CHAPTER-II

HISTORY OF CONSUMER MOVEMENT RELATING TO HEALTH IN INTERNATIONAL AND NATIONAL LEVEL
2.1. Introduction

Consumer protection was part of Indian ancient culture, but the introduction of boundless commercialization of activities eclipsed the old rich heritage. Laws are designed to ensure fair competition and the free flow of truthful information in the marketplace. The laws are designed to prevent businesses that engage in fraud or specified unfair practices from gaining an advantage over competitors and may provide additional protection for the weak and those unable to take care of themselves. Consumer protection laws are a form of Government regulation which protects the interests of consumers. For example, a Government may require businesses to disclose detailed information about products particularly in areas where safety or public health is an issue, such as food. Consumer protection is linked to the idea of "consumer rights" that consumers have various rights as consumers, and to the formation of consumer organizations which help consumers make better choices in the marketplace. The present study of history of consumer movement with respect to health in India has been discussed periodically-Ancient Period, Medieval Period and Modern Period.

2.2. Consumerism and Health in Ancient Period

Consumer Protection has its deep roots in the rich soil of Indian civilization, which dates back to 3200 B.C. In ancient India, human values were cherished and ethical practices were considered of great importance. However, the rulers felt that the welfare of their subjects was the primary area of concern. They showed keen interest in regulating not only the social conditions but also the economic life of the people, establishing many trade restrictions to protect
the interests of buyers. The historical perspective of consumer protection in India from the ancient period to the modern period briefly analyzes the development of consumer law in India. Finally, an attempt is made to discuss the legal framework of the Indian Consumer Protection Act of 1986 which led to the evolution of a new legal culture in India.

2.2.1. Dharma-sastras

In ancient India, all Sections of society followed Dharma-sastras which laid out social rules and norms, and served as the guiding principle governing human relations. The principles of Dharma were derived from Vedas. Vedas were considered the words of God, and law was said to have divine origin which was transmitted to society through sages. Thus, Vedas were the primary sources of law in India. Many writers and commentators of the ancient period documented the living conditions of the people through their innovative and divine writings, including Smriti (tradition) and sruti (revelation) and also prescribed codes to guide the kings and rulers about the method of ruling the State and its subjects. Consumer protection was also a major concern in their writings. Among the Dharma Sastras, the most authoritative texts are a) the Manu Smriti (800 B.C. to 600 B.C.); b) the Yajnavalkya Smriti (300 B.C. to 100 B.C); c) the Narada Smriti (100 A.D to 200 A.D.); d) the Bruhaspati Smriti (200 A.D. to 400 A.D.); e) the Katyayana Smriti (300 A.D. to 600 A.D). Among these, Manu Smriti was the most influential.

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58 Codes of morals. They also deal with the rules of conduct, law and customs.
59 Shraddhakar Supakar, Law of Procedure and Justice in India, 38 (1986). Veda means knowledge. There are four Vedas: the Rigveda, the Yajurveda, the Samaveda and the Atharvaveda.
60 Ibid at 39.
61 Ibid at 41.
62 It is also called Vedas.
63 The words of God.
64 The periods mentioned against each Smriti are taken from Gurjeet, supra note 1, at 705-6.
65 Manu, the ancient law giver, is the author.
2.2.2. Manu Smriti

Manu Smriti describes the social, political and economic conditions of ancient society. Manu, the ancient law giver, also wrote about ethical trade practices. He prescribed a code of conduct to traders and specified punishments to those who committed certain crimes against buyers. For example, he referred to the problem of adulteration and said “one commodity mixed with another must not be sold, nor a bad one not less nor anything that is at hand or that is concealed.” The punishment “for adulterating unadulterated commodities and for breaking gems or for improperly boring” was the least harsh. Severe punishment was prescribed for fraud in selling seed corn: “he who sells not seed-corn, he who takes up seed and he who destroys a boundary shall be punished by mutilation.” Interestingly, Manu also specified the rules of competency for parties to enter into a contract. He said “a contract made by a person intoxicated or insane or grievously disordered or wholly dependent, by an infant or very aged man, or by an unauthorized is invalid.” During the ancient period, the king had the power to confiscate the entire property of a trader in two instances when the king had a monopoly over the exported goods; and when the export of the goods was forbidden. There was also a mechanism to control prices and punish wrongdoers. The King fixed the rates for the purchase and sale of all marketable goods. Manu said “man who behaves dishonestly to honest customers or cheats in his prices shall be fined in the first

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66 It is interesting to note that Manu was the first to write about the eighteen heads or titles of litigation and matters pertaining to in this age of consumers, the regime of Indian consumer law will undoubtedly rule Indian markets and bestow a new phase on the existing Indian legal structure with its strong ancient legal foundations. Journal of Texas Consumer Law buyers and consumers, including money lending, deposits and pledges, sale without ownership of property, non-performance of contracts and breach of contract of sale etc.

68 Ibid at 393.
69 Ibid at 394.
70 Ibid at 283.
71 Ibid at 323.
72 Rajendra Nath Sarma, Ancient India According to Manu 142 (1980).
or in the middle most amercement." There was a process to inspect all weights and measures every six months, and the results of these inspections were duly noted.

All these measures show how effective ancient society was in regulating the many wrongs of the market place. These measures also show how developed the system was in identifying the market strategies of traders. Thus, Manu Smriti effectively dealt with various consumer matters, many of which remain of great concern in modern legal systems.

2.2.3. Kautilya's Arthasastra

Kautilya's Arthasastra which was written subsequent to Manu Smriti and it is considered to be a treatise and a prominent source, describing various theories of Statecraft and the rights and duties of subjects in ancient society. Though its primary concern is with matters of practical administration, consumer protection occupies a prominent place in Arthasastra. It describes the role of the State in regulating trade and its duty to prevent crimes against consumers. Between 400 and 300 B.C., there was a director of trade whose primary responsibility was to monitor the market situations. Additionally, the director of trade was made responsible for fair trade practices. The director of trade was required to be "conversant with the differences in the prices of commodities of high value and of low value and the popularity or unpopularity of goods of various kinds whether produced on land or in water and whether they arrived along land-routes or water-routes, and also should know about suitable times for resorting to dispersal or concentration, purchase or sale." The director of trade advised to "Avoid even a big profit that would be injurious to the subjects and he should not create a restriction as to time or the

73 Buhler, supra note 11, at 393.
74 400 B.C. to 300 B.C.
75 R.P. Kangle, The Kautiliya Arthasastra – Part II (2nd ed. 1972) [hereinafter Kangle Part II].
77 Kangle Part II, supra note 19, at 127.
evil of a glut in the market in the case of commodities constantly in demand.”

During this period, several measures were taken to maintain official standards of weights and measures. Kautilya observed, “The superintendent of standardization should cause factories to be established for the manufacture of standard weights and measures.”78 He further said “the superintendent should cause a stamping of the weights and measures to be made every four months. The penalty for unstamped weights is twenty seven panas and a quarter. Traders shall pay a stamping fee amounting to one kakani every day to the superintendent of standardization.”79

According to Kautilya, “the trade guilds were prohibited from taking recourse to black marketing and unfair trade practice.”80 Severe punishments were prescribed for different types of cheating. For example, “for cheating with false cowrie-shells, dice, leather straps, ivory-cubes or by sleight of hand, the punishment shall be cutting-off of one hand or a fine.”81 The rights of the traders were also well protected. Kautilya said, “On the subject of the return of an article purchased or payment of price thereof, there was fixed rule of time, after which an article could not be returned.”82 During Chandragupta’s period,83 in which Kautilya lived, good trade practices were prevalent. For example, “Goods could not be sold at the place of their origin, field or factory. They were to be carried to the appointed markets where the dealer had to declare particulars as to the quantity, quality and the prices of his goods which were examined and registered in the books.”84 Every trader was required to take a license to sell. A trader from outside had to obtain permission. The superintendent of commerce fixed the whole-sale prices of goods as they entered the Customs House. He allowed a margin of profit to fix retail prices.

78 Ibid at 134.
79 Ibid at 137.
80 Supakar, supra note 3, at 107.
82 Supakar, supra note 3, at 202.
83 Chandragupta Maurya ranks as one of the India’s greatest rulers period dates back to 323 B.C.
84 Radha Kumud Mookerji, Chandragupta Maurya and his Times 204 (4th ed. 1966).
Speculation and cornering to influence prices were prohibited. Thus, the State had a heavy responsibility for protecting the public against unfair prices and fraudulent transactions. There were severe punishments for smuggling and adulteration of goods. For example, public health was guarded by punishing adulteration of food products of all kinds, including grains, oils, alkalis, salts, scents and medicines.\footnote{Ibid at 140.}

Also during Chandragupta's period, easy access to justice for all, including consumers, was considered of great importance. The king was the central power to render justice. According to Kautilya, "The king should look to the complaints of the people of the town and village in the second part of the day. The mobile and circuit Courts worked at night, when necessity arose. They also must have worked on holidays in urgent matters."\footnote{Supakar, supra 3, at 114-15.} The king was required to pay full attention to the truth\footnote{Buhler, supra 11, at 26.} and he was primarily responsible for administering justice. Everyone could approach the King's Court for justice. However, standing was strictly followed. The king only entertained cases if the aggrieved presented a valid complaint. The king was directed not to "foster litigation by starting an action without a complainant, and moreover, the king was told that no complaint should be taken notice of when it proceeded from a person altogether unconnected with the person aggrieved."\footnote{Dutta, supra note 26, at 52.} In addition to this, different set of Courts were prevalent in ancient India. The Court system during Kautilya's time was well organized. There were two different benches comprising judges and magistrates to try civil and criminal cases. In civil matters, the judges themselves were empowered to take cognizance of the cases of disadvantaged persons who could not approach the Court, for example, the cases concerning ascetics, women, and minors, old, sick and helpless people\footnote{Kautilya-The Arthashastra 385 (L.N.Rangarajan ed., Penguin books India, 1992)}. Thus, rendering justice was regarded as one of the essential duties of the rulers,
and care was taken to ensure that justice was accessible to all. Indeed, this emphasis on justice for all remains a cornerstone of India’s legal system.

2.2.4. Arthashastra and Consumer Protection

Artha Shastra is an ancient literary compilation focusing on aspects related to politics, economics, and strategy. Written by the renowned genius Kautilya, Arthashastra is one of ancient India’s leading contributions to topics such as social welfare and ethics in economics. Consumer Protection is an area of particular prominence in Arthashastra, and a lot of materials in this voluminous text is focused on the duties of the Government in controlling aspects related to trade and prevention of wrong doings to consumers by sellers. Written in the 300 BC, Arthashastra has intimate details about standardizations of weights and measures which is a critical premise for consumer protection. A standards officer, appointed by the king, routinely visits factories, farms and markets carrying out inspections once every four months for a prescribed fee. All weights and measures had to be stamped by the standards officer, and heavy penalties would be imposed on traders who would use unstamped weights and measures. Additionally, the ruler of the kingdom would publish standard weights, measures, quality criteria and prices for all commonly used consumer commodities on a frequent basis so that the general public are not overcharged, exposed to adulterated or inferior goods, or sold manipulated measures of goods.

Chanakya suggests the role of minister of commerce who is the watch dog of the commodity markets; a vital role in achieving consumer protection. He would enforce and arbitrate issues with the intent of achieving a fair trade situation for consumers. Aspects controlled by the minister include pricing, popularity assessments, distribution channels, and market segmentation of consumable goods and commodities. This minister was vital in achieving a market where only fair profits can be availed and in ensuring the constant availability of goods in tumultuous supply and demand cycles. Trade guilds,
black marketing and unfair trade practices are prohibited as per Arthasastra and Kautilya emphasizes on the negative impacts such doings could have on the well being of an economy. Severe punishments are suggested for perpetrators of such crime. Although pro-consumer in nature, Artha Shastra still recognizes the importance of the rights of traders. Clearly established rules were suggested for return of goods, payment of bills for service rendered, and collection of escrow payments to ensure that sellers do not suffer at the hands of nefarious, unethical or non-creditworthy consumers. The cornerstone to any consumable commodity market’s consumer protection effectiveness is the efficiency of the supply chain and the regulation of the distribution system. Artha Shastra specifies that goods cannot be sold at the place of manufacture, cultivation or assembly. Clearly established rules exist for well regulated retail outlets where the sellers must clearly display the quantity and quality of their sale items. Arthasastra’s primary assumption is that the Government is effective in regulating the market and protecting the interests of the consumer. This was particularly true in Chandragupta Maurya’s period where the legal system was the finest in the world. It is amazing that a genius like Kautilya envisioned the rights of consumers and the tenets of consumer protection over 23 centuries before modern world consumerism was born and encapsulated his thoughts in this invaluable work for us.

Consumer protection was of paramount importance in the medieval period in India ranging from 1000 AD to 1750 AD. Several prominent Muslim rulers had ruled India during this period from their capital in Delhi. The Delhi Sultanate, being the start of such a long period of Islamic rule in India, laid the foundation to the economic, financial and commercial backbone of the Indian medieval period. The most notable achievements in Consumer Protection during the Delhi Sultanate were during the period of Alauddin Khilji (1296 AD to 1316 AD). Alauddin Khilji was the second ruler of the Khilji dynasty. During his reign, there were unprecedented improvements in the weights and measures standardization process bringing about dramatic changes in the
transparency practices of traders with consumers. Commodities were weighed and measured through standards established by the Sultan and people who did not follow standards were punished through fines and even capital punishment. The Sultan had judges who were omnipotent in enforcing the rights of the consumers and approaching the Courts when injustice occurred was simple and without bureaucracy. Several generations of rulers following the Khilji did not contribute much to the consumer protection cause until Sher Shah Suri who ruled during the brief period between 1540 and 1545 AD. Sher Shah Suri was a visionary in matters related to commerce. He envisioned that an economy is always dependant on how well its consumers are treated. He emphasized on standardized measures and set forth decimal and centenary systems with respect to measures. He also published quality guidelines especially for produce, grocery, confectionaries and pharmaceuticals. The financial system he introduced along with the currency Rupiyah forms the foundation of the monetary system of modern India. Although his reign was brief, he is thought to be one of the most important medieval ruler who has influenced consumer protection policies of modern India.

During the reign of Akbar (1556-1605), the third Mughal Emperor of India, several significant achievements were made in matters related to consumer protection. The right of the consumer to be informed perhaps found its earliest roots during the period. All traders were required to publish details regarding the quality and quantity of their merchandise including weights, measures, adulteration if any, age, grade, and usability. This law was strictly enforced through prefects and secret service personnel employed by the emperor. Violations and deceitful behavior were dealt with the harshest of punishments including amputation of limbs. Consumers also enjoyed the right to return merchandise which did not meet the standard requirements related to quality and quantity. Akbar’s contribution is notable in that his rule improved accountability and transparency in commodity transactions which were perhaps non-existent in the medieval days in India. Although the Mughal kings that
came afterwards did continue the achievements laid by their forefather, they concentrated more on literary, architectural and military pursuits. Eventually by the time the British gained control over the whole Indian peninsula, consumer issues had deteriorated into a stage that needed a rigorous revival. Nevertheless, the awareness, vision and perseverance through which the medieval rulers of India preserved the importance of consumer protection issues has been a source of fascination for international historians and economists.

2.2.5. The Quran and Consumer Protection

The Quran is the divine revelation given by Allah to Prophet Mohammed through angel Gabriel. Thought to be composed around the 632 AD, the Quran has one of the most effective, efficient and enforceable tenets that benefit consumers. Apparently consumer protection had been a topic of contemplation in the wise minds of men in the pre-Mohammedan era in the Arabian Peninsula. Islam arrived in India in the 7th century and has played a very influential role in Indian consumerism ever since. The story of how Islam came to India is an apt illustration of what Islam preaches when it comes to trade practices. In 624 AD, during the life of prophet Muhammed, one of his disciples Malik Bin Deenar came to Kerala. He started trading with the locals in a stark contrasting pattern; one filled with honesty, ethics and genuine concern for the consumer (buyer). The impressed locals informed the local king Cheraman Perumal, who summoned Malik to his Court room to understand why his practices were different from other traders. There Malik informed him that he was a follower of Islam and all his honest principles were derived from the teachings of prophet Muhammed. The story goes on that the impressed king Cheraman Perumal became the first Indian to convert as a Muslim, and thereafter he left for his hajj to Mecca. The message of the story is that the emphasis that Islam placed on honest and ethical practices was impressive enough to win the heart of a king himself along with several followers. For a Muslim businessman, there is no other way than to satisfy a consumer. Even if the market and economic forces drive down the profits, he still has to ensure his
consumers are satisfied. According to Islam, profits are just means to keep the business alive; the end is consumer satisfaction. Unlike other religious texts, the contrast of the Quran is that it is very specific about what can and cannot be done while conducting trade practices. The Quran is also stringent in imposing the harshest punishments on those who resort to unethical practices. The Quran is very verbal about the importance of contracts. In 5:1, the Quran quotes “The almighty says O you who believe Fulfill your contracts”. The concept of standardized weights and measures was well advanced in the Islamic society. Chapter 83, verses 1 to 3 goes, “Woe to those that deal in fraud; Those who when they have to receive by measure from men, exact full measure, but when they have to give by measure or weight to men, give less than due. Do they not think that they will be called to account”. Chapter 17, verse 35 further elaborates “Give full measure when ye measure, and weigh with a balance that is straight; that is the most fitting and the most advantageous in the final determination.” Today, in the day of hoarding for artificially manipulating the prices, it’s noteworthy that the Quran prohibits storage of food grains for more than 40 days with the idea of gaining prices.

It is amazing that a literary miracle written over 1400 years ago had the insights on post modern consumer concepts such as standardization/calibration of measures, anti-hoarding principles for the supply chain, contractual law, and necessity for transparency/accountability in the macroeconomic system of a nation. The consumer movement in India has gone through many a rough weathers and it has emerged out to be stronger for it. It had its trial and tribulation along its journey. Movement on the whole has had quite a cherished history undergoing metamorphosis from polite submissions to militancy to redressal through consumer forums and redressal cells. Broadly speaking the consumer movement has emerged through four different stages. The first stage of the movement was more representational in nature. The basic idea during this early phase was to make consumers aware of their rights. This was the tip of the iceberg, with every passing year more and more areas started coming
within its purview. Now it has come to practically encompass every sphere of life on this planet. The second stage was direct action. Direct action was based on boycotting of goods, picketing, demonstrations, etc. However, this seemed to be an ad hoc measure and no long-term benefits were derived from these activities for consumers. As man's intelligence is increased from generation to generation, from one historical period to another historical period habituated settled life from Nomadism.

As a part of human civilizations the crop yielding animal productions have increased remembrance and re-settled surplus in the production as a result of organization of different social groups in the society, in started exchange of agriculture and animal products. The system of exchange extended to necessaries like cloths, implements, goods and services system had been continued several decades. Due to changes in the social structure of human, several administrative systems have come into-force famously known as barter system. Barter system facilitated the exchange of goods and services. This system was an age-old method that was adopted by human beings to exchange goods and services. Barter system was used for centuries, before the advent of the currency money. People used to change the goods or services for other goods or services in return. During the ancient times, barter system was a local phenomenon, which involved people in the same locality. The advantage of bartering is that it does not involved monetary system. The barter system was one of the earliest forms of trading. It facilitated exchange of goods and services. The history bartering can be traced back to 600 B.C., It is believed that barter system was introduced by the tribes of Mesopotamia. This system was then adopted by the Phoenicians, who bartered their goods people in other cities located across the oceans. An improved system bartering was adopted in Babylonia too. People used to exchange their goods or weapons, tea, species and food items. Sometimes, even human skulls were used for barter. Another popular item used for exchange was salt was so valuable at that time, that the salary of roman soldiers was paid in salt. The main drawback of this system
was that there was no standard criterion to determine the value of goods and services in disputes and clashes. These problems were sorted out with the invention of money. At about 1200 B.C. in China, Cowry shells become the first medium of exchange, or money. The cowry has served as money throughout history even to the middle of the 20th century. China, in 1,000 B.C., produced mock cowry shells at the end of the Stone Age. They can be thought of as the original development of metal currency; the Chinese coins were usually made out of base methods which have holes in them. At about 500 B.C., pieces of silver were the earliest coins. Eventually the appearance of today and were imprinted with the numerous goods and emperors to mark their value. These coins were first shown in Lydia, or Turkey. In 118 B.C., banknotes in the form of leather money were used in China. From 9th Century to the 15th A.D., in China the first actual paper currency was used as money. At present ancients continue paper as well as metal as currency and continue to exchange their currencies.

2.3. Consumer Protection in Medieval and Modern Periods

In the medieval period, consumer protection continued to be of prime concern of the rulers. During Muslim rule, a large number of units of weights were used in India. During the Sultanate period, the prices used were determined by local conditions. During the rule of Alauddin Khalji, strict controls were established in the market place. In those days, there was unending supply of grain to the city and grain-carriers sold at prices fixed by the Sultan. There was a mechanism for price-enforcement in the market. Similarly, shop-keepers were punished for under weighing their goods.

90 Maulana Hakim Syed Abdul Hai, India-During Muslim Rule 127 (Mohiuddin 1977).
92 1296 – 1316.
94 Ibid at 88.
95 Ibid at 89.
In the modern period, the British system replaced the age old traditional legal system of India. However, one of the outstanding achievements of British rule in India was "the formation of a unified nationwide modern legal system." 96 During the British period, 97 the Indian legal system was totally revolutionized and the English legal system was introduced to administer justice. However, it is important to note that the traditions and customs of the Indian legal system were not ignored. "The law itself underwent considerable adaptation. The British institutions and rules were combined with structural features e.g. a system of separate personal laws and rules e.g. Dharma, and local custom which accorded with indigenous understanding. The borrowed elements underwent more than a century and a half of pruning in which British localisms and anomalies were discarded and rules were elaborated to deal with new kinds of persons, property and transactions." 98 To administer justice, "they were confronted with the problem of the value suitable to attach in practice to the Indian traditions and customs." 99 Despite the challenges of combining the British and Indian legal systems, "the fabric of modern Indian Law is unmistakably Indian in its outlook and operation" 100 and consumer protection is not an exception to this perception.

Some of the laws which were passed during the British regime concerning consumer interests are: the Indian Contract Act of 1872, the Sale of Goods Act of 1930, the Indian Penal Code of 1860, the Drugs and Cosmetics Act of 1940, the Usurious Loans Act of 1918, and the Agriculture Procedure (Grading and Marketing Act) of 1937. These laws provided specific legal protection for consumers. For fifty-five years, the Sale of Goods Act of 1930 (SGA) was the exclusive source of consumer protection in India. The SGA,

96 Galanter, supra 41, at 49.
97 From 1600 to 1947. The Regulating Act of 1773 was passed by the British Parliament and one of its objectives was to bring the management of the East India Company under the control of the British Parliament and British Crown.
98 Galanter, supra 41, at 48.
100 Galanter, supra 41, at 49.
drafted with precision, is "an admirable piece of legislation."\textsuperscript{101} It is also praised as a "Consumer's Charter." The main protection for the buyer against the seller for defective goods is found in Section 16 of the Act\textsuperscript{102}. It provides exceptions to the principle of Caveat emptor and the interests of the buyer are sufficiently safeguarded. Phrases such as "skill and judgment of the seller", "reliance on sellers' skill", and the test of "merchantable quality" provide effective remedies to buyers. Courts interpreted these rules in the consumer's favor\textsuperscript{103}. The SGA was the exclusive consumer legislation until 1986, with the passage of the Consumer Protection Act of 1986, designed to supplement the remedies already provided under the SGA. Consumer protection was also provided within India's criminal justice system. The Indian Penal Code of 1860 has a number of provisions to deal with crimes against consumers. It deals with offenses related to the use of false weights and measures\textsuperscript{104}, the sale of adulterated food or drinks, the sale of noxious food or drink, and the sale of adulterated drugs\textsuperscript{105}. Consumer protection legislation enacted after India's independence from Britain include: the Essential Commodities Act of 1955, the Prevention of Food Adulteration Act of 1954 and the Standard of Weights and

\textsuperscript{102} S.16 of Sale of Goods Act says "Subject to the provisions of this Act and of any other law for the time being in force, there is no implied warranty or condition as to the quality or fitness for any particular purpose of goods supplied under a contract of sale, except as follows: (1) Where the buyer, expressly or by implication, makes known to the seller the particular purpose for which goods are required, so as to show the that the buyer relies on the seller's skill or judgment and the goods are of a description which it is in the course of the seller's business to supply (whether he is the manufacturer or producer or not), there is an implied condition that the goods shall be reasonably fit for such purpose: Provided that, in the case of a contract for the sale of a specified article under its patent or other trade name, there is no implied condition as to its fitness for any particular purpose(2) Where the goods are bought by description from a seller who deals in goods of that description (whether he is the manufacturer or producer or not), there is an implied condition that the goods shall be of merchantable quality: Provided that, if the buyer has examined the goods, there shall be no implied condition as regards defects which such examination ought to have revealed.(3) An implied warranty or condition as to quality or fitness for a particular purpose many be annexed by the usage of trade.(4) An express warranty or condition does not negative a warranty or condition implied by this Act unless inconsistent therewith. Sale of Goods Act, No. 3 of 1930; India Code (1930), ch. 2 § 16.
\textsuperscript{103} Borrie and Diamond, supra note 46, at 66.
\textsuperscript{104} Indian Penal Code, No. 45 of 1860, ch. 13 §§ 264-67.
\textsuperscript{105} \textit{Ibid} at ch. 14 §§ 272-76.
Measures Act of 1976. A benefit of these acts is that they do not require the consumer to prove *mens rea*. Rather, "the offenses are of strict liability, and not dependent on any particular intention or knowledge."\(^{106}\) Criminal law in the field of consumer protection has acquired much significance, as consumers are less inclined to go to Civil Court for small claims. It has been said that "the functional value of criminal law in the field of consumer protection is a high one and it has a respectable pedigree."\(^{107}\) Another view is that there has been an attempt to look at consumer protection as "a public interest issue rather than as a private issue" to be left to individuals for settlement in Court. In addition to the remedies under contract and criminal law, consumers have rights under tort law. Based on its numerous legal intricacies, however, tort law is not the ideal remedy for injured consumers in India. For example, the traditional doctrine of negligence imposes heavy responsibility on the plaintiff to prove each of its required elements. These traditional legal requirements naturally encourage injured consumers to pursue legal remedies under different laws\(^{108}\). Not surprisingly, it is estimated that for about half a century from 1914 to 1965, only 613 tort cases came before the appellate Courts.\(^{109}\) The orthodox legal requirements under the law of torts and contracts forced the policy makers to craft specific legislation to protect consumers.

As a result, the Consumer Protection Act of 1986 was enacted with the objective of providing "cheap, simple and quick" justice to Indian consumers. In business and economic planning the consumer should be held supreme in any economy. It is his ultimate satisfaction that matters. While addressing a group of businessmen, Gandhiji also once said, "A customer is the most important visitor on our premises. He is dependent on us. We are dependent on him. He is not an interruption in our work. He is the purpose of it. He is a part of it. We are not doing him a favor by serving him. He is doing us a favor by

\(^{108}\) Worm ell Vs. R.H.M. Agriculture (East), Ltd. [1987] 1 W.L.R. 1901.
\(^{109}\) It is said, due to the congestion of courts with heavy arrears, it may take 5 to 15 years for a claimant to wade through the different levels of courts in tort litigation in India.
giving us an opportunity to do so." Gandhi's words place the consumer on a very high pedestal. But the consumer's high place is only a myth so far as the Indian economy is considered. Indian consumer is an utterly helpless fellow. He has no say in the quality or nature of goods that are sent to the market for his consumption. He is a victim of numerous malpractices. He is often made to buy adulterated or substandard goods. Second hand goods are passed on to him as new. Clever businessmen, through glossy salesmanship, misleading advertisements and tall claims about their products, rob the consumer of his hard-earned money. The consumer knows what is happening to him. But except making a loud, individual kind of protest, which has no effect on the mammon-worshipping businessmen, there is very little that he can do to check his systematic exploitation.

Since a majority of our consumers, particularly in the rural areas, are illiterate, they are not able to distinguish between the genuine and the spurious or the good and the bad. It is mainly these consumers who suffer at the hands of unscrupulous businessmen. Our consumers also suffer from a total absence of awareness among them. They know nothing about their rights, they are ignorant of the laws. First of all, the laws on trade marks, essential commodities, drugs, weights and measures are not very effective. Secondly, the standard of morals in our country being what it is, the businessmen do not find it difficult to steer clear of laws through greasing the palms of the inspection staff. Besides, litigation is such a costly and time consuming affair that no consumer has the courage and patience to throw cudgels on behalf of his ever suffering community. The cumulative result of these commissions and profit margins has been a lop-sided and totally unfair arrangement which seeks to take advantage of the plight of the consumer who realizes that he is being fleeced but is totally helpless to do anything about it. Fortunately, the realization has lately dawned on the authorities at various levels that something needs to be done to protect the interests of the consumer to save him from exploitation arid to ensure that he gets the worth of his money in respect of both quality and quantity.
Some years ago, Mr. Rajyadhyaksha, a former judge of the Supreme Court spoke of the rights of a consumer in a free society and of how these rights could be assured. In particular, he laid emphasis on three rights—the right to choose, the right to be informed and the right to be heard. All these rights assume the existence of certain conditions. The basic rights of a consumer were precisely defined by no less a person than the late President John F. Kennedy, who articulated what had long been known in advanced countries and among vigilant, highly educated people.

The rights as defined by him are: (1) the right to safety and to be protected against the marketing of goods which are health hazards or pose a danger to life itself; (ii) the right to be informed so as to be protected against fraudulent, deceitful or grossly misleading information, advertising, labeling or other such practices and to be given the facts he needs to make an informal choice; (iii) The right to choose and to be assured; as far as possible, access to variety of products and services at competitive prices, and in industries in which free competition is not workable and Government regulation is substituted to be assured satisfactory quality and service at fair prices; and (iv) The right to be heard and thus to be assured that consumer interests will receive full and sympathetic consideration in the formulation of governmental policy and fair and expeditious treatment in its administrative tribunals. Since India has for decades been a seller's market where the manufacturer and the trader have the upper hand and manage to sell whatever is marketed, the awareness of the consumer's basic rights as defined by former President, Kennedy and others, has taken a longtime coming. For all practical purposes, the consumer has been made the victim of monopolistic practices even where there are no monopoly goods. Until recently, there was no appropriate legislation on the statute book to ensure a fair deal to the consumer, where there was some kind of protective legislation, it was seldom enforced and remained on paper only. A few purposeful Acts have been passed by Parliament to protect the interests of the consumer and these reflect the Government's desire to do the needful in this
direction. But as stated above, the flaw has been in the implementation. The manufacturers, the traders, both wholesalers and retailers, know this and, therefore, they go on merrily overcharging and fleecing the consumer in both quality and quantity. The poor consumer is left high and dry. The Weights and Measures (Law Revision) Committee, commonly known as the Maitra Committee, estimated a few years ago that the faulty weights and measures enabled the trade to gain both ways; even one per cent error in commercial transactions carried out in the country by inaccurate weights and measures causes the consumer a loss of over Rs 170 crores in cities; the farmers stand to lose about Rs. 150 crores by such a fault. A later report released in January 1977 disclosed that under-weighing alone cheated the consumers to the extent of Rs. 3,000 crores annually. This indicates the magnitude of the loss the consumers suffer all through the lapse on the Government's part in enforcing a strict check on the weights and measures being used by traders at various levels.

The interests of the consumer can be protected by making more stringent laws and making the enforcement machinery perform its function honestly and diligently. Among the methods adopted by the Government in its effort to protect the consumer's interests are: the order requiring display of price lists in shop; the orders fixing the limits of stocks of certain commodities which can be stored at one time; the order requiring fixation of price tag& and printing weight and prices on cartons; opening of more fair price shops; the prescription necessitating a certificate from the Bureau Indian of Standards (BIS) regarding the quality of the stuff being sold. There is also the Monopolies and Restrictive Trade Practices Act (MRTP) to act as the watchdog of the Indian consumer. The consumer movement in India, unfortunately, has developed very slowly. Periodic efforts are made to organize a network of consumer societies, but the impact has been minimal. Again it is ironical that while defects in automobiles, freezers, fans, packed foods etc. have been, highlighted, not much attention has been given the people's essential requirements. The masses are virtually
voiceless in this field; they accept whatever is given by the 'grocer'. Owing to their general ignorance, they are the most common victims of the force of capitalist's exploitation. Consumer protection should start at the lower levels and work upwards. The laws of the land should be adjusted accordingly. The Indian consumer also needs to be educated about his rights, as has been done in the U.S.A., Britain and other advanced countries. Quality should become the norm instead of being the exception in this country. Every possible effort should be made to enable the consumer to get full value for his money. In this venture the co-operation of all sections of the people and also of the industrialists is essential. If industry exercises self-discipline and persuades all the manufacturers and businessmen to ensure quality and correct weights, much of the difficulty will vanish. Consumer's organizations exist in some towns of the country, but after the initial flush of enthusiasm they become silent and cease to function. The network of super patroni was established with high hopes, but they have made only a marginal impact on the general price level. They do have considerable patronage but owing to a certain bureaucratic practices and the time-consuming procedures they follow, many people prefer, to continue patronizing the petty traders near their homes.

2.3.1. The Consumer Protection Act of 1986

The Indian legal system experienced a revolution with the enactment of the Consumer Protection Act of 1986 (CPA), which was specifically designed to protect consumer interests. The Consumer Protection Act, 1986 was passed with avowed objectives. It is intended to provide justice which is less formal, and involves less paper work, less delay and less expense. The Consumer Protection Act, 1986 has received wide recognition in India as poor man's legislation, ensuring easy access to justice. However, the Consumer Protection Act, 1986 simply gives a new dimension to rights that have been recognized and protected since the ancient period. It is rightly said that “the present-day concern for consumer rights is not new and that consumer’s rights like the right to have safe, un-adulterated and defect-free commodities at appropriate prices
has been recognized since ancient times. The Consumer Protection Act, 1986 commands the consumer's support because of its cost-effectiveness and user-friendliness. In fact, the Consumer Protection Act, 1986 creates a sense of legal awareness among the public and at the same time, brings disinterest to approach traditional Courts, especially on consumer matters. It has changed the legal mindset of the public and made them think first of their remedies under the Consumer Protection Act, 1986, regardless of the nature of their case. In short, the Consumer Protection Act, 1986 has instilled confidence among the "teeming millions" of impoverished litigants. The way in which the consumer fora are flooded with cases and the mode in which these cases are being disposed off creates an impression of "judicial populism" in India in the arena of consumer justice. The greatness of the Consumer Protection Act, 1986 lies in its flexible legal framework, wider jurisdiction and inexpensive justice. One can find in the Consumer Protection Act, 1986 a mixture of principles of torts and contracts. Simply speaking, it is "a shorthand term to indicate all the many different aspects of general law."

Basically, the Consumer Protection Act, 1986 liberalizes the strict traditional rule of standing and empowers consumers to proceed under the Consumer Protection Act, 1986. Consumer groups, the central or any State Government are all empowered to lodge complaints under the Consumer Protection Act, 1986. This liberalization shows the care that has been taken to represent and fight for the cause of weak, indifferent and illiterate consumers. The novelty of the Consumer Protection Act, 1986 is the inclusion of both goods and services within its ambit. The consumer can bring suit for defective products as well as for deficiency of services. In the event of any deficiency, all services, whether provided by the Government or private

110 Singh, supra 1, at 719.
113 Ibid at ch. 2 § 1(b)(iii).
114 Ibid at ch. 2 § 1(c).
companies, can be questioned under the Consumer Protection Act, 1986. The Consumer Protection Act, 1986 also liberalized rigid procedural requirements and introduced simple and easy methods of access to justice. To proceed under the Consumer Protection Act, 1986, the consumer need only pay a nominal fee and need not send any notices to the opposite party. A simple letter addressed to the consumer forum draws enough attention to initiate legal action. Another major procedural flexibility is the option the consumer has to engage a lawyer. If the consumer prefers, he can represent himself. The simple measures of action drive consumers to avail themselves of the benefits of the Consumer Protection Act, 1986. The Consumer Protection Act, 1986 initiated a legal revolution by ushering in the era of consumers and developing a new legal culture among the masses to take recourse under the Consumer Protection Act, 1986 regardless of their grievance. The Consumer Disputes Redressal agencies, the National Commission, the State Commission, and the District Fora are working together in a way that is revolutionizing the present Indian legal system and challenging the traditional system of delivering justice. With easy access to the Courts guaranteed by the Consumer Protection Act, 1986, consumers now wage legal battles against unscrupulous traders or service providers without any hesitation.

The Indian Government is also taking an active interest in protecting consumer rights and promoting effective consumer movements. In 2003, the Planning Commission of India identified “Consumer Awareness, Redressal, and Enforcement of the Consumer Protection Act of 1986” as a priority, and as a result, a national action plan was prepared. The consumer fora created by the Consumer Protection Act, 1986 have proven to be effective, disposing of thousands of cases with few legal formalities, and leading the way toward well-founded consumer jurisprudence in India. The traditional Indian legal system, in addition to a huge backlog of cases, is experiencing a litigation explosion in the area of consumer protection. The total number of consumer cases pending...
in different fora was 359,469 cases as on June, 2004. Around 45,798 cases have been filed before the National Commission since its inception. At present, 8,884 cases are pending disposal. The huge backlog of consumer cases before consumer fora is forcing the Indian legal systems to think of "alternatives" for speedy disposal of consumer cases. India, home to the majority of the world's consumers, is committed to working for the welfare of consumers through new legal innovations.

Consumer protection is always a matter of great concern. In ancient India, effective measures were initiated to protect consumers from crimes in the market place. Ancient law givers ably described various kinds of unfair trade practices and also prescribed severe punishments for wrong doers. Mainly, acts of adulteration and false weights and measures were seriously dealt with. In ancient India, the king was the supreme authority to render justice, but his authority was circumscribed by the rules of Dharma. In the medieval period, some Muslim rulers developed well organized market mechanisms to monitor prices and the supply of goods to the markets. During the British period, the modern legal system was introduced in India and many laws were enacted to protect the interests of consumers generally. Today, the civil justice system is tainted with deficiencies that discourage the consumer from seeking legal recourse. However, the Consumer Protection Act of 1986, which provides easy access to justice, has brought a legal revolution to India as a result of its cost-effective mechanisms and popular support. At the same time, these mechanisms pose a great legal challenge to the traditional Courts which conduct litigation in orthodox ways. In this age of consumers, the regime of Indian consumer law will undoubtedly rule Indian markets and bestow a new phase on the existing Indian legal structure with its strong ancient legal foundations. Protection of

consumers has had relevance since the existence of consumers in India. It is surprising to see the roots of matters relevant to consumer protection in the Manu Smriti, a text which came into existence between 800 to 200 BC. Manu Smriti or Manusmriti is a semi-religious Hindu text recording the traditions narrated by Brahma to Manu, who is the first man to have lived on earth. The word Manu Smriti means the traditions as laid out by Manu. The significance of Manu Smriti in matters of consumer protection is in the fact that it heeds immense importance to the economical aspects of the society and in particular unethical trade practices. Manu Smriti lays out a charter of ethics for sellers on how to sell consumer products to consumers. It also specifies the penalties that must be handed out to sellers who are unethical in their actions.

Focus on prevention of adulteration is a key consumer protection issue even in those days and ages. Manu Smriti specifically prohibits the sale of any commodity that has been mixed with another commodity. This is particularly significant on purchase of items such as gold where by the purity of it becomes questionable due to adulteration. It is also significant in commodities the consumption of which could have a detrimental effect on the health of the consumer; commodities include pharmaceuticals, food or personal care supplies. Manu Smriti also mandates proper disclosure of quality and quantity of all items that are sold to consumers and prohibits the concealment of any aspects related to the product sold. This is particularly significant as the majority of consumer complaints arise around issues related to the quantity and quality of the consumed product. Manu Smriti gives guidelines on how often weights and measures have to be calibrated, inspected and also lays out the manner in which the results of inspections have to be dissipated. In the modern day, business contracts are significant to consumer protection. Very often we can see consumers and consumable companies engaging in Service Level Agreements (SLA) to safe guard consumer interests especially when purchasing services that are consumed regularly over extended periods of time. Interestingly the text of Manu Smriti also provides guidelines on how business
contracts may be executed and when such contracts may be deemed void. The most significant tenet of consumer protection is given absolute importance in the Smriti. The text explicitly prohibits any form of collusions in the market which could lead to monopoly or oligopoly. The king had the absolute right and the moral obligation to control the prices keeping in mind the absolute interest of the consumer. When viewed in the background of today’s antitrust laws and agencies, price conspiracies had its due share of attention even in the Pre-Christ period in India. Although in itself Manu Smriti’s sole focus is not consumer protection, this work seems to focus broadly on several aspects related to the well being of the consumer. It also shows how concerned the ancient society was in matters related to consumerism. It is also surprising that despite having such a pro-consumer oriented culture 2500 years or so ago, the consumer protection movement has still not evolved to meet the challenges that Indian consumers face in this day and age.

2.3.2. Achievements of the Consumer Movement relating to Health care

Some interesting developments which are helping the consumer movement include, developments taking place in the field of consumer education and some noticeable changes that have taken place among business organizations and their associations or federations. Consumer Protection is being incorporated in the courses at different levels in schools and colleges. Full-fledged courses have been introduced in management and law courses. A number of large organizations have set up Consumer Grievance Cells as an in-house redressal mechanism. The Government of India has set up a separate Directorate called Directorate of Public Grievances at Sardar Patel Bhavan, Sansad Marg, New Delhi. They deal with mop plaints relating to hawks, railways, insurance, pensions and related matters. In the long run, they will cover all the ministries. The nationalized banks are observing 15th of every month as the 'Customer Grievance Day, where an aggrieved consumer can walk into the top managers' offices in their respective town, district or zone.
The Council of Fair Business Practices, of more than 20 years standing, is also trying to help in the redressal of complaints against business from individual consumers or groups. Federation of Indian Chambers of Commerce and Industry has set up a Consumer Business Forum which meets once a quarter in different cities of the country. All stock exchanges in the country have also set up similar cells. The Advertisement Standard Council of India (ASCI), Confederation of Indian Industry (CII) and FICCI have evolved a code of ethics for their activities. Another significant achievement of the consumer has been the representation given to consumer organizations on the policy making bodies (regulator machinery) of Governments and Advisory Welfare Committees of big business organizations and the service sector. Central and State Government Consumer Protection Councils, regulatory departments of Preventions of Food Adulteration, Supplies of Food and Drugs, Weights and Measures Department, Quality Control Institutions like Bureau of Indian Standards (BIS) and AGMARK, Petroleum Product Department, Railway Commuters Welfare Committees, Regional Advisory Committees for Indian Airlines Services all have representatives of the various consumer organizations. Thus, consumers get full opportunity to participate in policy making aspects. It appears that the time has come when consumers in India can hope to be 'The King' in the market place very soon. The labour of dedicated individuals and groups who have fought relentlessly for consumers rights through the decades has not been in vain after all.

2.4. History of Consumer Movement relating to Health Care

The concept of medical negligence is about four thousand year old. The Babylonian kings Hammurabi introduce a law against the physicians whose patient loses an eye. The punishment for such malpractices was to cut the hand of the physician or surgeon. Even the Egyptian and Roman law had such similar provisions for medical malpractices causing death or serious injuries to the patient. The first case ever recorded under English law was in year 1374 against a surgeon J.Mert; the plaintiff had an injury in his hand due to wrong
treatment. In USA, the first case was recorded was in the year 1794, the case is known as Dr. Cross Vs. Guthrie. In this case patient’s husband sued Dr. Cross, a physician after the patient died as a result of postoperative mastectomy complications three hours after operation. The compensation of 40 pound was awarded to plaintiff. In India, since ancient times certain duties and responsibilities were borne by person who entered into medical profession as exemplified by Charakas Oath (1000BC) and the Hippocratic Oath (460BC). The civil laws for medical malpractices and medical negligence were introduced around 50 years ago, however very few law suits have been filed lately. This scenario completely changed with the introduction of the Consumer Protection Act, 1986. The complexity increased after Indian Medical Association Vs. V.P. Santha and other, when Court held to bring medical negligence cases under Consumer Protection Act, 1986.

Considering the importance of Kennedy’s speech to the US Congress on this day, and the resultant law, the CI took a decision in 1982 to observe 15 March as the World Consumer Rights Day from 1983. Peculiar though it may sound, 15 March is not observed as a special day in the world’s largest and most pulsating consumer society - the US. But at home in India the Government, adopted 15 March as the National Consumer’s Day. India is a country, which never fell behind in introducing progressive legislation - we were among the first in the world to introduce universal adult franchise for women. Gandhi had rightly said: “A customer is the most important visitor on our premises. He is not dependent on us. We are dependent on him. He is not an interruption in our work he is the purpose of it. We are not doing him a favor by serving him. He is doing us a favor by giving us the opportunity to serve him.” The right to redress lead to the passing of the Consumer Protection Act (COPRA) in 1986 in India which has been defined as the Magna Carta of consumers but, it recognizes only six of these eight rights:
1. Safety;
2. Information;
3. Choice;
4. Representation;
5. Redress and
6. Consumer Education.

Besides this statutory recognition, COPRA has succeeded in bringing about revolutionary judicial reforms by providing juristic quasi-judicial Courts solely for redressal of consumer grievances (where a price has been paid), for adjudication within a limited time frame of 90 to 150 days. The rights of basic needs and healthy environment could not be provided in COPRA as these symbolized the aspiration of the poor and the disadvantaged, and were not the subject matter of priced commodities and services available in the market place. However, these are the backbone of peoples' movements in both the developing and the developed worlds. Yet, inspite of pulsating movements, the rights of consumers could and were trampled on and often. There existed a vacuum in the definition of rights.

It was often seen that boycotts would be spontaneous or organized in an adversarial situation, examples of, which are numerous. On an occasion in Calcutta a boycott of fish was successfully organized and the marketing cartel had to bow down, by cutting the inflated prices, rather than store rotting fish. Consumer protection was part of its ancient culture and formed the core of its administration. Kautilya's 'Arthasasthra' was the basic law of ancient India and the same was strengthened with provisions to protect consumers. Sale of commodities was organized in such a way that general public was not put to any trouble. If high profits for the ruler put general public in trouble, then that trade activity was stopped immediately. For traders, profit limit was to be fixed. Even for services timely response was prescribed; e.g. for sculpturist, carpenter, tailor, washer man, rules for the protection of consumer interest were given.
Thus, for a washer man, it was said that he should return washed clothes in a given time period, i.e., light colored ones in five days, blue dark colored in 6 days and silken, woolen or embroidered in 7 days. Failing this they had to pay fine. The Superintendent of Commerce was to supervise weights and measures. For shortfall in weighing measuring, sellers were fined heavily. Weights and measures used in trade were manufactured only by the official agency responsible for standardization and inspected every four months. Sellers passing off inferior products as superior were fined eight times the value of articles thus sold. For adulterated things, the seller was not only fined but also compelled to make good the loss.

2.4.1. Consumer Health Care Movement in India

The consumer movement in India had its beginning (1900-1959) in the early part of this century. The first known collective body of consumers in India was set up in 1915 with Passengers in Traffic Relief Association (PATRA) in Bombay. It was formed with a view to ameliorate the hardship and trouble faced by passengers traveling by railways in steamers and also to redress the grievances of Indian trading community. With this aim in view it planned to create contract with concerned authorities to friendly establish a strong public body to represent the voice of commuters and the trading community. PATRA has been more than 75 years in existence. It works through judicious persuasions and through conferences and seminars. Though the organization planned to be a social national organization, it represents the problem faced by Bombay Commuters and not the rest of the country. Another organization which started in 1915 and still in existence is Women Graduate Union based in Bombay. The principal object of the organization was to provide opportunities and facilities for the impression of united opinion and concerted actions by the university women for the benefit and welfare of the members of all or any class and community of women. It has a number of committees which handle different projects including area of consumer protection. One of the earliest consumers co-operative was the Triplicate Urban Co-operative Stores (TUCS)
stated in the late 40s. Its object was to make direct purchases of their requirement from the wholesalers and distribute it amongst its members, with a fair and rational profit margin. Thus came into existence the present TUCS, a consumer's store, owned, managed and controlled by its shareholders, for their benefit and services only.

The earlier consumer associations were mainly localized with restricted aims. The Indian Association of Consumers (IAC) was set up in Delhi in 1956, an all India association for consumer's interest with Government support. Many eminent luminaries were its founders. However, the IAC did not make any headway inspite of the lead taken by eminent personalities and then financial backing of the Planning Commission. In the history of consumer movement decades (1960-1969) of the 60s has a very unique and special place. People were questioning the old system and paving the way for a new, better and more efficient order. This movement had made its impact felt in every sphere of life the world over. In India, the consumer movement was also in the take off stage trying to establish a base. In one of the rare instances, where consumers asserted themselves and which has been recorded in the history of consumer resistance is the Bengali's refusals to buy fish. Their staple diet, when its price really shot up in the late 60s. In just a couple of days, the sellers had to bring down the prices. This is a case in point where direct action had been employed effectively\textsuperscript{117}. One of the voluntary organizations still very active since 1960 is The Gayatri Charitable Trust in Thanaval, Gujarat. It has over the years worked in various fields, one of them being consumer's advocacy. Jyoti Singh Grahak Suraksha Vibhag was founded in 1962 in Ahmedabad.

The educational activities of the organization are conducting workshop and seminars, educational and promotional talks, exhibition on consumer issues and distribution of pamphlets and kits. Yet another of early consumer-oriented organization still in existence is the Bombay Civil Trust established by a group

\textsuperscript{117} Gurbax Singh, Law of Consumer Protection.
of eminent citizens of Bombay. The problem with the early consumer organizations was that they only offered advice, voiced feeble protest, held discussions, seminars, conferences and meetings or asked questions of which no answers were forthcoming, resulting in status quo or at times even worse. The plight of railway travelers had been worsening as regards unauthorized traveling in reserved compartments and touts continuing to sell tickets illegally. The first organization to really make an impact was started by nine housewives. In 1966 the drought and the war with Pakistan had resulted in scarcity of essential commodities and goods leading to rampant black marketing and food adulteration by dealers and traders. The nine housewives got together to inform, educate and organize consumers in order to protect their interests. They made an impact not through holding meetings or conferences or asking general questions but by testing the quality of items of daily use such as milk, oil, tea, etc. These activities gave the Consumer Guidance Society of India (CGSI) a real break which no amount of group meetings, exhibitions and printed leaflets could do. CGSI's main strength has been that the test report created a stir among traders as well as Government quarters leading to their nomination on a number of food and consumer products standard committees of the Government of India.

The test results also led to the certification of certain goods and conformation to ISI standards being made mandatory for a number of products such as food colors, household appliances, etc. The next move made by the CGSI was to handle complaints from consumers on an individual basis. This coupled with their testing products made the business community take cognizance of them and the Council for Fair Business Practices made CGSI a permanent invitee to their council and a member of their advisory board. The Organization got support and guidance from the International Organization, "The International Organization of Consumer Union" [IOCU]. This helped CGSI to have a more professional standing and an exposure to the working of the movement in the rest of the world and to incorporate some of the methods...
useful to local situations and environment. This CGSI has eight branches at various places. Baroda Citizen Council, a community development agency, formed in 1966 was engaged in improving the quality of life in Vadodra city. The aims and objectives of the Organization is to cooperate with the local body, voluntary and Government agencies in tackling city level problems especially of economically and socially weaker sections of the society. Another Organization which evolved because of similar circumstances and is quite successful is the All India Bank Depositors' Association (AIBDA) operating since 1968. It was first started in Calcutta and then Bombay as it is considered to be the financial capital of the country with Reserve Bank of India and several 'banks having their headquarters in the city. The Bombay branch has been the active one ever since. The depositors found laxity in the attitude of bank employees, some of the banking practices and norms not really helpful nor favorable to the customers. In 1969 the

Surat Consumer Association was formed to work in the areas of consumer advocacy, environment, food adulteration, health, legal redress, misleading advertisement share market/Investors' counseling and complaints handling taking cases to MRTP commission. In spite of so many Organizations of the decade, it can be emphatically said that only one Organization made its impact, nationally and also internationally and that was Consumer Guidance Society of India [CGSI]. But it was clear that in certain pockets of the country the consumers were starting to become aware of their rights and would not accept just anything. It was a big step a beginning. In this decade (1970-1979), second consumer Organization which made an impact in the field of making the cause of consumer known throughout the country and the consumer movement, was the Karnataka Consumer Services Society (KCSS) formed in 1970. Unlike most consumer organizations which started because the founder were dissatisfied with a particular situation product or service, the KCSS was started, by ten housewives who attended a programme on consumer information. The society spread the movement throughout the country specially among
Government circles at a time when the word consumer was not very familiar to many. The KCSS also organized national and regional seminars such as Second All India Consumer Conference, 1974. The Asian Seminar on Consumer Education in schools 1976 brought the organization to the notice of the late PM Mrs. Indira Gandhi which lead to Mrs. Mandanna being nominated to the Karnataka legislative council in 1976 this, gave more courage to KCSS to be able to influence the Karnataka Government to constitute a Karnataka consumer protection board in 1980. From 1976 onwards the society was represented on the Prevention of Food and Drug Adulteration Committee and also hold a directorship in Karnataka Food and Civil Supplies Corporation.

Each of the pioneering consumer organization which have made a significant contribution to the consumer movement have had a different approach which made an impact on the consumer environment. The Visaka Consumer Council was one such organization which started in 1973 in Vishakhapatnam in A.P. It started not to fight only against unscrupulous manufactures and traders but also to represent the plight of the poor, ration card holders and the LPG users.

In methods adopted to represent the poor man's needs and basic rights the VCCs style was unique and effective. They found that about six lakh people in Vizag were suffering and wasting long hours in queues due to the irresponsible attitude of the concerned authorities. They felt that this was one of the major problems of the masses so they proposed to have a public meeting to voice their grievances. The various publicity methods as distribution of printed leaflets, publication in various local news papers, established the VCC as a force to be reckoned with in the consumer movement not merely in Vizag, but throughout A.P. Finally, it achieved success by getting the necessary changes in the fair price shops and the public distribution system, all within three months a relatively short time for effecting change in the monolithic bureaucratic Government procedural system. Another effective tactics that VCC used was counter balancing the clout, that the trading community had with politicians by identifying and using selected, elected representatives to pose questions and
thus embarrass the ruling party into accepting the consumer demands. The Akhil Bhartiya Grahak Panchayat (ABGP) started in 1974 in Poona began with the same aim as TUCS, that is to wage a war against exploitation by the traders. But their system of functioning was unique in that the member of the ABGP decided to use the same quality and type of a product, be it rice, soap or even a sari. Another innovative scheme that the ABGP started was a 'Grahak Sangha' of monthly purchases by a group of neighbors. Though this idea of Grahak Sanghas has not caught on everywhere but it has been quite successful in Bombay where the Mumbai Grahak Panchayat branched off away from ABGP in 1979. The MGP while continuing its Grahak Sangha has broadened its scope and activities and has moved into publicity and information about the consumer movement specially the decision of the consumer redressal forum and commissions.

It has started consumer guidance cells in various districts. Through its various consumer-oriented programmes it has attracted the attention of various consumers. One of the important issues was banning Brominated Vegetable Oil (BVO) in the MRTPC. In 1974, the KCSS attended the second all India consumer conference at Bangalore felt the need for an all India body so that Indian consumers can organiz, assert their voice to the Government and act as a cohesive force to defend the foster their interest. However, the central agency could not take off because there were only four organizations instead of the requisite seven organizations needed to sign as founder members. In the eighties (1980-1989), all sorts of people started consumer organizations. But there were activities and associations whose interest in the cause of consumers were sincere and like the pioneers described earlier, achieved a lot towards ameliorating the plight of the consumer. Most of these organizations had started in the early or mid-eighties. Jagrut Grahak, one such association based in Baroda, Gujarat was started in 1980 by ten retired professionals to concertedly work in the gigantic task of consumer protection and enlightenment under difficult conditions and circumstances. They help consumers with their
It imparts consumer education through organizing seminars and its publication. In order to encourage the establishment of consumer bodies it offers guidance to workers in forming the Constitution, organization and management of consumer groups. It has a network of 45 complaint centers located in different parts of Baroda which receives the complaints from consumers or their area and then pass them on a regular interval to the main office. Mr. Parigi, the main force behind the VCC moved from Vizag to Hyderabad. Within six months of his moving to Hyderabad a new consumer organization, the Consumer Education Centre [CEC] was established in 1982 while VCC continued with its activities in Vizag. The strategy changed with the change in base. It was realized that in the first 3/4 years people may be actively interested but then gradually their interest dies. Thus to effectively push forward the consumer causes he concentrated on publicity. He started a consumer quarterly Consumer Network News of India, which focuses on publishing news from all over India. The paper invited organizations and individuals to forward articles and information of interests to consumers and consumer organizations and for publications. Specially reports on current issues and campaigns engaging the attention of local consumer organizations. The Voluntary Organization in the Interest of Consumer Education (VOICE) was founded when angry young students and teachers of the Delhi University could no longer stand the way consumers were being cheated and followed by not merely small companies like the TV manufacturers but also by corporate giants like Bata, ITC, etc. They therefore took on companies individually in protest against unfair trade practices and won most of them. It took up various cases
and advocated consumer causes before Courts of law and thought parliamentarians. Its battle against TV companies resulted in prosecution of 44 leading TV companies. Among other, VOICE, has taken on Maruti Udyog Ltd. and won its case in the Supreme Court against out of turn allotment of cars to VIP's. It has made soft drink companies in every advertisement that their drinks are artificially flavored and contain no fruit juice or fruit pulp. They realized that mere fighting in the Courts or lobbying through parliamentarians does not stop the consumer from being cheated and he still has to seek redressal and suffers. So they went about giving consumers information about the benefits or shortcomings of various products and brands which would give the consumer the edge over the seller, since he could make an informed choice.

VOICE has also been successful in executing India's first project on comparative testing of all leading brands of colour TVs for providing information to consumer in book titled "Consumers Buying Guide to Colour Television". It was released by Justice B.K. Eradi, Chairman National Consumer Disputes Redressal Commission at a workshop on Consumer Right to Information. The Consumer Unity and Trust Society (CUTS) which started in Jaipur in March 1984, made its impact not through handling of consumer complaints, nor through lobbying within corridors of powers, nor by taking the erring and recalcitrant product or traders to Court but by effectively making use of media and through publicity. The strategy adopted was to shock the reading and the viewing public into a rude awareness of the plight of the helpless consumers specially when bodies such as the municipal corporation do nothing to remedy the situation. For example, the Calcutta Roads like the roads in most cities were forever being dug up and left as such for days on end. Cuts employed an ingenious method of overcoming the above problem. They announced a prize for a photograph with the biggest pothole advertising this in most of the local newspaper editions. Similarly, they announced another prize for a photograph of the largest garbage heaps. When the first advertisement was published the authorities did not take any notice until the photograph started
being published as the contestants kept sending in photographs. When the second contest was announced the corporation immediately took cognizance and overnight the garbage dumps were cleared. While a number of consumer organizations keep celebrating Consumer's day every March 15, with wide publicity. CUTS did it differently one year with a silent rally that it organized in Jaipur on March 15, 1988. The Consumer Guidance Society of Jamshedpur was founded in 1984. The activities of the organization are to inform, educate and organize consumers so as to enable them to protect their interests and assert their right as consumers.

Most consumer organizations find paucity of funds, the most hampering cause for their not being able to do as much as they would wish to do for the consumers. So they restrict themselves mainly to handling individual complaints. The Consumer Action Group (CAG) based at Madras was founded in 1985. Most of the issues that CAG tackled since its formation were concerning civic amenities, health and environment such as water shortage in Madras, chemical pollution in the Adyar river causing health and environment hazards, stoppage of air conditioners in movie theatres, problem of loudspeakers in residential areas and obscene hoarding etc. From the Third Five Year plan onwards, there has been much emphasis on the development of consumer co-operatives by the Governments to make them viable. In 1975-76, Rs. 5.5 crores was invested for consumer co-operatives in accordance with the 20 point programme. Consumer co-operatives are very important for improving the distribution of essential goods through Public Distribution System (PDS) and combating inflation. It has been announced that 10 to 20% of the supplies of baby foods, bicycles, blades, cloth and students needs etc. would be through co-operatives. At present, in the distribution of consumer goods the co-operatives under P.D.S. account for about 28% of retail outlets (fair price shops) in rural areas. Nearly 51,000 village societies and their various branches distributed Rs. 2500 crores worth of consumer articles in rural areas in 1989-90. However, the co-operative movement treaded its path among the consumers
and as was the case in the West, in India to the co-operative movement was not organized as a measure for consumer protection of the modern type. Consumer movement did not make its presence felt in India till the 1960's when organized consumer groups came up. The basic reason for the development of consumer movement in India are different from those in the West. In western countries, consumer movement was the result of post-industrialization affluence—for more information about the merits of competing products and to influence producers especially for new and more sophisticated products. In India, the basic reasons for the consumer's movement have been: Shortage of consumer products; inflation of early 1970's Adulteration and the Black Market. Lack of product choices due to lack of development in technology. Thrust of consumer movement in India has been on availability, purity and prices. The factors which stimulated the consumer movement in recent years are increasing consumer awareness, declining quality of goods and services, increasing consumer expectations because of consumer education, influence of the pioneers and leaders of the consumer movement, organized effort through consumer societies.

2.4.2. Stages of Development of the Consumer Movement

The Consumer movement today is undergoing a silent revolution. The movement is bringing qualitative and quantitative changes in the lives of people enabling them to organize themselves as an effective force to reckon with. But the path to reach this stage has not been easy. It has been a struggle against bad business which always put profit before fairness in transactions. The first stage of movement was more representational in nature, i.e., to make consumers aware of their rights through speeches and articles in newspapers and magazines and holding exhibitions. The second stage was direct action based on boycotting of goods, picketing and demonstration. However, direct action had its own limitations, which led to the third stage of professionally managed consumer organizations. From educational activities and handling complaints, it ventured into areas involving lobbying, litigation and laboratory testing. This
gave good results. Thus, for instance business sector has started taking notice and co-operating with the movement. It has played a role in hastening the process of passing the Consumer Protection Act, 1986 which has led to the fourth stage. The Act enshrines the consumer rights and provides for setting up of quasi-judicial authorities for redressal of consumer disputes. This Act takes justice in the socio-economic sphere a step closer to the common man.

2.4.3. Health care and Consumer protection

It was recognized that in both developed and developing countries, the standard of health services the public expected was not being provided. The services do not cover the whole population. There is lack of services in some areas and unnecessary duplication in others. A very high proportion of the population in many developing countries, and especially in rural areas does not have ready access to health services. The health services favoured only the privileged few and urban dwellers. Although there was the recognition that health is a fundamental human right, there is a denial of this right to millions of people who are caught in the vicious circle of poverty and ill health. There are marked differences in health status between people in different countries as well as between different groups in the same country; the cost of health care is rising without much improvement in their quality. In short, there has been a growing dissatisfaction with the existing health services and a clear demand for better health care. The spate of new ideas and concepts, e.g., increasing importance given to social justice and equity, recognition of the crucial role of community participation, changing ideas about the nature of health and development, the importance of political will called for new approaches to make medicine in the service of humanity more effective. Against the above background, the 30th World Health Assembly resolved in May 1977, that "the main social target of Governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." This culminated in the international objective of health for all by the year 2000 as the social goal of all
Governments. The goal of health for all has two perspectives. Viewed in the long-term context, it simply means the realization of the WHO's objective of "attainment by all peoples of the highest possible level of health". But, what is of immediate relevance is the meaning that, as a minimum, all people in all countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live. Health for all means that health is to be brought within the reach of every one in a given community. It implies the removal of obstacles to health - that is to say, the elimination of malnutrition, ignorance, disease, contaminated water supply, unhygienic housing, etc. It depends on continued progress in medicine and public health.

Health for all was a holistic concept calling for efforts in agriculture, industry, education, housing and communications, just as much as in medicine and public health. The attainment of Health for all by 2000 AD was the central issue and official target of WHO and its Member Countries. It symbolised the determination of the countries of the world to provide an acceptable level of health to all people. Health for all has been described as a revolutionary concept and a historic movement is a movement in terms of its own evolutionary process. With increasing recognition of the failure of existing health services to provide health care, alternative ideas and methods to provide health care have been considered and tried (40,46). Discussing these issues at the Joint WHO-UNICEF international conference in 1978 at Alma-Ata (USSR), the Governments of 134 countries and many voluntary agencies called for a revolutionary approach to health care. Declaring that "The existing gross inequality in the health status of people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable", the Alma-Ata conference called for acceptance of the WHO goal of health for all by 2000 AD and proclaimed primary health care as way to achieving health for all. Primary health care is a new approach to health care, which integrates at the community level all the factors required for improving the health status of the population. It consists of at least eight elements described as "essential
health care". This presupposes services that are both simple and efficient with regard to cost, techniques, and organization, that are readily accessible to those concerned, and that contribute to improving the living conditions of individuals, families and the community as a whole. Primary health care is available to all people at the first level of health care. It is based on principles of equity, wider coverage, individual and community involvement and intersectoral coordination. Viewed in these terms, primary health care is a radical departure from the conventional health care systems of the past. While it integrates promotive, preventive and curative services, it is also conceived as an integral part of the country's plan for socio-economic development.

The Alma-Ata Declaration called on all Governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a national health system. It is left to each country to innovate, according to its own circumstances provide primary health care. This was followed by the formulation and adoption of the Global strategy for health for all by the 34th World Health Assembly in 1981. Primary health care got off to a good start in many countries with the theme 'Health for all by 2000 AD'. It presented a challenge so formidable that its implications boggle the bravest minds. The challenge brought us face-to-face with the Declaration of Alma-Ata. The practice of primary health care involves a good deal of "deprofessionalization" of medicine. Laymen have come to play a prominent role in the delivery of health care. While the physician still holds his unique position in the field of health care in general, the participation of a new cadre of health worker; (e.g., community health workers, anganwadi workers multipurpose workers, practitioners of indigenous medicine social workers) with relatively little training and support have been considered and tried to provide health care. They now comprise part of the "health teams". The medical man can restrict himself to his traditional role as diagnose of ailments, prescriber of pills and potions, and excise of lumps. He has acquired new roles - being an educator, case-finder, preventer, counselor and an agent of social change.
In September 2000, representatives from 189 countries met at the Millennium Summit in New York to adopt the United Nations Millennium Declaration. The leaders made specific commitments in seven areas: peace, security and disarmament; development and poverty eradication; protecting our common environment, human rights, democracy and good governance; protecting the vulnerable; meeting the special needs of Africa; and strengthening the United Nations. The road map established goals and targets to be reached by year 2015 in each of seven areas. The goals in the area of development and poverty eradication are now widely referred to as "Millennium Development Goals". The Millennium Development Goals place health at the heart of development and represent commitments by Governments throughout the world to do more to reduce poverty and hunger, and to tackle ill-health, gender inequality, lack of education, access to clean water and environmental degradation. Thus three of the eight goals are directly health related and all of other goals have important indirect effects on health; 8 of the 18 targets are required to achieve these goals, and 18 of the 48 indicators of the progress are health related.

2.4.4. Health system in India

A word of caution has to be exercised before generalizing an increase in longevity to excellent public health. There are many other indicators of public health like Infant mortality, maternal mortality and malnutrition, in which India lags behind even some developing countries. In the name of structural adjustments, the Government spending on public health has in fact decreased after the Economic liberalization. With a mere 1% of GDP allocation, India's public health spending is among the lowest in the world. There are only 40 doctors per 10,000 people in India, where as in United States, it is as high as 2300. The scarcity of doctors can be addressed if we allow greater private participation in setting up medical colleges and hospitals. Only when we address these issues can we hope that our people will be healthier while the country is getting wealthier. The "health system" is intended to deliver health services; in other words, it constitutes the management sector and involves
organizational matters, e.g., planning, determining priorities, mobilizing and allocating resources, translating policies into services, evaluation and health education. The components of the health system include: concepts (e.g., health and disease); ideas (e.g., equity, coverage, effectiveness, efficiency, impact); objects (e.g., hospitals, health centres, health programmes) and persons (e.g., providers and consumers). Together, these form a whole in which all the components interact to support or control one another. The aim of a health system is health development - a process of continuous and progressive improvement of the health status of a population. The goal of the health system had been to achieve "Health for all" by the year 2000. Health services are usually organized at three levels, each level supported by a higher level to which the patient is referred. These levels are a) Primary health care; b) Secondary health care and c) Tertiary health care.

It is recognized that the physician of today is overworked professionally. It is also recognized that many of the functions of the physician can be performed by auxiliaries, given suitable training. An auxiliary worker has been defined as one "who has less than full professional qualifications in a particular field and is supervised by a professional worker". The WHO no longer uses the term "paramedical" for the various health professions allied with medicine the practice of modern medicine has become a joint effort of many groups of workers, both medical and non-medical, viz. physicians, nurses, social workers, health assistants, trained dais, village health guides and a host of others. The composition of the team varies. The hospital team is different from the team that works in the community. Whether it is a hospital team or community health work team, it is important for each team member to have a specific and recognized function in the team and to have freedom to exercise his or her particular skills. In this context, a health team has been defined as "a group of persons who share a common health goal and common objectives, determined by community needs and toward the achievement of which each member of the team contributes in accordance with her/his
competence and skills, and respecting the functions of the other". The auxiliary is an essential member of the team. The team must have a leader. The leader should be able to evaluate the team adequately and should know the motivations of each member in order to stimulate and enhance their potentialities.

The health team concept has taken a firm root in the delivery of health services both in the developed and developing countries. The health team approach aims to produce the right "mix" of health personnel for providing full health coverage of the entire population. The mere presence of a variety of health professionals is not sufficient to establish teamwork; it is the proper division and combination of their operations from which the benefits of divided labour will be derived. After three decades of trial and error and dissatisfaction in meeting people's basic health needs, the World Health Assembly, in May 1977, decided that the main social goal of Governments and WHO in the coming years should be the "attainment by all the people of the world by the year 2000 AD of a level of health that will permit them to lead a socially and economically productive life". This goal has come to be popularly known as "Health for all by the year 2000" (HFA). The background to this "new" philosophy was the growing concern about the unacceptably low levels of health status of the majority of the world's population especially the rural poor and the gross disparities in health between the rich and poor, urban and rural population, both between and within countries. The concept of primary health care came into lime-light in 1978 following an international conference in Alma-Ata, USSR. It has been defined as: "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 the country can afford to maintain at every stage of their development in the spirit of self-determination" The primary health care approach is based on principles of social equity, nation-wide coverage, self-reliance, intersectoral coordination,
and people's involvement in the planning and implementation of health programmes in pursuit of common health goals. This approach has been described as "Health by the people" and "placing people's health in people's hands". Primary health care was accepted by the member countries of WHO as the key to achieving the goal of HFA by the year 2000 AD.

The concept of primary health care involves a concerted effort to provide the rural population of developing countries with at least the bare minimum of health services. The list can be modified to fit local circumstances. For example, some countries have specifically included mental health, physical handicaps, and the health and social care of the elderly. The primary health care approach integrates at the community level all the factors required for improving the health status of the population. As a signatory to the Alma Ata Declaration, the Government of India has pledged itself to provide primary health care. Obstacles to the implementation of primary health care in India include shortage of health manpower, entrenchment of a curative culture within the existing health system, and a high concentration of health services and health personnel in urban areas. In the Millennium Declaration of September 2000, Member States of the United Nations made a most passionate commitment to address the crippling poverty and multiplying misery that grip many areas of the world. Governments set a date of 2015 by which they would meet the Millennium Development Goals: eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, ensure environmental sustainability and develop a global partnership for development. Policies are general statements based on human aspirations, set of values, commitments, assessment of current situation and an image of a desired future situation. A national health policy is an expression of goals for improving the health situation, the priorities among these goals, and the main directions for attaining them. Health policy is often defined at the national level. Each country will have to develop a health policy.
of its own aimed at defined goals, for improving the people's health, in the light of its own problems, particular circumstances, social and economic structures, and political and administrative mechanisms. Among the crucial factors affecting realization of these goals are: a political commitment; financial implications; administrative reforms; community participation and basic legislation. A landmark in the development of health policy was the world-wide adoption of the goal of HFA by 2000 AD. A further landmark was the Alma-Ata Declaration (1978) calling on all Governments to develop and implement primary health care strategies to attain the target of HFA by 2000 AD and more recently, Millennium Development Goals.

Health care facilities and personnel increased substantially between the early 1950s and early 1980s, but because of fast population growth, the number of licensed medical practitioners per 10,000 individuals had fallen by the late 1980s to three per 10,000 from the 1981 level of four per 10,000. In 1991 there were approximately ten hospital beds per 10,000 individuals. Primary health centers are the cornerstone of the rural health care system. By 1991, India had about 22,400 primary health centers, 11,200 hospitals, and 27,400 dispensaries. These facilities are part of a tiered health care system that funnels more difficult cases into urban hospitals while attempting to provide routine medical care to the vast majority in the countryside. Primary health centers and subcenters rely on trained paramedics to meet most of their needs. The main problems affecting the success of primary health centers are the predominance of clinical and curative concerns over the intended emphasis on preventive work and the reluctance of staff to work in rural areas. In addition, the integration of health services with family planning programs often causes the local population to perceive the primary health centers as hostile to their traditional preference for large families. Therefore, primary health centers often play an adversarial role in local efforts to implement national health policies. According to data provided in 1989 by the Ministry of Health and Family Welfare, the total number of civilian hospitals for all states and union territories combined was
In 1991 there were a total of 811,000 hospital and health care facilities beds. The geographical distribution of hospitals varied according to local socioeconomic conditions. In India's most populous state, Uttar Pradesh, with a 1991 population of more than 139 million, there were 735 hospitals as of 1990. In Kerala, with a 1991 population of 29 million occupying an area only one-seventh the size of Uttar Pradesh, there were 2,053 hospitals. In light of the central government's goal of health care for all by 2000, the uneven distribution of hospitals needs to be reexamined. Private studies of India's total number of hospitals in the early 1990s were more conservative than official Indian data, estimating that in 1992 there were 7,300 hospitals. Of this total, nearly 4,000 were owned and managed by central, state, or local governments. Another 2,000, owned and managed by charitable trusts, received partial support from the government, and the remaining 1,300 hospitals, many of which were relatively small facilities, were owned and managed by the private sector.

The use of state-of-the-art medical equipment, often imported from Western countries, was primarily limited to urban centers in the early 1990s. A network of regional cancer diagnostic and treatment facilities was being established in the early 1990s in major hospitals that were part of government medical colleges. By 1992 twenty-two such centers were in operation. Most of the 1,300 private hospitals lacked sophisticated medical facilities, although in 1992 approximately 12 percent possessed state-of-the-art equipment for diagnosis and treatment of all major diseases, including cancer. The fast pace of development of the private medical sector and the burgeoning middle class in the 1990s have led to the emergence of the new concept in India of establishing hospitals and health care facilities on a for-profit basis. By the late 1980s, there were approximately 128 medical colleges—roughly three times more than in 1950. These medical colleges in 1987 accepted a combined annual class of 14,166 students. Data for 1987 show that there were 320,000 registered medical practitioners and 219,300 registered nurses. Various studies have shown that in both urban and rural areas people preferred to pay and seek the more
sophisticated services provided by private physicians rather than use free
treatment at public health centers.

Indigenous or traditional medical practitioners continue to practice
throughout the country. The two main forms of traditional medicine practiced
are the ayurvedic (meaning science of life) system, which deals with causes,
symptoms, diagnoses, and treatment based on all aspects of well-being (mental,
physical, and spiritual), and the unani (so-called Galenic medicine) herbal
medical practice. A vaidya is a practitioner of the ayurvedic tradition, and a
hakim (Arabic for a Muslim physician) is a practitioner of the unani tradition.
These professions are frequently hereditary. A variety of institutions offer
training in indigenous medical practice. Only in the late 1970s did official
health policy refer to any form of integration between Western-oriented
medical personnel and indigenous medical practitioners. In the early 1990s,
there were ninety-eight ayurvedic colleges and seventeen unani colleges
operating in both the governmental and nongovernmental sectors.

2.5. Consumer Health Law—International Level

Importantly, however, the legal powers of government are not unlimited.
Whatever the national legal tradition, government powers in public health are
constrained by universal human rights norms reflected in, for example, the
International Bill of Human Rights and the International Health Regulations.
The Universal Declaration of Human Rights, 1948 recognizes “the inherent
dignity” and the “equal and unalienable rights of all members of the human
family”. It is on the basis of this concept of the person, and the fundamental
dignity and equality of all human beings, that the notion of patient rights was
developed. In other words, what is owed to the patient as a human being, by
physicians and by the State, took shape in large part thanks to this
understanding of the basic rights of the person. Patients’ rights vary in different
countries and in different jurisdictions, often depending upon prevailing
cultural and social norms. Different models of the patient-physician relationship
which can also represent the citizen- State relationship have been developed, and these have informed the particular rights to which patients are entitled. In North America and Europe, for instance, there are at least four models which depict this relationship viz., the paternalistic model, the informative model, the interpretive model, and the deliberative model. Each of these suggests different professional obligations of the physician toward the patient. For instance, in the paternalistic model, the best interests of the patient as judged by the clinical expert are valued above the provision of comprehensive medical information and decision-making power to the patient. The informative model, by contrast, sees the patient as a consumer who is in the best position to judge what is in her own interest, and thus views the doctor as chiefly a provider of information. There were enormous debates about how best to conceive of this relationship, but there is also growing international consensus that all patients have a fundamental right to privacy, to the confidentiality of their medical information, to consent to or to refuse treatment, and to be informed about relevant risk to them of medical procedures.

The Universal Declaration of Human Rights has been instrumental in enshrining the notion of human dignity in international law, providing a legal and moral grounding for improved standards of care on the basis of our basic responsibilities towards each other as members of the human family, and giving important guidance on critical social, legal and ethical issues. But there remains a great deal of work to be done to clarify the relationship between human rights and right to health, including patient rights. Recognizing this challenge, the United Nations Commission on Human Rights (UNCHR) has designated a Special Reporter to provide it with a report that examines and clarifies the broader relationship between human rights and the right to health. This report has great importance for the World Health Organization, whose mission is to ensure “health for all”.
2.5.1. Education, Policy and protecting basic rights

Assuring that the rights of patients are protected requires more than educating policy makers and health providers; it requires educating citizens about what they should expect from their Governments and their health care providers about the kind of treatment and respect they are owed. Citizens, are having an important part to play in elevating the standard of care when their own expectations of that care are raised. Some countries have recognized this, and have advanced their knowledge of genomics in public, academic and scientific spheres. Some follow democratic procedures to vote on resolutions pertaining to genomics. This knowledge and active engagement empowers lay individuals to make informed decisions about the future of genomics, both at the personal and at the policy level. Switzerland is the only country that has made a vote on genetic engineering in the future, with nearly two-thirds of its population voting against a referendum to ban genetic engineering. Countries that have not made an active effort to educate and inform the public on the implications of genomics impede the development of policies and legislation that can protect patient rights by ensuring the appropriate development and application of genomic-based tools and genetic interventions. The creation of effective patient protection laws relies on public knowledge of genetic science and its applications, along with an awareness of the ethical, social, and legal issues surrounding genomics. Almost all the global countries has recognized the following rights as basic consumer rights

**Consumer Rights:** The consumers irrespective of the citizenship have the consumers rights. The brief discussion on the various rights of the consumers is as follows.

- *The Right to Safety:* means the right to be protected against products, production processes and services which are hazardous to health or life. The right to safety has been broadened to include the concern for consumers’ long-term interests, not only their immediate desires.
• The Right to be informed: means the right to be given the facts needed to make an informed choice or decision. The right to be informed now goes beyond avoiding deception and the protection against misleading advertising, labeling or other practices. Consumers should be provided with adequate information, enabling them to act wisely and responsibly.

• The Right to Choose: means the right to have access to a variety of products and services at competitive prices and in the case of monopolies, to have an assurance of satisfactory quality and service at a fair price. The right to choose has been reformulated to read: the right to basic goods and services. This is because the unrestrained right of a minority to choose can mean for the majority a denial of its fair share.

• The Right to be heard: means the right to be represented so that consumers' interest receive full and sympathetic consideration in the formulation and execution of economic policy. This right is being broadened to include the right to be heard and represented in the development of products and services before they are produced or set up; it also implies a representation, not only in Government policies, but also in those of other economic powers.

• The Right to Redress: means the right to a fair settlement of just claims. This right has been generally accepted since the early 1970s. It involves the right to receive compensation for misrepresentation or shoddy goods or services, and where needed, free legal aid or an accepted form of redress for small claims should be available.

• The Right to Consumer Education: means the right to acquire the knowledge and skills to be an informed consumer throughout life. The right to consumer education incorporates the right to the knowledge and skills needed for taking action to influence factors which affect consumer decisions.

• The Right to a Healthy Environment: means the right to a physical environment that will enhance the quality of life. This right involves protection against environmental problems over which the individual
consumer has control. It acknowledges the need to protect and improve the environment for present and future generations.

- *The Right to Basic Needs:* The right to basic needs means that availability of articles which are the basic need of every consumer must be ensured.

Specifically in India the Consumer Education relates to imparting knowledge and developing skills in consumers regarding consumer rights, consumer laws, product quality-standards, health aspects of various products, availabilities of various public and private services, units and measurements, redressal of consumer problems and making correct choices while buying different commodities. The right of each Indian citizen to be educated on matters related to consumer protection and about his/her rights is the last right given by the Consumer Protection Act 1986. This right simply ensures that the consumers in India have access to informational programs and materials that would enable them to make better purchasing decisions. Consumer education may mean both formal education through school and college curriculums and also consumer awareness campaigns run by both Governmental and non-Governmental agencies (NGO). Consumer NGOs, with little support from the Indian Government, primarily undertake the ardent task of ensuring this consumer right around the country. India is 20 years away from ensuring this right empowers the common citizen consumer. Every consumer has the right of keeping knowledge and skills regarding purchase, use and effects of products. He has a right to get educated about various products, markets and related things so as to protect him against any possible exploitation.

Consumer Education covers health, nutrition, food-borne diseases and food-adulteration, product hazards like hazards due to storage and consumption of a particular product, Product labeling pasting labels on the packaging of products regarding their composition status, weight, ecological impacts, purity standards, colour, preservatives used, date of manufacture and expiry, address of producer/manufacturer, matters pertaining to registration, trademarks, marks.
of standards etc. Protective laws framed by the Government to protect rights of consumers and seeks redressal, how and whom to approach for redressal, information regarding weight, measure, packaging, price quality and availability of basic needs. Environment, different types of pollutions, sustainable consumption so on and so forth. According to Griffiths (1972), "health education attempts to close the gap between what is known about optimum health practice and that which is actually practiced." Simonds (1976) defined health education as aimed at "bringing about behavioral changes in individuals, groups, and larger populations from behaviors that are presumed to be detrimental to health, to behaviors that are conducive to present and future health." Subsequent definitions of health education emphasized voluntary, informed behavior changes. In 1980, Green defined health education as "any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health (Green, Kreuter, Partridge, and Deeds, 1980). The Role Delineation Project defined health education as "the process of assisting individuals, acting separately or collectively, to make informed decisions about matters affecting their personal health and that of others" National Task Force on the Preparation and Practice of Health Educators, 1985. Consumers have a right to consumer education especially in the matters of health, information, education, awareness about the healthcare system, healthcare facilities, pharmaceuticals and medicines is very much essential. A well educated or informed citizen protects himself or herself from all forms of exploitations. It is a fact that nobody can take part in the development process without having a basic knowledge of what is given on

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around him or her. Education expands one's horizons\textsuperscript{123}. Prof. Peter forms the main contours of the concept of education in terms of a student succeeding in relation to certain tasks which the student and his teacher have been engaged in for a considerable period of time in terms of achievement relative to tasks. Since when one is educated, the achievement must be taken as worthwhile, the professor goes on to sort out as a part of the concept of education, the achievement of skills, knowledge, and understanding where such achievement in the contemporary society, the consumer is always faced with a mass of goods and services that are products of complex and advanced industrial, agricultural and service technologies.

The consumer education is essential to provide the skills and knowledge to empower consumers and enable them to use their resources effectively and increase their awareness of their wider role in society. The consumer education not only addresses problems of individuals, but also of sustainable consumption, social justice, human rights, ethical values and overcoming poverty. The consumer education has got certain aspects namely informed choice, value systems, recognition of rights and responsibilities and catalyst for action. A healthy life depends on many social, economic, political and cultural factors which the State should guarantee. These factors include providing people with adequate sanitation, clean air and water and an adequate livelihood, prohibiting discrimination and providing people with a mechanism for social change. The people should be aware of their rights as consumers of healthcare system. Unless this is recognized, the people cannot know their rights and cannot fight for their rights. Hence consumer education, especially consumer health education is very much essential for every individual in a country. The process of development along with the expanding globalization and liberalization process has increased the number of consumer related issues. Most developed nations consider health care as a fundamental right and quality of health care services as an essential pre-requisite of development. The

\textsuperscript{123} http://www.cuts-internationsl.org/state-I.C.htmhtm pg. 7
consumer for protecting from exploitations like adulteration of food, sales of medicines after expiry dates, spurious drugs, supply of contaminated blood, advertisement with false claims, dying from medical negligence, so on and so forth. Consumers are cheated in the market because they do not get proper "consumer education". Consumer education means to educate the consumers as to what, where, when, how and how much to buy and how to use what they have bought. The alone definition exists the relevance of educating people so that they can make the right choice. Consumers are cheated in the market because they do not get proper "consumer education". Consumer education has today become an important part of school and college curriculum.

In the words of the noted economist and diplomat, John Kenneth Galbraith: "It is not the consumer who is the king, but it is the large corporation who is the king in the economy. Whatever happens is not because the consumers want it that way, but simply because powerful large corporations prefer it that way." In other words, the perfect market place is a myth and an economist's dream and consumers are at the mercy of business, if not fully, but to a large extent. This goes against the notion of consumers' sovereignty, which says that the right person to make the decision is the consumer herself/himself. If the purpose of economic activity is to allocate resources to meet consumers' needs, then the purpose is most likely to be defeated unless there are planned efforts to educate the consumers. India is one of the very few countries where consumer education has already been introduced in school curricula. However, adult community education is just as important in order to build a society of critically aware consumers. Education programmes should therefore be geared towards the young as well as towards adults, the illiterate and the low-income consumers.

The United Nations Guidelines: The UN Guidelines for Consumer Protection, 1985, which include the right to consumer education, were primarily set up to promote the interests and needs of consumers. They were to be used as a standard against which various practices were production, supply,
dissemination of information, propaganda and campaigns, that have a bearing on consumers, would be tested for their beneficial or harmful aspects. Necessary legislation to curb unfair business practices that are harmful to consumers and encroach upon their rights as per the UN Guidelines, would have to be put in place. Governments as well as the international community should facilitate the process with help from the executive and judiciary. In India to educate consumer organizations and other sections of society, the Department of Consumer Affairs, under the Ministry of Consumer affairs and Public Distribution, is conducting training programmes in the field of consumer protection. These training programmes are being conducted to the State Government officials, non-judicial members to State Commissions/District Fora and voluntary organizations.

The Government of India, through the Consumer Welfare Fund, has a provision to fund consumer education programmes undertaken by consumer groups or State Governments. The Consumer Education and Research Centre (CERC), Ahmabad, the Federation of Consumer Organizations of Tamilnadu (FEDCOT), and Consumer Unity and Trust Society (CUTS), Jaipur and Calcutta, have produced videocassettes on consumer education. The Mumbai Grahak Panchayat, Mumbai, brings out a consumer magazine in Marathi. Over the years, CUTS has been publishing a consumer newsletter in Hindi, Upbhokta Tarang to reach out to society. Furthermore, since 1991, CUTS has also been conducting "Upbhokta Mitra Training" to train and educate young consumer leaders from rural areas, who then multiply their knowledge at local levels. As part of this programme, CUTS has published two relevant documents: "Reaching Out" and "Reaching Justice".

Furthermore, the Steering Committee of the Central Consumer Protection Council has welcomed the idea of setting up of the National Institute of Consumer Education by voluntary consumer organizations. Consumer Co-ordination Council: The Consumer Co-ordination Council has been conducting
several programmes on consumer education for activists and others. It has published training manuals covering:

The Consumer Protection Act, 1986;

• Water, food and public distribution system;
• Health, drugs and cosmetics; and
• Road transport and railways.

Regarding consumer education and awareness programme in the past few years, particularly after the enactment of the Consumer Protection Act (COPRA), 1986, there has been widespread interest among people about their rights as well as duties as educated consumers. The number of cases filed in various consumer forums and the spurt in the growth of consumer organizations is a reflection of growing consumer consciousness. The average consumer is now more assertive and cannot be taken for granted by the traders. While voluntary consumer organizations have been doing their best to bring about this awareness, the press and other media are also playing an effective role. Since the enactment of COPRA and even before that, newspapers and magazines have been responding to the needs of consumers in more than one way. Apart from publishing articles, columns and newspapers have also tried to come to the rescue of harassed consumers. For instance, the Indian Express was one of the first newspapers to start a consumer complaint column. It carried the problems and grievances of consumers and took up the responsibility of forwarding these to the concerned authorities for redressal. In many cases the results were published and consumers were able to get their grievances settled.

Role of Universities: In this regard, the Indira Gandhi National Open University (IGNOU), has made a beginning by developing a comprehensive syllabus which provides the basic framework for other universities to develop a curriculum for consumer education. The details are provided in Annexure-5.1—"Proposed Application Oriented Course in Consumer Studies". The course will
be conducted by the Faculty of Political Science of the School of Social Sciences of IGNOU. The Kakatiya University in Warangal, Andhra Pradesh, is already running a one-year Post Graduate Course in Consumer Law. The Maharashtra Open University in Pune is also offering courses in consumer education.

2.5.2. The International recognition of Human Right to Health

"Everyone has the right to a standard of living adequate for health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of sickness, disability. Motherhood and childhood are entitled to special care and assistance"

-Universal Declaration of Human Rights, Article 25

Everyone has the human right 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 human rights and freedoms. Human Rights relating to health are set out in basic human rights treaties and include:

- The human right to the highest attainable standard of physical and mental health, including reproductive and sexual health.
- The human right to equal access to adequate health care and health-related services, regardless of sex, race, or other status.
- The human right to equitable distribution of food.
- The human right to access to safe drinking water and sanitation.
- The human right to an adequate standard of living and adequate housing.
- The human right to a safe and healthy environment.
- The human right to a safe and healthy workplace, and to adequate protection for pregnant women in work proven to be harmful to them.
The human right to freedom from discrimination and discriminatory social practices, including female genital mutilation, prenatal gender selection, and female infanticide. The human right to education and access to information relating to health, including reproductive health and family planning to enable couples and individuals to decide freely and responsibly all matters of reproduction and sexuality. The human right of the child to an environment appropriate for physical and mental development.

2.5.3. International Obligations in Ensuring the Human Right to Health

From the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Elimination of All Forms of Racial Discrimination, and the Convention on the Rights of the Child. According to *International Covenant on Economic, Social and Cultural Rights, Articles 7, 11, and 12* "the States Parties has to recognize the right of everyone to just and favorable conditions of work which ensures the safe and healthy working conditions, the right to an adequate standard of living, the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken to achieve the full realization of this right shall include those necessary for the reduction of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; the creation of conditions which would assure to all medical service and medical attention in the event of sickness." According to the *Convention on the Elimination of All Forms of Discrimination Against Women, Articles 10, 12, and 14* stipulates that "the States Parties shall ensure to access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning, States Parties shall eliminate discrimination against women in health care to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning, ensure
appropriate services in connection with pregnancy. States Parties shall ensure that women in rural areas have access to adequate health care facilities, including information counseling and services in family planning.

Convention on the Elimination of All Forms of Racial Discrimination, Article 5 stipulates that "the States Parties undertake to eliminate racial discrimination and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law the right to public health, medical care, social security and social services". Convention on the Rights of the Child, Article 24 describes that "the States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health."

The Convention on the Rights of the Child Agenda 21, Chapter 6, paras. 1 and 12 ensures that the "Governments" commitments to ensuring the human right to health: "Health and development are intimately interconnected. Both insufficient development leading to poverty and inappropriate development can result in severe environmental health problems. The primary health needs of the world's population are integral to the achievement of the goals of sustainable development and primary environmental care. Cairo Programme of Action, Principle 8 and para. 8.6 states that "Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care. The role of women as primary custodians of family health should be recognized and supported. Access to basic health care, expanded health education, the availability of simple cost-effective remedies should be provided."

Copenhagen Declaration, Commitment 6 declares that "We commit ourselves to promoting and attaining the goals of universal and equitable access to the highest attainable standard of physical and mental health, and the access
of all to primary health care, making particular efforts to rectify inequalities relating to social conditions and without distinction as to race, national origin, gender, age or disability". *Beijing Declaration, paras 17 and 30* declares that "The explicit recognition of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment. We are determined to ensure equal access to and equal treatment of women and men in health care and enhance women's sexual and reproductive health as well as Health." *Further the Beijing Platform for Action, para. 89* stipulates that "Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology. To attain optimal health, equality, including the sharing of family responsibilities, development and peace are necessary conditions."

In addition to that the *Beijing Platform for Action, para. 106* stressed on women’s access that "the Strategic objective. Increase women's access throughout the life cycles to appropriate, affordable and quality health care, information and related services. Actions to be taken: Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation; Provide more accessible, available and affordable primary health care services of high quality, including sexual and reproductive health care. Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to health services; reduce maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015; make reproductive health care accessible to all no later than 2015 take specific measures for closing the gender gaps in morbidity and mortality where girls are disadvantaged, while achieving by the year 2000, the reduction of mortality rates of infants and
children under five by one third of the 1990 level by the year 2015 an infant morality rate below 35 per 1,000 live births. Ensure the availability of and universal access to safe drinking water and sanitation”

_Habitat Agenda, paras 36 and 128_ mentions that the "Human health and quality of life are at the centre of the effort to develop sustainable human settlements. We commit ourselves to the goals of universal and equal access to the highest attainable standard of physical, mental and environmental health, and the equal access of all to primary health care, making particular efforts to rectify inequalities relating to social and economic conditions without distinction as to race, national origin, gender, age, or disability. Good health throughout the life-span of every man and woman, good health for every child are fundamental to ensuring that people of all ages are able to participate fully in the social, economic and political processes of human settlements. Sustainable human settlements depend on policies to provide access to food and nutrition, safe drinking water, sanitation, and universal access to the widest range of primary health-care services to eradicate major diseases that take a heavy toll of human lives, particularly childhood diseases; to create safe places to work and live; and to protect the environment. Measures to prevent ill health and disease are as important as the availability of appropriate medical treatment and care. It is therefore essential to take a holistic approach to health, whereby both prevention and care are placed within the context of environmental policy”

2.6. Globalization, Liberalization and Consumerism

Influenced by broader trends in social science literature in the 1990s, health and health care research has begun to acknowledge a global dimension to health. This is evident in a variety of titles in the 1990s such as, ‘Global competition in health care’, in which is noted the expansion of American ‘for profit' health care plans into the developing countries.’ In a similar vein, Turner notes a growing trend or convergence towards the bureaucratization and rationalization of health care systems around the globe.’ Here, the concept is
deployed to describe what is seen as a growing internationalization of medical knowledge, technology and health care systems. The term has also been used to identify links between the growth of tobacco consumption and the export of western lifestyles around the globe. Other concerns are the global liberalization of trade and markets and the knock on effects for health linked to restructuring of labour markets and uncertain employment prospect. Potential threats to health are also being identified in relation to global changes in the physical environment such as ozone depletion and skin cancers or global warming and alterations in vector habitats and disease pattern. What is common to all this research is that whilst acknowledging a growth in scale and complexity of health issues associated with 'the global', the term itself and its implied characteristics are not critically examined. Instead, the existence of a global dimension to health is unwittingly constructed as some external and uniform process that will inevitably have consequences for health. What is not addressed is the complex and contested nature of these processes and, in particular, the uncertain ways in which they may come to insert themselves into local cultures and social relations. In this sense, the active, transforming processes that work to shape how global influences are expressed is not acknowledged. Instead, the social context and local social relations are constructed as passive recipients of external forces.

The need to problematize the global issue also evident in contemporary attempts to understand and redefine the uncertain roles of WHO and other UN bodies within the international health policy arena. It has been suggested that emerging global health problems call for a refocusing of the aforementioned organizations’ priorities and greater collaboration and vision in providing stronger international leadership. Useful though these insights may perhaps be in terms of the survival interests of bodies such as the WHO, a more critical analysis would need to consider the variety of ways in which global tendencies have been working to reshape the context within which international organizations operate, and which, in itself, seems to have created new problems
and uncertainties for procuring health which may not be amenable to reworked, traditional, bureaucratic forms of intervention. An example here is the ways in which policies and funding for health at an international level have become caught up in global economic policies and the workings of the market, as well as the variety of new agencies and interests which are active in seeking to shape agendas for health.

2.6.1. Positive implications

The process of development coupled with increasing liberalization and globalization across the country has enabled consumers to appreciate their increasingly important role in society and governance. Though it is said it to be 'self reliant' but in present scenario it seems unfeasible to tag along the same in this day and age the world has transformed into 'global village' not only due to the advancement of trade and commerce but more due to technological advancement. Therefore liberalization is inevitable for a nation- State disposed to develop itself. It is very difficult for any nation to produce everything to satisfy its customer citizens, so the process of globalization and free trade is serving a noble cause for all the probable consumers by satisfying their otherwise unaddressed desires\textsuperscript{124}. Globalization is almost inevitable but mostly desired at the same time from the consumer's point of view. In fact it enforces consumer's 'right to choice', as envisaged by UNO in its guidelines for consumer welfare, in more sensible manner by exposing him to varieties of availabilities\textsuperscript{125}.

2.6.2. Negative implications

Noam Chomsky, one of the world's noted intellectuals, describes globalization thus: "Insinuation of extension of transnational corporate


\textsuperscript{125} P Hirst and G Thompson (1995), Globalization and the Future of the Nation-state, 24 Economy and Society.
tyranny...Their first interest is profit but much broader than that it is to construct an audience of a particular type...addicted to a certain lifestyle with artificial wants, an audience atomized, separated from one another, fragmented enough so that they don’t enter the political arena and disturb the powerful.”

This, is what all about existing Indian consumer, who is now heading opposite to its own philosophy of consumerism when we compare and contrast it with that of the Gandhiji’s which says that “while there is enough on earth for every man’s need there is not enough for everyone’s greed and that poverty is really the other face of the problem of possessiveness. “

It is the consumerist mode of thinking.” Being the consumer of environment and nature today’s consumer of the third world is really underprivileged of his very deep-seated, fundamental and natural right in the newly evolved monstrous paradigm of globalization in which human well-being is equated with material consumption regardless of the impact of unregulated economic growth on social ties and the environment. 6% of the world’s population in America is usurping 40% of the earth’s non-renewable fossil fuel resources and non-fuel mining alone produces 1300 million tones of garbage annually. If everyone in the world were to enjoy the American standard of consumption, it has been estimated that three planets Earth would be needed! In the World Economic Forum 1999 meet, Nobel laureate and UNDP Goodwill Ambassador, Nadine Gordimer, condemned the process of Globalization for increasing consumption unprecedentedly, jeopardizing truly human prospects: “While those of us who have been the generations of big consumers need to consume less, for more than one billion of the world’s poorest people increased consumption is a matter of life and death and a basic want—the right to freedom from want.” She asserted that consumption is necessary for human development “when it enlarges the capabilities of and

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127 S.H. Venkatramani: “Wretched of the Earth”, The Times of India, 22.8.1995
improves people’s lives without adversely affecting the lives of others. 129 This is how globalization turns out fatal for present and probable consumers as well as for national entities also.

2.6.3. Law and globalized world

The presence of an international or transnational element is likely to make the application of political will, translated into law, extremely difficult. International law does not operate directly on human behavior, or the behavior of corporations; the effective actors in international law are nation-States. Rights and remedies acquired under the law of one nation may be recognized and enforced in another nation, but this is not guaranteed. To obtain redress of grievances may be difficult and technically complex quite apart from the practical difficulties of language, location of parties, and finding a party with sufficient assets to justify initiating enforcement procedures. Even where nation-States have the political will to unify or harmonize their legal rules, there may be difficulties in securing an expression of the policy which produces the same effects. However, the crucial factor in achieving any political solution to the control of anti-social behavior lies in the effective application of legal rules by entities sufficiently capable of asserting sanctions to affect their efficacy. If citizens can remove themselves from the scope of national laws, nation-States may defeat the political process and it is not sufficiently clear what sanctions they may impose to assure compliance with rules they may themselves promulgate. Since 1960, most developed countries with common law legal systems, the nations of Europe and most recently of Asia have enacted significant consumer protection legislation. For example, Japan, Korea and Taiwan have all recently introduced product liability legislation which is based on the 1985 Product Liability Directive of the European Communities 130. Such laws are national, and operate only within the geographical limits of the


enacting jurisdiction, except where conflict of laws rules permit them to be applied as part of the law of some other country. Attempts to apply such existing laws to activities outside the geographical boundaries of the enacting State might prove ineffective.

2.7. Consumer Protection Laws in the Global World

Consumers have sought protection through legislation because the general laws and market forces have failed to provide it. Many consumer protection laws either relate to the terms and conditions of contracts that consumers make with suppliers for the supply of goods and services, or to conduct intended to encourage the making of such contracts marketing, packaging, advertising and provision of information. Previous laws, especially the law of contracts, assumed that the parties to contracts are legally equal in terms of power and information. In substance, in real markets, almost invariably consumers have markedly less power and information than suppliers. The law deems the action of a consumer in buying a commodity to be the making of a contract in theory a free, consensual act. In practice, the legal consequences are attributed to the action by the law without any consideration of what the consumer actually knows or wants. The common law of contracts simply cannot afford consumers the protection they probably would seek if they were rational, fully informed, and equal in economic power to the supplier. Because contract law offers an inadequate basis for an equitable legal transaction, it must be modified by legislation131 in order to afford greater protection to consumers than they can negotiate individually for themselves.

2.7.1. Problems and perspectives of legislative jurisdiction Consumer Protection Laws

Both public and private international law restricts the power of nation­States to provide legal sanctions and remedies. United States anti-trust law

provides a good example of globalization being challenged in its earliest stages. The year, 1892, saw the passage of Anti Trust Laws which made the nascent industries of the big business era accountable to the people and the Government of the day. Recently, Bill Gates was brought to the book for Anti Trust violations, which turned out to be a big theme for the US economy in the first tenure of George Bush. How law, politics and practicalities intersect in ways that destroy international goodwill. Attempts by any single nation to proscribe activities beyond its physical boundaries by people who are neither residents nor citizens are likely to create the problem of legislative jurisdiction. When this happens, a State may enforce its extraterritorial laws within its own boundaries, but other States will steadfastly, block any attempt to enforce those laws within their own territories. A preferable solution seems to be bilateral or multilateral international agreements under which Governments concur that each will make criminal, under its domestic laws, the conduct which all desire to prohibit. This process is sometimes called “unification” or “harmonization” of law. If any activities in the net world are to be made criminal, even though this process seems cumbersome, it may be the only acceptable means available. There are problems of securing agreement of uniform laws. Indian consumer suffers from lack of political willingness to enforce consumer rights emphatically. V.R. Krishna Iyer, former Chief Justice of India, expresses himself more stridently. The country’s greatest enemy is GATT and the pro-MNC politics leading to decolonization of India. Their capacity to corrupt, terrorize, propagandize, destabilize, colonies and subvert has been the disaster of our country and of many others”.

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132 Lea Brilmeyer, (1986), An Introduction to Jurisdiction in the American Federal System, Charlottesville, VA, Chap 10;
2.7.2. Health law lack of consumer's awareness

Strange as it may seem, most consumers do not know that the law is on their side. It is for the consumers to enforce the provisions of law by vitalizing enforcement. The machinery is available. It has to be use effectively. Marilyn Ferguson writes in The Aquarian Conspiracy, “Countries like ours are full of people who have all the material comforts they desire, yet lead lives of quiet and at times noisy desperation, understanding nothing but the fact that there is a hole inside them and that however much food and drink they pour into it. Therefore, being aware about rights a consumer should also understand his responsibilities for procuring the better outcomes.

2.7.3. Food Safety and Global Health: An International Law Perspective

Following the recurrence of serious events of food contamination across the globe, food safety has become a matter of ever increasing international concern and the World Health Organization has defined food borne diseases as a global public health challenge. Protecting global health from food borne hazards is a compelling duty and a primary interest of both States and non-State actors; it calls for enhanced proactive cooperation between national and international institutions. Unfortunately, the present state of international law on food safety regulation and governance is still unsatisfactory and reforms are desirable in many respects. The improvements and progresses could be achieved in three major areas of intervention: a) the human rights framework, where the profile of the emerged right to safe food should be raised by way of express recognition in international human rights law, backed up by authoritative interpretation by the UN Committee on Economic, Social and Cultural Rights and strengthening of accountability and remedial measures; b) the regulatory framework, where trade and health issues related to food safety should be addressed in a way that contributes to easing tensions between trading parties while prioritizing consumer protection over freedom of trade; c) the sanitary framework, where international preparedness and response to
public health hazards posed by food borne diseases should benefit, where appropriate, from the extended application of the International Health Regulations and the possible devise of enforcement measures aimed at ensuring international health security.

2.8. Conclusion

Thus health is a common theme in most cultures. In fact all communities have their concepts of health as part of their culture. Modern medicine is often accused for its preoccupation with the study of disease, and neglect of the study of health. Health continues to be a neglected entity despite lip service. At the individual level, it cannot be said that health occupies an important place and it is usually subjected to other needs defined as more important, eg: wealth, power, prestige, knowledge, security. However, during the past few decades there has been a reawakening that health is a fundamental human right and a worldwide social goal that it is essential to the satisfaction of basic human needs and to an improved quality of life and that it is to be attained by all people. The changing concepts in the understanding of health are the basis of all health care. Health has evolved over the centuries as a concept from an individual concern to a worldwide social goal and encompasses the whole quality of life. Thus the new philosophy of health is summarized as:

- Health is a fundamental human right,
- Health is an integral part of development,
- Health is central to the concept of quality of life,
- Health and its maintenance is a major social investment,
- Health involves individuals, State and international responsibility,
- Health is worldwide social goal.