CHAPTER ONE
Right to Health: Understanding Health from Human Rights Concerns

Introduction
This chapter reflects the philosophical foundation of the setting human rights standards and right to health and it also traces the historical background of human rights and health issue. This study also focuses on the concept and history of standard setting exercise of human rights and right to health and gradual evolution of the concept in human civilization. This includes discussion on the law, ethics including bioethics which are essential for a deeper grasp of the essence of human rights standard setting and the process of enforcement.

In the past decade, the thinking has been that international action on human rights should move from setting legal standards to the implementation of existing standards. The usefulness of some new standards has been questioned, and there is evidence that disenchantment is gradually growing. At its simplest, the issue is that treaty making in the area of human rights has, in some ways, become complicated, and even in cases where a text is adopted, there is no guarantee that the treaty is effectively enforced. Recent negotiations on particular standards—for example, the Optional Protocols to the Convention on the Rights of the Health and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment—show that some states are reluctant to support new and heightening standards.

This study examines and analyzes the effectiveness of the processes, the role of different actors within those processes, and also seeks to identify possible new avenues in standard setting. It is also an attempt to understand the processes involved in standard setting and draws lessons through the examination of different standards and their contexts. It also looks at fresh thinking of human rights experts who seek to initiate or advocate for new human rights standards and thinking or approach of officials engaged in inter-governmental and governmental organizations. The overall pursuit is to examine the
process of relevance of standard setting in the heights discourse with specific focus on right to health.

**Norm-Setting in International Law and Human Rights: Historical Antecedents**

The normative regime of international human rights law to be specific originated in liberal theory and philosophy. The rise of the modern nation-state in Europe and its monopoly over violence and the instruments of coercion gave birth to a culture of individual rights to contain the abusive and invasive state. John Locke reduced this relationship between the state and the individual to a philosophy in his Two Treatises of Government\(^1\). In liberal theory, individual rights act as a bar against the despotic proclivities of the state. It is on this theoretical foundation that international human rights law raises. Thus, the modern state is the primary guarantor of human rights, while it is at the same time the basic target for international human rights law\(^2\). For several centuries, however, these normative limitations remained the exclusive province of constitutional and other domestic legal regimes. The creation of a binding system of international human rights law did not happen until after World War II—following the abominations of the Third Reich. Human rights law is therefore at its core an internationalization of the obligations of the liberal state.

To be certain, the post-war international human rights regime did not spring into existence overnight. It has its historical antecedents in a number of mass struggles, international law doctrines, and institutions. These include anti-colonial struggles, state responsibility for injuries to aliens, struggles against (and from) religious persecution, the Mandates and Minorities Systems of the League of Nations, the protection of minorities, humanitarian intervention, international humanitarian law, the struggle for women’s rights, anti-slavery campaigns, and anti-apartheid and other anti-racist struggles.


In its original formulation, international law was the exclusive preserve of the Society of Nations\(^3\). The responsibility for the initial construction of the basic principles of international law belonged to this small core of states. Standard setting and norm creation at the dawn of international law were therefore an exclusively European exercise. That is why the spirit of the discipline of international law, as well as its theoretical and philosophical predicates, is regarded as Eurocentric\(^4\).

International standard setting law, which was originally state-centered, exclusively governed relationships between nation-states. States alone made and applied international law. Thus, only a select few states were subjects of international law and therefore had any rights under this legal order. After World War I, however, several newly created international organizations were recognized as having some limited rights under international law. Generally, individual human beings did not have any international legal rights; as such, a state’s treatment of its natural persons was not the business of any other state or of the international community.

With the passage of time, the individual started gaining currency in international law. The doctrine of humanitarian intervention, very early on in the development of international law, recognized “as lawful the use of force by one or more states to stop the maltreatment by a state of its own nationals when that conduct was as brutal and large-scale as to shock the conscience of the community of nations”\(^5\). Later, the individual gained more protection from the nineteenth century treaties to ban the trans-Atlantic slave trade in Africans and the conclusion of treaties to protect Christians in the Turkish (Ottoman) Empire.

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In the early twentieth century, the League of Nations provided that colonial powers observe the “principle that the well-being and development” of native [colonized] peoples “form a sacred trust of civilisation.” The League Covenant also called for “fair and humane conditions of labour for men, women, and children.” The International Labour Organization took up that challenge and produced a plethora of instruments on labour standards and worker’s rights. The League also pushed for the development of an international system for the protection of minorities. International humanitarian law—the law of war—also provided for the care of the wounded or sick combatants and the protection of medical personnel and hospital facilities in wartime.

While these international legal doctrines and institutions played a critical role in the early foundation of human rights norm-setting, popular mass struggles by marginalized groups and colonized peoples were no less important in giving content to the post-war human rights movement. Examples of these struggles are the anti-colonial and anti-racist movements by the peoples of different nation-states. These struggles for self-determination and independence have left an indelible mark on human civilization. The process of standard setting takes its own stance.

The Process of Standard Setting in Human Rights

The process of standard setting at the international level suggests complexity, negotiation, and consensus building. It also calls into play competing national interests, cultures, and ideologies. As if these aspects were not enough, more difficult matters of the asymmetry of power, the ability to participate effectively in the process, and the capacity to own both the process and the product come into play. Unpacking process, therefore, is a tricky and pivotal question. For it is quite often the case that control over the process makes the final outcome predictable and, sometimes, moot. Where complex and competing players exist, the process becomes as essential as the product itself. Thus,

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7 Ibid. Article, 23.
questions must be asked about fairness, transparency, ownership, democracy, and participation in any probing discussion of process.

There is, moreover, a tendency by those involved in the human rights discourse to use the terms “standard,” “norm,” and “right” interchangeably as though they were synonymous or have an identical meaning. Other terms with similar connotations, such as “entitlement” or “claim,” are sometimes thrown in. All these terms conjure up the following images: ideal, threshold, floor, benchmark, aspiration and privilege. They suggest things that should be striven for and imply an expectation of the fulfilment of a promise or a duty. However, because the human rights corpus is a species of international Law—essentially a legal regime that binds states—it is imperative that analyses of the terms adopt a precise legal lens. The language of the law seeks precision about the legal meaning of words and determines their legal status and the nature of the obligations or privileges it envisages. In fact, it can be plausibly argued that the process of standard setting in human rights is a struggle over the meaning of language and its implications on the conduct of states. Perhaps the most elastic of these terms is the word “standard” itself, which has no particular legal meaning and does not necessarily imply a legal obligation of any kind. A standard is a vacuous, empty receptacle into which one can fit almost anything. It refers to a level of achievement or expectation that may carry with it moral, cultural, or other civilizational aspiration.

The UDHR, for example, which was initially only meant to carry moral authority referred to itself as a “common standard of achievement for all peoples and all nations.” It is almost certain that the UDHR would not have acquired its current authority had it been a legally binding instrument. It is in the flexibility of the term ‘standard’ that lies hidden therein its wide reach and scope. It can be argued that freeing the term from the narrow strictures of the law gives it more authority and propels it to the forefront as a universal civilizational value that knows no cultural or geographic boundary. In other words, a standard is a phenomenon that is above a mere legal rule; it is an inherent and self-revealing virtue, one that demands obedience without question. There are advantages,

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9 UDHR, Supra Note 15, Preamble (Emphasis Added.)
therefore, to employing the loose ended term particularly if one seeks a wider consensus without any obvious or immediate legal bond.

The term “norm” is more complicated than “standard” although it, too, has the advantage of transcending the narrow confines of the law. A “right” is the most crystallized of all these terms. It is the element that is laid bare once the other terms like standard and norm—are boiled down to their simplest forms. Arguably the single most important term in any legal regime, the word “right” is the foundation and basis of the human rights movement.

In human rights discourse, rights provide the avenues through which human dignity is secured and guaranteed. The term implies both a duty and the bearer of that duty. In human rights law, the state bears the primary duty of protecting rights, which are enjoyed by individuals and groups. A right is viewed as an entitlement.10

While the rule of law is the bar between tyranny and democracy, human rights are the most sacred of all legal entitlements. Once a claim achieves the status of a human right, it acquires the aura of irreversibility, irrevocability, timelessness, and universal validity. Human rights are regarded as the zenith of human civilization. A human right is a crystal clear phenomenon, an attribute that lacks the hazy outlines of a standard or a norm. It is in this respect that a right—in this case a human right—is a clear distillation and a more careful use of terminology than the more general “norm” or “standard.” It is, therefore, important to note that the term standard encompasses both norms and rights. That is why the process and exercise of the creation of expectations and obligations in human rights can be referred to as standard setting, an expression that covers both binding and non-binding rules and codes of conduct.

On the other side of the argument is that while the modern Law of Human Rights may have a short formative period of no more than three centuries, both the principle and the history of the Dignity of Man—together with his common citizenship in society—can be

seen for thousands of years. Indeed, almost from the very beginnings of recorded history of humanity, the quest for a validation of human rights has been found, not so much perhaps in reason, as with an instinctive feeling of what is both right and good. Thus, it has been said, “Human rights have always existed with the human being,” as with the concept of human dignity.

Under one interpretation of human rights, they are seen as “non-positivistic, principled, legal limits to what states, state actors, and state agents can do to their citizens.” As such, they impose no obligations on states; rather, they impose limits to state action. This view is drawn from the philosophy of the Bill of Rights and rooted in a neo-Lockean conception of the rule of law as a “commitment to a determinate set of legal rules.” In the international human rights community, however, a contrary view is taken—a view which holds to the notion that these rights either obligate state action under certain circumstances or, alternatively, obligate restraint by the state.

Although a concrete notion of human rights appears absent from the Greek and Roman legal systems as well as the Chinese and other ancient civilizations, certain claims to parental authorship have—over time—been tied to Magna Carta 1215 and the Bill of Rights 1689, as well as the American Declaration of Independence 1776, and the French Declaration of the Rights of Man and of The Citizen 1789. Yet, from the standpoint of historical accuracy, the French Declaration is seen correctly as the first document of its

11 Fali Nariman, the Universality of Human Rights, 50 Revolution Instruments Community Jurist 9, 11, (1993)
14 Ibid. P. 93
15 Ibid. P. 95
16 Ibid. P. 93
scope and nature which is reference to contemporary social, economic, and cultural rights styled originally as the rights to education, work, property ownership and social protection.\textsuperscript{19}

Even though viewed as a type of generalized philosophical manifesto for the Western World, the French Declaration was not embraced by subsequent European constitutions.\textsuperscript{20} Indeed, these new constitutions were seen as not only less pragmatic as the Declaration but they also were prone to de-emphasize “the philosophy of inalienable rights.”\textsuperscript{21} Rights were, thus, constitutional in origin. The European constitutions of the 19\textsuperscript{th} century were the frameworks or mechanisms for declaring rights to be protected constitutionally within legal boundaries. Put simply, then, it was solely within the legislative power where fundamental rights were not only declared but limited\textsuperscript{22} Latin American constitutionalism de-emphasized the “inalienability of rights” and—instead—during the 19\textsuperscript{th} and 20\textsuperscript{th} centuries, chose to reference only those laws established by state authorities.\textsuperscript{23}

In this study we focus more on the context of the Constitution of India which is one of the most rights-based constitutions in the world. Drafted around the same time as the Universal Declaration of Human Rights (1948), the Indian Constitution captures the essence of human rights in its Preamble, and the sections on Fundamental Rights and the Directive Principles of State Policy.

The Constitution of India is based on the principles that guided India’s struggle against a colonial regime that consistently violated the civil, political, social, economic and cultural rights of the people of India. The freedom struggle itself was informed by many movements for social reform, against oppressive social practices like sati, child marriage,

\textsuperscript{21} Ibid.
\textsuperscript{23} Ludwikowski, Supra Note 10, P. 21
untouchability etc. Thus by the mid-1920s, the Indian National Congress had already adopted most of the civil and political rights in its agenda. The movement led by Dr B R Ambedkar against discrimination of Dalits also had an impact on the Indian Constitution. In spite of the fact that most of the human rights found clear expression in the Constitution of India, the independent Indian State carried forward many colonial tendencies and power structures, including those embedded in the elite Indian Civil Service. Though the Indian State under Jawaharlal Nehru took many proactive steps and followed a welfare state model, the police and bureaucracy remained largely colonial in their approach and sought to exert control and power over citizens. The casteist, feudal and communal characteristics of the Indian polity, coupled with a colonial bureaucracy, weighed against and dampened the spirit of freedom, rights and affirmative action enshrined in the Constitution.

Over a period of 58 years, the articulation and assertion of human rights within civil society has grown into a much richer, more diverse and relatively more powerful discourse at multiple levels. A brief historical sketch of the different trajectories of human rights discourse will help us to locate human rights in the historical context. There are four specific trajectories of human rights discourse in the Indian context:

- Civil and Political Rights,
- Rights of the Marginalized (such as women, Dalits and Adivasis),
- Economic, Social and Cultural Rights, and
- The Right to Transparent and Accountable Governance.

Though each of these trajectories is interconnected, they were promoted by different sets of actors (often with varying ideological affiliations) at different points in time. There has always been tension and lack of mutual appreciation between those who promoted civil liberties and the left-oriented groups who worked towards the structural transformation of socio-economic conditions and consequently of the State.
As the concept of human rights was perceived as a western idea to gloss over inequalities and as a means of legitimizing the capitalist and imperialist projects of the west (particularly the US) the left-oriented groups were clearly skeptical about human rights, particularly as expressed by the civil liberties groups. Though in some quarters such skepticism still exists, there has been a greater recognition of the need to promote and protect human rights, in spite of the misuse of the human rights discourse by the new imperialist forces.

Rights need critical assessment to draw the clear cut understanding of health rights. In attempting to distinguish human rights from fundamental constitutional rights, socialist jurisprudence sought to ignore any inherent or natural rights theories and treated them as philosophical rights—this, while recognizing the constitutionally created rights as political in origin. Even though constitutions drafted during the post-socialist period failed to follow the socialist concept of granted right, there remained a dilemma: how to develop a “middle-ground approach” which would validate the idea that “a consensus reached by the people at the constitution’s adoption is the result of their recognition of some commonly accepted values.” 24 It was all too apparent to those drafting new constitutions that securing fundamental recognition of a selection of core rights was not guaranteed by a designation that these rights were “natural.” 25

Indeed, throughout the subsequent history of human rights, “cultural relativism” has been a dominant force with which to reckon—for, the values of some people are not always capable of being judged by the norms shared by others. 26 Even with vagueness and imprecision as the all-too-often banner of contemporary human rights, a trend toward the “internationalization of human rights movements” is evidenced. 27 Yet, such a trend by no means can be seen as an integration of internationalization of human rights with special reference to international human rights movements. Rather, it must be accepted as

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24 Ibid. P. 22
25 Ibid. P. 22
26 Ibid. P. 23
27 Ibid. P. 40
“toleration for human rights which is monitoring by government and access to the most important human rights treaties.”28

The crux of the argument is whether one can claim health as human right or it is merely a social service, if one claims health as human rights than what legal support does one require. The central thrust of the argument is that the enjoyment of the highest standard of human rights is one of the fundamental human rights of every human being, without distinction of race, religion, political belief or social condition. The Universal Declaration of Human Rights, Article 25 is concerned with the right to health. According to this Article, ‘everyone has the right to a standard of living, adequate for the health of himself, including food, clothing, housing, medical care and necessary services.’ The preamble of the World Health Organization states that the enjoyment of the highest standard of health is a fundamental right of every human being29.

Standard setting process entails sensitivity to ethics. Human rights constitute a set of norms governing the treatment by state and non-state actors or individuals and groups on the basis of ethical principles incorporated into national and international legal systems as the subject matter of norms in question relates to the treatment of human beings. Human rights overlap to a considerable degree with ethics (but should not be confused with ethics). Similarly, because human rights include the right to health and refer to essential social determinants of health and well-being of people, they overlap with many principles and norms of bioethics. However, human rights and bioethics differ in scope, sources, legal nature, and the mechanisms of monitoring and applying the norms.

The scope of bioethics is the ethical issues arising from health care and biomedical sciences, whereas that of human rights embraces the claims individuals and groups can legitimately make against state and non-state actors to respect their dignity, integrity, autonomy and freedom of action as defined in an officially endorsed set of standards or norms. Bioethics regulates clinical encounters with patients on the basis of principles

28 Ibid. Pp. 41-42
such as beneficence, non-malfeasance, confidentiality, autonomy and informed consent; whereas human rights are the special rules agreed upon in a given society to achieve justice and well-being and overcome the pain and suffering that result from repression (somatic violence) and oppression (systemic violence).

The source of human rights is the norm-creating process of national and international legal systems, whereas that of bioethics is the deliberations and published opinions of leading thinkers, review boards and professional associations on the ethical issues they address. ‘Source’ is used here as the formal validation of normative positions rather than an abstract grounding of ethical reasoning in moral philosophy or a biological assessment of empathy or altruism. Bioethics and human rights share this deeper distal grounding but have recourse to different proximate sources. The proximate source of human rights is typically an international human rights treaty or declaration and of bioethics is a professional code or review board guidelines. Exceptionally, the proximate source is identical when an instrument of international law addresses directly an issue of bioethics and human rights, such as UNESCO’s Universal Declaration on the Human Genome and Human Rights or the Council of Europe’s Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine, both of 1997.

The legal nature of human rights norms ranges from merely aspirational claims to the justiciable and enforceable legally binding obligations. The former include nonbinding norms through which advocates of various causes draw upon human rights discourse to seek social change. The latter refer to legally binding rules of domestic (normally constitutional) and international law requiring governments to respect, ensure, promote and fulfill certain norms, with opportunities for persons denied their rights, non-governmental organizations and various international agencies to obtain redress or change policy consistent with those norms. In so far as those norms concern health and medicine, they contribute to the tasks of bioethics, although the legal nature of bioethical standards is less a matter of constitutional and international law than a field of inquiry, and reasoned philosophical discourse that may be used in law reform and litigation takes
on a legal form through codes of conduct formally adopted by professional bodies with authority over the conduct of their members.

An important distinction may clarify further the difference between human rights and bioethics, namely that between ‘rights’ and ‘human rights’. In ethics a right refers to any entitlement, the moral validity or legitimacy of which depends on the mode of moral reasoning the ethicist is using. In law, a right is any legally protected interest. In human rights discourse, a human right is a higher-order right authoritatively defined using the expression ‘human rights’ with the expectation that it carries a peremptory character similar to Rawls’s idea of the “priority of liberty”\textsuperscript{30} or Dworkin’s “rights as trumps”.\textsuperscript{31} In other words, in case of conflict human rights prevail over other (ordinary) rights. This distinction is relevant to both the natural law and positive law foundations of human rights.

As defined in natural law, a human right is usually considered inalienable, immutable and absolute, whereas in positive law it is dependent upon a political and legal process that results in a declaration, law, treaty or other normative instrument and may vary over time and be subject to derogations or limitations designed to optimize respect for human rights rather than impose an absolute standard. Although much confusion arises regarding moral and legal bases of human rights, the relationship between the two may be understood by considering that human rights emerge from claims of people suffering injustice, based on moral sentiment, but become part of the social order when they are proclaimed by an authoritative body, through a process that is law-based. During the process from moral sentiment to legal entrenchment, claims not yet formally recognized as human rights may nevertheless be legitimate and have consequences without being incorporated into binding law. However, the most solid basis for asserting that an act or omission is or is not in conformity with human rights standards is positive law. That is why the

International Bill of Human Rights,\textsuperscript{32} along with the other human rights treaties of the UN and of regional organizations, constitutes the primary source and reference point for what properly belongs in the category of human rights.

The moral or natural law basis of human rights is essential to challenging abusive power and advancing human rights, but its universality may be questioned because it is culturally determined by contextualized moral and religious belief systems. The consensual or positive law basis of human rights reflects compromise and historical shifts but attains a higher degree of universality by virtue of the participation of representatives of virtually every nation in the norm-creating process.

The methods of monitoring compliance with human rights include moral judgments made with reference to recognized human rights, quasi-judicial procedures of investigation and fact-finding leading to official pronouncements of political bodies regarding compliance, and enforceable judicial decisions. Those of bioethics also include moral judgments made with reference to principles or codes of bioethics and official pronouncements of professional bodies that may result in altering research design or the behavior or liability of health professionals in their relations with patients or in policies affecting the health of populations.

The overlap of human rights and bioethical discourse and differences between the two will become clearer as one clarifies the emergence of human rights in political and legal discourse, the content of the right to health as defined in human rights instruments, the other human rights as they relate to health and well being, and the role and responsibility of health professionals, governments, international organizations and non governmental organizations to respect, protect, promote and provide for these rights.

\textsuperscript{32} The International Bill of Human Rights Consists of the Universal Declaration of Human Rights of 1948, Office of the United Nations High Commissioners for Human Rights, Geneva, (UDHR) and the Two International Covenants of 1966- One on Civil and Political Rights, the other on Economic, Social and Cultural Rights
II. Emergence of human rights

The early formulation of norms we characterize today as human rights is inseparable from historical and philosophical manifestations of human striving for justice. The deepest origin of human rights no doubt derives from basic human instincts of survival of the species and manifestations of empathy and altruism that evolutionary biology is only beginning to explain.\(^3\) Since human evolution is driven by reproductive selfishness, one could wonder why the human species would develop any ethical system, like that of human rights, according to which individuals manifest feeling for the suffering of others (empathy) and even more surprising act in self-sacrificing ways for the benefit of others without achieving any noticeable reproductive advantage. And yet, as Paul Ehrlich notes in Human Natures, “empathy and altruism often exist where the chances for any return for the altruist are nil.”\(^3\) Natural selection does not provide the answer to moral behavior as “there aren’t enough genes to code the various required behaviors” but rather “cultural evolution is the source of ethics”\(^3\) and therefore of human rights.

In legend, literature, religion and political thought, justice and eventually the concept of human rights became socially constructed over time into complex webs of social interaction striving toward a social order in which human beings are treated fairly as individuals and collectivities. The best-known histories of the human rights movement\(^3\) tend to begin with the ancient religions and societies.

Religion and law have an ambiguous role in this historical process. The history of religions is replete with advances in the moral principles of behavior ‘many of which directly influenced the drafting of human rights texts’ but also in crimes committed in the name of a Supreme Being. Similarly, the emergence of the rule of law has been critical to the advance of justice and human rights against the arbitrary usurpation of power in most societies but also in preserving the impunity of oppressors.

\(^3\) Ibid., p.312.
\(^3\) Ibid., p.317.
Scholars trace the current configuration of international human rights norms and procedures to the revolutions of freedom and equality that transformed governments across Europe and North America in the 18th century and liberated subjugated people from slavery and colonial domination in the 19th and 20th centuries. Enlightenment philosophers derived the centrality of the individual from their theories of the state of nature, social contractarians, especially Jean-Jacques Rousseau, predicated the authority of the state on its capacity to achieve the optimum enjoyment of natural rights, that is, of rights inherent in each individual irrespective of birth or status. He wrote in Essay on the Origin of Inequality among Men that “it is plainly contrary to the law of nature” that the privileged few should gorge themselves with superfluities, while the starving multitude are in want of the bare necessities of life.37 Equally important was the concept of the universalized individual (‘the rights of Man’), reflected in the political thinking of Immanuel Kant, John Locke, Thomas Paine and the authors of the French and American Declarations. Much of this natural law tradition is secularized in contemporary human rights.

World War II was the defining event for the internationalization of human rights. In 1940, H.G. Wells wrote The Rights of Man or What are We Fighting For?; Roosevelt’s four freedoms speech was given in 1941; the UN Charter established in 1945 an obligation of all members to respect and observe human rights and created a permanent commission to promote their realization; and the trial of Nazi doctors defined principles that were codified in the Nuremberg Code in 1946. In the war’s immediate aftermath, foundations of human rights texts were adopted: the Genocide Convention and the Universal Declaration of Human Rights in 1948, the Geneva Conventions in 1949, followed in 1966 by the International Covenants on Human Rights. NGOs played a role in all of these developments and in subsequent drafting of treaties on the rights of the child, discrimination against women, and the International Criminal Court, as well as in the creation of investigative and accountability procedures at the intergovernmental level.

Drawing heavily on the debates in the Third Committee of the General Assembly in 1948, one finds that the philosophy of the Universal Declaration was linked to that of the French Declaration of 1789 but that 18\textsuperscript{th} century deism had been replaced by 20\textsuperscript{th} century secular humanism, as evidenced by the rejection of the explicit reference to “nature.”\textsuperscript{38} This is not only true for the legislative history of the Universal Declaration but is also an accurate characterization of the grounding of international human rights in the 21\textsuperscript{st} century.

The valuation of every individual through natural rights was a break with the earlier determination of rights and duties on the basis of hierarchy and status. Commenting on the French Revolution’s break with the past, Jürgen Habermas wrote that this “revolutionary consciousness gave birth to a new mentality, which was shaped by a new time consciousness, a new concept of political practice, and a new notion of legitimization.”\textsuperscript{39} Although it took more than a century for this new mentality to include women and slaves, the awareness that the “rights of man” should extend to all human beings was forcefully argued in the same period by Mary Wollstonecraft\textsuperscript{40} and by the Society for the Abolition of the Slave Trade, founded in 1783. The movement to abolish slavery was the precursor of today’s vast array of human rights non-governmental organizations (NGOs).

The secular tradition of human rights over the past three centuries has reflected a certain tension between political liberalism and democratic egalitarianism, between Locke and Rousseau, between liberty and equality, between civil and political rights and economic, social and cultural rights. Marx and other socialist scholars questioned the “bourgeois” character of a limited interpretation of individual human rights. Community interest and egalitarian values are not the sole prerogative of Marxists and socialists; they are reflected in the Universal Declaration’s balancing of “bourgeois” liberal rights with

duties to the community and social, economic and cultural rights as correctives to abuses of property rights. Significantly, the Declaration acknowledges that “Everyone has duties to the community in which alone the free and full development of his personality is possible.” While socialist thought and positions taken by Soviet bloc countries supported concepts of duties and economic, social and cultural rights, these are also deeply rooted in other cultural and political traditions, including European social democracy and Roosevelt’s proposal for an economic bill of rights. The emphasis on community and duties is also found in conservative elements of some societies, like Islamic, Hindu and other Asian societies. The simultaneous affirmation of rights and duties, of protecting individual freedoms and meeting social and economic needs which refers to group rights and individual rights. It is also part and parcel of human rights, adding to it, complexity and depth to the norms, but also ambiguity and tension. Notwithstanding this balancing, the debate over the “universality” of human rights continues. The matter was not settled by the compromised language of the World Conference on Human Rights (Vienna, June 1993), according to which:

“All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.”

This statement captures an important feature of human rights today, namely, the claim that they are universal and the reality of geo-cultural diversity. To understand it fully the challenge this feature represents requires an understanding of the normative content of the current catalogue of human rights.

III. The normative content of human rights: The right to health

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41 UDHR, Article 29
The current catalogue of human rights consists of some fifty normative propositions enumerated in the international bill of human rights, extended by a score of specialized UN treaties, a half-dozen regional human rights treaties, and hundreds of international norms elaborated in the fields of labor, refugees, armed conflict, and criminal law. This corpus of human rights law, enriched by declarations, programs of action and other formulations of human rights in the process of becoming legally binding, is the source of the norms that properly fall with the category of international human rights.

The human rights framework takes on particular relevance for bioethics when the meaning, scope and practical significance of the right to health are considered. The right to health as understood in international human rights law is defined in Article 25 of the 1948 Universal Declaration of Human Rights (UDHR) (“Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing, medical care and necessary social services”). Article 12 International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) which states “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

Variations on this definition are found in Article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965 (“The right to public health, medical care, social security and social services”), in Articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 (CEDAW) (“the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction”[and] to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning [and] ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.) and in Article

41 International Covenant on Economic, Social and Cultural Rights, Adopted and Opened for Signature, Ratification and Accession by General Assembly Resolution 2200A (XXI) of 16 December 1966
24 of the Convention on the Rights of the Child of 1989 (CRC) ("the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health"). Regional human rights treaties also define the right, as in Article 11 of the European Social Charter of 1961 as revised in 1996, (states, obligation to take measures, to remove as far as possible the causes of illhealth; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; to prevent as far as possible epidemic, endemic and other diseases, as well as accidents and the duty to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition); Article 16 of the African Charter on Human and Peoples’ Rights of 1981 (the right to enjoy the best attainable state of physical and mental health [and the obligation of the state to] take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick); and Article 10 the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (enjoyment of the highest level of physical, mental and social well-being and measures to ensure “(a) Primary health care, that is, essential health care made available to all individuals and families in the community; (b) Extension of the benefits of health services to all individuals subject to the State’s jurisdiction; (c) Universal immunization against the principal infectious diseases; (d) Prevention and treatment of endemic, occupational and other diseases; (e) Education of the population on the prevention and treatment of health problems; and (f) Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable").

In a General Comment on the Right to Health, the Committee on Economic, Social and Cultural Rights (CESCR) (created to monitor the ICESC) analyzed the normative content of the right in terms of accessibility, affordability, appropriateness and of quality of care,
and specified the duties of the state to respect, protect and provide this right. 44 It also listed the following 14 human rights as integral components of the right to health: the rights to food, housing, work, education, human dignity, life, nondiscrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. 45 In other words, these related rights defined to a large extent the determinants of health.

The right to health does not mean the right to be healthy, since being healthy is determined in part by health care, but also by genetic predisposition and social factors. What is of greater significance for the realization of healthy lives is the extent to which respect for other human rights has a direct bearing on the right to health or on the social factors that contribute to healthy lives. The field of social epidemiology has excelled at establishing correlations between discrimination based on race, class or gender, denial of education and of decent working conditions, as well as other factors that contribute directly to increased rates of mortality and morbidity. 46 These social determinants may also be defined in human rights terms as deprivation of these health-related rights. The rapid survey which follows seeks to underscore the function of human rights as determinants of health by highlighting the normative content and their relation to health.

IV. Health-related human rights

Human rights have been categorized in various ways, such as economic, social and cultural or civil and political rights; as first, second, and third-generation or ‘solidarity’ rights are the most recently recognised category of human rights. Rights in this category include self-determination as well as a host of normative expressions whose status as human rights is controversial at present. These include the right to development, the right to peace, the right to a healthy environment, and the right to intergenerational equity.

45 Ibid., Para. 3
The right to a healthy environment requires a healthy human habitat, including clean water, air, and soil that are free from toxins or hazards that threaten human health. The right to a healthy environment entails the obligation of governments to (i) refrain from interfering directly or indirectly with the enjoyment of the right to a healthy environment, (ii) prevent third parties such as corporations from interfering in any way with the enjoyment of the right to a healthy environment, and (iii) adopt the necessary measures to achieve the full realization of the right to a healthy environment.

For the purposes of relating the core internationally recognized human rights to the realization of health and well-being, it is proposed here to group human rights into three categories, those that relate to the physical and mental existence of humans (“rights of existence”); those that relate to autonomy of thought and action of individuals (“rights of autonomous action”); and those that involve social interactions of individuals and groups from the family to the political, cultural and international communities (“rights of social interaction”).

a. Rights of Existence
The right to death with dignity is sometimes claimed as the human rights grounding for domestic legislation on the subject. Although there is no explicit international human right to death, some scholars construe this right from various recognized rights, such as the rights to dignity and freedom from cruel, inhuman, or degrading treatment.

Another controversial aspect of the right to life is the tension between the claim that it includes the right to life of the foetus from the moment of conception and the claim that reproductive rights of the pregnant women include the right to voluntary termination of her pregnancy. The right to an abortion is recognized in various national legal systems but not explicitly in international human rights due to the large opposition by Catholic and Islamic countries.

The right to “a standard of living adequate for the health and well-being” of oneself and one’s family was defined in the Universal Declaration of Human Rights as including
“food, clothing, housing and medical care and necessary social services” as well as “the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond [one’s] control.” Subsequently, the rights to health, work, safe and healthy working conditions (occupational health), adequate food and protection from malnutrition and famine, adequate housing, and social security (that is a regime covering long-term disability, old age, unemployment and other conditions) have been further elaborated. The rights to work and to decent conditions of work have been the responsibility of the International Labour Organisation since 1919, and specific rules have been developed through some 200 ILO conventions and recommendations, constituting a highly developed sub-field of human rights. The other rights relating to an adequate living standard have also been expanded upon by treaties, international conferences and summits, and the work of special rapporteurs and treaty bodies.

b. Rights of Autonomous Action

The great civil liberties, freedom of oral and written expression, freedom of conscience, opinion, religion or belief, as well as rights to a fair hearing and an effective remedy for violations of human rights, and protection of privacy in domicile and correspondence all support the autonomy of individuals to act without interference from the state or others. The implications for mental health of these freedoms are easy to identify. Similarly, freedom from arbitrary detention or arrest, from torture or other forms of cruel, inhuman or degrading punishment or treatment, and humane conditions of detention for those legally deprived of their liberty have obvious implications for physical and mental health. Human rights standards in UN and regional texts provide the definitions and means of redress for these rights. A separate but related human right is that of informed consent to medical experimentation, which was included in post-1945 enumerations of rights due to the abhorrent abuse of that right during World War II.

Freedom of movement means the right to reside where one pleases and to leave any country, including one’s own, and to return to one’s country. The right to seek and enjoy asylum from persecution is also a human right, which has been developed and expanded
by international refugee law, the practice of the UN High Commissioner for Refugees and recent codes relating to internally displaced persons. This right, like many others, is not absolute; limitations may be imposed, for example, in time of epidemic, as long as certain safeguards, defined in human rights law, are observed.

c. Rights of Social Interaction
The third set of rights that are also determinants of health relate to the participation of individuals in their society. Social well-being ‘an element of health’ relates to group rights, education, family, culture, political and cultural participation, gender and reproductive rights, scientific activity, the environment and development, all of which are the subject of specific human rights.

The right to education includes compulsory primary education, availability and accessibility of secondary education and equal access to higher education, and the role of parents in choosing their child’s educational institution. Several instruments relating to discrimination in education, technical aspects and content of education have been adopted by UNESCO. In addition to the right to education, rights of the child have been codified in several instruments, primarily the 1989 Convention on the Rights of the Child (CRC), which has been ratified by every county except the U.S. Defining a child as anyone under 18, the CRC makes ‘the best interest of the child’ the primary consideration and defines rights relating to the child’s identity, health and access to health care, expression of opinion, conditions of adoption, and protection from abuse, torture, capital punishment, and traditional practices prejudicial to the child’s health.

Health issues loom large in human rights standard-setting and policy determination regarding gender, sexual rights, and reproductive rights. The basic human rights texts have been supplemented by a specialized Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979. Considerable advances in mainstreaming women’s rights as human rights were made at the international conferences in Vienna (human rights, 1993), Cairo (population, 1994), and Beijing (women, 1995). Further developments have been made to deal with violence against
women (through a 1993 Declaration and a Special Representative to study the problem) and traditional practices harmful to health, such as female genital cutting or mutilation, about which the World Health Organization, UN Children’s Fund (UNICEF) and the UN Fund for Population Activities issued a statement in 1996.

Reproductive rights begin with “The right of men and women of marriageable age to marry and to found a family shall be recognised”\footnote{International Covenant on Civil and Political Rights, Adopted and Opened for Signature, Ratification and Accession by General Assembly Resolution 2200A (XXI) of 16 December 1966, Article 23 (2)} which is closely related to the right of men and women . . . to decide freely and responsibly on the number and spacing of their children. (CEDAW, Article 16 (1) (e)), and “to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice”\footnote{Report of the International Conference on Population and Development, U.N. Doc A/CONF.171/13, Oct. 18, 1994}. Various internationally approved programs and plans of action have set out in considerable detail the specific ways in which this right can be realized.

Bioethical concerns overlap with human rights with respect to the right to enjoy the benefits of scientific progress and the right to scientific research.\footnote{ICESCR, Article 15} The former refers to the positive and equitable use of scientific advances while the latter protects freedom to conduct research and disseminate results and the requirement of informed consent of human subjects.

In the same way that the distinction between civil and political and economic, social and cultural rights is losing its relevance in the post-Cold War, so too is the third category of solidarity or third generation rights less helpful than it was twenty years ago.\footnote{Stephen Marks, “Emerging Human Rights: A New Generation for the 1980’s?” Rutgers Law Review, vol. 33, no. 2, 1981, Pp. 435-452; Philip Alston, .Peoples. Rights: Their Rise and Fall, in Alston, Peoples. Rights, Oxford University Press, 2001, Pp. 259-293} It referred to certain global values such as peace, a healthy environment, development, communication, humanitarian intervention or assistance and the like, which were raised to the level of human rights, notwithstanding the complex matter of defining the rights-and duty-holders and the precise obligations involved. While the literature continues to
refer occasionally to all these values as constituting human rights, and some support exists in the literature and declarations of political bodies, two have become more systematically developed and enshrined in authoritative texts, namely the right to a healthy environment and the right to development.

The right to a healthy environment (or a related formulation such as “to live in an environment adequate for their health and well being”) has been recognized in some 90 national constitutions, including most national constitutions enacted since the 1992 Rio Conference on Environment and Development. South Africa’s Constitution is exemplary in this regard: “Everyone has the right (a) to an environment that is not harmful to their health or well being; and (b) to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that (i) prevent pollution and ecological degradation; (ii) promote conservation; and (iii) secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development.”

The right to development has been recognized in numerous UN resolutions and specifically in the 1986 Declaration on the Right to Development, as well as in the African Charter on Human and Peoples’ Rights. The Declaration defines this right as “an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized.” The right implies that development policies of governments and partner agencies should “aim at the constant improvement of the well-being of the entire population and of all individuals, on the basis of their active, free and meaningful participation in development and in the fair distribution of the benefits resulting there

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51 UN General Assembly Resolution 45 /94 of 14 Dec. 1990
52 Constitution of the Republic of South Africa, as adopted on 8 May 1996 and Amended on 11 October 1996 by the Constitutional Assembly, Article 12
53 The Declaration on the Right to Development was Adopted by the General Assembly in its Resolution
54 Ibid., Article 1
from.” Now, the important issue has to be discussed in the light of health and human rights and modern concepts of health.

**Health and Human Rights**

Explanations for the dearth of communication between the fields of health and human rights include differing philosophical perspectives, vocabularies, professional recruitment and training, societal roles, and methods of work. In addition, modern concepts of both health and human rights are complex and steadily evolving. On a practical level, health workers may wonder about the applicability or utility (‘added value’), let alone necessity of incorporating human rights perspectives into their work, and vice versa. In addition, despite pioneering work seeking to bridge this gap in bioethics, jurisprudence, and public health law, a history of conflictual relationships between medicine and law, or between public health officials and civil liberty advocates, may contribute to anxiety and doubt about the potential for mutually beneficial collaboration. Yet health and human rights are both powerful, modern approaches to defining and advancing human well-being. Attention to the intersection of health and human rights may provide practical benefits to those engaged in health or human rights work, may help reorient thinking about major global health challenges, and may contribute to broadening human rights thinking and practice. However, meaningful dialogue about interactions between health and human rights requires a common ground. To this end, following a brief overview of selected features of modern health and human rights, this chapter proposes a provisional, mutually accessible framework for structuring discussions about research, promoting cross-disciplinary education, and exploring the potential for health and human rights collaboration.

**Modern Concepts of Health**

Modern concepts of health derive from two related although quite different disciplines: medicine and public health. While medicine generally focuses on the health of an individual, public health emphasizes the health of populations. To oversimplify,

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55 Ibid., Article 3
individual health has been the concern of medical and other health care services, generally in the context of physical (and, to a lesser extent, mental) illness and disability. In contrast, public health has been defined as, “...(ensuring) the conditions in which people can be healthy.” Thus, public health has a distinct health-promoting goal and emphasizes prevention of disease, disability and premature death. Therefore, from a public health perspective, while the availability of medical and other health care constitutes one of the essential conditions for health, it is not synonymous with “health”. Only a small fraction of the variance of health status among populations can reasonably be attributed to health care; health care is necessary but clearly not sufficient for health.

The most widely used modern definition of health was developed by the World Health Organization (WHO): “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Through this definition, WHO has helped to move health thinking beyond a limited, biomedical and pathology-based perspective to the more positive domain of “well-being.” Also, by explicitly including the mental and social dimensions of well-being, WHO radically expanded the scope of health, and by extension, the roles and responsibilities of health professionals and their relationship to the larger society.

The WHO definition also highlights the importance of health promotion, defined as “the process of enabling people to increase control over, and to improve, their health”. To do so, “an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment”. The societal dimensions of this effort were emphasized in the Declaration of Alma-Ata (1978), which described health as a “...social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.”

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60 World Health Organization, Constitution, in Basic Documents, 36th ed. (Geneva, 1986)
61 Ottawa-Charter for Health Promotion, presented at First International Conference on Health Promotion, Ottawa, November 21, 1986
Thus, the modern concept of health includes beyond health care to embrace the broader societal dimensions and context of individual and population well-being. Perhaps the most far-reaching statement about the expanded scope of health is contained in the preamble to the WHO Constitution, which declared that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.”

A Provisional Framework: Linkages between Health and Human Rights

The goal of linking health and human rights is to contribute to advancing human well-being beyond what could be achieved through an isolated health- or human rights-based approach. This study proposes a three-part framework for considering linkages between health and human rights; all are inter-connected, and each has substantial practical consequences. The first two are already well documented, although requiring further elaboration, while the third represents a central hypothesis calling for substantial additional analysis and exploration.

First, the impact (positive and negative) of health policies, programs and practices on human rights will be considered. This linkage will be illustrated by focusing on the use of state power in the context of right to health.

The second relationship is based on the understanding that human rights violations have health impacts. It is proposed that all rights violations, particularly when severe, widespread and prolonged, engender important health effects, which must be recognized and assessed. This process engages health expertise and methodologies in helping to understand how well-being is affected by violations of human rights.

The third part of this framework is based on an overarching proposition: that promotion and protection of human rights and promotion and protection of health are fundamentally linked. Even more than the first two proposed relationships, this intrinsic linkage has

63 Supra Note 8
strategic implications and potentially dramatic practical consequences for work in each domain.

The First Relationship: The Impact of Health Policies, Programs and Practices on Human Rights
Around the world, health care is provided through many diverse public and private mechanisms. However, the responsibilities of public health are carried out in large measure through policies and programs promulgated, implemented and enforced by, or with support from, the state. Therefore, this first linkage may be best explored by considering the impact of health policies, programs and practices on human rights. The three central functions of health include: assessing health needs and problems; developing policies designed to address priority health issues; and assuring programs to implement strategic health goals. Potential benefits to and burdens on human rights may occur in the pursuit of each of these major areas of health norms and standards.

For example, assessment involves collection of data on important health problems in a population. However, data are not collected on all possible health problems, nor does the selection of which issues to assess occur in a societal vacuum. Thus, a state’s failure to recognize or acknowledge health problems that preferentially affect a marginalized or stigmatized group may violate the right to non-discrimination by leading to neglect of necessary services, and in so doing, may adversely affect the realization of other rights, including the right to “security in the event of...sickness (or) disability…” (UDHR, Article 25), or to the “special care and assistance” to which mothers and children are entitled (UDHR, Article 25).

Once decisions about which problems is to be assessed have been made, the methodology of data collection may create additional human rights burdens. Collecting information from individuals, such as whether they are infected with the human immunodeficiency virus (HIV), have breast cancer, or are genetically predisposed to heart disease, can clearly burden rights to security of person (associated with the concept of informed consent) and of arbitrary interference with privacy. In addition, the right of non-discrimination may be threatened even by an apparently simple information-gathering
exercise. For example, a health survey conducted via telephone, by excluding households without telephones (usually associated with lower socioeconomic status), may result in a biased assessment, which may in turn lead to policies or programs that fail to recognize or meet needs of the entire population. Also, personal health status or health behavior information (such as sexual orientation or history of drug use) has the potential for misuse by the state, whether directly or if it is made available to others, resulting in grievous harm to individuals and violations of many rights. Thus, misuse of information about HIV infection status has led to: restrictions of the right to work and to education; violations of the right to marry and found a family; attacks upon honor and reputation; limitations of freedom of movement; arbitrary detention or exile; and even cruel, inhuman or degrading treatment.

The second major task of health is to develop policies to prevent and control priority health problems. Important burdens on human rights may arise in the policy-development process. For example, if a government refuses to disclose the scientific basis of health policy or permit debate on its merits, or in other ways refuses to inform and involve the public in policy development, the rights to “seek, receive and impart information and ideas...regardless of frontiers” (UDHR, Article 19) and “to take part in the government...directly or through freely chosen representatives” (UDHR, Article 21) may be violated. Then, prioritization of health issues may result in discrimination against individuals, as when the major health problems of a population defined on the basis of sex, race, religion or language are systematically given lower priority.

The third core function of health, to assure services capable of realizing policy goals, is also closely linked with the right to non-discrimination. When health and social services do not take logistic, financial, and socio-cultural barriers to their access and enjoyment into account, intentional or unintentional discrimination may readily occur. For example, in clinics for maternal and child health, details such as hours of service, accessibility via
public transportation and availability of daycare may strongly and adversely influence service utilization.\textsuperscript{64}

It is essential to recognize that in seeking to fulfill each of its core functions and responsibilities, health may burden human rights. In the past, when restrictions on human rights were recognized, they were often simply justified as necessary to protect the health. Indeed, health has a long tradition, anchored in the history of infectious disease control, of limiting the “rights of the few” for the “good of the many”. Thus, coercive measures such as mandatory testing and treatment, quarantine, and isolation are considered basic measures of traditional communicable disease control.\textsuperscript{65}

The principle that certain rights must be restricted in order to protect the community is explicitly recognized in the International Bill of Human Rights: limitations are considered permissible to “(secure) due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society”, (UDHR, Article 29). However, the permissible restriction of rights is bound in several ways. First, certain rights (e.g., right to life, right to be free from torture) are considered inviolable under any circumstances. Restriction of other rights must be: in the interest of a legitimate objective; determined by law; imposed in the least intrusive means possible; not imposed arbitrarily; and strictly necessary in a “democratic society” to achieve its purposes.

Unfortunately, public health decisions to restrict human rights have frequently been made in an uncritical, unsystematic and unscientific manner. Therefore, the prevailing assumption that public health, as articulated through specific policies and programs, is an unalloyed public good that does not require consideration of human rights norms must be challenged. For the present, it may be useful to adopt the maxim that health policies and programs should be considered discriminatory and burdensome on human rights until proven otherwise.

\textsuperscript{64} Emily Friedman, “Money isn’t Everything: Non-financial Barriers to Access”, Journal of the American Medical Association 271, No. 19, May 18, 1994, Pp. 1535-1538
\textsuperscript{65} American Public Health Association, Control of Communicable Disease in Man, 15\textsuperscript{th} ed., Washington, D.C.: APHA, 1990
This approach raises three related and vital questions. First, why should health officials be concerned about burdening human rights? Second, to what extent is respect for human rights and dignity compatible with, or complementary to health goals? Finally, how can an optimal balance between public health goals and human rights norms be negotiated?

Justifying health concern for human rights norms could be based on the primary value of promoting societal respect for human rights as well as on arguments of public health effectiveness. At least to the extent that health goals are not seriously compromised by respect for human rights norms, health, as a state function, is obligated to respect human rights and dignity.

However, it is also important to recognize that contemporary thinking about optimal strategies for disease control has evolved; efforts to confront the most serious global health threats, including cancer, cardiovascular disease and other chronic diseases, injuries, reproductive health, infectious diseases, and individual and collective violence, increasingly emphasize the role of personal behavior within a broad social context. Thus, the traditional health paradigm and strategies developed for diseases such as smallpox, often involving coercive approaches and activities which may have burdened human rights, are now understood to be less relevant today. For example, WHO’s strategy for preventing spread of the human immunodeficiency virus (HIV) excludes classic practices such as isolation and quarantine (except under truly remarkable circumstances) and explicitly calls for supporting and preventing discrimination against HIV-infected people.

The idea that human rights and health must inevitably conflict is increasingly tempered with awareness of their complementarity. Health policy-makers’ and practitioners’ lack of familiarity with modern human rights concepts and core documents complicates efforts to negotiate, in specific situations and different cultural contexts, the optimal balance between health objectives and human rights norms. Recently, in the context of HIV/AIDS, new approaches have been developed, seeking to maximize realization of
public health goals while simultaneously protecting and promoting human rights. Yet HIV/AIDS is not unique; efforts to harmonize health and human rights goals are clearly possible in other areas.

The Second Relationship: Health Impacts Resulting from Violations of Human Rights
Health impacts are obvious and inherent in the popular understanding of certain severe human rights violations, such as torture, imprisonment under inhumane conditions, summary execution, and ‘disappearances’. For this reason, health experts concerned about human rights have increasingly made their expertise available to help document such abuses. Examples of this type of medical-human rights collaboration include: exhumation of mass graves to examine allegations of executions; examination of torture victims; and entry of health personnel into prisons to assess health status.

However, health impacts of rights violations go beyond these issues in at least two ways. First, the duration and extent of health impacts resulting from severe abuses of rights and dignity remain generally under-appreciated. Torture, imprisonment under inhumane conditions, or trauma associated with witnessing summary executions, torture, rape or mistreatment of others have been shown to lead to severe, probably life-long effects on physical, mental and social well-being. In addition, a more complete understanding of the negative health effects of torture must also include its broad influence on mental and social well-being; torture is often used as a political tool to discourage people from meaningful participation in or resistance to government.

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34
Second, and beyond these serious problems, it is increasingly evident that violations of many more, if not all, human rights have negative effects on health. For example, the right to information may be violated when cigarettes are marketed without governmental assurance that information regarding the harmful health effects of tobacco smoking will also be available. The health cost of this violation can be quantified through measures of tobacco-related preventable illness, disability and premature death, including excess cancers, cardiovascular and respiratory disease. Other violations of the right to information, with substantial health impacts, include governmental withholding of valid scientific health information about contraception or measures to prevent infection with a fatal virus (HIV).

As another example, the enormous worldwide problem of occupation-related disease, disability and death reflects violations of the right to work under “just and favorable conditions”, (UDHR, Article 23). In this context, the World Bank’s identification of increased educational attainment for women as a critical intervention for improving health status in developing countries powerfully expresses the pervasive impact of rights realization (in this case to education, and to non-discrimination on the basis of sex) on population health status.72

A related, even more complex problem involves the potential health impact associated with violating individual and collective dignity. The Universal Declaration of Human Rights considers dignity, along with rights, to be inherent, inalienable and universal. While important dignity-related health impacts may include such problems as the poor health status of many indigenous peoples, a coherent vocabulary and framework to characterize dignity and different forms of dignity violations are lacking. A taxonomy and an epidemiology of violations of dignity may uncover an enormous field of previously suspected, yet thus far unnamed and therefore undocumented damage to physical, mental and social well-being.

72 Supra Note 7
Assessment of rights violations' health impacts is in its infancy. Progress will require: a more sophisticated capacity to document and assess rights violations; the application of medical, social science and public health methodologies to identify and assess effects on physical, mental and social well-being; and research to establish valid associations between rights violations and health impacts.

Identification of health impacts associated with violations of rights and dignity will benefit both health and human rights fields. Using rights violations as an entry point for recognition of health problems may help uncover previously unrecognized burdens on physical, mental or social well-being. From a human rights perspective, documentation of health impacts of rights violations may contribute to increased societal awareness of the importance of human rights promotion and protection.

The Third Relationship: Health and Human Rights Exploring an Inextricable Linkage
The proposal that promoting and protecting human rights is inextricably linked to the challenge of promoting and protecting health derives in part from recognition that health and human rights are complementary approaches to the central problem of defining and advancing human well-being. This fundamental connection leads beyond the single, albeit broad mention of health in the UDHR (Article 25) and the specific health-related responsibilities of states listed in Article 12 of the ICESCR, including: reducing stillbirth and infant mortality and promoting healthy child development; improving environmental and industrial hygiene; preventing, treating and controlling epidemic, endemic, occupational and other diseases; and assurance of medical care.

Modern concepts of health recognize that underlying “conditions” establish the foundation for realizing physical, mental and social well-being. Given the importance of these conditions, it is remarkable how little priority has been given within health research for precise identification and understanding of modes of action, relative importance, and possible interactions.
The most widely accepted analysis focuses on socio-economic status; the positive relationship between higher socio-economic status and better health status is well documented. This analysis has at least three important limitations. First, it cannot adequately account for a growing number of discordant observations, such as: the increased longevity of married men and women compared with their single (widowed, divorced, never married) counterparts; health status differences between minority and majority populations which persist even when traditional measures of socio-economic status are considered; or reports of differential marital, economic and educational outcomes among obese, compared with non-obese women.

A second problem lies in the definition of poverty and its relationship to health status. Clearly, poverty may have different health meanings; for example, distinctions between the health-related meaning of absolute poverty and relative poverty have been proposed.73

A third, practical difficulty is that the socio-economic paradigm creates an overwhelming challenge for which health workers are neither trained nor equipped to deal. Therefore, the identification of socio-economic status as the “essential condition” for good health paradoxically may encourage complacency, apathy and even policy and programmatic paralysis.

However, alternative or supplementary approaches are emerging about the nature of the “essential conditions” for health. For example, the Ottawa Charter for Health Promotion (1986) went beyond poverty to propose that, “the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity”. Experience with the global epidemic of HIV/AIDS suggests a further analytic approach, using a rights analysis.74

More broadly, the evolving HIV/AIDS deadly disease has shown a consistent pattern through which discrimination, marginalization, stigmatization and, more generally, a lack of respect for the human rights and dignity of individuals and groups heightens their vulnerability to becoming exposed to HIV. In this regard, HIV/AIDS may be illustrative of a more general phenomenon in which individual and population vulnerability to disease, disability and premature death is linked to the status of respect for human rights and dignity.

Further exploration of the conceptual and practical dimensions of this relationship is required. For example, epidemiologically-identified clusters of preventable disease, excess disability and premature death could be analyzed to discover the specific limitations or violations of human rights and dignity which are involved. Similarly, a broad analysis of the human rights dimensions of major health problems such as cancer, cardiovascular disease and injuries should be developed. The hypothesis that promotion and protection of rights and health are inextricably linked requires much creative exploration and rigorous evaluation.

The concept of an inextricable relationship between health and human rights also has enormous potential practical consequences. For example, health professionals could consider using the International Bill of Human Rights as a coherent guide for assessing health status of individuals or populations; the extent to which human rights are realized may represent a better and more comprehensive index of well-being than traditional health status indicators. Health professionals would also have to consider their responsibility not only to respect human rights in developing policies, programs and practices, but to contribute actively from their position as health workers to improving societal realization of rights. Health workers have long acknowledged the societal roots of health status; the human rights linkage may help health professionals engage in specific and concrete ways with the full range of those working to promote and protect human rights and dignity in each society.

From the perspective of human rights, health experts and expertise may contribute usefully to societal recognition of the benefits and costs associated with realizing, or failing to respect human rights and dignity. This can be accomplished without seeking to justify human rights and dignity on health grounds (or for any pragmatic purposes). Rather, collaboration with health experts can help and voice to the pervasive and serious impact on health associated with lack of respect for rights and dignity. In addition, the right to health can only be developed and made meaningful through dialogue between health and human rights disciplines. Finally, the importance of health as a pre-condition for the capacity to realize and enjoy human rights and dignity must be appreciated. For example, poor nutritional status of children can contribute subtly yet importantly to limiting realization of the right to education; in general, people who are healthy may be best equipped to participate fully and benefit optimally from the protections and opportunities inherent in the International Bill of Human Rights.

Every country in the world has accepted that human rights are universal but all are challenged, in one way or another, to achieve progress with respect to those rights they neglect, however proud they may be of achievements with respect to other rights. The normative content of the corpus of human rights standards is probably the most complete catalogue of the determinants of physical, mental and social well-being. The methods of implementation or intervention to ensure compliance are not directly linked to medical and health practice as is the case with bioethics.

Another dimension is to analyse human rights and health which provides philosophical foundation to preserve human life. This preservation of life can be argued to be sacred, or important, whether it is viewed religiously, socially, economically and culturally. Religions universally value the preservation of life and the soul from the perspective of immortality. Socially, we need preservation of life so that we have like beings with which to interact. Economically, we need taxpayers and workers. Even the culturally places an extremely high value on its personnel because of the costs of social norms and the necessary values and norms needed for interventions of certain activity. Thomas
Hobbes\textsuperscript{76} (1588–1679) felt that reason would allow man to figure out what must be done to preserve life. To this end, in his epic work, Leviathan, he presents his rules, or Laws of Nature, and explains, “A law of nature (lex naturalis) is a precept or general rule, found out by reason, by which a man is forbidden to do that which is destructive of his life or taken away the means of preserving the same, and to omit that by which he thinks it may be best preserved.

Hobbes reasoned that every person has a “Right of Nature” in that, “every man has a right to everything, even to one another’s body”. In other words, anybody can do anything. However, as soon as we come to our senses we realize there is laws of nature that rein in this liberty. These laws that are put into place give us the concept of “obligation”.

Hobbes presents three important laws of nature that cause us obligation in regard to our actions. Hobbes’ laws involve (1) seeking peace, (2) laying down the right of nature and making covenants, and (3) performance of covenants. In following Hobbes’ laws to the conclusion an argument can be made that a covenant exists between members of a society, though unwritten, to provide security or well-being for one another. Furthermore, since “we the people” are the government, such a covenant may actually exist between the members of a society and the government as to the provision of access to health care services.

Hobbes’ first law is to seek peace, “that every man ought to endeavour peace, as far as he has hope of obtaining it; and when he cannot obtain it, that he may seek, and use, all helps, and the advantages of society. He follows this statement with the advisory that society should “seek peace, and follow it’, and if a society cannot get peace, they must defend themselves.

In regard to health service, seeking peace and defending one’s self can be manifested in the form of negotiations and the use of the electoral process to gain a favourable hearing on the argument that health service is a right to be shared by or available to all. However, this becomes difficult for the uninsured or the underinsured to pursue because they are without economic strength, many times they are racial minorities and can be marginalized by the political process.

Hobbes’ second law, “lay down the right of nature”, also applies and is extremely important. Here Hobbes indicates that we should lay down our right “to do anything” if others are willing to do the same. The rule “requires each of us to be satisfied with as much liberty toward other human beings as we are willing to allow them with respect to ourselves”. When we give up liberty (or portions there of) we can: “Renounce this right or transfer it to someone else. In engaging in either of these acts, we are removing an impediment to someone else’s use of those same things or someone else’s exercise of their right to them. In this way we are bestowing benefits on these other people. If we are not care who receives the benefit, we are said to renounce our right; if we wish the benefit to accrue to someone or more particular persons, we are to speak of transferring our right to them, which amounts to a gift. We may, then, either abandon our right or give it away to other people”77.

This second law leads to the concept of contracts, or covenants. When people renounce or transfer the “right of nature” a contract, or covenant, is made. Covenants may “not be explicitly conveyed and acknowledged by words. The sign or indication of a contract may be by inference and be implicit or covert”. Hobbes claims that, “generally a signed by inference of any contract is whatsoever sufficiently argues the will of the contractor”. The “right” at stake here is the right of the medically needy to “transfer” their need (per Hobbes’ theory) for health service to a society in which all of its members have pledged mutual cooperation by agreeing to Hobbes’ second law. This acquiescence to Hobbes’ second law has in fact occurred in our society although it seems not to have been acknowledged. Hobbes’ third law regards the performance of covenants. When a

77 Ibid
covenant is made it is important that “men perform their covenants made: without which, covenants are in vain, and but empty words, and the right of all men to all things remaining, we are still in the condition of warren”. If we have agreed to live in mutual security then we must make good on our promises, implied or otherwise.

The concept of “inference” or “implicitness”, regarding Hobbes’ second law, and the obligation of performance of covenants regarding the third law are very important. The citizens of the country have come to hope and expect availability of health care service access. The growing number of persons that are uninsured, or underinsured, have a limited access to prompt and adequate healthcare. The provision of healthcare is an implied covenant that the medically needy have hoped and expected society to embrace. This constitutes a potentially rich framework for the improvement of health, which is the objective of the emerging sub-field of health and human rights.

**Conclusion**

The theory and philosophy helps in understanding the framework of standard setting exercise in the context of right to health. Standard setting exercise is not new in global as well as local level. The above arguments bring out the essence of standard setting and conceptualize the entire gamut of the debate ranging from global to local and theoretical to philosophical and also from policy formulation to implementation. It not only gives an outline of right to health and human right issues but it sparks the debate on standards, norms, values of the society. The argument also focuses on norm setting in international law and human rights, natural law, positive law and negative law. It captures the link between health and human rights in different ways and different context.

There is considerable interest in extending the concept of rights to social benefits, such as right health. There is little point in establishing such rights unless the loci of responsibility for delivering on them are clearly defined. It may be possible to establish international public health laws that set minimum standards for certain activities. This would define the responsibilities of the international community and national governments. The minimum standards could cover, public health programmes and
services that address fundamental health rights needs of the poor; essential regulation of the systems for training and supervision of health workers and distribution of drugs, provision of information on health problems, resource use and health sector performance. This may involve, for example, balancing measures to establish high standards for health insurance and provision of health care against the need to ensure that the poor have access to effective and affordable health services. International governance structures will be needed with the political legitimacy necessary to make and enforce to widen the scope of right to health. It would be difficult to reach international agreement on the kind of framework described above. However, an important first step is to move beyond idealised visions of a future international health system to a clear acknowledgement of reality and of the strategic options for change. This would provide a starting point for serious discussions.

In the next chapters, we begin with a brief review of how India’s health care is delivered, focusing on the implications for its regulation. We then turn to see how the different approaches to overseeing the health sector are working in India, beginning with the formal administrative approaches. We then highlight consumer oriented approaches, largely because this is a departure for the government into the area of health empowerment, and where there is now enough experience to see what effect it is having in health sector. We then turn to the other approaches that attempt to harness the standard setting for healthcare, notably contracting and professional self-regulation, before examining the prospects for new collaborative of health models of regulation involving institutionalized co-production.

We posit that in India, pursuing the traditional attempts to enforce the rules through administrative and bureaucratic controls are unlikely to add much value, largely because they fail to deal with the political economy and the social realities of health care. We look forward that Indian governments should pay more attention to create norms that are currently working and are valued, and link them to open and negotiated standards that involve a wider range of actors in civil society. This would involve broader use of health and human rights oriented approaches, as well as institutionalized co-production. This approach would shift regulation from a state-led exercise to a more collaborative
approach a shift that is more in keeping with India’s current and future health system. The law has to be enforced by the court. The main problem is not with the law as it exists on paper, but with the law as it is practiced. The limited ability to enforce civil and criminal laws in India is well known. Infractions that are considered criminal become difficult to prosecute, whereas the huge backlog of civil cases has overburdened the courts. In this environment, it is difficult to see how an emphasis on enforcement of legal instruments will have a major impact on health services in India in the near future.

Human rights of health need an international legal instrument to claim health as right but state has to recognize it. The law has to be enforced by the court and patient most get his/her rights which is recognized by constitution of India. The above argument gives glimpse to understand the standard setting at different levels and different geographical boundaries. The slowness of standard-setting processes is a further deterrent. Even if there are exceptions to every rule, most recent negotiations have been cumbersome and long-winded, and their outcomes have been uncertain. Some texts have been watered down, others have been abandoned. The creation of standards is so time-consuming that many states have become reluctant to discuss and to take initiatives. Now we can discuss about the scope and methodology of study which plays pivotal role in the argument and also to claim health as human rights.