INTRODUCTION
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“Happiness, happiness, happiness
it may be of different origins on this earth
but the happiness of being healthy
is the real happiness”\(^1\)

Health and well being of a person are considered to be two personal matters, but it is then, when we or the person close to us fall ill that we recognize that Health is in fact a public issue and there is the chronic importance of Health Rights in our day today life. Access to quality health is not only a human need, a right of citizenship and a public good, but it is also a prerequisite to good health, which is essential to enjoy and achieve fruits of equitable development. While the right to health would be the ultimate aim, the right to health care would be a first step, a tangible and feasible demand of today’s society.

Health is one of the most difficult terms to define. Health can mean different things to different people. A strict understanding of right to health implies that everyone has the guarantee of perfect health. Access to quality health care is not only a human need, a right of citizenship and a public good, but it is also a pre-requisite to good health, which is essential to enjoy and achieve fruits of equitable development.\(^2\) Health does not mean merely physical health or the absence of disease, disability or infirmity. It is a state of complete physical mental, emotional, social, and spiritual well being both of the individual and of the nation. Every woman, man, youth and child has the human rights to the highest attainable standard of physical and mental health without discrimination of any kind. Enjoyment of the human right to health is vital to all aspects of a person’s life and well being and is crucial to the realization of many other fundamental rights and freedoms.\(^3\) A strict understanding of a right to health implies, somewhat absurdly, that everyone has the guarantee of perfect health. A Pan-American Health Organization study in 1989 suggested that it would be more

\(^1\) S. L. Goel, *Public Health Administration*, Sterling, New Delhi, 1984, p.29.
\(^3\) Available at <http://findarticles.com> last visited on 20 July 2007.
correct to speak of a right to health protection, including two components, a right to health care and a right to healthy conditions\textsuperscript{4}

At a United Nations workshop on The Right to Health in 1979 Theo Boven, then Director of the UN Division of Human Rights, stated that “Three aspects of the right to health have been enshrined in the unemotional instruments on human rights: the declaration of the right to health as a basic human right; the prescription of standards aimed at meeting the health needs of specific groups of persons; and the prescriptions of ways and means for implementing the right to health.” The term, therefore, tends to be used for the sake of convenience and implies a reasonable as opposed to an absolute standard. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) defines the right to health as the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The right to health includes the right to health care; it goes beyond health care to encompass the underlying determinants of health, such as safe drinking water, adequate sanitation and access to health-related information. The right includes freedoms, such as the right to be free from discrimination and involuntary medical treatment. It also includes entitlements, such as the right to essential primary health care. The right has numerous elements, including child health, eternal health and access to essential drugs. Like other human rights, it has a particular concern for the disadvantaged, the vulnerable and those living in poverty. The right requires an effective inclusive health system of good quality. The World Health Organization uses a holistic definition of health according to which health does not merely consist of the absence of disease or handicaps but refers to the highest attainable standard of physical, mental and social well being. While this definition is more inclusive and allows various aspects of life to be taken into account in health issues, this wide understanding of health can be a double-edged sword. On the one hand, if appears to avoid restricted, paternalist or imperialist interpretations of the concept, but on the other hand, it leaves plenty of room for relativist interpretations of what is to be

included in health and what it means to be Healthy. After all, even when we think about Health merely in terms of lack of disease of handicap, there might be differences in interpretations of its meaning across cultural, national and generational borders.\(^5\)

The right to health can be viewed as having two basic components: a right to health care, and a right condition. It should not be seen as a girth to be healthy. The state cannot be expected to provide people with protection against every possible cause of ill health or disability nor should the right to health be seen as a limitless right to receive medical care for any and every illness or disability that may be contracted. Instead, the right to health should be understood as a right to the enjoyment of a variety of facilities and conditions which the state is responsible for providing as being necessary for the attainment and maintenance of good health.\(^6\)

The Article 25 of the Universal Declaration of Human Right states that:

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

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.\(^7\)

International human rights law is realistic and recognizes that the right to the highest attainable standard of health for all cannot be realized overnight. States have an obligation to give effect to the right to health in the context of the resources available to them, and through making a concerted effort to operationalise the right over a period of time. Although qualified in this way, nonetheless the right to health imposes some obligations of immediate effect, such as non-discrimination, and the


\(^6\) Ibid.

requirement that the State at least prepares a national plan for health care and protection.

Under international law, acceptable health care is that which both meets ethical standards and is culturally appropriate. This requires binding ethical guidelines for doctors and other medical practitioners. Medical personnel should also, whenever possible, share the same culture and language as their patients. In addition, acceptable health care requires that ethical and cultural training be part of a medical education. The state must ensure that health facilities, goods, and services are scientifically and medically sound. Quality requires skilled medical personnel that prescribe medicines and medical procedures appropriately. Health facilities must be adequately supplied with, among other thing, potable water and sanitation services, scientifically approved and unexpired medicines and hospital equipments, adequate sanitation, and skilled medical personnel.\(^8\)

The issue to be addressed is therefore: Can one on the basis of international law argue that a person’s right to health is violated if that person is denied access to health care services or the underlying determinants of health on economic grounds; that is, either because that person does not have sufficient resource herself to pay for the services or the state claims that such cases are violations of international law, then one would have an effective way of mobilizing resources for health based on human rights framework. If one adopts this approach, one challenge is, in the words of the Special Rapporteur that “although there is a growing national and international jurisprudence on the right to health, the legal content to the right is not yet well established.

According to the Special Rapporteur the right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. The right to health contains both freedoms and entitlements. Freedoms include the right to control one’s health, including the right to be free from non-consensual medical treatment and experimentation. Entitlements include the right to a system of health

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8 CESCR General Comment 14, para 12.
protection (i.e. health care and the underlying determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health.

With regard to these elements, General Comment 14 proposes that the right to health can be taken to imply four interrelated criteria; availability, accessibility, acceptability and quality. By availability is meant that functioning facilities, goods and services relating to health care and the underlying determinants of health must be available in sufficient quantity. By accessibility is intended that these facilities, good and service must be available to everyone without discrimination; they must be within the reach of all members of society, including those with disabilities; goods and services to be respectful of medical ethics, culturally appropriate and sensitive to gender and age requirements, and designed to respect confidentiality and actually improve health status. Finally quality points to the need for the sense, for instance, those skilled personnel are used and good standards of hygiene maintained.  

The right to health is a broad concept that can be broken down into more specific entitlements such as the prevention, child and reproductive health; healthy workplace and natural environments; the prevention, treatment and control of diseases, including access to essential medicines; access to safe and potable water.

Relation between Health and Human Right

In their strongest sense, rights are justified claims to the protection of persons’ important interests. When the rights are effective, this protection is provided as something that is owed to persons for their own sakes. The upholding of right is thus essential for human dignity. Although Wesley N. Hayfield distinguished four different meanings of a right claims, liberties, powers, and immunities. Claims-rights are the most important kind of right because they entail correlative necessary duties to forbear from interfering with persons’ having the objects of their right or in some situations, to help persons to have these objects. The general structure of all claim-right is given by this formula: A has a right to X against B by virtue of Y. There are five main elements here: first, the subject (A) of the right the right holder; second, the

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nature of the right; third, the object (X) of the right; fourth, the respondent (B) of the duty-bearer, fifth, the justifying ground (Y) or the right.\(^{10}\)

Two problems about redundancy are answered by reference to this formula. First, although rights are correlative with duties, rights are not redundant because their objects are benefits to the right-holder while duties are burdens of the respondents. Second, rights cannot be justification for being protected on one’s benefit or interests, such that the right-holder is personally entitled to have benefit as his due and for his own sake. Legal rights, to be justified, must ultimately have moral justification.

Human rights are a more politically correct alternative to the more eloquent ‘Rights of Man’. They are much the same as the older natural rights which, however, embrace the rights which humans possess independently of positive law. The human rights framework does provide us with an appropriate understanding of what values should guide a nation’s health policy, and a potentially powerful means of moving the health agenda forward. It is also, however, argued that appeals to human rights may not necessarily be effective at mobilizing resources for specific health problems one might want to do something about. Specifically, it is not possible to argue that a particular allocation of scarce health care resources should be changed to a different allocation, benefiting other groups.

Human Rights framework helps to argue that we have obligations, in one way or another, to do something about the human suffering among the large number of poor in the world. The argument is that the suffering of the poor is a violation of their human rights, and the international human rights instruments place an obligation on us to do something about it. The exact details of the argument vary among different commentators, but they all have in common this basic argument structure. Rarely, however, are we provided with any details about exactly how one should understand particular violations of human rights or exactly how one arrives at recommending a particular action to rectify the alleged violation of a human right. Nevertheless, many are confident that a linkage to human rights will prove useful when we want to mobilize resources for the world’s poor. The pairing of health and Human Rights is a

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powerful one because they are both goals that the vast majority of humanity agree should have very high priority and, together they work to enhance each other.11

Promoting and Protecting Health and Respecting, Protecting and Fulfilling Human Rights are inextricably linked. Violations or lack of attention to human rights can have serious health consequences (e.g. harmful traditional practices, slavery, torture and inhuman and degrading treatment, violence against women and children). Health policies and programmes can promote or violate human rights in their design or implementation (e.g. freedom from discrimination, individual autonomy, rights to participation, privacy and information). Vulnerability to ill-health can be reduced by taking steps to respect, protect and fulfil human rights (e.g. freedom from discrimination on account of race, sex and gender roles, rights to health, food and nutrition, education, housing).

Examples of the linkages between health and human rights12

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12 Available at <http://www.who.int/hhr/HHR%20linkages.pdf> last visited on November 14, 2011.
Initially Human Right focused on civil, political economic and social rights. Now it includes concerns about environment, global socio-economic development etc. Concepts are enlarging, focusing on the relationship between the individual and the state and other social institutions.\textsuperscript{13} Health and Human Right are both powerful and modern approaches to defining and advancing human well being. Adoption of the Human Rights paradigm has the potential to revolutionize the health.\textsuperscript{14} Concerns about Health overlaps with concerns about Human Rights. The human rights violations can have adverse consequences for health. We can take here the example of torture where human rights abuse affects Health. Also domestic violence, unsafe working conditions and the sexual exploitation of children further illustrates how the human rights violations can affect health.

Thus where the state violates its obligations with respect to human rights by providing inadequate protection against various forms of abuse, an equally obvious danger to health may arise.\textsuperscript{15} Further activities in the field of health may themselves violate Human Rights. For example medical records being kept in manner inconsistent with rights to privacy and information. Likewise mentally ill people may be involuntarily hospitalized on the basis of procedures that do not fully respect their right to personal liberty and security. Compulsory treatment may be administered in circumstances that cannot be reconciled with rights to physical integrity, privacy, freedom of religion, and possibly even life. And health policies may be elaborated which do not meet obligations of non discrimination.\textsuperscript{16}

The interrelation between health and human Rights need not be negative, and is in fact often mutually strengthening. The activists in the field of Health may also serve to promote the enjoyment of human right. One example of this may be the way programmes for child health lend support for the right to education. Much more generally, though programmers of immunization, treatment for infectious diseases, primary health care, and reproductive and maternal health are crucial to the realization of many of the most basic human Rights, in as much as those programmes facilitate

\textsuperscript{13} Susan Marks & Andrew Clapham, note 9, pp. 197-198.
\textsuperscript{14} Ibid, p 119.
\textsuperscript{15} Ibid, pp. 197-198.
\textsuperscript{16} Ibid, p. 198.
physical survival, and beyond that the capacity to take part in collective life. Finally the protection of human rights may itself assist in raising levels of public health.\textsuperscript{17} As all rights are encompassing each other. For the protection of health rights, the other human rights have to be protected simultaneously. The right to health is then to be understood as encompassing both health care and the underlying determinants of health.

\textbf{Origin of Health Rights}

Health is one of the components of an adequate standard of living. Historically the protection of health has been accompanied by legal regulations. Health law is as old as law itself. Its development demonstrates that the state of an individual health is often determined by factors beyond a person’s medical condition.\textsuperscript{18} The idea and concept of health is something we have all learnt at the WHO’S knee but it is an idea that repays examination. People are familiar with the idea of individual well being or the lack of it, and most can content the analogy to social health, but the idea that health, whether individual or social is the outcome of specific technological social and political intervention is of much more recent origin.\textsuperscript{19} The concept of health or the scientific study of illness in populations is only about 200 years old. Thus the technical apparatus for the comparative evaluation of different interventions of health is only that old.\textsuperscript{20}

The idea of health right is also relatively new concept. The well being of the people has always been considered a royal obligation. For instance Ashoka acknowledged that the people’s health was his responsibility. However it was only when the democratic idea of the human rights of man came together with the possibility of health interventions that health as a right was born. Today when we talk of health in an operational sense, we generally refer to the entire gamut of interventions that may be deployed by society in general or the state in particular in

\textsuperscript{17} Ibid, pp. 198-199
\textsuperscript{19} Available at <http://cesr.org> last visited on July 9, 2008.
\textsuperscript{20} Susan Marks & Andrew Clapham, note 9, p.1.
order to give effect to desired changes in the health of the people.\textsuperscript{21} The concept of right grows out of perception of the inherent dignity of every human being. Thus use of rights in connection with health emphasizes that the dignity of each person must be central in all aspects of health. Conceptualizing health status in terms of rights underscores health as a social good and not solely a medical, technical or economic problem.\textsuperscript{22}

The goal of extending the benefits of sustainable health over an expanding life span, to all members of the human family is the cardinal tenet of health rights. The declaration of human rights eloquently upholds the right to life as an inalienable entitlement of all human beings. As the mutually nurturing relationship between health and development becomes increasingly clear, protection of health becomes integral to the mandate of human rights. Such a shared vision and shared mission paved way for a natural alliance between the advocates of health and the defenders of human rights.\textsuperscript{23} Both health and human rights grew as individually powerful and modern approaches to define and advance human well being as violation of human rights in health matters would increase the risk of poor health outcomes.

What exactly is it that human beings need in order to live well, to survive and to prosper. Whatever it is, far too many times in the history of human kind people have been without that which is essential for their well being. The inception of the modern human rights movement is generally linked to the aftermath of World War II and the founding of United Nations. Its foundation is the internationally promulgated documents such as UDHR, ICCPR and the ICESCR. Therefore the human rights movement is equal and deserving of a certain set of fundamental rights for no other reason that he is a member of human race.\textsuperscript{24}

Right to health was first recognized as Fundamental Right in 1946 when the constitution of the World Health Organization was adopted at the international health conference held in New York from June 19 to 22 July by the representatives of 61

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\begin{itemize}
\item \textsuperscript{21} Ibid, p 7.
\item \textsuperscript{22} \textit{Regional Consultation on Public Health-Reports and Recommendations} (New Delhi: National Human Rights Commission, 2001), p. 119.
\item \textsuperscript{23} Ibid, p. 6.
\item \textsuperscript{24} Jonathan M. Mann, et al., \textit{Health and Human Rights} (London: Routledge, 1999), p. 505.
\end{itemize}
states. Right to health is now contained in numerous international treaties including ICECC, the WHO and the UNICEF declaration of Alma-Ata the UDHR and ECHR.\textsuperscript{25} A strict understanding of right to health implies that it would be more correct to speak of a right to health protection including two components a right to health care and a right to healthy conditions.\textsuperscript{26}

The concept of rights grows out of a perception of the inherent dignity of every human being. Thus, use of rights language in connection with health emphasis that the dignity of each person must be central in all aspects of health.\textsuperscript{27} The health of any nation is the sum total of the health of its citizens, communities and settlements in which they live. Here it is important to bring into notice that in 1943, President Franklin D. Roosevelt proposed a Second Bill of Rights for Americans, declaring freedom from want to be one of four essential liberties necessary for human security. Roosevelt’s conception of freedom included the right to adequate medical care and the opportunity to achieve and enjoy good health. The right to health was subsequently enshrined in the Universal Declaration of Human Rights, drafted with American guidance, and has since been recognized in numerous international and regional human rights treaties.

The International Covenant on Economic, Social and Cultural Rights (ICESCE) was the first human rights treaty to require states to recognize and realize progressively the right to health, and it provides key provisions for the protection of the right to health progressively:

1. The States parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

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

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

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

\textsuperscript{25} See http://www.amnesty.usa.org.
\textsuperscript{26} Ibid.
\textsuperscript{27} Regional Consultation on Public health-Reports and Recommendations, note 22, p. 119
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical services and medical attention in the event of sickness.

The nature of the legal obligations of State parties is set out in article 2 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). The Committee on Economic, Social and Cultural Rights (CESCR) which monitors States parties implementation of the International Covenant on Economic, Social and Cultural Rights, has adopted General Comment 14 which expands upon Article 12 of the ICESCR, and is the most comprehensive interpretation of the international right to health, and corresponding state obligations, to date.

The committee on Economic, Social and Cultural Rights in General Comment No. 14 defined the obligations that States parties have to fulfill in order to implement the right to health at the national level. These are as follows:

1 The obligation to respect the right to health requires States to, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstain from enforcing discriminatory practices as a State policy; and abstain from imposing discriminatory practices relating to women’s health status and needs.

2 The obligation to protect includes, inter alia the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties. States should also ensure that third parties do not limit people’s access to health-related information and services.

3 The obligation to fulfill requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. This obligation
entails also the state to take positive measures that enable and assist individuals and communities to enjoy the right to health.

States have some minimum core obligations which are of immediate effect. These immediate obligations include the guarantees of non-discrimination and equal treatment, as well right to health, such as the preparation of a national public health strategy and plan of action. Progressive realization means that States have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health.

Thus, CESCR General Comment 14 identifies the core obligations that arise from the right to health as including at least the following obligations.

1  Immunization against the major infectious diseases;
2  Measures to prevent, treat and control epidemic and endemic diseases;
3  Essential medicines, as defined by WHO’S Action Programme on Essential Medicines;
4  Reproductive, maternal (pre-natal and post-natal) and child health care;
5  Essential primary health care;
6  Right of access to health facilities without discrimination especially for the poor, and otherwise vulnerable and disadvantaged groups;
7  Equitable distribution of all health facilities, goods and services; and in the case of underlying determinant of health, governments must provide:
   (i) access to the minimum amount of food that is sufficient, nutritionally adequate and safe, to ensure their freedom from starvation and malnutrition; and
   (ii) access to basic shelter, housing and sanitation, together with an adequate supply of safe and potable water.
   (iii) education and access to information about the main health problems in the community, including methods of prevention and control; and
   (iv) appropriate training for medical and other health professionals, including education in health and human rights.
When formulating a national health policy, governments must adopt and implement a national public health strategy and plan of action, which is based on epidemiological evidence, and which takes into account the health concerns of the whole population. The strategy and plan of action must be developed through a participatory and transparent process and subject to regular review. Specific objectives and a cost-effective strategy must be adopted for using available resources, as well as method such as right to health indicators and benchmarks, by which progress can be closely monitored. The process, by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

Thus, statements made in the General Comment might indeed lead one to believe that a state has strong legal obligations to provide sufficient resources to ensure adequate health for all. It is said, for example, that health facilities, foods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, have to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. One could take this to mean that it prohibits denial of health care services on economic grounds. Other statements seem to support this claim “functioning public health and health care facilities, goods and services, as well as programmes, have to available in sufficient quantity within the State party.” Central to the General Comment is the principle of non-discrimination. This is reinforced by the special rapporteur: "Accordingly, international human rights law proscribes any discrimination in access to health care, and the underlying determinants of health, on the internationally prohibited grounds, including health status, which has the intention or effect of impairing the equal enjoyment of the right to health".

Taken together, these statements seem to give a strong endorsement to the claim that it is a violation of a person’s health rights to deny him treatment on the grounds that treating that person is too expensive for the state. If one denied treatment to persons who happen to have diseases that are expensive to treat, one does not ensure equal access to health care services to all. Although the state has an obligation to
provide health care in “sufficient quantity” “the precise nature of the facilities, goods and services will vary according to numerous factors, including the State party’s developmental level”. Furthermore, “the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources”. It is therefore, in spite of the strong statements that everyone should be assured access to health care, in principle legitimate for a state to claim that it can deny access to health care to patient groups who happen to have diseases that are expensive to treat, a state’s claim that it does not have sufficient resources to provide access to health care or its determinants to a particular group because of its costs can, of course, be challenged. We would then need some principled way of adjudicating between the competent claims: on the one hand those of the group denied health care access claiming that its health rights are violated and on the other hand those of state claiming that its resources can be utilized better elsewhere. The official documents on how we should understand a right to health do not provide us with much guidance on how one should adjudicate between such competing claims.

There are many issues like the above discussed in regard to right to health which has to be addressed sincerely by the world forum. Under international human rights law, developed states have some responsibilities towards the realization of the right to health in poor counties. Article 2(1) of the ICESCR establishes that the implementation of the rights recognized in the Covenant is undertaken individually and through international assistance and co-operation. This has fuelled an emerging position in international human rights law literature that international assistance and cooperation is not simply a moral duty but is a legal duty which is grounded in binding international legal instruments.

As providers of health services, health professionals play an indispensable role in the promotion and protection of right to health. They have played an important role in helping document and redress violations of human rights, such as violence and torture. Medical associations, as associations that represent doctors, have an important role to play in protecting members who seek to prevent violations and in acting when members commit violations.
Doctors and medical associations also have a positive duty to do something. For instance, doctors working in the forefront of the problems faced by a public health system and often witness how resources affect the provision of medical care to patients. Action by medical associations or doctors to fight for more resource, or to ensure that resources are distributed in a manner that reaches the most vulnerable populations, have played an important role in supporting the realization of the right to health. The paradigm of individual health, focused on a right to individual medical care, is no longer applicable to a globalizing world, compelling a renewed focus on the societal factors that facilitate the spread of disease and promote poor health. These health determinants do not fall within the framework of medicine but within the health systems.\(^{28}\) The resources available to national medical association vary; while some are well resourced, others may have fewer resources to support such activities.

Thus, acknowledging a Right to Health can shift policy debates from a narrow focus on efficiency (itself a spurious notion when many costs e.g. the loss of productivity due to employee health problems are simply externalized.) to questions of how to guarantee people an effective voice in policy and programming decisions that affect their well-being. Therefore, when violations of the right to health take place, States must provide remedies. Remedies may redress individual abuses by providing civil or criminal penalties, or they may seek to correct system-wide violations by introducing changes in policy or governing legislation. States must ensure that patients are fully able to participate in decision regarding their own health. For example, patients should not be excluded from treatment decision due to insurance company policies.

States are required to ensure that their population receives adequate information and education about medical practices and services (including those related to sexual and reproductive health).\(^{29}\) The procedural requirement for information overlaps with the four substantive categories because having access to information regarding medical facilities, treatment, quality, and condition in the first step to any successful


\(^{29}\) Ibid, p.777.
preventative measure or treatment. People should become more sensitive to health disparities and should work to get their rights through social sectors. The four substantive elements and their four procedural counterparts show that the right to health goes beyond the latest drugs or sterile needles. Instead, it requires a more holistic approach to improving health for the largest possible number of people. The governments obligation to respect, protect, and fulfill the to health demands that policy makers approach health care reform with a view to promoting good health care overall rather than implementing piecemeal fixes to discrete problems. Equity deserves a prominent position in health care at both national and international level. As globalization proceeds, it become obvious to almost all, that little real attention is to be paid to equity in health care,

  Although health is a fundamental human right, without no other rights would be possible, those committed to global justice cannot move forward solely on the inertia of an established individual right to health. The social transformations inherent in globalization engage an evolving framework for health rights. With globalization transmuting health risks from the individual to collective level, responding to changes in underlying determinants of health demands the evolution of health rights to encompass a collective right to health. It is significant to point out here that when administrative complexities create barriers to accessibility, inhibit the ability to monitor delivery of health services, and deprive people of having a voice in their own treatment; those inefficiencies become human rights concerns. Thus the challenge before us is not merely the promotion of health, but providing a fair and reasonable chance for all to achieve it.

  In the present scenario of 21 century right to health has become an important right equal to life. The world is becoming global village and MNCs are playing their vital role in the service providing sectors. As the governments all over the world has adopted the policy of liberalization which is integral part of globalization and cutting its involvement in the economic activity with the aim to provide basic infrastructure for social sectors like education and health etc. it is the obligation of the government to provide all the basic necessities for good health and education. State active
participation in providing right to health to its all citizen without any distinction of caste, religion and creed will pave the way for a healthy state.

But it is important to note here that due to rapid industrialization and urbanization health problems are increasing quite rapidly, and for a welfare country like India it is essential to recognize right to health as a fundamental right. It does not need to be emphasized that specific important aspects of this right to health, such as women and children’s right to health care, mental health rights, HIV and AIDS-affected persons health care rights, workers health rights, the right to essential drugs, etc. need to (and will) be woven into the study, bringing diverse branches of the global health movement into a broad coalition working for public health systems that strengthen universal access to health care.

The Health projects including Family Welfare schemes are conceived planned and implemented by respective State Governments. The Ministry of Health implements a few schemes related to Health. Under few other schemes, Central assistance is provided to the State Governments for national importance in various health related problems. Despite substantial health management works, the health related problems in the country are on the increase and with the increasing population pressure, further failure of service delivery and consequent poor health management is expected. As a structural measures, hitherto adopted for combating diseases, alone have not given desired results and death due to diseases continue, there exists a strong need to have a comprehensive planning approach for the realm of health various projects executed under the health management and control schemes of the Ministry of Health. It is of paramount important to evaluate and assess the degree of progress of various Health related projects, and ascertain the outcomes and socio-economic impacts of the schemes implemented at the state level. It becomes extremely difficult for administrators responsible for deciding on such health related schemes and programmes to come to a firm judgment on the overall usefulness of these programmes. The problem gets specially compounded because many of the impacts, particularly those related to the social aspects are intangible in nature. As a result, decision making process becomes highly difficult and complex. Different interest groups and lobbies tend to put pressure on the government to swing the decision one
way or the other. In the absence of any establishes objective methodology, it is not easy to have a holistic view which is free from the subjective considerations.

The controversy in many cases originates from the rigid approach adopted by the proponents and opponents of large schemes and programmes. In sharp contrast to the prescribed methodology of planning as well as practices in developed countries, formulators of these schemes and programmes in India usually start with and pursue only one variant of a scheme and resist attempts to consider other variants. Moreover, they have been traditionally used to confining their analysis to only a few impacts of the schemes while ignoring several others. The social activists too fix their attention only on one or a few impacts but from a different set and controversies persist. Sometimes, these result in agitations as well as legal wrangles. As a result, progress of several schemes and programmes gets slowed down, leading to enormous costs to the exchequer along with diminishing hopes of millions of aspirants who fail to derive the promised benefits. The administrative ministers in the Government and/ or Planning Commission have prescribed criteria or guidelines for selection of large health related schemes usually in terms of technical and economic considerations which are easily quantifiable and objective though not entirely satisfactory. But social aspects generally do not form part of such criteria.

OBJECTIVES AND METHODOLOGY OF THE STUDY

The present study aims at exploring the question of right to health in the context of Indian law and practice. It will attempt to answer the basic question as to whether the right to health in India does exit. Although, there is no direct recognition of right to health under Indian constitution, however, there do exist host of laws which includes health safeguards for various categories of people. Supreme court of India has also inferred from fundamental rights particularly from right to life- a derivative right to health. It has also used the directive principles of state policy to highlight the right to health in India. Besides that the government of India has also come out with various policy directives regarding right to health.

The main question that would be addressed in this study includes what is right to health? What is the protection available in constitution of India regarding right to health? What are the constitutional provisions, policies and laws with regard to right
to health in India? What has been the response of judiciary regarding right to health? This study would be based on the interpretation of international legal measures, provisions in Indian Constitution, Indian laws and policies regarding right to health and the case laws of Supreme Court. This study would not only endeavor to give a broader outlook for the right to health in India but also highlights that to what extent these provisions regarding right to health has been implemented in practice.

Besides above some other significant objectives include:

i. To evaluate the extent to which the objectives of the various Health related schemes of the Ministry of Health & Social Welfare have been achieved.

ii. To identify the actual outcome and socio-economic impact of the Right to Health in India.

iii. To assess the methodology and cost effectiveness of the schemes related to Right to Health.

iv. To diagnose the constraints and difficulties encountered by the implementing agencies and concerned stakeholders causing inefficient implementation of the programmes in relation to Right to Health in India and sub optimal achievements.

v. To suggest recommendation in terms of modification of the scheme guidelines, and appropriate change in the operational structure for ensuring successful execution and effectiveness of the schemes related to Right to Health in India which is under consideration.

For the purpose of the study data and information needed for the study have been collected from published and unpublished documents of the government and non-government organisations. The major sources of data and information required for the study were collected from Ministry of Health & Family Welfare, Ministry of Law, and the Concerned Government Departments like National Commission on Human Rights. Due to time and financial constraints only cases of Supreme Court related to Right to Health has been taken into account to analyze the existing discrepancies in laws and practice.
STRUCTURE OF THE STUDY

The present study is divided into five chapters. The first chapter deals with the introduction of health and human rights at international level. This chapter examines the position of right to health through various international covenants and treaties and also goes through the development of right to health in various developed and developing countries. The second chapter surveys the status of right to health in India. Beginning with the growth of health rights in India this chapter explains the role of panchayati raj, the five year plans and Indian health policies and programmes for health promotion. The third chapter deals with health legislations in India. In addition to the Constitution, this chapter discusses the main health provisions of the health legislations in the Indian legal system that deal with regulation of health care and safeguard individuals against medical negligence. The fourth chapter primarily deals with judicial responses to the health and human right issues. In the light of constitutional provisions and the judicial pronouncements following thereafter this chapter covers major right to health problems and the way Indian judiciary articulate and recognize this specific right to health. Finally the fifth chapter presents the general conclusion of the study and proposes suggestions to improve the present condition of right to health in India.
CHAPTER-I
RIGHT TO HEALTH AT INTERNATIONAL LEVEL
CHAPTER-I

RIGHT TO HEALTH AT INTERNATIONAL LEVEL

(A) INTRODUCTION

By their nature, human rights are universal because they are derived from inherent dignity of each individual person.30 Some people have questioned the universality of human rights, or of particular rights. International law, however, is unequivocal on the universality of human rights.31 “The universal nature of these rights and freedoms is beyond question”.32 A variety of human rights are implicated in a right based approach to health because realizing the right to health is dependent upon attaining other human rights, for example, the rights to food, housing, work, access to information and freedom of movement, among others.33 The right to health is fundamental to the exercise of other human rights. The right to health can be construed as (1) a right to health care and (2) a right to conditions that promote good health. This is not a right to be healthy. Individual genetics, choices and susceptibility all affect health.34 Rather, in its most common formulation, it is the right to the highest attainable standard of health.35 Individuals and communities are “rights holders” – they hold or claim the right to health; states or public authorities are “duty bearers” – they are duty bound to provide for the realization of the right to health in practice. The right to health is applicable to all people, in every country.36 It is a universal entitlement that is nonnegotiable.37 Governments must take action to progress towards realizing this right, whether or not they have ratified treaties that

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35. Ibid. 
36. Ibid.
37. Ibid.
invoke the right to health, even though certain specific obligations pertaining to this right are affected by whether a country has ratified the relevant treaties. Most countries, including many of the poorest, have ratified pertinent treaties.\(^{38}\)

Health is one of the components of an adequate standard of living. Historically, the protection of public health has been accompanied by legal regulation - health law is as old as law itself. Its development demonstrates that the state of an individual's health is often determined by factors beyond a person's medical condition. The right to health includes access to adequate health care (medical, preventative, and mental), nutrition, sanitation, and to clean water and air. It also includes occupational health consequences such as chronic injuries and diseases resulting from unhealthy and hazardous working conditions. This does not mean that an individual has the right to be healthy since no government can assure a specific state of health. The state of health depends on the person's genetic makeup, and is moulded by environment and health interventions.

Is there such a thing as a right to health? If so, what is its precise intent and purpose, and how can it be enforced? These questions are of central relevance because although health is universally recognized as one of the basic prerequisites for a decent life, there are nevertheless still doubts at both national and international levels whether a corresponding subjective right does in fact exist. This is because of the discrepancy found in many countries between the Endeavour to provide the best possible medical care and the actual care rendered to a (large) part of the population, coupled with the difficulties of financing comprehensive health care on a permanent basis. Thus, depending on a state’s level of development and the responsibility it assumes for granting healthcare benefits, the spotlight is on building the necessary institutional structures, thereby taking account of societal and medical progress. And in this context, such a right to health represents a major and urgent concern. It could contribute to achieving the goal of comprehensive healthcare provision, but is simultaneously burdened by the problems that always and necessarily arise when seeking to postulate social rights.

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While the government must work to promote health within the limits of its resources, it cannot be held responsible for ensuring any particular individual’s health *per se*, unless their health problems stem directly from discrimination or other human rights violations.\(^{39}\) The right to health is not equivalent to a guarantee that one will actually be healthy.\(^{40}\) The right to health requires not only that certain minimum standards of care be met or exceeded, but also that people be safeguarded from health threats such as water and air pollution, as well as workplace hazards.\(^{41}\) Basic prerequisites of good health also include the rights to shelter, food, and means of adequate sanitation.\(^{42}\) 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.\(^{43}\)

The right to health is entrenched in a series of international treaties as well as numerous national constitutions. Alongside regional conventions in the field of economic, social and cultural rights such as the European Social Charter, the African Charter on Human and Peoples’ Rights, and the Protocol to the American Convention on Human Rights. Among the most important instrument at the international level guarantying right to health is the Universal Declaration of Human Rights (UDHR).\(^{44}\) Although the UDHR is a General Assembly declaration instead of a treaty, it may be legally binding on the countries as either customary international law or as authoritative interpretation of the U.N. Charter.\(^{45}\)

A major international standard-setting instrument is the International Covenant on Economic, Social and Cultural Rights. Notably Article 12 of this Covenant lays down the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. A General Comment attempts to circum-scribe the


\(^{40}\) Ibid.

\(^{41}\) Ibid.


content of this article in greater detail. Yet such a commentary or any effort, for that matter, to give concrete substance to contractual provisions at international level will always be infused with the need to affect a compromise between representatives of highly differing countries.

Additionally, the right to health is recognized, inter alia, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights.46

The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

The General Comment, adopted in the year 2000, on Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) delivers crucial insights into the conceptual specification of the right to health. It shows that the right to health cannot be equated with the right to being healthy. Rather, in formulating the aim of enabling individuals to enjoy the highest attainable standard of health, a twofold condition is put forward: the right to health is first of all reliant on the individual’s biological and socio-economic circumstances, and secondly, on the financial resources of the government. This limitation was reflected in the rejection of the WHO definition of health upon framing the Covenant. The WHO defines health as

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46 Committee on Economic, Social & Cultural Rights resolution 1989/11, as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments. The United Nations General Assembly in 1991 resolution 46/119
“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. 47

Accordingly, elements of the right to health within the meaning of the Covenant include availability, i.e. the existence of a sufficient number of health facilities; attainability, i.e. non-discriminatory access in physical, economic and informational terms; acceptability, i.e. respect for ethnic and cultural distinctions; as well as the necessary quality of healthcare benefits. The second paragraph of Article 12 ICESCR specifies the obligations of the state as follows: reduction of infant mortality; improvement of environmental and industrial hygiene; prevention, treatment and control of epidemic, endemic, occupational and other diseases; and creation of conditions which enable all persons to obtain medical service and medical attention in the event of sickness. Systematically speaking, the state is responsible for respecting and protecting its inhabitants, and for granting access to benefits and services. 48

Governments are obliged to enforce the human right to health fall in three distinct ways: they must respect the right, they must protect the right, and they must fulfill the right. To respect means a government itself must not to violate the right to health, as it would by cutting funding for doctors working in underserved areas, for example. To protect entails that a government is responsible for preventing third parties from violating the right to health. Eviscerating environmental regulations arguably violates the right to health, as does allowing price gouging by monopolistic pharmaceutical companies. And the obligation to fulfill emphasizes that a government must ensure that all citizens have access to basic health services.

(B) WORLD HEALTH ORGANIZATION AND THE RIGHT TO HEALTH

The WHO Constitution was the first international instrument to enshrine the enjoyment of the highest attainable standard of health as a fundamental right of every

47 U.N. Committee on Economic, Social and Cultural Rights, General Comment 14, the right to the highest attainable standard of health, note 13.
48 Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health, note 13.
human being ("the right to health"). The Preamble of the WHO Constitution is a masterfully coherent statement, claiming as its own the full area of contemporary international public health. In the same spirit as the Charter of the United Nations, the Preamble asserts that the principles it states are basic to the happiness, harmonious relations and security of all peoples, thus expressing a modern set of universal aspirations. Health, it says, is an essential condition for their attainment, and the highest possible attainment of health is a fundamental right of every human being without distinction of any kind. The preamble defines health positively, as complete physical, mental and social well-being, not merely negatively as the absence of disease or infirmity. The concept of public health is contemporary, but in its phrasing the Preamble echoes the rhetorical cadences of the Age of Reason in the last part of the 18th century. In this view certain rights — such as those to health, or to life, liberty and the pursuit of happiness—cannot be granted or denied by any government because they are fundamental, inalienable human rights, which all of us, being human, already have.

The Preamble goes on to analyse the obligation of nations to contribute to the health of their people. This obligation is not imposed from the outside, but follows from the fundamental right of every human being, and therefore of humanity as a whole. The Preamble goes on to analyse the obligation of nations to contribute to the health of their people. This obligation is not imposed from the outside, but follows from the fundamental right of every human being, and therefore of humanity as a whole. From the fundamental right to health of every human being, the Preamble moves to the health of all peoples, observing that this is fundamental to their attainment of peace and security, and depends on the fullest cooperation of individuals and states. The connection between health, peace and security is self-evident when diseases coupled with poverty and other social ills destabilize governments and societies.

49 In February 1946 the Economic and Social Council of the United Nations established a Technical Preparatory Committee of Experts to prepare an agenda for the International Health Conference in New York, to be held from 19 to 22 July 1946. The agenda included the preparation of a constitution for a World Health Organization (WHO). The Conference eventually approved the WHO Constitution on 22 July, and designated an Interim Commission to carry out essential public health activities until the new organization was established. Representatives of sixty-one states signed the WHO Constitution on July 22, 1946, after which it remained open for signature until it came into force on April 7, 1948.

The Preamble notes that the achievement of any state in the promotion and protection of health is of value to all. It follows that unequal development in the promotion of health in different countries, and particularly in the control of disease, is a common danger. The Preamble also stresses upon the basic importance of the healthy development of the child, noting that it is essential to a child's development to live harmoniously in an ever-changing environment. For the fullest attainment of health, the benefits of medical, psychological, and related knowledge must be extended to all peoples. This principle serves as a reminder that the availability of essential knowledge and medicines must not be stopped at any national border, and that such interference must not be tolerated for any political or economic reasons.\textsuperscript{51} The Preamble acknowledges another precondition for accomplishing WHO's task: the responsibility of governments for the health of their people can be met only by the provision of adequate health and social measures. This means that not only government action but also social and economic measures are needed if the responsibility of states for the health of their people is to be fulfilled. The mention of this suggests awareness of the need for flexibility in the development of health policies.\textsuperscript{52}

Recognizing the difficulty of the task ahead, the Preamble notes that the need for informed opinion and active cooperation on the part of the public are essential for the improvement of the health of the people. The Preamble acknowledges another precondition for accomplishing WHO's task: the responsibility of governments for the health of their people can be met only by the provision of adequate health and social measures. This means that not only government action but also social and economic measures are needed if the responsibility of states for the health of their people is to be fulfilled. The Preamble obliges the member states not only to advance the health of their own people but to support WHO's cooperative initiatives to advance the health of all the people in the world. Because health is understood to be a fundamental human right, it may well be judged to overcome narrow constraints of nationality and sovereignty.\textsuperscript{53}

\textsuperscript{51} Frank P Grad, Ibid.
\textsuperscript{52} Frank P Grad, Ibid, p. 982
\textsuperscript{53} Ibid.
One must agree that this preambular language of the WHO Constitution would codify far-reaching human rights norms commensurate with contemporary public health discourse – creating what would be referred to as a “Magna Carta of health,”54 “represent[ing] the broadest and most liberal concept of international responsibility for health ever officially promulgated,”55 and encompassing the aspirations of WHO’s mandate following the ravages of the Second World War.56

As the United Nations’ (UN’s) principal specialized agency with purview over the conditions necessary for health, WHO possesses a unique institutional responsibility to implement the right to health through its directing and coordinating authority in international health. The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance. When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO. Further, when preparing their reports, States parties should utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.57

(C) THE UNIVERSAL DECLARATION OF HUMAN RIGHTS

The first catalogue of human rights and fundamental freedoms enumerated by the UN was UDHR, a declaration of the United Nations General Assembly (UNGA) adopted in Paris, France, on 10th December 1948.58 The UDHR is a milestone document in the history of human rights. The adoption of the UDHR was the first occasion on which the organized community of nations made a Declaration of human rights and fundamental freedoms. It was conceived as a common standard of

achievement for all peoples and all nations. The UDHR has become a yardstick by which to measure the degree of respect for, and compliance with, international human rights standards.

Its preamble includes the “four freedoms” enumerated in Franklin D. Roosevelt’s famous speech to the U.S. Congress, and its adoption marked the first time that international law protected the individual rights of citizens within their own countries. The catalogue of human rights and fundamental freedoms set out in UDHR contains special provision relating to health under article 25. In fact this provision laid down the foundations for the international legal framework for the right to health, which is pre-condition for the enjoyment of all other human rights. The provisions contained in article 25 were expanded and flourished in the ICESCR and many other international legal instruments.

It affirms in article 25 that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection. Since the adoption of the UDHR, the right to health has become widely accepted as a fundamental human right, explicitly recognised in various international and regional human-rights treaties, as well as in national constitutions, domestic laws, policies, and programmes.

(D) THE INTERNATIONAL COVENANT ON ECONOMIC SOCIAL AND CULTURAL RIGHTS

The UDHR’s provision on the right to health is complemented by the provision in the International Covenant on Economic, Social, and Cultural Rights

59 Available at: http://www1.umn.edu/humanrts/instree/l1viedec.html last visited on 26th June 2008.
61 See Article 25 of Universal Declaration of Human Rights.
(ICESCR), which is meant to elaborate on its meaning. This covenant was the first human rights treaty to require states to recognize and realize progressively the Right to Health, and it provides key provisions for the protection of Right to Health in International law.\textsuperscript{62} Article 12 of the Covenant provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right". Such steps include:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.\textsuperscript{63}

\textsuperscript{63} Committee on Economic, Social and Cultural Rights, General Comment 14, note 13.
To clarify and operationalize the above provisions, the UN Committee on Economic, Social and Cultural Rights, which monitors compliance with the ICESCR, adopted a General Comment on the Right to Health in 2000.\textsuperscript{64} The Committee was aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties. With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, General Comment focuses primarily on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee's experience in examining States parties' reports over many years.

According to the General Comment, the right to health also has a "core content" referring to the minimum essential level of the right. Although this level cannot be determined in the abstract as it is a national task, key elements are set out to guide the priority setting process. Essential primary health care; minimum essential and nutritious food; sanitation; safe and potable water; and essential drugs are included in the core content. Another core obligation is the adoption and implementation of a national public health strategy and plan of action. This must address the health concerns of the whole population; be devised, and periodically reviewed, on the basis of a participatory and transparent process; contain indicators and benchmarks by which progress can be closely monitored; and give particular attention to all vulnerable or marginalized groups.\textsuperscript{65} The General Comment sets out that the right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy

\textsuperscript{64} Ibid
\textsuperscript{65} Ibid.
occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.  

**Normative Content of Article 12**

Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties' obligations. The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a

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66 Ibid.
number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

1) **Availability**. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe

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67 Common Article 3 of the Geneva Conventions for the protection of war victims (1949); Additional Protocol I (1977) relating to the Protection of Victims of International Armed Conflicts, Art. 75 (2) (a); Additional Protocol II (1977) relating to the Protection of Victims of Non-International Armed Conflicts, Art. 4 (a).
and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.  

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

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

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

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

- **Information accessibility:** accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of

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information should not impair the right to have personal health data treated with confidentiality.69

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

4) **Quality.** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.70

The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs.

**Article 12.2 (a). The right to maternal, child and reproductive health**

"The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" \{art. 12.2 (a)\} may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information. (According to WHO, the stillbirth rate is no longer commonly used, infant and under-five mortality rates being measured instead)

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69 See paras. 18 and 19 of this General Comment & article 19.2 of the International Covenant on Civil and Political Rights.

Article 12.2 (b). The right to healthy natural and workplace environments

"The improvement of all aspects of environmental and industrial hygiene" (art. 12.2 (b)) comprises, inter alia, preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population's exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health. Furthermore, industrial hygiene refers to the minimization, so far as it is reasonably practicable, of the causes of health hazards inherent in the working environment. Article 12.2 (b) also embraces adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition, and discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances. 71

Article 12.2 (c). The right to prevention, treatment and control of diseases

"The prevention, treatment and control of epidemic, endemic, occupational and other diseases" (art. 12.2(c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States' individual and joint efforts to, inter alia, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control. 72

71 See ILO Convention No. 155, art. 4.2.
Article 12.2 (d). The right to health facilities, goods and services

"The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.  

Non-discrimination and equal treatment

By virtue of article 2.2 and article 3, the Covenant prescribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. It is worth to recall the Committee’s General Comment No. 3, paragraph 12, which states that even in times of severe resource

Ibid.
constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.\footnote{Source General Comment 14 of Article 12 of the International Convention on Economic, Social and Cultural Rights, note 13.}

With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.\footnote{Ibid.}

\textbf{Gender perspective}

The Committee has recommended that States integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.\footnote{Ibid.}

\textbf{Women and the right to health}

To eliminate discrimination against women, the Committee emphasizes a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including

\footnotesize{\begin{itemize}{\item Source General Comment 14 of Article 12 of the International Convention on Economic, Social and Cultural Rights, note 13. \item Ibid. \item Ibid.}\end{itemize}}
sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

Children and adolescents

Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness.77 The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behavior and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.78 Thus, States parties should provide a safe and supportive environment for adolescents that ensure the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counseling and to negotiate the

78 See World Health Assembly resolution WHA47.10, 1994, entitled "Maternal and child health and family planning: traditional practices harmful to the health of women and children".
health behavior choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services. In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.  

Older persons

With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.

Persons with disabilities

The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

Indigenous peoples

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79 See World Health Assembly resolution WHA47.10, 1994, entitled “Maternal and child health and family planning: traditional practices harmful to the health of women and children”.
80 See Paragraphs 34 and 35 of General Comment No. 6 of ICESCR.
81 Paragraph 34 of General Comment No. 5 of ICESCR.
In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples, the Committee deems it useful to identify elements that would help to define indigenous peoples' right to health in order better to enable States with indigenous peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health. (Recent emerging international norms relevant to indigenous peoples include the ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989); articles 29 © and (d) and 30 of the Convention on the Rights of the Child (1989); article 8 (j) of the Convention on Biological Diversity (1992), recommending that States respect, preserve and maintain knowledge, innovation and practices of indigenous communities; Agenda 21 of the United Nations Conference on Environment and Development (1992), in particular chapter 26; and Part I, paragraph 20, of the Vienna Declaration and Programme of Action (1993), stating that States should take concerted positive steps to ensure respect for all human rights of indigenous people, on the basis of non-discrimination. See also the preamble and article 3 of the United Nations Framework Convention on Climate Change (1992); and article 10 (2) (e) of the United Nations Convention to Combat Desertification in Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa (1994). During recent years an increasing
number of States have changed their constitutions and introduced legislation recognizing specific rights of indigenous peoples)
Limitations-

Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee emphasizes that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society. In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.

I. States Parties' Obligations

General legal obligations

While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health.\(^\text{82}\)

\(^{82}\) See General Comment No. 13 of ICESCR
The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12.83

As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources.84

The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect protect and fulfil. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.85 (According to General Comments Nos. 12 and 13, the obligation to fulfil incorporates an obligation to facilitate and an obligation to provide. In the present General Comment, the obligation to fulfil also incorporates an obligation to promote because of the critical importance of health promotion in the work of WHO and elsewhere)

**Specific legal obligations**

83 General Comment No. 3, Para. 9 of ICESCR; General Comment No. 13 of ICESCR
84 Ibid.
85 See General Comment no. 12 and 13 of ICESCR
In particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.\textsuperscript{86}

In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.\textsuperscript{87}

Obligations to protect include, inter alia, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment

\textsuperscript{86} The United Nations General Assembly resolution 46/119, (1991)
\textsuperscript{87} Ibid.
and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services.  

The obligation to fulfil requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as

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88 Ibid.
demonstrated by epidemiological data. For this purpose they should formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services.89

The obligation to fulfil (facilitate) requires States inter alia to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to fulfil (provide) a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal.90 The obligation to fulfil (promote) the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include:

(i) fostering recognition of factors favouring positive health results, e.g. research and provision of information;

(ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups;91

(iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services;

(iv) Supporting people in making informed choices about their health.92

II. International Obligations-

89 See ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161)
90 Ibid.
91 Ibid.
92 Ibid.
In its General Comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. In the spirit of article 56 of the Charter of the United Nations, the specific provisions of the Covenant (articles 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.93

To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required. States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater

attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.

States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population. Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard.

III. Core Obligations-

In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12.94 Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

94 See General Comment No. 3. of ICESCR
(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.95

The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights.96


96 Ibid.
IV. Violations –

When the normative content of article 12 (Part I) is applied to the obligations of States parties (Part II), a dynamic process is set in motion which facilitates identification of violations of the right to health. The following paragraphs provide illustrations of violations of article 12. In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12. This follows from article 12.1, which speaks of the highest attainable standard of health, as well as from article 2.1 of the Covenant, which obliges each State party to take the necessary steps to the maximum of its available resources. A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above.97

Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. The adoption of any retrogressive measures incompatible with the core obligations under the right to health constitutes a violation of the right to health. Violations through acts of commission include the formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health.98

Violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from legal obligations. Violations through acts of omission include the failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health, the failure to have a national policy on occupational safety

98 Ibid.
and health as well as occupational health services, and the failure to enforce relevant laws.\(^9\)

**Violations of the obligation to respect**

Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include the denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination; the deliberate withholding or misrepresentation of information vital to health protection or treatment; the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations.\(^{10}\)

**Violations of the obligation to protect**

Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the

\(^9\) Ibid.
\(^{10}\) Ibid.
failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.\textsuperscript{101}

\textbf{Violations of the obligation to fulfil}

Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates.\textsuperscript{102}

\textbf{V. Implementation at the National Level}

\textbf{Framework legislation}

The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify

\begin{thebibliography}{9}
\bibitem{101} Ibid.
\bibitem{102} Ibid.
\end{thebibliography}
the resources available to attain defined objectives, as well as the most cost-effective way of using those resources.\textsuperscript{103}

The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people's participation. In particular, the rights of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States.\textsuperscript{104}

The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health. In order to create a favourable climate for the realization of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.\textsuperscript{105}

States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time-frame for their achievement; the means by which right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures. In monitoring progress towards the realization of the right to health,

\textsuperscript{103} Ibid.
\textsuperscript{104} Ibid.
\textsuperscript{105} Ibid.
States parties should identify the factors and difficulties affecting implementation of their obligations.\textsuperscript{106}

\textbf{Right to health indicators and benchmarks}

National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party's obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children's Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.\textsuperscript{107}

Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.\textsuperscript{108}

\textbf{VI. Remedies and Accountability}

Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or

\textsuperscript{106} Ibid.
\textsuperscript{107} Ibid.
\textsuperscript{108} Ibid.
guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients’ rights associations or similar institutions should address violations of the right to health.109

The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant. Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.110

(E) THE AFRICAN CHARTER AND THE RIGHT TO HEALTH

The African Charter111 is the foundational normative instrument for the protection and promotion of human rights in Africa. It has been applauded as a document which departs from the norms in that it contains civil, political, economic, social and cultural rights. Article 16 of the African charter on human and peoples’ rights enshrines the right to the highest possible level of health. The States parties to the Charter are required to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. The Charter also contains other provisions which are directly linked to health such as the right to be free from the exploitation and degradation of man, particularly slavery, slave trade, torture, and cruel, inhuman or degrading punishment and treatment (article 5) or the obligation of States parties to care for the physical and moral health of the family (article 18) and ensure the protection of the rights of women, children and the disabled (article 18).

109 Ibid.
110 See General Comment No. 2, Para. 9 of ICESCR
The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa\textsuperscript{112} which was adopted on 13 September 2000 specifically protects the right to health in article 14 (health and reproductive rights). It also prohibits violence against women, including sexual violence, discrimination and harmful practices. Another African instrument which also enshrines the right to health is the African Charter on the Rights and Welfare of the Child, adopted under the auspices of the then OAU which expressly defines the right to health in article 14 and lists specific measures that States parties must take to implement the right to health for African children. The Charter in addition protects other rights which may directly or indirectly impact a child’s enjoyment of the right to health.\textsuperscript{113}

The African charter on the rights and welfare of the child also includes recognition of the right to health.\textsuperscript{114} African charter is a duty based charter unlike others and so the duty is bestowed on the state to protect the rights of the citizens including right to health. The state parties to the charter are obligated with the duty to take necessary steps to protect and promote health and well being of their citizens. The observatory will promote accountability and transparency in health systems in Africa in order to build confidence in plans and health outcomes. This recognizes that the health workforce is the glue and central asset of health systems.\textsuperscript{115}

(F) ALMA-ATA DECLARATION

The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health. In 1978, at a joint WHO-UNICEF conference in Alma-Ata, Kazakhstan, ministers of health from throughout the world agreed a major statement regarding the health policies deemed necessary to achieve

\textsuperscript{112} OAU Doc. CAB/LEG/66.6.

\textsuperscript{113} See e.g. articles 3 (non-discrimination); 13 (handicapped children); 15 (child labour); 16 (protection against child abuse and torture); 18 (protection of the family); 21 (protection against harmful social and cultural practices); 23 (refugee children); 27 (sexual exploitation); and 28 (drug abuse).

\textsuperscript{114} Enrique Gonzalez; Right to Health, Module -3 on Circle of Rights, Amnesty International, India, page 272-86

Available at< http://www.afro.who.int > last visited on 3\textsuperscript{rd} November 2008.
the WHO goal of health for all by the year 2000.\textsuperscript{116} This was important in propounding a broad and consistent philosophy and strategy for the attainment of health for all.\textsuperscript{117} The assembly called upon every competent United Nations body to coordinate with, and support, the efforts of the world health organization to achieve that goal.\textsuperscript{118} The declaration adopted at the conference expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world.

The Conference strongly reaffirmed that health, which is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. It was stated that the existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries. The participating states agreed that the people have a right and duty to participate individually and collectively in the planning and implementation of their health care.

The declaration acknowledged that economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace. It was also emphasized the governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of

\textsuperscript{116} The Alma Ata conference drew representatives from 134 countries, 67 international organisations, and many non-governmental organisations. (China was notably absent.)

\textsuperscript{117} Andrew Green, \textit{An Introduction to Health Planning in Developing Countries} (Oxford: Oxford University Press, 1993), Page 43.

governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

The most important aspect of the declaration was the recognition of the fact that primary health care is the key to attaining this target as part of development in the spirit of social justice. Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process.

The goal set in the declaration to have an acceptable level of health for all the people of the world by the year 2000 can only be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.119 In the polarised world of the cold war, the declaration inevitably reflected political and semantic compromises. However, the social and political goals of Alma Ata provoked early ideological opposition and were never fully embraced in market oriented, capitalist countries. In many health systems, a medical model of primary care dominated by professional vested interests resisted the expansion of

community health workers with less training. Geographic and financial inaccessibility, limited resources, erratic drug supply, and shortages of equipment and staff have left many countries’ primary care services disappointingly limited in their range, coverage, and impact.120

At a follow-up congress held twenty years after Alma Ata, figures were published that showed how primary health care has improved the quality of life of people in developing countries. The infant mortality rate worldwide had dropped to 90 out of each 1,000 live births in 1975 to 59 out of 1,000 in 1995 (a decrease of 34 percent), while the immunization of children under the age of one year, increase over the same time frame from twenty percent to 80 percent. In the mid-70s, only 38 percent of people in developing countries had access to safe drinking water and 32 percent to sanitary facilities; by 1995 these figures rose to 66 percent and 53 percent respectively. At the end of the twentieth century, however, effective health systems in developing countries were under tremendous pressure, not only because of incessant military conflict, but also because of the HIV/AIDS epidemic that has had a devastating effect on the delivery of health care. Southern Africa has been especially hard hit, carrying the heaviest HIV load in the world with 16.3 million sufferers.

The Alma-Ata Conference mobilized a “Primary Health Care movement” of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the “politically, socially and economically unacceptable” health inequalities in all countries. The Declaration of Alma-Ata was clear about the values pursued: social justice and the right to better health for all, participation and solidarity. There was a sense that progress towards these values required fundamental changes in the way health-care systems operated and harnessed the potential of other sectors. The translation of these values into tangible reforms has been uneven. Nevertheless, today, health equity enjoys increased prominence in the discourse of political leaders and ministries of

health, as well as of local government structures, professional organizations and civil society organizations.

(G) DOHA DECLARATION ON TRIPS AND PUBLIC HEALTH

In 2001, on 14th November WTO members adopted a special ministerial declaration at the WTO ministerial conference in Doha to clarify ambiguities between the need for governments to apply the principles of public health and the terms of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The Declaration responds to the concerns of developing countries about the obstacles they faced seeking to implement measures in the interest of health. Since the implementation of the TRIPS Agreement, one of the main issues of concern which has arisen is how to ensure that patent protection for pharmaceutical products does not prevent people in poor countries from having access to medicines. To address this issue, the Ministers at the Doha meeting put forward a public health declaration which stressed that the TRIPS agreement must be interpreted in a way that supports public health via the easy accessibility to existing medicines and the creation of new medicines. It emphasized that the TRIPS Agreement does not prevent member governments from acting to protect public health and affirmed their right to use compulsory licensing (where a third party is allowed to reproduce the patented process or product under license) and parallel importing.

Earlier on June 20 the TRIPS council held a discussion on the intellectual property and access to medicines. This subject was put on the agenda at the request of the African Group — i.e. the African members of the WTO. The goal was to initiate discussions on the interpretation and application of the relevant provisions of the TRIPS agreement with a view to clarifying the flexibilities that members are entitled to and in particular establish link between intellectual property rights and access to medicines. The meeting was in response to public concerns worldwide on how patents were causing monopoly situations enabling exorbitant prices of medicines for treating AIDS and other diseases, making them unaffordable especially in developing countries. At the meeting, 47 developing countries submitted a Joint Paper, asking for action in the WTO to affirm that nothing in TRIPS prevents countries from taking
measures to protect public health. They called for confirming a flexible interpretation of TRIPS, especially in relation to the use of compulsory licenses and parallel imports. They wanted action before and at the Doha WTO Ministerial Conference on the issue of intellectual property rights and access to medicines.

In September 200, the TRIPS Council had another round of discussion on the topic of access to medicines. At this meeting a draft text addressing political principles to ensure that TRIPS did not undermine the legitimate right of WTO Members to formulate their own public health policies, was presented by the African Group, joined by nineteen other countries for a ministerial declaration on TRIPS and Public Health. The text also provided practical clarifications for provisions related to compulsory licensing, parallel import, data protection, and production for export to a country with insufficient production capacity. In addition, the draft included a proposal for evaluating the effects of TRIPS on public health, with particular emphasis on access to medicines and R&D for the prevention and treatment of diseases predominantly affecting people in developing and least-developed countries.

At the meeting the developed countries including the United States, Japan, Switzerland, Australia, and Canada circulated an alternate draft primarily aimed at limiting the flexibilities of TRIPS during crisis and emergency situations. The United States adopted the position that the TRIPS Agreement strikes a balance between incentives for innovation and access to essential medicines. The United States also argued that compulsory licensing under Article 31 should be read together with Article 27.1, which would prevent member countries from taking steps to protect public health and to ensure their citizens’ access to essential medicines. The United States and Switzerland even had threatened that they would not endorse any proposal at the WTO Ministerial Conference in Doha that affirmed that the TRIPS Agreement permits countries to take measures to ensure access to essential medicines. Notwithstanding these divergent positions, a Declaration on TRIPS and

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Public Health was issued by a consensus of all WTO members at the Doha Ministerial meeting in Qatar in November 001.

The Doha Declaration is a direct consequence of the multiple controversies concerning patents in the health sector. The Declaration recognized the gravity of the public health problems afflicting many developing and least-developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics. Its importance is linked to the recognition that the existence of patent rights in the health sector does not stop from taking measures to protect public health. The essence of the declaration was reflected in Paragraph 4 which reiterated the fact that TRIPS Agreement should be interpreted and implemented in light of the members’ right to public health and to promote access to medicines for all: “We agree that the TRIPS Agreement does and should not prevent Members from taking measures to promote public health. Accordingly while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of the WTO’s members right to protect public health and in particular to promote access to medicine for all”.\textsuperscript{123} This text thus unequivocally acknowledges the right of countries to take measures to protect public health. It clarifies the relationship between the TRIPS Agreement and public health interests while reaffirming the Members’ commitment to the Agreement. It should also be noted that paragraph 4 makes a specific reference to the issue of “access to medicines for all” indicating that in interpretation of the Agreement’s obligations, special consideration should be given to the achievement of this goal.\textsuperscript{124}

In paragraph 5, the Declaration lays out the key measures and flexibilities within TRIPS i.e. compulsory licenses\textsuperscript{125} which can be used to overcome intellectual property barriers to access medicines. Under TRIPS the fastest way in which a country could get a compulsory license was to claim a national emergency. The declaration categorically makes it clear that that the use of compulsory licensing is in

\textsuperscript{123} World Trade Organization, Doha Ministerial Declaration on the TRIPS Agreement and Public Health, para 4, WTO Doc No WT/MIN(01)/DEC/2(2001).


\textsuperscript{125} A compulsory license is a license granted by the competent national authority to allow a third party to manufacture a patented drug without the authorisation of the right holder.
no way limited to cases of ‘emergency’ or ‘urgency’. It reasserts the sovereignty of member states by giving them the discretion in not only declaring a compulsory license but also in ascertaining for themselves what amounts to a national emergency. Finally this paragraph resolves the issue of whether measures like parallel trade are acceptable in the TRIPS Agreement by allowing members to establish exhaustion regimes without challenge. It must be noted that the use of compulsory licenses contributes to raising the degree of competition, which causes a reduction in price.

This strengthens the position of countries that want to take advantage of the existing flexibility within TRIPS. In other words, the declaration does not open new avenues within TRIPS but confirms the legitimacy of measures seeking to use to the largest extent possible the in-built flexibility found in TRIPS. The declaration focuses mainly on questions related to the implementation of patents, such as compulsory licensing. Compulsory licensing has long been used as a tool to regulate the exclusive rights conferred by patents. In the case of health, the rationale is to make sure that the existence of a patent does not create a situation where a protected medicine is not available to the public because of non-health related factors. The TRIPS Agreement has not done away with the notion of compulsory licenses but provides a more restrictive framework than the current regime in force in India. The recognition in the Doha Declaration that TRIPS member-states can use the flexibility provided in the agreement and can, for instance, determine the grounds on which compulsory licenses are granted must thus be understood in the context of a generally increasingly restrictive international patent regime.

The declaration has been hailed as a major step forward in the quest for making the TRIPS Agreement more responsive to the needs of developing countries and more specifically to individuals who are unable to afford the cost of patented drugs. The Doha Declaration was in theory a breakthrough for developing countries because it appears to solve the quintessential dilemma between which is supreme public health or Intellectual Property rights. Developing country Members sent a clear signal that they would take steps to protect and advance their essential interests. They raised certain basic points for the consideration. In their view public health concerns must be considered in a broad context. While HIV/AIDS and other crises
are of the utmost grave concern, they do not represent the limit of developing country interests in public health and medicines. They were firm on the issue that patents raise the price of medicines and are therefore of serious concern as it affect access to medicines. The developing countries demonstrated that by establishing a coalition, and maintaining it throughout a negotiating process, they could prevent themselves from being outmanoeuvred by the EU–US block.\textsuperscript{126} During Doha process the developing countries emerged as a cohesive group articulating and advocating an essentially common position. The very fact that public health and access to medicines have been singled out as major issues needing special attention in TRIPS implementation indicates that health care and health care products need to be treated differently from other products. In fact, the Doha Declaration takes a large step toward ensuring that intellectual property protection actually serves the public interest, an interest broader than that of the commercial sector. The Doha Declaration lays out the options countries have available when prices of existing patented drugs are too high for their populations. But Doha did not solve every problem: the lack of R&D investment in new drugs for the particular health needs of the poor remains to be addressed.\textsuperscript{127}

In fact, it addresses a number of important issues related to the implementation of medical patents. However, it fails to take up the much more fundamental questions of the scope of patentability and the duration of patents in the health sector. The Doha Declaration remains an important instrument in India for two main reasons. Firstly, at a political level, India was amongst the most vocal developing countries at the ministerial conference in putting forward developing Countries' interests. Secondly, the declaration was adopted while the joint committee of Parliament was finalizing its report.


\textsuperscript{127} World Trade Organization, Doha General Ministerial Declaration, para 17, WTO Doc No WT/MIN(01)/DEC/1 (Nov 14, 2001) (“We stress the importance we attach to implementation and interpretation of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) in a manner supportive of public health, by promoting both access to existing medicines and research and development into new medicines and, in this connection, are adopting a separate declaration.”).
(H) CONCLUSION

Health is a fundamental human right, indispensable for the exercise of many other human rights, and necessary for living a life in dignity. The right to the highest attainable standard of health as a normative standard was first enunciated in 1946 in the Constitution of the World Health Organization (WHO), and has since been reiterated in a number of WHO declarations; foremost amongst them is the 1978 Alma-Ata Declaration on Primary Health Care. The most influential and basic document in this respect is, however, the Universal Declaration of Human Rights of 1948 (UDHR), which, when adopted by the UN General Assembly, was initially legally non-binding in nature, but has since assumed the status of customary international law for most of its provisions. The UDHR together with the International Covenant on Economic Social and Cultural Rights form the backbone of the human right to health under international law. However, the provisions of the two treaties are general. While they recognize the right of everyone to enjoy “the highest attainable standard” of health, they do not offer an exact recipe for implementation, nor do they take a position on the respective desirability of public or private financing for health care. The U.N. Committee on Economic, Social, and Cultural Rights (CESCR), the primary body responsible for interpreting the ICESCR, has however developed guidelines on how the right to health should be interpreted at the national level. The first fundamental component of those guidelines is a minimum floor below which no country may fall, which in the case of health means ensuring essential primary health care for the entire population. The right to health is, however, also contained in regional international standards, and the most notable among them is the African Charter on Human and Peoples’ Rights. The adoption of the Doha Declaration on TRIPS and Public Health is yet another significant development giving effect to the right to health at the international level.