1960s the availability of medical care in urban India was already well within the WHO's acceptable standard norm of one hospital bed per 500 persons, whereas rural India was 16 times worse off with regards to these data.

90 Planning Commission, *Third Five-Year Plan* (Government of India, New Delhi, 1968), p. 657.

91 *Ibid., p.* 652.

92 Ministry of Health and Family Welfare, *National Health Policy* (Government of India, New Delhi, 1983), p. 1.

93 National Health Policy, 1983, available at <http://www.communityhealth.in/~commun26/wiki/index.php?title=National_Health_Policy-1983> (last visited on December 30, 2012). The salient features of the National Health Policy (NHP) of 1983 include:
a. A critical assessment of the curative-oriented Western model of health care
b. Emphasis on a preventive and rehabilitative primary health care approach
c. Recommendations for a decentralized system of health care, focusing on minimizing expenditures, deprofessionalization (the use of volunteers and paramedics), and community participation
d. A proposed expansion of the private curative sector to help reduce the government's burden
e. The establishment of a nation-wide network of epidemiological stations to facilitate the integration of various health interventions
f. Targets for achievement that was primarily demographic in nature.

94 Planning Commission, *Ninth Five-Year Plan: Draft* (Government of India, New Delhi, 2000).

95 Tenth Five Year Plan, available at <www.planningcommission.nic.in/> (last visited on December 20, 2012).

96 Ravi Duggal, S. Nandraj, A Vadair, "Health Expenditure Across States", *Economic and Political Weekly*, (April 15, 1995).

97 Srilatha Batliwala, *The Historical Development of Health Services in India* (FRCH, Bombay, 1978).

98 Planning Commission, *Ninth Five-Year Plan* (Government of India, New Delhi, 2003), p. 503.

99 Ministry of Health and Family Welfare, *Draft National Health Policy 2001* (Government of India, New Delhi, 2001). Paragraph 3.1.

essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to overcrowding, and consequentially to a steep deterioration in the quality of the services.[100]

The flip side of the policy was that it lacked structure and road map to achieve its goal of assuring an acceptable standard of good health among the general population of the country.[101] Thus, inchoate and non-coherent policies further strengthened the claim to shift from policy to rights-based approach.[102]

In 2005, the Government of India launched the National Rural Health Mission (NRHM) to "improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children."[103] The Mission has led to an increase in the human resources deployed in the public health sector, with around 100,000 health service providers and managers contracted into the system across the country.[104] While the NRHM has initiated a decentralized delivery of services to reach the poor, a 2009 review of the Mission revealed that a huge amount of money allocated to the states still remained unspent and there still remain vacancies and a dearth of health personnel in many states.[105] According to WHO 2012 statistics, only 37% of births are attended by health personnel in rural areas in India, as compared to 73% in urban areas.[106] Other government programmes on health include the Janani Suraksha Yojana launched in 2005 which introduced a conditional cash transfer mechanism to encourage women to give birth in a health facility and the Rashtriya Swasthya Bima Yojana started in 2008 to provide hospitalisation for people living below the poverty line.[107]

There is no doubt that there has been marginal improvement in the healthcare situation in India. For example, the death rate in the country has declined from 9.8 to 7.3 over the period 1991–2009.[108] However, a lot still needs to be done. The pace

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100 *Ibid.,* Paragraph 2.4.1.

101 *Ibid.,* Paragraph 3.1.

102 *The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among the UN Agencies* (United Nations, May 2003), available at <http://www.crin.org/docs/resources/publications/hrbap/HR_common_understanding.doc> (last visited on December 30, 2012); Also see, A. D. Exter et al., "A Conceptual Model of Health Care Law Making in Central and Eastern Europe", *Med. & L*, vol. 19 (2000), p. 165.

103 Preamble, National Rural Health Mission (2005-2012): Mission Statement, available at <http://www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf> (last visited on January 2, 2013).

104 Institute of Applied Manpower Research, Planning Commission, India Human Development Report 2011, p. 168, available at <http://www.pratirodh.com/pdf/human_development_report2011 .pdf> (last visited on January 1, 2013).

105 *Ibid.*

106 World Health Organization, World Health Statistics 2012, p. 148, available at <http://www.who.int/healthinfo/EN_WHS2012_Full.pdf> (last visited on January 1, 2013).

107 Richard Horton & Pam Das, "Indian Health: The Path from Crisis to Progress", *The Lancet*, no. 377, p. 181 (15 January 2011), available at <http://www.thelancet.com/journals/lancet/article/ PIIS0140-6736%2810%2962179-4/fulltext> (last visited on January 17, 2013).

108 India Human Development Report 2011, note 104, p. 151.

of development has been slow and falls short of national and Millennium Development Goal targets.[109] Further, although the average national health indicators show overall improvements in health, they fail to highlight the vast regional and social disparities in healthcare availability.[110] There are also huge disparities between health situation of men and women, with lower healthcare use for women than for men, infants, and young children; sex-based disparities in fetal, infant, and child mortality; and serious maternal health concerns, such as high fertility and maternal mortality, and lack of knowledge and autonomy on reproductive health among women.[111] The India Human Development Report 2011 released by the Planning Commission noted that the biggest failure of the public health system in India is its inability to reach out to the poor, excluding around 800 million people.[112]

The India Human Development Report 2011 also pointed out that the "public expenditure on healthcare is abysmally low in India", with the total expenditure (both public and private) on health being only 4.1 percent of the GDP in 2007. This is lesser than China (4.3%), the African region (6.2%) and all South Asian countries (except Bangladesh and Pakistan).[113] The fact that the state is not fulfilling its responsibility to provide good quality healthcare to its citizens is further evident from the great disparity between public and private expenditure on health. It is not feasible to rely on private health services or public-private partnerships in health services; establishing a universal public health system in India is indispensable.[114]

In 2008, of the total healthcare expenditure (public and private), public expenditure on health constituted only 28 per cent while private expenditure was the remaining 72 per cent. In comparison, in Brazil, South Africa, and China public

109 Vinod Kumar Paul et al., "Reproductive Health, and Child Health and Nutrition in India: Meeting the Challenge", *The Lancet*, no. 377 (22 January 2011), p. 332, <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2961492-4/fulltext> (last visited on January 17, 2013).

110 Vikram Patel et al., "Universal Health Care in India: The Time is Right", *The Lancet*, no. 377, (5 February 2011), p. 448 <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2962044-2/fulltext> (last visited on January 17, 2013); Binayak Sen, "Securing the Right to Health for All in India", *The Lancet*, no. 377, (12 February 2011), p. 532, available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2962182-4/fulltext> (last visited on January 17, 2013); Y. Balarajan, "Health Care and Equity in India", *The Lancet*, no. 377 (5 February 2011), p. 505, available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2961894-6/fulltext> (last visited on January 17, 2013).

111 Anita Raj, "Gender Equity and Universal Health Coverage in India", *The Lancet*, no. 377 (19 February 2011), p. 618, available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2962112-5/fulltext> (last visited on January 17, 2013).

112 World Vision, "The Right to Health in India", Stakeholder Report on India, May 2012, available at <http://lib.ohchr.org/HRBodies/UPR/Documents/session13/IN/WV_UPR_IND_S13_2012_WorldVision_E.pdf> (last visited on January 17, 2013).

113 *Note* 104, p. 163.

114 Amit Sengupta & Vandana Prasad, "Towards a Truly Universal Indian Health System", *The Lancet*, no. 377 (26 February 2011), p. 702, available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2962043-0/fulltext#bib5> (last visited on January 17, 2013).

expenditure on health was more than 40 per cent of the total expenditure.[115] This is a matter of grave concern since private healthcare services are both inefficient and inequitable, adversely affecting the poorest section of the society.[116] The quality of healthcare services in India is also poor, with only 9 hospital beds per 10,000 population, as compared to 30 in China, and 6 physicians per 10,000 population compared to 14 in China.[117] Further, the nurse to population ratio in India is 1:1205 as against 1:100–150 in Europe. The nurse to doctor ratio is about 1.3:1 as compared to 3:1 in most developed countries.[118] Corruption in healthcare services is another issue seriously affecting public health situation in India, with the health sector being the second most corrupt sector in India.[119] Corrupt, unethical and illegal practices are not limited to government healthcare services, but also pervade private health services. For example, a nexus between corrupt regulatory bodies and pharmaceutical industry has led to sale of unsafe and unlawful drugs in India.[120]

However, on a more positive note, the government has decided to triple the government expenditure for the 12th Five Year Plan from 2012-2017.[121] The Indian Prime Minister also declared that the 12th Five Year Plan will focus on health, just as 11th Five Year Plan focused on education.[122] Aiming to focus on women's and children's health, India is strengthening its efforts in 235 districts that account for nearly 70% of all infant and maternal deaths. It is hoped that by 2015, India also provide technical assistance to other countries.[123]

In 2011, *The Lancet* Series on public health in India proposed a call to action for India to achieve health care for all by 2020.[124] This is an important and urgent

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115 *Note* 104, p. 167

116 *Note* 104, p. 165; See also Mohan Rao, "Health in Crisis", *Frontline*, vol. 28(21), (October 2011), available at <http://www.frontline.in/fl2821/stories/20111021282102800.htm> (last visited on January 17, 2013).

117 *Note* 104, p. 166.

118 *Note* 104, p. 167.

119 Hanumappa Sudarshan & N. S. Prashanth, "Good governance in Health Care: The Karnataka Experience", *The Lancet*, no. 377 (5 March 2011), p. 790, available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2962041-7/fulltext#bib1> (last visited on January 17, 2013).

120 Mohan Rao, *note 116*, p. 6; R. Ramachandran, "Toxic Nexus", *Frontline*, (October 2011), available at <http://www.frontline.in/fl2821/stories/20111021282102800.htm> (last visited on January 17, 2013).

121 "12th Five Year Plan will Triple Spending on Health, says Prime Minister Manmohan Singh", IBN Live, 3 November 2012, available at <http://ibnlive.in.com/news/12th-five-year-plan-will-triple-spending-on-health-says-prime-minister-manmohan-singh/303699-3.html> (last visited on January 17, 2013).

122 R. Ramachandran, *Public Health Crisis*, *Frontline*, (13 July 2012), p.4, available at <http://pay.hindu.com/ebook%20-%20ebfl20120713part1.pdf> (last visited on January 17, 2013).

123 *Note 112*.

124 K Srinath Reddy, "Towards Achievement of Universal Health Care in India by 2020: A Call to Action", *The Lancet*, no. 377, p. 760 (26 February 2011), available at <http://www.thelancet.com /journals/lancet/article/PIIS0140-6736%2810%2961960-5/fulltext> (last visited on January 17, 2013).

call and requires a holistic approach to create a universal system of healthcare in India. It also requires examination of how the rights-based approach can contribute towards making this proposal a reality.

C. Right to Health as a Human Right

Besides the dearth of sound policies, India's international commitments to recognize the right to health as a fundamental right underscores the shift in favour of rights based approach. India is committed to make *enjoyment of the highest attainable standard of health* as *fundamental right* under the obligations imposed upon it through the constitution of WHO which was adopted in 1946.[125] Even the Universal Declaration of Human Rights adopted by the General Assembly of United Nations on Dec. 10th, 1948 through Article 25 imposes an obligation on India to provide for right to health to all its citizens. Article 25 of UDHR reads:[126]

> "(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

India, having ratified the ICESCR on April 10th, 1979 is under an obligation to implement Article 12 of the Covenant which provides for the *right of everyone to enjoyment of the highest attainable standard of physical and mental health and the creation of conditions, which would assure medical service and medical attention to all in the event of sickness.*[127] The UN Committee on Economic, Social and Cultural Rights (CESCR) which is a body of independent experts formed under the ECOSOC Resolution 1985/17 of 28 May 1985, for monitoring the implementation of ICESCR in the member state in its 22nd session in Geneva in 2000 in its General Comment No.14 defines Article 12.1 - Right to Health**, '***as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.'*[128]

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125 World Health Organisation, 1946*, Constitution of World Health Organisation,* available at <http://www.who.int/governance/eb/who_constitution_en.pdf> (last visited on December 28, 2012).

126 Universal Declaration of Human Rights, 1948, available at <http://www.un.org/en/documents/udhr/> (last visited on December 28, 2012).

127 UN International Covenant on Economic, Social and Cultural Rights, 1966, available at <http://www2.ohchr.org/english/law/cescr.htm> (last visited on December 28, 2012).

128 UN Committee on Economic, Social and Cultural Rights (CESCR), 2000, General Comment No.14, available at <http://www.unhcr.org/refworld/docid/4538838d0.html> (last visited on December 28, 2012).

This elucidation on Article 12 of ICESCR serves as a beacon light for India in offering shape and structure to its policy defining right to health. India is also signatory to Alma Ata Declaration of 1978 and is under an obligation to ensure a, *'state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, which is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.'*[129]

India having signed the Convention on the Elimination of Discrimination Against Women, 1979[130] through its Article 12 and Convention on the Rights of the Child, 1989[131] through its Article 24, is duty bound[132] to cater to women and children, enjoyment of the right to protection of health and access to health care.[133]

Human rights are interrelated. The human right to health is also dependent on, and contributes to, realization of other human rights, including the right to food, water, adequate standard of living, equality, privacy, access to information, participation, and the right to benefit from scientific progress and its applications.[134] Without the realization of the right to physical and mental health, other rights like right to work cannot be enjoyed.[135]

The argument of making right to health as a fundamental right gains more prominence especially in the light of the views expressed by the Supreme Court of India in myriad of cases. Supreme Court's role has been that of a crusader which has acknowledged the superiority of right to health over other socio-economic rights[136]

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129 Alma Ata Declaration, 1978, available at <http://www.who.int/social_determinants/ tools/ multimedia/alma_ata/en/index.html> (last visited on December 28, 2012).

130 UN Convention on the Elimination of All Forms of Discrimination Against Women, 1979, Part III, available at <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm# article12> (last visited on December 28, 2012).

131 UN General Assembly, 1989, Convention on the Rights of the Child, Document A/RES/44/ 25 (12 December 1989) with Annex, available at <http://www.cirp.org/library/ethics/UN-convention> (last visited on December 28, 2012).

132 See *Vishaka v. State of Rajasthan*, AIR 1997 SC 3011, where the Supreme Court held as follows: "Any International Convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into these provisions to enlarge the meaning and content thereof, to promote the object of the constitutional guarantee." Article 21 has been interpreted in light of the CRC in the case of *Parents Forum for Meaningful Education and Anr. v. Union of India and Anr.*, AIR 2001 Delhi 212. The Delhi High Court read the provisions of the CRC into Article 21 and held that imposition of corporal punishment violates Article 21.

133 Ravi Duggal, "Resource Generation Without Planned Allocation", *Economic and Political Weekly*, (Jan 5, 2002).

134 World Health Organization, "The Right to Health", Factsheet No. 31, 2008, available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf> (last visited on January 17, 2013).

135 *Ibid.*

136 Nariman, "Economic Social and Cultural Rights and the Role of Lawyers", *ICJ Review* no. 55 (1995).

like right to education which has already made its way to Article 21 as Article 21A through 86th constitutional amendment in 2002.[137]

However, the rights-based jurisprudence for right to health has not developed as strongly as it has in the context of right to education. The discussion on the priority accorded to right to health assumed seminal importance before the apex court in *Bandhua Mukti Morcha and ors. v. Union of India and ors.*[138] In this case, a letter was sent by the Bandhua Mukti Morcha to the Supreme Court on the inhumane living conditions of the labourers in some of the stone quarries situated in Faridabad district of State of Haryana. Supreme Court treated the letter as a writ petition[139] and appointed a commission for conducting an inquiry into the alleged allegations by the petitioner. Commission observed that the living conditions of the laborers were miserable and their health was put at bay. They could not breathe properly as there was dust all around the stone quarries nor they had hygienic water to drink as they were forced to drink dirty water from Nullah.[140] The court, expanding the definition of right to life under Article 21 which included the right 'to live with human dignity', as was held in *Francis Coralie Mullin v. Union Territory of Delhi*[141], held that 'right to health' is also part and parcel of right to life under Article 21. The Court observed:

> "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."[142]

Supreme Court explicitly for the first time held right to health as part of right to life under Article 21 in *Consumer Education and Research Centre v. Union of India*[143]. Empathizing with the pain and vulnerable work conditions of the labourers working in the asbestos industry, the court read Article 21 with the relevant directive principles[144] guaranteed in articles 39 (e), 41 and 43 holding that right to health and medical care is a fundamental right and it makes the *life of a workman meaningful*

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137 Observation made by the Hon'ble Supreme Court in Society for *Un-aided Schools of Rajasthan v. Union of India* AIR 2012 SC 3445 on Para. 64.

138 AIR 1984 SC 802.

139 *Ibid.*

140 *Ibid.*

141 1981(1) SCC 608.

142 *Note* 138.

143 (1995)3 SCC 42.

144 Article 37 pertaining to the application of the principles contained in Part IV of the constitution states, **"**The provisions contained in this Part shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws."

and purposeful with the dignity of person.[145] In delivering these judgments court was not oblivious of India's international obligations to recognize right to health as part of constitutional scheme.[146]

Supreme Court has even gone to the extent of recognizing right to health for all as intrinsic part of a welfare state[147] in *Paschim Banga Khet Mazdoor Samity and Ors. v. State of West Bengal*[148] with an instruction to the State for formulating a blue-print for primary health care with particular reference to the treatment of patients during emergency.[149] In *State of Punjab v. Mohinder Singh Chawla*,[150] the Supreme Court reiterated that the government has constitutional obligation to provide the health facilities, which includes the duty to provide healthcare to government servants, including bearing their health expenditure.

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145 *Note* 143.

146 In *CESC v. Subhash Chandra Bose* 1992(1) SCC, Supreme Court while holding right to health as part of right to life under Article 21 of the Indian constitution, premised the ruling on Article 25 of UDHR and Article 7(b) of ICESCR which provides for India's international obligation to assure right to health is offered to its citizens.

147 Competence lies with the welfare state to legislate on the entries pertaining to health. The Constitutional provisions (Schedule 7 of article 246) are classified into three lists, including a concurrent list which both central government and states can govern, but the overriding power is with the central government. The list here includes original entry numbers Central List: 28.Port quarantine, including hospitals connected therewith; seamen's and marine hospitals 55. Regulation of labour and safety in mines and oilfields State List: 6. Public health and sanitation; hospitals and dispensaries 9. Relief of the disabled and unemployable Concurrent List: 16. Lunacy and mental deficiency, including places for the reception or treatment of lunatics and mental deficients 18. Adulteration of foodstuffs and other goods. 19. Drugs and poisons, subject to the provisions of entry 59 of List I with respect to opium 20A. Population control and family planning 23. Social security and social insurance; employment and unemployment. 24. Welfare of labour including conditions of work, provident funds, employers' liability, workmen's compensation, invalidity and old age pensions and maternity benefits 25. Education, including technical education, medical education and universities, subject to the provisions of entries 63, 64, 65 and 66 of List I; [vocational and technical training of labour.] 26. Legal, medical and other professions 30. Vital statistics including registration of births and deaths. http://alfa.nic.in/const/schedule.html (last visited on December 30, 2012).

148 1996(4) SCC 37.

149 In *Paschim Banga Khet Mazdoor Samity and Ors. vs. State of West Bengal,* one of the members of the petitioner fell off from the train and suffered serious injuries. He was taken to several state hospitals but they all refused to admit him on the ground of lack of availability of bed space. He was finally taken to a private hospital where he was offered treatment. Later through the petitioners, he filed a writ petition under Article 32 of the Indian Constitution for holding state liable contending it was his right to receive urgent medical aid under Article 21 of the Constitution in case of emergency. Holding state responsible and attesting right to receive medical aid as part of Article 21, Supreme Court held that state cannot take the defense of financial constraint for skipping their liability and shirking their hands off from the constitutional obligation imposed upon them under Part III.

150 (1997) 2 SCC 83.

The apex court held that the contours between the civil and political rights on one hand and social, educational and cultural rights on the other are getting smudged.[151] The court gave several illustrations wherein social, educational and cultural rights have been made enforceable in various countries, foremost amongst them being South Africa. Giving the example of right to education in India, the court reiterated right to health on a superior footing[152], which gives strong impetus to the claim of making it as a constitutional right.

However, the courts in India have still not enunciated any comprehensive definition of the core content of the right to health. At a minimum, the right to health can be stated to include a person's entitlement to adequate health care (including emergency health care) and adequate medical facilities.[153]

Jan Swasthya Abhiyan[154] which is the Indian chapter of International People's Health Movement, in liaison with the National Human Rights Commission (NHRC) had held public hearings[155] on the health right issue in 2004 which paved the way for National Health Bill, 2009 conferring various statutory rights to the patients like right to be treated during emergency without police clearance, right to seek summary of patient's condition and seek second opinion, right to know the name of the doctor offering treatment, etc.[156] What makes this bill incredulous is its promise to provide free access to healthcare to vulnerable and marginalized sections.[157] This bill fails to clarify about those who would not hit above sections but are still poor.[158] This further strengthens the claim to make right to health as a fundamental right.

As long as legislature and executive do not remedy their failure in establishing and enforcing the right to health, the citizens are left with the judiciary as the only resort to seek state accountability.[159] However, litigation by itself cannot bring about the structural and systemic changes necessary to ensure adequate and good quality healthcare for all. This is more so because judgments of the courts in health rights

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151 *Note* 138, p. 67; the court also expressed that Right to education is a socio-economic right and so is right to healthcare. Right to shelter and right to work also fall under the same category. It observed that Article 47 and 48 of the Indian Constitution along with India's International obligations under ICCPR, ICESCR, UDHR and UNCRC are not merely *pious declarations but for guidance and governance of the State policy.*

152 *Note* 138.

153 *Note* 86.

154 Jas Swasthya Abhiyaan, available at <http://www.phmovement.org/en/india> (last visited on December 30, 2012).

155 Public Hearing on Access to Health Care Delivery System, available at <http://www.nhrc.nic.in/disparchive.asp?fno=796> (last visited on December 30, 2012).

156 National Health Bill, 2009, available at <http://www.medindia.net/news/indiaspecial/THE-NATIONAL-HEALTH-BILL-2009-49956-1.htm> (last visited on December 30, 2012).

157 Health Bill May Deny the Poor Free Care, Times of India, available at <http://indiatoday.intoday.in/story/Health+bill+may+deny+the+poor+free+care/1/85102.html> (last visited on December 30, 2012).

158 *Ibid.*

159 *Note* 86.

litigation are not backed by serious penalties for noncompliance.[160] Therefore, there is an urgent need make right to health as a fundamental right.

D. Constitutionalising the Right to Health in India

The recognition of rights is about ensuring the autonomy of the individual. Expansion of the civil and political rights and their recognition in constitutions around the world has underscored the importance of autonomy of the individual. However, when it comes to social rights, this has not been the case. Cecil Fabre has observed that, "one of the reasons why we want to assign civil, political and social rights to people and why we want to constitutionalise the first two sets of rights, thereby protecting the interests encapsulated in those rights from the democratic majority, is indeed that they give people some degree of control over their life. The main reason why those rights ought to be constitutionalised is precisely that autonomy requires it..."[161]

Societies need to make decisions as to what objectives, social, economic and political they ought to pursue. There will be debates as to what kind of rights that constitutions need to recognize towards fulfillment of the objectives that the state wants to pursue. There is no doubt that recognizing rights is an important decision and will involve not only allocation of resources for fulfilling these rights, but also formulation of new legislative frameworks, creation of institutional mechanisms and more importantly, making policy choices in the process of fulfilling certain rights over the other. However, if autonomy of the individual is a reason for the recognition of civil and political rights, it is as important for the recognition of economic and social rights as it is for the civil and political rights. Cecil Fabre has further observed: "…Just as autonomy powerfully justifies constitutional civil and political rights, it also justifies assigning them social rights to decent levels of minimum income, education, housing and health care. Giving these resources to people is important because without them they would be unable to develop the physical and mental capacities necessary to become autonomous. If we are hungry, thirsty, cold, ill and illiterate, if we constantly live under the threat of poverty, we cannot decide on a meaningful conception of the good life, we cannot make long-term plans, in short we have very little control over our existence…"[162]

India has gained rich experience in the constitutionalisation of rights through the judiciary playing a significant role in liberally interpreting the legal and constitutional rights to achieve critical social and welfare objectives. This has been achieved through the process of expansion of the right to life in article 21 of the Constitution of India to include many civil, political, economic, social and cultural rights including the right to education. The constitutionalisation of the right to education in India through the insertion of article 21 A by the 86th Amendment to

160 *Note* 86.

161 Cecil Fabre, *note* 21.

162 *Ibid.*

the Constitution of India is a remarkable example of how the legislature has been able to commit itself to the process of recognizing economic and social right within the constitution. The amended article is as follows:

"21A. The State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine."

There is a strong impetus for the development of the right to health both as a legally recognised right through a progressive interpretation of the provisions of the Constitution of India by the courts and through a statutory process, through which India has recognized some form of right to health both under domestic law and international human rights law. However, this is inadequate and in many respects, not effective to galvanise social consciousness as well as institutional frameworks to respect, protect and fulfill the right to health. Constitutionalisation of the right to health through an amendment to the Constitution of India akin to the right to education is a necessary path that India has to take not only for a stronger and deeper commitment to recognition of this right, but also to ensure transparency and accountability in the implementation of the right to health.

Articles 39 (e) and (f) and article 47 of the Constitution of India under the directive principles of state policy make a reference to health. Article 39 (e) and (f) mentions health in the context of "certain principles of policy to be followed by the state" and the provisions underscore specific aspects of health.

39. Certain principles of policy to be followed by the State.—The State shall, in particular, direct its policy towards securing—

(e) that the health and strength of workers, 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.

Article 39 (e) marginally reflects the objective of the state in underscoring the importance of health as it discussed the issue of health in relation to work and avocations to be pursued. However, article 39 (f) makes a stronger attempt in recognizing that development of children "in a healthy manner" is critical, although this has been limited to children and youth.

Article 47 of the Constitution of India makes a stronger reference to public health and the importance of public health as an objective of state policy.

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…

Article 47 of the Constitution of India makes a fervent attempt to recognize that the improvement of public health is one of the primary duties of the state. This does provide an important framework for the next level of effort to strengthen the right to health in India. There is a case for an amendment to the Constitution of India inserting article 21B that recognizes the right to health for the children of the country. The

proposed amendment to the Constitution of India could be as follows:

> "21B. The State shall provide free health care to all children up to the age of fourteen years in such manner as the State may, by law, determine."

While it is recognised that this provision limits the constitutional recognition of the right to health to the children, it also balances the issue of progressive realization of economic and social rights with the question of availability of resources. While the existing provisions of the Constitution in the directive principles of state policy and other statutes provides for the enforcement of the right to health for all, this effort is to focus on the constitutionalising the right to health for children.

While constitutionalizing the right to health and other ESCR is important, it is also essential to note that the obligations on states with respect to ESCR are to progressively realize these rights by taking all available means to the maximum of the available resources.[163] If the fundamental right to health is drafted too broadly in a manner impracticable for the state to implement, it might risk non-implementation of the entire right. Rather, the right should be drafted in a manner that gives the state clear guidelines about its obligations and allows citizens to hold the state accountable in case of non-implementation.

The South African experience in the implementation of the right to health may help understand this dilemma. Article 27 of the South African Constitution provides:

27. Health care, food, water and social security

1. Everyone has the right to have access to -
   a. health care services, including reproductive health care;
   b. sufficient food and water; and
   c. social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
3. No one may be refused emergency medical treatment.

Further, Article 28 provides that every child has the right "to basic nutrition, shelter, basic health care services and social services".[164] The South African Constitution guarantees the right to health in very broad terms. However, difficulties in implementing such a broad right and holding the state accountable soon started arising. In *Soobramoney v. Minister of Health*[165]*,* the question was whether the refusal by a state hospital to provide periodical renal dialysis treatment necessary to sustain the life of the plaintiff was violative of the right to health. The court held that the

163 Article 2, ICESCR.

164 South African Constitution, Article 28(1)(c); available at <http://www.info.gov.za/documents/constitution/1996/96cons2.htm#28> (last visited on January 18, 2013).

165 1998 (1) SA 765 (CC).

right of equal access to healthcare must be balanced with a governmental need to prioritize the allocation of its resources. Reaffirming the principle of progressive realization, the court held that state can devise its own rational policy of prioritization of patients, thus allowing a significant margin of state discretion.[166] In another case, *Minister of Health v. Treatment Action Campaign*[167], the court rejected the UN concept of "minimum core" rights, which must be fulfilled by states irrespective of availability of resources. Instead, the court held that it was impossible to give everyone access even to even a minimum core immediately. The state is expected only to reasonably provide access to socio-economic rights on a progressive basis.[168] Thus, despite the existence of a constitutional right to health, the court narrowed down the scope of government obligations in both cases. While this approach of the court may be criticized by some, it is important to recognize that a court needs to take into account the social reality and considerations of practicability before imposing wide and strict government obligations.

The need to focus on the right to health of children is necessitated by the poor state of healthcare of children in India. Children till the age of 14 years constitute one-third of the total population of India.[169] Providing good quality healthcare to children is important to ensure that they grow up into healthy adults. It is during early childhood, that is the first six years of life, when the foundations are laid for cognitive, social and emotional language, physical/motor development and cumulative lifelong learning.[170] Young children are most vulnerable to the vicious cycles of malnutrition and disease, "all of which influence the present condition of a child at micro level and the future human resource development of the nation at the macro level."[171] Thus, ensuring access to good quality health and nutrition to children is extremely important for a nation.[172] The Under-Five Mortality Rate, expressed as a rate per 1000 live births, is estimated at 59 and it varies from 66 in rural areas to 38 in urban areas.[173] For the age group between 5 to 14 years, the death rate (deaths per thousand) is estimated to be 0.9, varying from 0.6 in urban areas and 1.0 in rural areas.[174] According to a report by NGO "Save the Children", India lags behind most countries in children's health and has slipped down by 12 ranks the in the area of child health between the years 1995 and 2010.[175] India

166 *Ibid.*

167 2002 (5) SA 703.

168 *Ibid.*

169 Government of India, Children In India 2012: A Statistical Appraisal, http://mospi.nic.in/Mospi_New/upload/Children_in_India_2012.pdf (last visited on January 18, 2013).

170 *Ibid.*

171 *Ibid.*

172 *Ibid.*

173 *Ibid.*

174 *Ibid.*

175 *India Lags Behind Most Countries in Children's Health: Save the Children*, 20 July 2012, available at <http://health.india.com/news/india-lags-behind-most-countries-in-childrens-health-save-the-children/> (last visited on January 18, 2013).

records 1.25 million infant deaths per year and 42 percent children are underweight.[176] According to UNICEF Report, India has the highest child mortality rate in the world with 16.55 lakh deaths of children under five years of age in 2011.[177] India contributes to more than 20 per cent of the child deaths in the world.[178]

The Supreme Court of India has declared that a child is a national asset and the state has a duty to look after the child to ensure the full development of a child's personality.[179] Further, in *M.C. Mehta v. State of Tamil Nadu*[180], the Supreme Court held that children below the age of 14 years cannot be employed in any hazardous industry or mines or other works. The court also recognized that the Indian Constitution desires that a child must be given "opportunity and facility to develop in a healthy manner".[181]

All these facts makes a strong case for recognizing right to health as a human right and to constitutionalize the right to health for children below the age of 14 years.

The poor state of healthcare and the lack of an effective legal system to recognize and implement the right to health in India pose serious concerns. These concerns include both the extent of state obligations to fulfill the right to health as well as the limits of state action. Such concerns gain wider proportions and raise fundamental issues especially at the time of a healthcare crisis in any country. The wider jurisprudence regarding right to health and the enforcement framework for the same strongly affects a government's response to the crisis situation. The SARS public health crisis in Hong Kong is a case study which demonstrates how several human rights and government accountability issues get implicated in the times of epidemic.

IV. SARS PUBLIC HEALTH CHALLENGE IN HONG KONG: A CASE STUDY[182]

The SARS epidemic that started as a medical problem became a public health problem and grew to pose a challenge to governance and human rights in both China and Hong Kong.[183] While there may be a tendency, when faced with life and

176 *Ibid.*

177 *India has Highest Child Mortality Rate in the World, Says UN Report*, *India Today* (13 September 2012), available at <http://indiatoday.intoday.in/story/india-has-highest-child-mortality-rate-in-the-world-says-un-report/1/217109.html> (last visited on January 18, 2013).

178 UNICEF, *The Situation of Children in India: A Profile* (May 2011), p.4, available at <http://www.unicef.org/sitan/files/SitAn_India_May_2011.pdf> (last visited on January 18, 2013).

179 *Sheela Barse v. Union of India*, JT 1988 (3) 15.

180 AIR 1997 SC 699.

181 *Ibid.*

182 This section is drawn from a previous work, C. Raj Kumar and Michael C. Davis, "The Scars of the SARS: Balancing Human Rights and Public Health Concerns", *Honk Kong Lawyer,* (May 2003), pp.58-67.

183 See Lau JTF, Yang X, Tsui H, Kim JH. "Monitoring Community Responses to the SARS Epidemic in Hong Kong: From Day 10 to Day 62", *Journal of Epidemiol Community Health*, vol. 57(11) (Nov 2003).

death decisions, to dismiss talk of human rights as frivolous, a closer look reveals that human rights standards have important implications both for fighting the spread of an epidemic and limiting the scope of injury. A crisis such as the SARS epidemic serves to remind us why tried and tested human rights practices developed and why they remain important.[184] Such standards are important for evolving a suitable approach to governance that balances both public health and human rights concerns.

Several human rights and governance issues are implicated in the SARS crisis: *first*, the issues surrounding the outbreak of atypical pneumonia in China and Hong Kong and their general implications for public health, human rights and governance; *second*, the international human rights framework in respect of the right to health and transparency in governance; *third*, the legal and human rights compatibility of the travel and quarantine restrictions imposed on residents of Hong Kong; *fourth*, the relevance of the Siracusa Principles and the World Health Organisation (WHO) Guiding Principles for ensuring that restrictions of human rights on public health grounds are reasonable; and *fifth*, the interface of transparency in governance and the right to health with reasonable restrictions. All of these aspects are important for good governance and human rights and represent a sound foundation for public health policy.

A. The Problem

When atypical pneumonia first became a matter of concern in several countries abroad, it had already reached a crisis stage in Hong Kong.[185] While authorities in Hong Kong worked hard to arrest the expansion of this epidemic, doctors had to both treat the patients in their care and avoid contracting the disease. As reported in the WHO press briefing on 2 April 2003, Hong Kong found itself in mid-March facing the opening salvo of a crisis.[186] At that time there had been 9 people – travelers, tourists or businessmen from Beijing, Taiwan,[187] and Singapore – who returned to Hong Kong infected with SARS.[188] Even before the severity of the public health challenge was known, the governance and human rights deficiencies set the tone of this challenge.[189]

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184 See Lau JT, Thomas J. "Risk Behaviours of Hong Kong Male Residents Travelling to Mainland China: A Potential Bridge Population for HIVI Infection", *AIDS Care,* vol. 13(1) (Feb 2001).

185 See Donnelly CA, Ghani AC, Leung GM, *et al.* "Epidemiological Determinants of Spread of Causal Agent of Severe Acute Respiratory Syndrome in Hong Kong", *The Lancet*, (2003), p. 361.

186 "SARS: A WHO-induced Panic?", *Far Eastern Econ Rev*, (22 May 2003).

187 Department of Health, Republic of China (Taiwan), Press Release by the SARS Contingency Committee: Planning for Worst Case Scenario and Putting a Halt to Hospital Infections, (May 17, 2003), available at <http://sars.doh.gov.tw/news/2003051702.html> (last visited on December 30, 2012).

188 See Peiris M, Lai ST, Poon LM, *et al., Coronavirus as a Possible Cause of Severe Acute Respiratory Syndrome* (Lancet, 2003).

189 J. W. Saspin, L. O. Gostin, J. S. Vernick et al., "SARS and International Legal Preparedness", *Temple Law Review*, vol. 77 (2004), pp. 155–173.

It turned out that the crisis, which had begun in China several months earlier, had been kept under wraps by a regime that was seemingly worried about the economic consequences of public disclosure. The lack of public information and democratic institutions was sorely felt. Hong Kong's initial response was also a bit tepid, causing some to worry that the officials were reluctant to point fingers too directly at the mainland regime. The slow start was quickly turned around in the face of Hong Kong's vigorous press. A variety of rights, including the right to transparency in governance, the right to information and the right to health are clearly implicated.

While the expanding epidemic and the growing number of deaths finally focused the attention of both levels of government, the track record that emerged was uneven. In China, continuing attempts to hide the crisis put innumerable people at risk at home and abroad, including Hong Kong.[190] In Hong Kong, official uncertainty as to the seriousness of the crisis and some reluctance to confront the mainland government remained.[191] The strong measures that, in hindsight, were needed were eventually instituted. Problems of governance, as Hong Kong goes from crisis to crisis, remain with us.[192] Efforts should surely be made to assess the response of the HKSAR government to the crisis.[193] Emerging human rights practices in this area may offer helpful standards both to assess the quality of governance and adherence to basic human rights standards.

B. The International Human Rights Framework and its Relevance for SARS

On an international level, the organisations and agencies of the United Nations have begun to consider the relevance of human rights to their work in the health field.[194] The 1997 Program for Reform put forth by UN Secretary-General Kofi Annan has been pivotal in directing the UN's conceptual emphasis on human rights in the work of the various UN agencies. The policy of 'mainstreaming human rights' refers to the programme of enhancing human rights and integrating them into the broad range of United Nations activities. The UN reform programme states that human rights cut across four substantive fields of United Nations' work: peace and security, economic and social affairs, development co-operation and humanitarian affairs.[195]

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190 B. Tomlinson, C. Cockram, *SARS: Experience at Prince of Wales Hospital* (Lancet, Hong Kong, 2003).

191 SH. Lee, *Prevention and Control of Communicable Diseases in Hong Kong* (Government Printer, Hong Kong, 1994).

192 "SARS in Hong Kong: from Experience to Action," SARS Expert Committee Summary Report, October 30, 2003, available at <http://www.sarsexpertcom.gov.hk/english/reports/ summary/ files/e_sumprt_fulltext.pdf>, (last visited on December 30, 2012).

193 Clifford Krauss, "The SARS Epidemic: The Overview: Travelers Urged to Avoid Toronto Because of SARS", *The New York Times*, (April 24, 2003).

194 "Beijing's SARS Attack," *Time* Magazine, October 29, 2003, available at <www.time.com/ time/asia/news/printout/0,9788,441615,00.html> (last visited on December 30, 2012).

195 Secretary-General's Programme for Reform, UNDoc. A/51/950, 14 July 1997, paragraphs 78 -79.

The human right to health is well revealed in the international human rights regime.[196] The ICESCR 'recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[197] Article 12 of the ICESCR requires that the state parties take steps for the 'prevention, treatment and control of epidemic, endemic, occupational and other diseases' and 'the creation of conditions which would assure to all medical service and medical attention in the event of sickness'. Health can be understood from the description given in the preamble of the WHO Constitution, as a 'state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity'.

Hence, the rights relating to non-discrimination, autonomy, transparency, information, education and participation are integral parts of the achievement of the highest attainable standard of health.

The government of the HKSAR has found it necessary to take forceful steps to treat and confine the SARS epidemic.[198] In carrying out these policies there are important human rights obligations, both to ensure health and to limit rights restrictions to those, which are absolutely necessary to contain the problem.[199] The international regime imposes strong obligations on governments to protect human rights in accordance with international treaties.[200] These obligations should be perceived as not just restrictions on government but as tried and tested methods of good governance. Fulfilling the human right to health, in the present case of atypical pneumonia, means that the government of the HKSAR has to take all appropriate measures – legislative, administrative, budgetary, and judicial – towards fulfilment of such right. The HKSAR government would be in violation of the right to health if it failed to allocate sufficient resources to meet the public health needs of the Hong Kong community.[201]

A variety of practical guidelines are evident in human rights practice. The UN Human Rights Committee, in its General Comments, has indicated that state obligations to protect the right to life should include positive measures designed to reduce infant mortality, and protection against malnutrition and epidemics.[202] The

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196 Lance Gable, "The Proliferation of Human Rights in Global Health Governance", *Journal of Law, Medicine & Ethics*, vol. 35 (2007).

197 Article 12, ICESCR.

198 Keith Bradsher, "The SARS Epidemic: Asia: To Broad Support, Hong Kong Police Take On an Expanded Role in Fighting SARS", available at <http://www.nytimes.com/2003/04/25/world/sars-epidemic-asia-broad-support-hong-kong-police-take-expanded-role-fighting.html> (last visited on December 30, 2012).

199 *Ibid.*

200 For example, see United Nations Covenant on Economic, Social and Cultural Rights, 1976; United Nations Convention on the Rights of Child, 1990; United Nations Human Rights, "International Human Rights Law", available at <http://www.ohchr.org/en/professionalinterest/Pages/InternationalLaw.aspx> (last visited on January 2, 2013).

201 Joseph Kahn, "The SARS Epidemic: Beijing; Quarantine Set in Beijing Areas to Fight SARS", *New York Times*, (April 25, 2003).

202 UN Doc HRI/GEN/1/Rev3 (1997) 6-7.

UN Committee on Economic, Social and Cultural Rights also made some useful observations in its General Comments given during its twenty-second session (2000) with reference to Article 12.2 (c) of the ICESCR. The Committee noted that, 'the prevention, treatment and control of epidemic, endemic, occupational and other diseases' (Art 12.2(c)) requires the establishment of prevention and education programmes for behaviour-related health concerns. The right to treatment includes creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations.[203]

The ICESCR Committee has underlined that the control of diseases refers to state, individual and joint efforts to make technologies available, using epidemiological surveillance and data collection on a disaggregated basis to facilitate the implementation and enhancement of immunisation programmes and other approaches for the prevention and control of infectious diseases.[204]

C. Legally Justified Limitations on Human Rights Because of SARS

Though human rights considerations need to be borne in mind while fashioning any public policy, it is sometimes quite acceptable to restrict rights in order to achieve an important public health or safety objective. Both the Basic Law and the Bill of Rights Ordinance of the HKSAR recognise that restrictions on rights may be allowed in the interest of public health and safety.[205] On this basis it may be argued that merely imposing compulsory quarantine or travel restrictions does not violate human rights. But such restrictions, even to contain an epidemic such as atypical pneumonia, cannot be excessive. On one side, the restrictions go to achieving the right to public health in the face of an epidemic. At the same time, restrictions that are wrongly targeted may victimise the population even more. Restrictions on personal freedom should be at the level necessary to forcefully deal with the crisis and no more. As with local restrictions, foreign restrictions should not just broadly target one ethnic group or nationality for exclusion. Restrictions should be calibrated precisely to the risk and carried out in a manner that minimises the restraints on individual liberty.

Public health measures have traditionally focussed on curbing the spread of disease by imposing restrictions on the rights of those already infected or thought to be most vulnerable to becoming infected.[206] In the face of epidemics, coercion, compulsion and restrictions have historically been necessary components of public

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203 Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003).

204 *Ibid.*

205 Wayne Arnold, "In Singapore, 1970s Law Becomes Weapon Against SARS", *New York Times*, (June 10, 2003).

206 See David Cyranoski, "Taiwan Left Isolated in Fight Against SARS", *Nature*, no. 422 (2003), p. 652.

health maintenance. In past centuries, however, measures taken have often been excessive in the face of public panic. These experiences have culminated in a growing emphasis on human rights in this area. It is recognised that targeted interference with freedom of movement, when instituting a quarantine or isolation for a serious communicable disease – for example, Ebola fever, syphilis, typhoid, untreated tuberculosis and now atypical pneumonia – are restrictions on rights that may be necessary for better maintaining public health. Such restrictions, properly instituted and carried out, are considered legitimate measures under international human rights law.

On the other hand, certain arbitrary measures taken by public health authorities that do not consider less intrusive alternatives may be found to be abusive of both human rights principles and good public health practices. In the above-noted comments, the UN Committee on Economic, Social and Cultural Rights stated that all restrictions imposed on the grounds of public health must be in accordance with law, including international human rights standards, compatible with the nature of the rights protected by the ICESCR, in the interest of legitimate aims, and strictly necessary for the promotion of the general welfare in a democratic society.[207]

The Committee also observed the need for the limitations to be proportional.[208] This means that, where several types of limitations are available, the government of the HKSAR ought to adopt the least restrictive alternative.[209] Moreover, even when such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.[210]

To meet the government's obligations, restrictions should not target any group unfairly; there should be adequate compensation for those who suffer deprivation in the public interest; and public information must be maintained at a high level so as to assist every person in the maintenance of their own health and the safety of others. The principle of non-discrimination is fundamental to human rights thinking. Hence, the United Nations Commission on Human Rights has stated 'all are equal before the law and entitled to equal protection of the law from all discrimination and from all incitement to discrimination relating to their health status' (UN 1992)[211].

D. The Siracusa Principles and the WHO Guiding Principles

International groups and institutions have refined these basic obligations in the public health area. The Siracusa Principles[212] on the Limitation and Derogation

207 *Note* 203.

208 Sofia Gruskin, "SARS, Public Health and Global Governance: Is there a Government in the Cockpit: A Passenger's Perspective on Global Public Health: The Role of Human Rights, *Temple Law Review*, no. 77 (2004), p. 313–333 at p. 322.

209 Lawrence O. Gostin, "Public Health Strategies for Pandemic Influenza: Ethics and the Law", Journal of the American Medical Association, vol. 295(14) (2006).

210 *Note* 203.

211 See Article 7, United Nations Declaration of Human Rights.

212 See also Susan Marks and Andrew Clapham, *International Human Rights Lexicon* (Oxford University Press, Oxford, 2005), p. 206.

Provisions in the International Covenant on Civil and Political Rights[212a] adopted in May 1984 by a group of international experts, offer a useful guideline for divining the boundaries between positive action and permitted restrictions. These principles have long been recognised by those concerned with human rights monitoring and implementation as relevant to analysing government action. They have also begun to be considered a useful tool in a number of places by those responsible within government for health-related policies and programs (WHO/UNAIDS 1999).

According to the Siracusa Principles, when a government limits the exercise or enjoyment of a right, it must be a last resort and will only be considered legitimate when the following criteria are met: (i) the restriction is provided for and carried out in accordance with law; (ii) the restriction is in the interest of a legitimate objective of general interest; (iii) the restriction is strictly necessary in a democratic society to achieve the objective; (iv) there are no less intrusive and restrictive means available to reach the same goal; and (v) the restriction is not imposed arbitrarily, ie, in an unreasonable or otherwise discriminatory manner.[213] In addition, Siracusa Principles 25 and 26 specifically recognise that public health may be invoked as a ground for limiting certain rights, allowing a state to take measures dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured. Due regard should be had to the international health regulations of the World Health Organization which was revised by the World Health Assembly in May 2005 and enforced in June 2007.[214]

One of the important lessons of the SARS outbreak is the need for health emergency preparedness,[215] including relevant legislation, policies, plans and programmes, in line with human rights law coupled with an exigent requirement of having a well-functioning national health systems for the control of epidemic diseases, capable of providing urgent medical care and relief.[216] Strengthening of health

212aUN Doc. E/CN4/1984/4.

213 United Nations, Economic and Social Council, U.N. Sub-Commission on Prevention of Discrimination and Protection of Minorities, Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, Annex, UN Doc E/CN.4/1984/4 (1984), available at <http://graduateinstitute.ch/faculty/clapham/hrdoc/docs/siracusa.html> (last visited on January 2, 2012).

214 Gian Luca Burci and Riikka Koskenmäki, *Human Rights Implications of Governance Responses to Public Health Emergencies: The Case of Major Infectious Disease Outbreaks, available at* <http://www.swisshumanrightsbook.com/SHRB/shrb_03_files/22_453_Burci_Koskenmaki.pdf>, (last visited on December 27, 2012).

215 WHO, *Ethical Considerations in Developing a Public Health Response to Pandemic Influenza,* WHO/CDS/EPR/GIP/2007.2 (WHO, Geneva, 2007), p. IX, available at <http://www.who.int/csr/resources/publications/WHO_CDS_EPR_ GIP_2007_2/en/index.html>; See also, L. O. Gostin, J. S. Vernick et al., "SARS and International Legal Preparedness", *Temple Law Review*, no.77 (2004), pp. 155–173, at pp. 155–173.

216 Primary Health Care: Report of the International Conference on Primary Health Care (WHO, Geneva, 1978) in particular the definition of primary health care at p. 3.

systems should thus be a high priority and based, according to the UN Special Rapporteur on the right to health, on a right-to-health approach.[217]

The IHR, as revised in 2005, are a complex and innovative instrument that opens a new era in international health law.[218] A major distinguishing feature of the revised IHR is that, unlike the predecessor Regulations, they contain provisions seeking to ensure that measures are applied consistent with human rights and freedoms, aiming to strike a balance between the protection of public health, interference with international traffic and trade,[219] and the protection of fundamental human rights.[220]

The most important protective measures in the IHR include the requirement to apply the least intrusive and invasive medical examination that achieves the public health objective[221] and the need for prior express informed consent except in special circumstances[222]. States parties must treat travellers undergoing health measures with respect for their dignity and human rights, and provide certain facilities to minimize their discomfort.[223] The Regulations provide some protection as to confidentiality and lawful use of personal data collected under the IHR[224]. They also introduce a general requirement of transparency and nondiscrimination in the application of health measures.[225]

While invoking the limitation or restriction of rights granted under the ICCPR in the implementation of the IHR, it should be subject to the test laid down in Siracusa Principles.[226] It is reiterated here that Sircausa Principles state that "due regard shall

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217 Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc. A/HRC/7/11, (31 January 2008).

218 *Note* 215, *p.* 350.

219 IHR, Article 11 defines the term "international traffic" as "the movement of persons, baggage, cargo, containers, conveyances, goods or postal parcels across an international border, including international trade."

220 For human rights related provisions in the IHR, see e.g. D. P. Fidler, "From International Sanitary Conventions to Global Health Security: The New International Health Regulation", *Chinese Journal of International Law*, vol. 4(2) (2005), pp. 325–392, Table 2; and B. Plotkin, "Human Rights and Other Provisions in the Revised International Health Regulations", *Public Health*, no. 121 (2007), pp. 840–845.

221 Under Articles 17, 23, 31 and 43, the WHO Director-General also has an obligation to consider health measures "that, on the basis of a risk assessment appropriate to the circumstances, are not more … intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection."

222 Article 23, International Health Regulations, 2005, available at <http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf>.

223 *Ibid.*, Article 32.

224 *Ibid.,* Article 45.

225 *Ibid.,* Article 42.

226 H. L. Lambertson, "Swatting a Bug without a Flyswatter: Minimizing the Impact of Disease Control on Individual Liberty under the Revised International Health Regulations", *Penn State International Law Review*, vol. 25(2) (2006), pp. 531–555 at p. 554.

be had to the International Health Regulations of the World Health Organization", strengthening the importance of the IHR as a reference for achieving a balance between respect for human rights and protection of public health.[227]

The WHO Guiding Principles for International Outbreak Alert and Response articulate the consensus of partners in the Global Outbreak Alert and Response Network on how to prepare for field activity, activate international support, co-ordinate response in the field and evaluate and follow up outbreaks of international importance.[228] In fact, the SARS outbreak has witnessed this response from the WHO. Detailed standard operating protocols supplement the Guiding Principles and address the broad spectrum of operational issues. One of the important Guiding Principles states, 'all network responses will proceed with full respect for ethical standards, human rights, national and local laws, cultural sensitivities and traditions'.[229] This further underlines the argument made earlier that human rights are included as a part of the mandate of the WHO. Such commitment not only ensures that the right to health is protected and promoted, but also ensures that, in the process of fulfilling this right, other human rights are not violated. Further, WHO norms require state accountability on violation of the right to health. This requires monitoring at the national, regional and international levels to ensure state accountability.[230]

V. CONCLUSION: INTEGRATING PUBLIC HEALTH, HUMAN RIGHTS AND GOOD GOVERNANCE

In order to ensure the provision of adequate healthcare to all people, it is essential to adopt a rights based approach. However, the rights based approach can work effectively only when the artificial dichotomy between CPR and ESCR is discarded. Human rights jurisprudence has now come to accept that these two sets of rights are inalienable. It is important that the same approach be adopted in the context of the human right to health so that right to health is treated as a justiciable, and not merely as an aspirational right.

The necessity to recognize the justiciable human right to health is extremely urgent. The SARS crisis in Hong Kong shows that the importance of having an effective human rights regime and governance mechanism to effectively respond to a public health challenge. The Indian Supreme Court has been proactive in recognizing the right to education as a fundamental right. Unfortunately, the human right to health has not developed as effectively in India. There is a strong case for developing a strong and effective human right to health in India. Such recognition will also impact legal and policy reforms in India and help in improving the healthcare

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227 *Note* 215, p. 352.

228 World Health Organization, WHO Guiding Principles for International Outbreak Alert and Response, available at <http://www.who.int/csr/outbreaknetwork/guidingprinciples/en/index.html> (last visited on January 2, 2013).

229 *Ibid.*

230 *Note* 134.

situation in the country. The human rights approach should draw from the jurisprudence on right to education developed by the Indian Supreme Court, international law regime on the right to health, as well as the experiences of other countries in South Asia region as well as the rest of the world.

Ultimately, the rights and the governance components of the right to health interact to serve the public interest. Human Rights create entitlements for right-bearers and, at the same time, the right to health creates an obligatory duty on states, as well as other appropriate bodies and individuals, to fulfill the mandate necessitated by the particular right. In this sense, rights may chart avenues of good governance. At the same time, adherence to human rights best creates the conditions for good governance. The Nobel laureate Amartya Sen has long warned that good public information is important to creating official incentives to deal with crises and can shape the adequacy of response.[231] The legal enforcement mechanisms associated with the right to health add to the public health and moral imperative inherent in this sound public policy. Enforcement mechanisms, whether administrative or judicial, become vehicles for further public discussion and refinement of norms in support of legislative and administrative processes and social justice.

231 *Note* 38.