RIGHT TO HEALTH: A HUMAN RIGHTS PERSPECTIVE

Dissertation submitted to National Law University, Assam

in partial fulfillment for award of the degree of

MASTER OF LAWS

Supervised by

Dr. Kasturi Gakul

Assistant Professor of Law

Submitted by

Nihal Chhetri

ID- SM0220017

2020-21, II Semester

National Law University, Assam

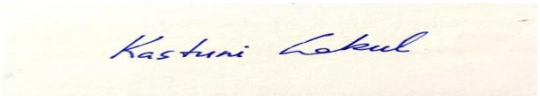
2021

NATIONAL LAW UNIVERSITY AND JUDICIAL ACADEMY, AMINGAON, ASSAM - 781031

CERTIFICATE

This is to certify that the dissertation entitled **"RIGHT TO HEALTH: A HUMAN RIGHTS PERSPECTIVE"** submitted to National Law University And Judicial Academy, Assam is a bonafide study conducted by **Nihal Chhetri** as a requirement for the completion of the course for the Master of Laws (LL.M) degree under my constant guidance and supervision.

This is also certified that he has fulfilled all the regulations and requisite of National Law University and Judicial Academy, Assam for preparing and completing the dissertation for Master Degree in Laws.



Date : 15-07-2021 (Dr. Kasturi Gakul)

Place: Guwahati

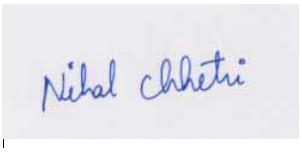
NATIONAL LAW UNIVERSITY AND JUDICIAL ACADEMY,

AMINGAON, ASSAM - 781031

DECLARATION

I hereby declare that, this dissertation titled "**RIGHT TO HEALTH : A HUMAN RIGHTS PERSPECTIVE"** is a bonafide and genuine research work carried out by me under the guidance of **Dr. Kasturi Gakul, Assistant Professor of Law, National Law University and Judicial Academy, Amingaon, Assam.**

I further declare that to the best of my knowledge the dissertation does not contain any part of work, which has not been submitted for the award of any degree either in this University or any other institutions without proper citation.



Date :
Place : Guwahati

Nihal Chhetri

LLM

National Law University and
Judicial Academy, Assam

ACKNOWLEDGEMENT

It is indeed a privilege for me to be able to appreciate all those, far and near, whose help, encouragement, suggestions as well as constructive criticism helped me in completing this phenomenal task of preparing a dissertation.

I sincerely thank Prof (Dr.)V.K.Ahuja, Vice-Chancellor, National Law University and Judicial Academy, Assam for allowing me to carry out the study in this institution.

I am grateful to Dr. Indranoshee Das, ACS, Registrar, National Law University and Judicial Academy, Assam and Dr. Nandarani Choudhury, Assistant Registrar, National Law University and Judicial Academy, Assam for their priceless and untiring support.

I express my sincere thanks to the Examination Section of the University for the constant and vigorous assistance.

I shall always be indebted to my guide Dr. Kasturi Gakul, Assistant Professor of Law, National Law University and Judicial Academy, Assam, who apart from her constant guidance and valuable suggestions throughout the period of this study, will always be fondly remembered as an affectionate teacher who is a constant source of inspiration.

I also take this opportunity to express my sincere thanks to all my teachers, Prof. (Dr.) Subhash Chandra Singh, Dr. Diptimoni Boruah, Mr. Saheb Chowdhury, Mr. Thangzakhup Tombing, Mr. Himangshu Ranjan Nath, for their encouragement and for sharing their rich knowledge and expertise.

I express my sincere thanks and gratitude to Dr. Kankana Baishya, Assistant Librarian, National Law University and Judicial Academy, Assam and the Library Section for their invaluable help in carrying out my dissertation study.

I am also grateful to the Administrative Section, Finance and Accounts Section, Engineering Section, Health and Counselling Centre, Hostel facilities, IT Section for their valuable support throughout the study.

I am highly grateful to my colleagues Neelima Gaur, Bhagyashree Agarwal, Chay Rabha Anindita Deb, Trishna Devi, Pubali Krishna and all my other classmates for their constant help and support during my dissertation study.

I am thankful to all the staff members of the University for their valuable help.

I sincerely thank my parents for their constant support in every step of my life which enabled me to carry on and complete my work. Finally, I submit to the Almighty without whose blessings this endeavor would not have been possible.

Nihal chhetri

TABLE OF CASES

30. Mrs Rathi v. Union of India
31. Municipal Corporation Delhi v. Female Workers
32. Municipal Council, Ratlam v. Vardhichand
33. M Vijaya v. Chairman, Singareni Collieries Hyderabad
34. Mr. X v. Hospital Z
35. Niyamakendran V. Corporation of Kochi
36. Parmanand Katara v. Union of India
37. Paschim Banga Khet Mazdoor Samity v. State of West Bengal
38. People's Union for Civil Liberties v. Union of India
39. Praveen Rashtrapal v. Chief Officer, Kadi Municipality
40. Rajesh Kumar Shrivastava v. A.P. Verma
41. Rakesh Chandra Narayan v. State of Bihar
42. Rakesh Malhotra v. Government of National Capital Territory of India and others
43. Re: (Sup Moto) v. Union of India & others
44. Rishi v. State of Haryana
45. R.D. Upadhyay v. State of A. P
46. Rural Litigation and Entitlement Kendra, Dehradun v. State of Uttar Pradesh
47. Saarthak Registered Society and Anr v. Union of India
48. Sanjay Phophalia V. Rajasthan
49. Santosh Kumar Gupta v. Secretary
50. Shivani Kaushik v. Union of India
51. State of Andhra Pradesh v. M/s Linde India Ltd
52. Suo Motu v. Ahmedabad Municipal Corporation
53. Supreme Court Legal Aid Committee v. State of MP
54. Smt. Lucy R. D'Souza v. State of Goa
55. State of Punjab v. Ram Lubhaya Bagga
56. Sunil Batra II v. Delhi Admiration
57. Upendra Baxi v. State of UP
58. Veena Seth v. State of Bihar
59. Vincent Panikurlangara v. Union of India

60. Virender Gaur v. State of Haryana

61. Welfare Society v. Haryana Urban Development Authority

TABLE OF STATUTE

YEAR	STATUTE
1948	The Factories Act.
1956	The Indian Medical Council Act
1860	The Indian Penal Code
1987	The Goa Daman and Due Public Health Act
1987	The Mental Health Act
1955	The Persons with Disability (Equal opportunities, Protection of Rights and Full Participation) Act
1999	The National Trust for Welfare of Persons with Autism Cerebral Palsy, Mental Retardation and Multiple Disability Act
1952	The Mines Act
1981	The Air Pollution Act
1975	The Cigarettes (Regulation of Production, supply and Distribution) Act
1986	The Consumer Protection Act
1940	The Drugs and Cosmetic Act

TABLE OF ABBREVIATION

1	AIR	All India Reporter
2	CEDEW	Convention on the Elimination of all forms of Discrimination against Women
3	CRC	Convention on the Rights of Child
4	ICDS	Integrated Child Development Services
5	ICESCR	International Covenant on Economic, Social and Cultural Rights
6	Ltd	Limited
7	Ors	Others
8	Retd	Retired
9	SCC	Supreme Court Cases
10	TRIPS	Trade Related Aspects of Intellectual Property Rights
11	UDHR	Universal Deceleration of Human Rights
12	WHO	World Health Organization
13	WP	Writ Petition

CONTENTS

CHAPTER-1

INTRODUCTION

`1.1 INTRODUCTION

Every human being by virtue of being born as a human has certain human rights which can't be taken away, and one such right is the right to health. As human being's health of all the people we love is of prime importance. Irrespective of age, gender, socioeconomic conditions etc health is our biggest asset. The right to health is one of the fundamental human rights. Every individual has the right to health i.e., to obtain a standard of health care and it's the obligation of the state to provide people with the same. The World Health Organisation defines right to health as "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity". It is the duty of the state to ensure both freedom and entitlement. The former would include the right to one's body, right to choose in terms of any treatment or medication, sexual and reproductive freedom and the later includes health care facilities which are affordable and adequate, and things that are interrelated to health such as food, clean drinking water, sanitation, housing, poverty and safe environment of working condition for health.

1.2 STATEMENT OF THE PROBLEM

Health is of prime importance to each individual since the inception of time and there has been advancement also in the field of health care, but access to modern healthcare facility is available to people on the basis of socio-economic condition of individuals country to country. The objective of human rights and right to health is common and i.e., wellbeing of individual, but there has been uneven distribution of nutrition in India specially because a huge fraction of population is below poverty line and are malnourished. There have been various international and national instruments that mentions about right to health and how such standards can be attained but yet people's access to proper healthcare has remain a big question both National and International sphere. Health and human rights are complementary to each and various human rights violation affect the health of individual. This study is an approach to understanding these factors which affect people's access to right to health.

1.3 AIM'S AND OBJECTIVES

The objectives of the present study are as follows-

(i) To study the provisions relating to right to health under international and regional human rights instruments.

(ii) To discuss the relationship between human rights and right to health.

(iii) To analyse the legal provisions relating to right to health in India.

(iv) To study various intervention of the Government of India to provide health facilities to general public to safeguard their right to health.

(v) To discuss the role of judiciary in safeguarding the right to health in India.

1.4 SCOPE

The scope of the present study is confined to the analysis on right to health under International and regional human rights instruments, National perspective and Indian judicial approach.

1.5 LITERATURE REVIEW

J.M. Mann, L. Gostin, S. Gruskin, T. Brennan, Z. Lazzarini & H.V. Fineberg, "*Health and Human Rights"*, 1HHR.6,7-23 (1994)

In this article the author discuss how health and human rights are complementary to each other and, is one of the important aspects for people's wellbeing. The article is divided into three parts the first one involves the analysis of health policies and its impact on public health, the second part of the article deals with the aspect of how violation of human rights effect one's right to health, the third part of this article deals about promotion and protection of human rights and dignity. The author tries to establish an inextricable linkage between health and human rights.

V.A. Leary, "*The Right to health in International Human Rights Law"* 1HHR.24,25-56 (1994)

In this article the author has discussed the concept of right to health in International Human Rights Law. The term right to health has not been a very popular terminology to be found in international texts although the world health organization mentions that Right to health means as "Highest Attainable standard" of health. According to the author approaching health through the lenses of Right adds a different perspective to the concept of health. The author adds furthermore that 'right to health' links health with issues pertaining to dignity, Non-discrimination and justice. The author further discussed about the efforts of United Nations organs and other human right schools in developing the scope and obligations of Right to health.

P. Hayden, *"The human rights to health and the struggle for recognition"* RIS.3W8,569-588 (2012)

In this article the author throws light on the persistent health inequalities that exists globally. Affecting high-income countries and blighting the developing world. Health inequalities currently are one of the greatest challenges facing realisation of the human right to health. The author in the article argues that the struggle for the right to health in the face of such inequalities requires embracing three critical considerations: redistribution, representation, recognition.

S.K. Chopra & S. Kandasamy, "*Constitutional and Legal Protection of right to health in the perspective of governance in India"* 8OIIRJ.121,122-127 (2018)

In this article the author discusses the constitutional provisions relating to right to health and the interpretation of Right to health with respect to fundamental Rights enshrined in the Constitution od India. The researcher further throws light on different legal judgements, medico-legal cases, right to health cases and about the working and living conditions of labourers. The author further adds that irrespective of technical advancements in the field of health care people in India have not been able to attain their Right to health.

S. Sekalala, L. Forman, R. Habibi & B.M. Meier, *"Health and human rights are inextricable linked in the COVID-19 responses"* BMJGH.1-7 (2020)

In this article the authors have discussed and established an inextricable link between health and human rights. The authors stress on the fact that human rights should guide government responses to COVID-19, strengthen the public health response to COVID-19 by framing restrictions on individual liberties, managing COVID-19's impacts on medical care, public

health and social and economic rights, and realizing global solidarity through international collaboration and assistance.

1.6 RESEARCH QUESTION

(i) What are the provisions relating to right to health under International and regional human rights instruments?

(ii) What is the relationship between human rights and the right to health?

(iii) What are the legal provisions relating to right to health in India?

(iv) What are the interventions undertaken by the government of India for safeguarding the right to health?

(v) What is the role of judiciary with regard to right to health in India?

1.7 RESEARCH METHODOLOGLY

The methodology adopted in the study is doctrinal. The study is carried on a legal proposition by analysing the existing statutory provisions and cases. The case law study method is also adopted which helped the author to understand how legislative provisions are implemented and how the judiciary plays an active role in protection and promotion of right to health. Different aspects are studied keeping in mind the existing laws relating to health and human rights, Supreme Court of India and High Court landmark judgements.

1.8 LIMITATION OF THE STUDY

Rights to health is a very vast umbrella and studying each and every aspect of health would demand a lot of time which is a constrain for the researcher. The study is doctrinal and involves case study method. The study is focusing on the legal aspect of right to health from a human rights perspective. The researcher could not do field study due to the outbreak of COVID-19 which has added another limitation to the study. The study is centred towards analysis of existing legal provisions and landmark Supreme Court of India and High Court Judgement.

CHAPTER-2

HEALTH AND HUMAN RIGHTS – AN INEXTRICIABLE LINKAGE

As rightly said by Ms Helena Nygren-Krug, "Linking health with human rights would act as an agent to foster the needs and rights of the most vulnerable and disadvantaged. Putting health under the periphery of human rights means making people conscious about their oppression and possibility of change"[1]. Attainment of highest standard of health as a fundamental right has been articulated in the WHO constitution of 1946, but the implementation has not seen much progress largely due to cold war politics. Right to health in concurrence with human right is a new experience and the concept of linking health with human right is recently developed and a new momentum on health and human rights has been initiated. It has been rightly said that "since the beginning of this millennium, the human rights movement has witnessed extraordinary developments in advancing the right to health, giving us an excellent opportunity to promote and protect the health of populations throughout the world[2].

Human rights are not a concept which is taken from the western countries exclusively. In India through the concept of Dharma covers all what is implied in the concepts of rights, freedoms and duties in the West. But there were certain limitations as the caste system was much more rigid and because of its enjoyment of rights and freedom were not open to all equally and uniformly. Protecting and promoting right to health as a human right has positive consequences on the health care system. It broadens health issues beyond the domain of clinical medicine and focuses on the individual health care. In a human rights framework, health is placed in the context of social justice and linked with principles of equity and non-discrimination so that it cannot be challenged as violative of fundamental rights. Recognizing health as a human right issue dramatically re-frames health issues and focuses it to be in a humanitarian point of view. When health is not described simply in terms of needs by also in terms of rights, governments find it far more difficult to justify the withholding of basic provisions and services on account of alleged financial constraints or because of discriminatory priorities.

[1] Health and Human Rights, WHO.
[2] Dr. Gro Harlem Brundtland, Director-General WHO.

The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information and the freedoms of association, assembly and movement. These and all other rights and freedom address integral components of the right to health. Further health and human rights are intricately linked. Health has always to be read in conjunction with human rights.

2.1 LINKAGE BETWEEN HEALTH AND HUMAN RIGHTS

● Each human right is inextricably linked to health and Violations or lack of attention to human rights can have serious health consequences[3].

● Health policies and programmes can promote or violate human rights in the ways they are designed or implemented, like poorly designed or implemented health programmes and policies can violate human rights.

● Vulnerability and the impact of ill health can be reduced by taking steps to respect, protect and fulfil human rights like focusing those groups which are most vulnerable for instance, children; ethnic, religious or linguistic minorities; refugees; the elderly and the disabled also to detect discrimination on the basis of gender, race, religion, health status, etc

Human rights as envisaged in the international documents and implemented by the member states are very basic to all human beings. Each human right has been inextricably linked with health issues and we can very well form a link between every human right with that of health. An attempt has been made to link health with human rights as follows: Right to health is very well grounded with human rights in the international conventions and national laws and has been recognized and reaffirmed by India in numerous international treaties and documents. Article 12 of the ICESCR and Article 5(e) (IV) of CERD specifically provides for highest attainable standard of physical and mental health

2.2 VIOLATION OF HUMAN RIGHTS AND ITS IMPACT ON HEALTH

(a) *Right against discrimination: -*

[3] Mann J, Gostin L, Health and Human Rights: An International Journal, Vol. 1, No. 1,1994.

Discrimination against ethnic, religious and racial minorities, as well as on account of gender, sexual orientation, political opinion or immigration status, compromises or threatens the health and well-being and, all too often, the very lives of millions. Discriminatory practices threaten physical and mental health and deny people access to care altogether, deny people appropriate therapies, or relegate them to inferior care. In extreme forms of discrimination, as exemplified by Apartheid, ethnic cleansing and genocide, the devaluation of human beings as other has had devastating consequences. The Universal Declaration of Human Rights talks about equality principle[4]. It entitles to all equal protection against discrimination in violation of the rights proclaimed under the declaration

(b) *Torture: -*

Torture is one of the forms which affect the health to a very large extent. The international instrument on Civil and Political Rights under Article 7 says, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation." Torturing a person is a violation of human right. Torture remains pandemic in dozens of countries around the world. It brings both acute trauma and long-lasting physical or psychological suffering to victims, their loved ones, and society at large and thereby affecting their physical and mental health. The prohibition of torture is also articulated in other human rights instruments, including the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and Article 37 of the Convention on the Rights of Child.

(c) *Education: -*

The Constitution of India has recognized right to education as a fundamental right under Article 21 A. Education is one of strongest predictors of health status and an intrinsic quality of well-being. Education has a direct effect on the health of human beings. We find that where the level of illiteracy is high people are more prone to hazardous health effects as they are unable to understand the health hazard and are more inclined towards traditional therapies which affects the health-of the people negatively. The Right to education has been provided in human rights Instruments under Article-13 of ICESCR, Article-5 of CERD, Article-10 and 16 of CEDAW and Article-19,24,28 and 33 of CRC.

[4] Article-7

(d) *Freedom of Expression*

As we all know that promoting and protecting human rights is fundamental to promoting and protecting health. Suppressing a person's independence could cause serious health problems. Freedom of expression helps the State to take positive steps towards the control of diseases and to implement health policies and programs effectively.

(e) *Violence against Women and Children: -*

The health of women and children are largely affected by physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse influencing the health. The Convention on Right of child and Convention on Elimination of all form of discrimination Against women protects the rights of women and children keeping health as a main concern. Article-6 of CEDAW and Article-34 of CRC protects the women and children respectively from sexual exploitation and prevention of prostitution and other unlawful sexual practice.

(f) *Right to Information: -*

Information helps people to access various human rights and fundamental freedoms, freedom to seek receive and impart information and ideas of all kind is articulated in several international instruments such as Article-19 of ICESCR, Article-10,14 and 16 of CEDAW and Article-13,17 and 24 of ICESCR.

(g) *Right to enjoy Scientific progress: -*

Advancement in scientific progress has resulted into treatment of various diseases. Article-15 of ICESCR provides that "parties to the covenant recognize the right to enjoy benefits of scientific progress and application"[5]. Taking about a country like India in which people are drawn towards traditional practices for treating themselves when suffering from diseases, the recognition of this right will act as a catalyst in the protection and promotion of health.

(h) *Right to adequate Food and Nutrition: -*

Food and nutrition are one of those basic things which are needed to lead a healthy life.

Adequate food and nutrition will help in safeguarding communities that are vulnerable to malnutrition. Malnutrition leads to various diseases and by providing adequate food and nutrition communities can be saved. It is well articulated under

[5] Article-15 (c) of ICESCR

Article-12 of CEDAW which provides state parties to take appropriate measures to eliminate discrimination against women in the field of healthcare and take steps to provide adequate nutrition during pregnancy and lactation. Article-27 of CRC provides that state parties should take appropriate measures for combating diseases and malnutrition within the framework of primary healthcare. Article-11 of ICESCR puts state parties under obligation to ensure equitable distribution of food.

(i) *Right to an adequate standard of living: -*

Food, clothing, housing and medical care are some of the basic elements needed for a human being or his family to maintain an adequate standard of living. The provisions relating to same has been provided under Article-25 of UDHR, Article-11 of ICESCR and Article-27 of CEDAW.

(j) *Right against harmful traditional practices: -*

Traditional practises have a direct effect on the health and wellbeing of a person. The convention on the Right of child provides that "effective and appropriate measures with the view to abolish traditional practices prejudicial to the health of children"[6]. The Declaration on the Elimination of Violence against women provides for the "prohibition of harmful traditional practices against women"[7].

Initially health focused on civil, economic and social rights and now it includes concern about environment, global socio-economic developments etc. The concepts are enlarging, focusing on the relationship between the individual and the state and other social institutions. Health and human rights are both powerful and modern approach to defining and advancing human wellbeing. Adoption of the human rights paradigm has the potential to revolutionize the health. Concerns about health overlaps with concerns about human rights. The human rights violation can have adverse consequence for help. We can take the example of torture were human rights abuse effects health. Also, domestic violation, unsafe working conditions and the sexual exploitation of children further illustrates how the violation of human rights affect health. Thus, where the state violates its obligation with respect to human rights by providing inadequate protection against various forms of abuse, an equal obvious danger to heath may arise. The interrelation between health and human rights need not be negative, and is in fact often mutually strengthening.

[6] Article-24(3) of CRC
[7] The joint general recommendation No.31 of CEDAW

The relationship between health and human rights can be seen in these international instruments, where there are provisions directly and indirectly pertaining to health. These instruments today have helped us in understanding and establishing a relationship between health and human rights. All human rights are universal and interdependent and interrelated, and the international community has also through its various documents treated human rights in a fair and equal manner, on the same footing and with the same emphasis.

CHAPTER-3

INTERNATIONAL AND REGIONAL PERSPECTIVE ON THE RIGHT TO HEALTH

As we all know human rights are universal in nature because of its derivation from inherent dignity of each individual person[8]. The right to health is enlisted in various international treaties and some national constitutions, the major standard setting instrument is the International Covenant on Economic, Social and Cultural Rights. The right to health has also been recognized in, the convention on the Elimination of all form of Racial discrimination against Women of 1979 and the Convention on the Rights of Child of 1979. Regional human rights instrument recognizes right to health such as the European social charter of 1961, the African charter on human and people's rights of 1981, the UDHR also mentions about the right to health. Although UDHR is not a treaty but a General Assembly resolution, it may be legally binding in the form of International Customary law or as interpretation of the U.N. Charter[9]. This chapter takes the general discussion further and discusses about various international instruments pertaining to Right to health.

3.1 World Health Organization and RIGHT TO HEALTH

WHO is one of the first international instruments to include the enjoyment of highest attainable standard of health as fundamental Right of every human being i.e., Right to health in its constitution. The preamble of WHO asserts the right to health is a fundamental right of every individual. The preamble provides with a definition of health, as complete physical, mental and social well-being and not just merely as the absence of diseases or infirmity. Public health is a contemporary concept, but in its phrasing the preamble echoes the rhetorical cadences of the age of reason in the last part of 18th century, therefore rights specially the ones related to health, or to life, liberty cannot be granted or denied by a government because these are rights guaranteed to us by virtue of being a human and

[8] AUDREY. R & CHAPMAN, EXPLORING A HUMAN RIGHTS RIGHTS APPROACH TO HEALTH CARE REFORMS 22 (1ST ed. American Association for the Advancement of Science 1993)
[9] HENRY. J. STEINER & PHILIP ALSTON, INTERNATIONAL HUMAN RIGHTS IN CONTEXT: LAW, POLITICS, MORALS 143 (2nd ed. Oxford: OUP 2000)

moreover, they are fundamental and inalienable[10]. The preamble furthermore puts nations into obligation in order to contribute towards the health of people. The obligation is not imposed from the outside but instead due to the fundamental right by virtue of being a human being. The preamble moves to the health of all people, because it is fundamental for attainment of peace and security and is largely influenced by the cooperation between state and individual. The connection between health, peace and security is self-evident because diseases coupled with other ills destabilizes government and societies. The preamble further stresses on the fact that the states achievement in the promotion and protection of health is something from which everyone draws benefit from. Countries with unequal development and promotion of health coupled with the uneven safeguard and measures for diseases poses and common danger. The preamble also provides for the development of the health of a child and to adopt measures for the same. For health benefits to be provided for all medical and psychological knowledge must be extended to all people. This principle serves as an important reminder that medicine and person with the essential knowledge of the same must not be stopped in national boarders for economic and social reasons[11]. The preamble acknowledges the fact that for the accomplishment and attainment of WHO's task not only government but socio-economic measures must be adopted for health of people to be fulfilled. One fact has to be agreed by all that the preamble of the WHO constitution would codify far reaching human rights norms commensurate with contemporary public health discourse, creating what would be referred to as the "Magna Carta of health"[12]. The WHO came up with advice for general public to stop the spread of COVID-19 by ways of busting myth such as a hydroxychloroquine does not prevent illness or death from COVID-19, an alcohol-based sanitizer does not create antibiotic resistance. WHO, UNICEF and the International Federation of Red Cross and Red Crescent Societies (IFRC) also issued guidelines on how to report misinformation and do's and don'ts to be followed while going out in public. WHO has constantly been involved in multiple media briefing which are available online and covers topics such as clinical management, laboratory and virology, infection prevention and control, mathematical modelling, seroepidemiology etc. The open WHO learning platform has 149 courses available to support the COVID-19 response, spanning 22 topics and 44 languages for COVID-19.

[10] Frank P Grand, *"The preamble of the Constitution of the World Health Organization",* Bulletin of the World Health Organization. 2002; 80(12): 981-982

[11] Supra Note.9

[12] Parran T. Remarks at concluding meeting of international health Conference, UN Doc. E/H/VP/18. 2. Reprinted in Parran T. Chapter for world health. Public health reports 1946; 61:1265-1268

3.2 THE UNIVERSAL DECLARATION OF HUMAN RIGHTS

The first catalogue of human rights and fundamental freedoms enumerated by the UN was the UDHR, a declaration of the United Nations General Assembly (UNGA) adopted in Paris, France, on 10th December 1948[13]. The UDHR is a milestone document because it became the basis of common achievement of standards for all people and all nations. The UDHR acts as a yardstick for the measurement for respect and compliance with international human rights standards. The provision relating to health has been enumerated in article 25 of UDHR. It provides that everyone has the right an adequate standard of living necessary for the wellbeing and health of an individual and his family and would include food, clothing, housing, medical care and necessary social service. It also provides for the right of security in the event of unemployment, sickness, disability, old age or over lack of livelihood in circumstances which is beyond his control. Furthermore Article-25 gives special attention to mothers and children and makes provision which entitles them special care and assistance. All children born in or out of wedlock are also entitled to same social protection.

3.3 THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

The provisions of ICESCR and that of the UDHR are complementary to each other, in other words the provisions of ICESCR elaborates the meaning. The covenant is the first international document the recognizes the right to health and provides key feature for its protection[14]. Article-12 of the covenant enumerates the provisions relating to health. According to Article 12(i) of the covenant the state party recognizes "the right of everyone to the enjoyment of highest attainable standard of physical and mental health" while on the other hand Article 12(ii) of the covenant provides for "steps and measures to be taken for the full realization of this right".

The steps for the same includes the following viz.

(a). The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

[13] PAULl SIEGHART, THE INTERNATIONAL LAW OF HUMAN RIGHTS 24 (oxford: Clarendon Press, 1993)
[14] Amnesty International Report, 2007

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

(c). The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

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

While drafting Article-12 of the convention, the definition of health provided by preamble to the constitution of WHO i.e., a state of complete physical social and mental well-being and not merely the absence of diseases or infirmity" was not adopted by the third committee of the United Nations General Assembly. However, the reference in Article 12(ii) of the covenant "the highest attainable standard of physical and mental health" is not just confined to right to health. On the contrary, the drafting history and the express wording of Article 12(ii) acknowledges that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinant of health such as food, nutrition, housing, access to safe and portable water, adequate sanitation, safe and healthy working conditions and a healthy environment[15]. For the operation of the provision the UN commission on Economic Social and Cultural Rights, which monitors compliance with ICESCR, adopted a general comment on Right to health on 2000[16]. The committee was very well aware of the fact that right to health for disadvantaged communities seems like a distant dream because of various socio-economic reasons. The committee is also aware of the obstacles due to international and other factor which are beyond the control of the state. With the view to provide assistance to the states for the implementation of the covenant and fulfilment of the reporting obligation, General comment focuses primarily on the state party obligation, violations and implementation at the national level. The general comment is based on the experience of the state parties reports over many years.

3.4 AFRICAN CHARTER AND RIGHT TO HEALTH

The normative instrument for the protection and promotion of human rights in Africa is the African Charter. The documents are highly acknowledged because it contains civil, political,

[15] Committee on Economic, social and Cultural Rights, General Comment 14, note 13.
[16] Ibid

economic social and cultural rights. Article-16 of charter contains provisions with regards to health i.e., the right to highest possible level of health. The charter further provides for the state parties to take measures for the protection of health of people and to ensure that the sick has access to medical attention as in when needed. It contains provisions that are directly linked to right to health such as right to be free from exploitation and degradation of man, particularly slavery, slave trade, torture, cruel inhuman or degrading punishment and treatment under Article-5. Article-18 and Artcle-19 of the charter obliges the state parties to take care of the physical and moral health of the family and ensure the protection of right of women, children and disabled. The charter has specifically adopted on 13th September 2000, The Protocol to the African Charter on Human and People's Rights on the Rights of women in Africa. Article-14 of the charter prohibits violence against women, including sexual violence, discrimination and harmful practices. The African Charter on the Rights and welfare of the child is another instrument which contains provisions regarding health under Artcle-14 which provides that specific measures must be taken to protect the health of African children. The African Charter differs from other charters because it is a duty-based charter, the duties are bestowed upon the state to protect the right of citizens.

3.5 ALMA-ATA DECLARATION

In the year 1973 an international conference on primary health care was held in Alma-Ata (now Almaty, Kazakhstan). The declaration was co-sponsored by the world health organization, is a brief document that expresses "the need for urgent action by all government, all health and development workers, and the world community to protect and promote the health of all the people of the world". The declaration is the first international documents which focuses on the importance of primary healthcare and outlining the world government's role and responsibilities to the health of the world's citizens. The declaration provides that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, is a fundamental human right and the attainment of highest possible health is the most important social goal. The declaration further calls for government to work towards attainment of global health irrespective of conflicts and politics. The main goal for the countries those who ratified the declaration was to achieve health for all by the year 2000.

3.6 DOHA DECLARATION

The declaration on Trade related aspects of intellectual property rights (TRIPS) and public health was adopted on 14th November, 2001 by the 4th World Trade organization ministerial meeting at Doha, Qatar. The main aim of the declaration was to implement and interpret the provision of the TRIPS Agreement in a manner that is supportive of a WTO member right to protect public health and promote access to medicine for all. The main concern with regards to the TRIPS agreement was that patent protection for pharmaceuticals products does not prevent in poor countries in order to access them. The declaration is the direct consequence of controversies concerning patents in the health sector. It recognizes the issues of public health problems especially in developing countries and least developed countries with regards to HIV/AIDS, tuberculosis, malaria and other epidemics. The essence of the declaration was reflected in paragraph 4 which reiterated the fact that TRIPS agreement should be implemented and interpreted in the light of members "right to public health and promote access to all. It should also be noted that paragraph 4 makes a specific reference to the issue of "access to medicine for all" indicating that in interpretation of this agreement's obligations, special consideration should be given to the achievement of this goal[17]. In paragraph 5, the declaration lays out the key measures and flexibilities within TRIPS i.e., compulsory licensing[18]. This will help overcome intellectual barriers to access to medicine. Under the TRIPS the fastest way in which a country could get a compulsory license was to claim a national emergency. The declaration categorically makes it clear that the use of compulsory licensing is in way limited to the case of emergency or urgency. The use of compulsory licence contributes to raising degree of competition, which causes a reduction in price. Health is a fundamental human right and is important to live a decent life. The right to highest attainable standard of health was first enumerated in the constitution of who and since then has been expressed and defined in many international documents, the first one happens to be the Alma-Ata declaration on health care in the year 1978. The UDHR along with the International Covenant on Economic, Social and Cultural rights acts as a back bone for health as a human right under international law. Along with these international documents there are regional instruments that have affirmed the right to health such as the African charter on

[17] Carlos M Correa, "Implication of the Doha Declaration on the TRIPS Agreement and Public Health", World Heath Organisation Publications, June 2002.

[18] A compulsory licence is a licence granted by the competent national authority to allow a third party to manufacture a patented drug without the authorisation of the right holder.

people and human rights, the adoption of Doha Declaration on TRIPS and public health is yet another significant development giving effect to the right to health in international level.

CHAPTER-4

RIGHT TO HEALTH IN INDIA: AN ANALYSIS

Health is an important indicator of human development and human development acts as an ingredient of social and economic development. The right to healthcare in India has been recognized and protected since early times, independent India approached public as the right holder and the state as the duty-bound primary provider of health for all. The Indian constitution does not expressly recognize the right to health, however there are provisions enshrined in the constitution with regards to health. India has also come up with certain programmes and policies for the protection and promotion of primary health in India. This chapter briefly discusses the provisions enshrined in the constitution with regards to health and various policies and programmes pertaining to health.

4.1 CONSTITUTIONAL PROVISIONS FOR RIGHT TO HEALTH

The preamble of the Constitution of Indian is not a part of the constitution and is not enforceable in the court of law but it acts as a guide that highlights the core value and principles that guide the constitution of India. The constitution is interpreted in the light of the preamble and majority of the supreme court judgements has held the objectives of justice, equality, liberty and fraternity stated in the preamble of the constitution. The preamble directs the state to initiate measure to establish justice, equality and to ensure dignity etc., which has a direct bearing on people's health[19]. The Constitution of India directly does not provide for right to health, it has been evident in the form of judgements given by Indian judiciary from time to time. Human rights in India have been divided into separate parts viz. part-III that contains the fundamental rights and part-IV which contain the Directive Principles of State Policy (DPSP). In the beginning the right to health was placed in the DPSP because direct implementation was found difficult by the makers of the constitution. Initially the supreme court of India enforced the right to health through various public interest litigation which came in front of the Indian judiciary. With the passage of time the judiciary found out that right to life under Article-21 of the constitution is incomplete without various rights such as

[19] N.B. Sarojini & others, *Women's Right to health, 85* (New Delhi: National Human Rights Commission, 2006),

education, livelihood, housing and health etc. thus right to health became the part of the Fundamental Right and was further incorporated under article-21 of the Indian Constitution.

Article-21 of the Indian constitution deals with protection of life and personal liberty. It lays down that no person shall be deprived of his life and personal liberty except according to procedure established by law. Right to life means leading a meaningful, complete and dignified life and something more than mere animal existence. The right to live with human dignity under Aarticle-21 is derived from Directive Principles of state policy and particularly clause (e) and (f) of article-39 and article-41 and 42 and at the least, therefore, it must include protection of health and, opportunities and facilities for children to develop in a healthy manner, just and human condition of work etc., these minimum requirements are necessary in order to live with human dignity and neither central nor state government has the right to take any actions which will deprive a person of the enjoyment of these basic essentials.

According to article-47 of the Constitution the state shall regard the raising of level nutrition, the standard of living of its people and the improvement of public health as among its primary duties. The state shall further prohibit the consumption of intoxicating drinks and drugs which can cause serious harm to health except for medical purpose.

4.2 ROLE OF PANCHYAT RAJ IN PROTECTION OF HEALTH

The village panchayat has existed in India since ancient time. These panchayats have proved to be effective in past. The system has played an important role after independence in the improvement of health services in India. After independence community development programmes was started in 1952. But it did not prove to be very effective because people took it as a burden provided by the government. A team was formed under the leadership of Balwantrai Mehta to find out the root cause of the problem. The team concluded that the reason for the failure of the programme was no organization at the village level, to implement and interpret government policies[20]. The committee suggested that the organizations should act as representatives of the villagers and ensure their development. In this way Balwantrai Mehta tried to establish a local self-government through panchayats. The state of Rajasthan was the first state to adopt the three-tire government[21]. In 1977 the Ashok Mehta committee

[20] "Panchayati Raj System in independent India", Nation Institute of Rural Development
[21] "Panchayati Raj System in independent India", Nation Institute of Rural Development

reviewed the working of the panchayat system proposed that the system should be given or be empowered with more authority[22]. The central government therefore passed the 73rd Amendment Act of 1992 which became effective from 20th April 1993[23]. The panchayat raj system acquired constitutional status on 1993. The National Health policy 2002 lays great emphasis to the implementation of public health programmes through local self-government institutions. The structure of National disease control programme will have specific component for implementation through such entities. The policy urges all the state government to consider decentralizing the implementation of programmes by such institutes by 2005.

4.3 FIVE YEAR PLAN AND HEALTH

The first five-year plan of 1951-56 provided 65.2 crore for health development schemes. The objectives of the first (1951-1956) and the second (1956-61) five-year plan was basic infrastructural and manpower development which was visualized by the Bhore Committee. During the first five-year plan priority was given to water supply and sanitation; control of malaria; preventive health care for rural population by setting up mobile units at villages; health service for mother and children; education training and health education; self-sufficiency in drugs and equipment; family planning and population control. Certain programmes such as The Malaria control programme, programme for control of TB, filariasis, leprosy and venereal diseases was launched. However, the programme failed to create much impact[24]. In the second (1961-1966) five-year plan health along with water supply and sanitation was allocated Rs.88.765 crore. During this phase family planning received much attention due to rapid increase in population. The primary objective was to create and ensure a minimum level of physical wellbeing and create conditions favourable for the same. The PHC in rural areas were strengthened. The fourth, fifth and sixth five-year plan gave focus an intensive comprehensive approach towards further development of health service was required to established to serve the actual health need priorities of the country which resulted in the development of National Health Policy (NHP) was evolved by the government.

[22] Supra Note.19
[23] Ibid.
[24] "Primary Health Care in India: Review of policy, plan and committee Reports". https://www.researchgate.net/publication/312211554_Primary_Health_Care_in_India_Review_of_Policy_Plan_and_Committee_Reports

The 10th five-year plan essentially aimed at providing primary health care, specially to underprivileged segment of the society. It sought to develop responsibilities and funding for healthcare in the country. The 11th five-year plan aims to give more focus on district and block specific health plane. These plans will ensure involvement of all health-related sectors and encourage partnership with NGO's. The NRHM is an example of such plan which has strengthened the healthcare in rural areas. The 11th plan takes special care of people suffering from HIV in particular women[25]. It will also address the special health need of the elderly, especially those who are socially and economically vulnerable[26].

4.4 HEALTH POLICIES AND PROGRAMMES

4.4.1 NATIONAL HEALTH POLICY

In India a National Health Policy was first adopted in the year 1983. The policy was a collective effort by the government to secure a healthy life for all Indians. The main focus of the policy was development of health services, appropriately supported by medical education and research, with special reference to public health[27]. With the Enactment of the 73rd constitutional amendment Act 1992, the panchayat raj institutes were revitalized and the process of democratic decentralization ushered in, with similar provisions made for urban local bodies, municipalities and nagarpalikas. The importance of panchayat raj institutions also recognized in the 10th five-year plan (2002-2007) to ensure local accountability of healthcare[28]. The main objective of the national health policy of 2002 is to achieve an acceptable standard of good health amongst the general population of the country[29]. The same is to be achieved by establishing structures in places of need and upgrading the ones already in existence. It also provides for privatization of secondary and tertiary level care. The national health policy of 2002 is quite different in approach, it recognizes globalization with the view of TRIPS and its impact and regulation of private healthcare sector[30]. The national health policy of 2017 is to inform clarify, strengthen and prioritize the role of government in

[25] Towards Faster and more inclusive Growth: An Approach to the 11th five-year plan 2007-2012 https://www.indiawaterportal.org/articles/towards-faster-and-more-inclusive-growth-approach-11th-five-year-plan-government-india
[26] Ibid.
[27] MANOJ KUMAR SINHA, ENFORCEMNT OF ECONOMIC SOCIAL AND CULTURAL RIGHTS-NATIONAL AND INTERNATIONAL PERSPECTIVE 262 (1st Edition, Manak Publications Pvt. Ltd, 2006)
[28] Economic Survey 2003-2004 https://www.indiabudget.gov.in/budget_archive/es2003-04/price.htm
[29] Ibid.
[30] Supra Note 26

shaping help system in all its dimensions and increase investment in health organization of health services, prevention of diseases and promotion of good health through cross sectoral actions, access to technologies, developing human resources, encouraging medical pluralism, building knowledge base, developing better financial protection strategies, strengthening regulation of health assurance[31]. The main goal of the 2017 policy is to facilitate the attainment of highest possible level of health and wellbeing for all at all ages by adopting a preventive and promotive healthcare orientation in all developmental policies and universal access to good quality health care services without anyone having to face financial hardship as a consequence[32]. It recognizes the importance of sustainable development goals (SDG's).

4.4.2 NATIONAL RURAL HEALTH MISSION

The mission was launched by the government in 2013 by subsuming the National Rural Health Mission and National Urban Health Mission. It has further been extended in march 2018 to continue until march 2020[33]. The goal of the mission is to improve the availability of and access to quality health by people specially residing in rural areas, poor women and children[34]. The aim is to improve health by providing equitable, affordable and quality health care that is accountable and responsive to the people's needs, reducing child and maternal deaths as well as stabilizing population and ensuring gender and demographic balance. The mission will help in enabling the system to effectively handle the increased allocation and promote policies that strengthen public health management and service delivery in the country.

4.4.3 NATIONAL POPULATION POLICY

The government announced the National population policy 2000, related to prevention and control of communicable diseases, giving priority to containment of HIV/AIDS infections; the immunization of child against all major preventable diseases; addressing the unmet needs for basic and reproductive health services, and supplementation of infrastructure. The synchronized implementation of the National Health policy and National Population Policy

[31] National Health Policy 2017
[32] Ibid
[33]Govt. of India, National Rural Health Mission 2005-201.
[34] Ibid

will be the very cornerstone of any national structural plan to improve the health standards in the country. National population policy was the preparation to expand and improve the quality of health services such as public- private partnership to cater for the growing population if the economic growth is to be sustained.

4.5 TRIPS, INDIAN PATENT ACT AND RIGHT TO HEALTH

The control and regulation of the price of pharmaceuticals serve as an important tool in promoting equity in access to healthcare. The pharmaceuticals policy 2002 of the government of India emphasized upon diluting drug prices control by suggesting criteria for price control that will reduce the basket of price control to a bunch of irrelevant 30or so drugs. The drugs that are left under price control are irrelevant to public health. The Drug Price Control Order of 1995 conspicuously omitted drugs for anaemia, diarrhoea, the majority of drugs for tuberculosis, hypertension, diabetes, and all drugs for cancer. The TRIPS agreement has impacted drug policy and pricing negatively for India because there has been a shift from the realm of health to that of trade. Right to health in India has not been enlisted as one of the fundamental rights in the Indian constitution, instead it is listed in the Directive Principle of State policy. In order to ensure health for all in an equitable basis, the political will is necessary which would necessitate a constitutional amendment and incorporate health within the ambit of Fundamental rights. India has come up with some basic policies to provide right to health but these policies are not able to provide best results because of the socio-economic factor of individual living in India. There is a big gap between the poor and rich and privatisation has widened that gap further and has made access to health care difficult for marginalized communities. Health in India is falling under the ambit of trade because of agreements like TRIPS and access to basic drug an issue. It’s time for India to come up with a strategy that all these issues will be resolved and health care is accessible to all.

CHAPTER-5

JUDICIAL APPROACH ON RIGHT TO HEALTH IN INDIA

Article-21 of the Constitution of India guarantees protection and life and personal liberty, it provides that "no person shall be deprived of his life and personal liberty except according to procedure prescribed by law"[35]. Public interest litigation has been founded in this provision for providing special treatment to children in jail; against health hazards due to pollution; against health hazard due to harmful drugs; for redress against failure to provide immediate medical aid to injured person; against starvation death; against inhuman conditions in after care homes and on scores of other aspects which makes life meaningful and not a mere vegetative existence. The Supreme Court of India by imposing a positive obligation on the states to take effective steps for ensuring to the individual a better enjoyment of his life. The courts till the beginning of 1970s provided the interpretation of life as right to exist, but during the late 1970s the meaning and scope of the word "life" and Article-21 started to widen. Over the years Artcle-21 provides that life does not only mean animal existence but the life of a dignified human being. Until early 1980s the judicial approach to issues in India were essentially centred on cases of medical negligence which was again very few in number. The environmental litigation helped majorly to recognize the right to health because it demanded decent and pollution free environment that followed the right to public health and healthcare. During 1980s majorly two developments that lead to increase in the number of health litigation i.e., firstly the establishment on consumer court that made it cheaper and speedier to sue doctors for medical negligence and secondly increase of public interest litigation and recognition of right to health care as a fundamental right. Article-21 has therefore expanded its meaning. In this chapter further various supreme court and high court judgements have been discussed.

5.1 PROTECTION OF RIGHT TO HEALTH DURING EMERGENCY

One of the most important aspect of health is emergency medical care. The court has done a commendable job in interpretation of Article-21 with respect to health in cases of an emergency. For the very first time the question of emergency medical care was picked up in

[35] INDIAN CONST. art.21

the case of Parmanand Katara v. Union of India[36]. In this case a human rights activist filed a case seeking directions against union of India that an injured person if brought for treatment, the same should start immediately to preserve life and the procedural criminal law should be allowed thereafter. It was observed that if a patient was brought before the hospital, doctors would not start treating them immediately but instead wait for the formalities by the police to be completed. Some doctors happen to not treat them even after the procedure is completed in the fear of happening to visit the court. The supreme court in the following case held that, there is no legal impediment for a medical professional when he called upon or requested to attend an injured person needing his medical assistance immediately. The top priority should be given to save a person's life not only by the medical practitioner but also police and any ordinary citizen. It is the professional obligation of a doctor to extend his service for protection of life. No state or law can intervene to avoid delay and discharge of the paramount obligation upon the member of the medical professional. It was further observed that medical profession is a respectable profession and doctors are the only hope of common man when someone is fighting for their life but the emergency cases were not looked upon because it was considered a medio-legal case. The court cleared some doubt regarding the law of procedure, the regulation of police and priority in situation of Emergency. The court made it clear in the affidavit that someone in the medical profession should not be harassed for the purpose of interrogation or unnecessarily dragged to the police station for the same. The courts are directed not to summon medical professional for evidence unless it is necessary and if summoned, should not be subjected to long waiting hours. The court further directed that if a medical professional is approached during emergency and it occurs that better medical support is needed, the case should be referred without any delay.

Another landmark case that of Paschim Banga Khet Mazdoor Samity v. State of West Bengal[37]. In this case Hakim Sheikh, a member of the Paschim banga khet mazdoor fell off a train and suffered head injury. He was immediately brought to a number of state-run health centres and specialist clinic for treatment. Seven state run hospital was not able to provide emergency treatment to him because of lack of bed, no trauma and neurological service. He was taken to a private hospital where he received treatment. Aggrieved by the situation, the petitioner filed a case for compensation. The court held that under Article-21 the states are under obligation to take every measure to protect life. The court also found that the primary

[36] AIR 1989 SC 2039
[37] AIR 1966 SC 2426

duty of a welfare state is to provide proper medical facility and treatment. The court gave guidelines such as upgrading of the state-run hospitals, a centralized helpline for emergency, ambulance facility. Irrespective of these guidelines there hasn't been much improvement and implementation because as seen in the public interest litigation filed in the year 2000 in the case of Dr. Chander Prakash v. The Ministry of Health[38]. The petitioner, a surgeon wrote a letter to the Chief Justice which was treated as a writ petition. The petitioner in the letter pointed out the inadequacy, inefficiency in medical care in case of emergency. He prayed to the court to issue guidelines for the same and the court referred to the above two decisions, wherein guidelines have been issued for the same. The court also referred to Article-141 and states that the same judgement laid down by the Supreme court is binding on all the courts and the provided guidelines to be strictly followed.

5.2 WORKERS RIGHT TO HEALTH

There are large number of workers in India with very little earning contribute a lot for the progress of the country. These workers are generally uneducated and belonging from low socio-economic background which adds up to their miseries, number of Human Rights are violated in every phase of their life. The supreme court after being well aware of the situation have ensured the protection of human rights of these works through judicial decisions. In the case of C.E.S.C. Ltd. V. Subhash Chandra[39] the supreme court placed reliance on international instruments and declared the right to health is a fundamental right, it further provided health is not merely absence of sickness. It was observed by the court that in the light of Articcle-21 to 25 of Universal Declaration of Human Rights, International Convention on Economic, Social and Cultural Rights and in the light of socio-economic justice assured in our constitution. Right to health is a fundamental human right to workmen. In the year 1955 a PIL filed in the supreme court concerning occupation disease faced by workers in the asbestos industry in the case of Consumer Education and Research Centre v. Union of India[40]. The court held that right to life is an integral part of right to health and gave seven guidelines with regards to occupational health hazard i.e., industries are directed to keep health records of workers, all industries should adopt "the membrane filter test", all

[38] AIR 2002 Del 188
[39] (1992) 1 SCC 441
[40] (1995) 3 SCC 42

employees should be insured, determine standard permissible exposure limit, cover workmen under Factories Act of 1948 and re-examination of workmen suffering from asbestosis.

In the case of State of Punjab v. Ram Lubhaya Bagga[41]. The responded a government servant claimed reimbursement for treatment at a private hospital as per the policy dated 13th February,1995. The court held that the state can neither urge nor say that it has no obligation to provide medical facility. If that was so it would be ex facie violation of Article-21. Under the new policy the medical facility continues to be given and now an employee is given free choice to get treatment in any private hospital in India but the amount of payment towards reimbursement is regulated.

In the case of Municipal Corporation Delhi v. Female Workers[42]. The issue in this case was of Maternity leave, which was provided only to the regular working women of the company and the same was denied to the irregular ones on the ground that their service was not regularized, therefore they are not entitled to maternity leave. In this case the court held that workmen or those employed on muster roll for carrying out activity would be termed as workmen and the dispute between team to be tackled according to the provisions of the industrial law, hence they are eligible for maternity benefit.

The major issue of sewage was tacked by the court in the case of Praveen Rashtrapal v. Chief Officer, Kadi Municipality[43]. The PIL was filed for the sewage workers as because the condition of working for them was posing serious health danger sometimes which resulted into fatality. The petition brought under light the issue of sewage in Ahmedabad and other major cities in India. The effluent from the industries and domestic waste mixes together and results in emission of poisonous gas that can make a person inside the drain unconscious.

The court issues several guidelines because for protection of health of workers viz.

(i) a manhole should be properly investigated before entering and the person entering the hole should be provided with all the safety equipment's such as torch, mask, oxygen, gumboots etc

(ii) If the hole is found to be unsafe for the worker, the worker should not be allowed to enter the hole. If he is force to enter by the office the same shall be given in writing and in case of

[41] AIR 1998 SC 1703.
[42] AIR 2000 SC 124
[43] 2006 (2) GLC 786

any accident the responsibility will lie on the officer and exposing them to civil or criminal liability

(iii) The manhole if undergo cleaning, the office on spot should collect sample and do necessary testing. It the hole is found to have poisonous maters the entry and cleaning should be prohibited

(iv) works should be provided with a small pocket book containing information relating to the nature of manhole work and emergency contact number.

(v) Health and Safety training should be provided to the workers

(vi) The preventive and supervisory measures should be taken care by a safety committee.

(vii) Regular medical check-up of the workers should be conducted and if someone found affected should be transferred to a health facility

(viii) Every civic body should provide facilities such as accommodation and education to help them and the families to live a dignified life.

(ix) The works are to be insured and the premium to be paid by the civic body.

5.3 HIV PATIENTS AND THEIR RIGHTS

In the society individuals suffering from HIV have to face largescale discrimination. People suffering from the virus are often denied care and support which results in the violation of rights. The court has dealt with the issue by delivering judgements. The Andhra Pradesh High court in the case of M Vijaya v. Chairman, Singareni Collieries Hyderabad[44] observed AIDS as a public health issue and it needs to be articulated in reference to the constitutional guarantee to the right to life, making the health providers and employers accountable for negligence, omission or failure to confirm to procedure. The issue in the case was that Vijaya had undergone a surgery in the company's hospital for which her brother donated blood. 15 days after the surgery she felt sick and after the suggested tests it came out that Vijaya was HIV positive while her husband was negative but Vijaya's brother tested positive. It was observed by the court that the hospital did not test the blood before collection. The court awarded a compensation of Rs 1 lakh rupees to the aggrieved.

[44] 2001 (LD) 522 (LB)

The protection of privacy of a person is of outmost importance but there are exceptions as well, which was seen in the famous case of Mr. X v. Hospital Z[45]. In this case the appellant tested HIV+ and had proposed for marriage which had been accepted. There was a risk of another person being infected by the virus, so the doctor disclosed about the patient's condition. The appellant approached the National Consumer Dispute Redressal Commission for damages on the ground that the information was to be kept private. The commission dismissed the case by station that the civil court is to be approached for the same. The court held that the Hippocrates oath is not enforceable in the court if law because it has no statutory force, the code of professional conduct made by the Indian Medical Council Act regulates the protection of information about a person. The court also brought reference about English law that permits limited disclosure when public interest is under question, and in this case the circumstance was such that the person marrying the appellant had an immediate health risk not remote or past. So, the disclosure does not violate privacy because the lady was saved by such disclosure. The court observed that mental and physical health is of prime importance in a marriage and one of the objects of marriage is procreation of children. The court also put light under section 269 and 270 of the Indian Penal Code which states that it is an offence if a person suffering from a dreadful disease knowingly marries another. The court made it clear that when there is a clash of two fundamental rights, the right that would advance public interest and morality would prevail. Another case of similar significance was that of Smt. Lucy R. D'Souza v. State of Goa. In this case according to section 53(1)(viii) of The Goa, Daman and Diu public Health Act, 1987 empowered the state government to put people suffering from HIV into isolation as it deems fir. The Act was challenged on the ground that it was violative of Article 14, 19(1) and 21 of the Indian Constitution. The court held that the above Act id not violative and is reasonable because the Act was dealing of patients suffering from a dreadful disease and it's a preventive measure the protect the general public from the risk of getting infected by the virus. The court also made it clear that in case of conflict between individual right and public interest, the former must yield to the later.

5.4 PRISONERS' RIGHT TO HEALTH

Some of the basic fundamental rights such as right to freedom of movement or to choose a profession are few rights that are not available to Prisoners and under trail and very few are

[45] AIR 1999 SC 495

available to them, right to life is one such right that is available to the prisoners or under trails when they are behind the bar. Cases have been reported wherein they were denied basic fundamental rights such as health, food, clean drinking water and sanitation. Cases relating to same has been discussed here. One such famous case where supreme court ensured rights of under trail prisoners was Hussainara Khatoon v. State of Bihar[46]. This was a PIL which was based on a newspaper report published by Indian Express reporting several under trails, including women and children in the prisoners of Bihar waiting for their trail for years. The court provided for free legal aid along with medical aid. On the basis of the data provided by the Bihar government regarding the pending cases and the ratio of judges and prisoners, the Apex Court also considered the situation of person of unsound mind. The court ordered that person with unsound mind should not be kept in ordinary jail along with other under trail prisoners. Another case dealing with the right of under trail prisoners is Marri Yadamma v. State of Andhra Pradesh[47]. In this case an under-trail prisoner died of congestive cardiac failure inside the jail and the spouse filed a petition on his behalf stating that there has been negligence on part of the jail authority. The doctors in the jail were not able to provide proper medicine and care, the patient was not even referred to a specialist outside the jail. The court held that the ailment from which the petitioner was suffering is developed over time and this proves that there has been negligence on the part of the respondent because he often complained of ill health yet he was not referred to the surgeon or specialist. The court added that one person by being inside a jail loses his right of movement but all other rights such as right to treatment remain intact. The court also provided for 2 lakh rupees as a public remedy to the widow.

A famous case of torture has been addressed by supreme court in Anil Yadav v. State of Bihar[48]. In this case a letter was considered as a writ petition. Some 20 under trail prisoners were tortured in the Bihar jail. The person during investigation inflicted pain by piercing eyes with acid and spikes which resulted in the prisoners turning blind. The court ordered to give medical aid and rehabilitation at the expense to the Bihar government. Again, in the case of Sunil Batra II v. Delhi Admiration[49]. In this case the court guaranteed the right to prisoners, the court emphasised on the fact that a prisoner does not lose all his rights when he is taken under custody or put in jail. A letter was written to the Supreme Court by a life convict that

[46] AIR 1979 SC 1819
[47] (1981) 1 SCC 622
[48] 2003 ACJ1087, 2001(6) ALD821
[49] AIR 1980 SC 1579

the jail warden inflicted injuries and ordered money from his relatives. The court treated the letter as a writ petition and observed that a prisoner may be deprived of his right to movement but all other freedoms such as right to health remain intact. The court took cognizance in the matter of illegal detention of prisoners in jail in the case of Veena Seth v. State of Bihar[50]. In this case six prisoners were insane and they had to be released by orders of the supreme court for medical treatment. The court remarked and observed that there must be adequate number of institutions for looking after mentally sick and sending lunatic and person of unsound mind to jail for safe custody is not at all a healthy or desirable practice, because jail is not the place where they can be treated. The court directed the jail superintendent to have such mental patients to be examined by a physiatrist once every six month and submit a report to the district judge. If the result of such examination suggests that the person is sane the judge will order their release and the state government will provide an expense which will be used during the journey to the native place and also for a week stay. The court choose not to interfere in the case of poisoners of unsound mind who were sentenced for different offence and their sentence of imprisonment is yet to expire. But in their respect as well the court directed a half-yearly report about their mental conditions must be submitted to the state government.

The court provided for procedures to be followed while arrest in order to address the issue of custodial violence in the case of D.K. Basu v. State of West Bengal[51]. The direction related to health was that the arrestee should be subjected to medical examination by a trained doctor every 48 hours during his detention in custody by a doctor on the panel of approved doctors appointed by director, health service of the concerned state or union territory. The director should prepare such a panel for all tehsils and districts as well.

5.5 VIOLATION OF RIGHT TO HEALTH IN PROTECTIVE HOME/ MENTAL HOSPITALS

In the case of Indian Council of Legal Aid & Advice v. Union of India and others[52] the Supreme Court directed to have compulsory periodic medical examination and treatment of blind school inmates. Further the court directed to draw a scheme for such inmates and issue

[50] (1982) 2 SCC 583
[51] (1997) 1 SCC 416
[52] (1995) 1 SCC 732

notices to health secretaries of all state. The court took Suo moto acting in the case of Saarthak Registered Society and Anr v. Union of India[53]. In this case 25 chained inmates were dead due to fire in their asylum house which at Ervadi in Ramanathanpuram district in Tamil Nadu. The inmates could not escape the fire due blaze because they were chained to poles and beds. It was submitted to the court that The Mental Health Act, 1987 was not at all implemented by the concerned authority and also the central and state government failed to look into the implementation. The court held that the provisions of the Act was not implemented and issued direction for the implementation of the provisions of the Act in full vigor. The guidelines also specifically were relating to licencing and de-licencing of all registered and unregistered bodies. The court further directed the Chief Secretary or Additional Chief Secretary to be nodal agency in the implementation of Mental Health Act, 1987; The persons with disability (Equal opportunities, Protection of Rights and Full Participation) Act, 1955 and The National Trust for Welfare of Persons with Autism Cerebral Palsy, Mental Retardation and Multiple Disability Act, 1999. Furthermore, awareness campaign under the supervision of central and state government with special focus to educate people as to provisions of law relating to mental health, rights of mentally challenged person, the fact that chaining of mentally challenged persons is illegal and the mental patients should be sent to doctors instead of religious places like temples and dargahs.

The supreme court in continuation of the order given in the case above issued direction for maintenance of psychiatric hospital and mental hospital. The union government were directed to

● To frame policies and take steps for the establishment of one central government run metal hospital in each state along with a mental hospital run by the State Government in each state as per guidelines provided under Section 5 of The Mental Health Act 1987.

● To constitute a committee which would provide recommendation in case of mentally challenged persons who has no immediate relative or are abandoned by one.

● To NGO's working in the field of mental health to follow framed norms and the service provided by the NGO is supervised and rendered by a qualified/ trained person.

● To provide patients with free legal aid as because they are unaware of their rights.

● Guardians and patients to be informed about their rights.

[53] AIR 2002 SC 3693

● The central government should formulate a Board that would visit every state and private hospitals at least once in a month.

● A rehabilitation scheme to pe processed for patients getting discharged and not having background support.

Another case in which the supreme addressed the issue of inhuman condition in asylum was that of Upendra Baxi v. State of UP[54]. In this case a letter was written by doctor addressing the inhuman conditions of an Agra Home and was turned into a petition by a court. The court directed a panel of doctors to visit the home and investigate the status of the inmates. It was found out by the panel that 50 of them were suffering from TB, many other from mental retardation, disorder and serious contagious diseases. The superintendent of the home was questioned by the court whether the inmates ever had a medical check-up and directed to provide enough number of latrins and bathrooms, vocational training scheme, rehabilitation and reconstitution of the board of visitors who's termed had expired. Minor girls who were kept in the company of prostitutes rescued from brothels and suffering from disease were ordered to kept separately. There were several other orders passed simultaneously to monitor the progress of the implementation.

The court addressed the issue of abominable conditions of a mental hospital in the case of B.R. Kapoor v. Union of India[55]. In this case Shahdara mental hospital run by Delhi Administration which lacks basic amenities, medical care and no separation between criminal lunatics and others. The court asked a panel of doctors to visit the home and inspect the allegations. The committee submitted a three-volume report on all aspects confirming most allegation made in the petition, it suggested 35 remedial steps regarding admission to the hospital, treatment and discharge of patients, constitution of board of visitors, sanitary conditions, food and kitchen, staffing pattern, ill-treatment of patients by staff, attempts to commit suicide, deaths in the hospital and availability of emergency medical care. The Court asked the Delhi Administration to rectify the defects pointed out, but it was "very slow" in responding to the matter and took three years to file its reply to the court. So, the Court recommended to the Central Government to take over the hospital from the Delhi Administration in view of the fact that it is in the capital. Another case dealing with the detreating condition of hospital by the court is Rakesh Chandra Narayan v. State of Bihar[56].

[54] (1983) 2 SCC 308
[55] (1989) 3 SCC 387
[56] AIR 1989 SC 348

In this case the Ranchi mental Hospital in Bihar was in a pathetic condition but the state government was neglecting its duty to improve the conditions in the hospital. A letter was written by two citizens of Patna to the Chief Justice of India stating the condition of the mental hospital which was run by the Bihar health department with financial aid from Orissa and West Bengal. There was acute shortage of water, toilets were not in order, fans were not in a condition to function, no lighting, lack of clothes for patient, no account of medicine, lack of medical equipment and sanctioned food of Rs. 3 per say per head. The court asked the health secretary to put forth a scheme for the improvement of conditions and also passed several directions such as raising the food allowance to 10, proper water supply, restoration of sanitary facility, provisions of mattress and blankets, appointment of psychiatrists and scrapping ceiling for cost of medicine. One more case with abominable condition of hospital that supreme court dealt with was Supreme Court Legal Aid Committee v. State of MP[57]. In this case dealt with the Ranchi Asylum highlighting the condition there. The court order for constitution for looking after the admirative matter instead of health departments.

5.6 CHILDRENS' RIGHT TO HEALTH

The question with regards to right of children has been dealt in the case of R.D. Upadhyay v. State of A. P[58]. In this case a writ petition was filed before the court highlighting upon the inadequate arrangements of children living in jail with prisoner mother pertaining to education, medical care and overall development of children. The Prison Management Bill, 1998 was studied which provides for various rights and duties of prisoners like right to live with human dignity, adequate diet, health and medical care, clean hygienic living conditions and proper clothing etc. The court clarified that the rights of children of women prisoners living in jail are broader than these all rights, since the children are not prisoners as such but are merely victims of unfortunate circumstances. The court in this case issued various guidelines for the children. Guidelines pertaining to the health and development of the child as issued by the court are mainly focused as follows:

(i) Not to treat a child as an under-trial/convict while in jail with his/her mother. Such a child is entitled to food, shelter, medical care, clothing, education and recreational facilities as a matter of right.

[57] AIR 1994 SC 601
[58] AIR 2006 SC 1946

(ii) A woman prisoner who is found or suspected to be pregnant should be provided with adequate pre-natal and post-natal medical care.

(iii) The fact that the child is born in prison should not be recorded in the birth certificate.

(iv) Adequate clothing suitable to the climate be provided to the children.

(v) Nutritional and dietary needs of the children be taken care for proper development of his physical and mental health.

(vi) Clean drinking water be provided to the children.

(vii) Regular examination of children by a Medical Office be done to monitor the physical growth and for timely vaccination.

(viii) Children should not be placed in crowded barracks amidst women convicts, undertrials as it is certainly harmful for the development of their personality

The court also ordered to give priority to cases of women prisoners who are staying with their children in jails.

In People's Union for Civil Liberties v. Union of India[59]. The supreme court directed the state government to fully implement the Integrated Child Development Services (ICDS) scheme by 2008. It also directed the Centre to ensure that, by 2008, 14 lakh anganwadis should be set up. The orders were in response to a public interest litigation filed in 2001 by the People's Union for Civil Liberties (PUCL) seeking directions to the Centre and State Governments to implement the ICDS properly and fully. During the hearing of the case in 2004 the court expressed its dismay over the poor implementation of ICDS. The court put light on the fact that anganwadis are run under Integration Child Development programme whose aim is to increase nutritional and health status of pre-school children, pregnant women and nursing mothers by providing them supplementary nutrition package, pre-school education, immunization, health check-ups, referral programmes, nutritional and health education. India has set up more than 500,000 anganwadis centre but its working hasn't been satisfactory. The above decision is an important step and example of judicial activism and looks into implementation of the concept of health and universal literacy as the fundamental right of all the citizens in India. The court observed that right to health has been declared to be a fundamental right in CERC case. The Court reinterpreted Article 21 of the Constitution of

[59] AIR 1997 SCC 301

India and reinforced "right to life" as a fundamental right, side-stepping the issue whether the Directive Principles of State Policy are legally enforceable.

The case that dealt with the working condition of children in factories is M.C. Mehta v. State of Tamil Nadu[60]. In this case a match factory located in the sivakshi town of Tamil Nadu, where children were made in dangerous condition and denied fundamental rights. The judge gave a clear statement that the working of children in should dangerous conditions should be strictly prohibited. It is also violative of Article 39(f) and Article 45 of the constitution of India that provides for protection of children and free and compulsory education thill the age of 14. Children can be employed only in the place of packing away from production due to safety reasons. Facilities that improve the quality of life such as education, recreation and socialisation should be provided. The government was directed to provide recreational and medical facility and consideration should be given to diet as well.

Similar issues were addressed by the court about dealing with child labour in hazardous condition in the case Bandhua Mukti Morcha v. Union of India[61]. In this case factories such as slate pencil mines, diamond cutting, silk, brocades and circus industries which can be hazardous for a child's health. The court ask the employers who employed children to pay a compensation of Rs. 2000 for every child employed. The inspectors appointed under child labour Act were directed to collect compensation and to deposit them in the child labour Rehabilitation cum Welfare fund. The funds generated is to be used for rehabilitation of children.

A public interest litigation was filed to address the issue of Children suffering from leprosy in the case Mrs Rathi v. Union of India[62]. In the PIL filed a prayer was made to provide separate school with vocational training along with hostels and medical facilities in every district of Uttar Pradesh for children of lepers. The petition pointed out the lepers of three leprosy homes in Allahabad were not getting any assistance from the government except the medicines which is at the free will of hospital authorities. Hence considering the relief claimed by the petitioner just and in accordance with Article 21 of the Constitution of India which has been interpreted by the Supreme Court to mean that every citizen is entitled to a life of dignity the court ordered to provide all facilities including medical facilities to the children of lepers.

[60] AIR 1991 SC 417
[61] AIR 1997 SC 2218
[62] AIR 1998 ALL 331

5.7 INCREASING POLLUTION LEVEL AND THE RIGHT TO HEALTH

Increasing pollution has been one of the biggest concerns in the world we live in today. There has been active judicial intervention for safeguarding the right to health and one such case is Rural Litigation and Entitlement Kendra, Dehradun v. State of Uttar Pradesh [63]. In this case the concern was about limestone quarries of Mussorie Hills and the health of the people living in the valley. The petitioner highlighted the fact that dams, quarries, factories and tourism projects threaten the villages and suburbs and the health of the people living there. Furthermore, the petitioner Rural Litigation Kendra filed a writ petition alleged that the lime stone quarries were destroying the flora and fauna of the Himalayan Valley and therefore their continued operation was a threat to the lives of the people there. Air and water are polluted and causes health hazards and therefore their fundamental right under Article 19 and 21 were violated. The Court in this case appointed several committees to verify the allegations contained in the petition. One of such committees, the Bhargav Committee visited the area and divided the quarries into three categories. One category of quarries was so hazardous that they had to be shut down. The Court ordered their closure permanently. The other two categories of quarries were less harmful and so another committee was appointed which recommended some corrective measures. The Court pointed out that the present laws like The Mines Act, 1952 or the Metalliferous Mines Regulations 1961 were not implemented properly. The main question in this case was whether for social safety and for creating hazardless environment for the people to live in, mining in the area be permitted or stopped. Hence the court considering the health of the people gave directions regarding the erring mines.

The supreme court has dealt with the issue of environmental pollution in the case of A.P. Pollution Control Board-II v. Prof. M.V. Nayudy (Retd.) & ors[64]. In this case State of A.P. was directed to identity polluting industries located within 10 k.m. radius of Osman Sagar and Himayaat Sagar lakes which catered to the needs of over 50 lakhs people, in Hyderabad and Secunderabad, and to take action in consultation with the A.P. Pollution Control Board to

[63] AIR 1985 SC 652
[64] 2000 SCCL.COM 686

prevent pollution to the drinking water in the reservoirs. The Supreme Court held that Article 21 of the Constitution of India includes right to healthy environment.

The Supreme Court issued directions to the Delhi government regarding the established and closure of industries located around residential areas in Delhi in the case of M.C. Mehta v. Union of India and others[65]. the Supreme court issued Directions to the Delhi Government about all Industrial Units that have come up in Residential/non-conforming areas in Delhi on or after 1st August, 1990 shall be closed down and stop operating as per the schedule. The Central Government was directed to finalize the list of permissible household industries within a period of three months. The court further held that the Delhi Government may announce a policy within six weeks giving such incentives as it may deem fit and proper to those industrial units which came to be established after 1st August, 1990 and may close down on their own before the expiry of the time fixed in this order clarifying further that the non-announcement of incentives by the Government shall not, however, delay the closure process etc.

Another case of pollution in Delhi is M.C. Mehta v. Union of India[66]. In this case the Supreme Court, taking into consideration the increasing pollution levels in New Delhi due to diesel emissions, and that such exposure to toxic air would violate to the right to life and health of the citizens, directed all private non-commercial vehicles to conform to Euro-II norms within a specified time period. Apart from this decision relating to pollution the petitioner Mr. M.C. Mehta, a social activist has filed a number of cases in the Supreme Court in relation to Ganga Water Pollution, closure of hazardous units etc.

In Virender Gaur v. State of Haryana[67], the Supreme Court held that environmental, ecological, air and water pollution, etc., should be regarded as amounting to violation of right to health guaranteed by Article 21 of the Constitution.

In Santosh Kumar Gupta v. Secretary[68] a public interest litigation was filed because of the pollution of the air in the city of Gwalior on account of plying of a large number of motor vehicles using unauthorized kerosene oil and diesel causing health hazards to the inhabitants. The court taking into consideration health hazards due to the pollution of the atmosphere by smoke, emitted by the vehicles issued directions to measure the pollution level by different

[65] 2004 SCCL.COM 550
[66] AIR 1996 SCC 9
[67] AIR 2001 SC 1544
[68] AIR 1995 SCC 577

instruments and thereby strictly complying to Section 20 of the Air Pollution Act which deals with the power of State board to give instructions for ensuring standards for omission from automobiles. The court said that the human life is more important than the traffic and vehicles and so the law and the rules framed in respect to ensure environment cleanliness should be strictly followed.

B.L.Wadehra v. Union of India[69] the case dealt with right to live in clean environment. As clean environment is very important for health of citizens the court gave several directed to all the civic authorities in the country. The directions were relating to distribution of polythene bags and door to door collection of garbage for disposal, installation of incinerators in all major hospitals and nursing homes, inspection by the Central Pollution Control Board to verify the collection and proper disposal of garbage, education of people on civic duties through TV, building of compost plants and expert study of alternative garbage disposal system and solid waste disposal.

In Sanjay Phophalia V. Rajasthan[70], a writ petition was filed praying to take custody of the animals roaming in public roads and places. It was stated that no appropriate steps have been taken by the respondents restraining the roaming of number of animals on the roads, hospitals, railway station, and High Court premises and in the city. The petitioner said that this not only creates hindrance in the public transport but also has created a havoc amongst the public as the roaming dogs, pigs, oxes, cows, camels, buffaloes, donkeys etc. are dangerous to the people and children. Numerous incidents and accidents were taken place regarding the biting and assaulting by the aforesaid animals for which the public at large has to suffer. Hence common man was deprived of his right to life guaranteed under Article 21 of the Constitution of India. The court relied upon Municipal Council, Ratlam v. Vardhichand[71], wherein it was observed that a responsible Municipal Council constituted for the precise purpose of preserving public health and providing better finances cannot run away from its principal duly by pleading financial inability. The court also relied on the case of L.K. Koolwal v. State of Rajasthan[72] wherein it was observed that 'it is primary, mandatory and obligatory duly of Municipality to keep city clean and to remove insanitation, nuisance etc. Hence emphasizing the duty of the Municipality, the Court very well intended to protect right to health.

[69] AIR 1996 SCC 594
[70] AIR 1998 RAJ 96
[71] AIR 1980 SC 1622
[72] AIR 1998 RAJ 2

In Law Society of India vs. Fertilizers and Chemical Travancore Ltd[73] the court dealing with hazardous industries held that right to life includes right to environment adequate for human health and well-being. Hence while running hazardous industries using highly advanced technology; it is imperative that human safety be given prime importance. Environment which is adequate for human health is included in right to life.

5.8 BAN ON PUBLIC SMOKING TO PROTECT RIGHT TO HEALTH

The Supreme Court has well observed the adverse effect of passive smoking and to look after the health of non-smokers the court has prohibited public smoking time and again. The court has prohibited public smoking in the case of Murli Deura v. Union of India and Others[74]. The case was a public interest litigation which prohibited public smoking on the ground that public smoking is injurious to health to the health of passive smokers. Directions were given by the court to the central and state government to take appropriate measures for the same. The court prohibited smoking in public places such as auditorium, hospitals, health institutions, library, court, educational institutes, public office and public place of conveyance including the railway station. The court took reference from The Cigarettes (Regulation of Production, supply and Distribution) Act, 1975 which provided that smoking is harmful habit and in the course of time it can lead to grave health hazard. According to researches conducted in different parts of the world have confirmed that relationship between smoking cigarettes and lung cancer. Chronic bronchitis, cancer of bladder, prostrate, mouth pharynx and oesophagus, peptic ulcer etc. are some of the other ill effects of cancer.

A similar case addressing the issue of public smoking and effect on passive smokers is K. Ramakrishnan v. State of Kerala[75]. In this case the issue of how while smoking in public place the non-smokers or passive smokers involuntarily consume more toxin than the actual smoker and how it turns it affects them more. The court held that smoking of tobacco in any form of cigarettes, cigars, beddies or otherwise in public places such as educational institutes, hospitals, shops, restaurant, commercial establishment, bars, factories, cinema theatres, bus stops and stations, railway station and compartment is illegal, unconstitutional and violative of Article 21 of the Constitution of India because it adversely affect the life of a citizen by slow and insidious poison thereby reducing the very life span itself. The court observed that

[73] AIR 2002 SC 40
[74] AIR 2002 SC 40
[75] AIR 199 Kerala 385

smokers along with themselves are putting lakhs of non-smokers at risk. The foundation of human body is health and in a welfare state it is the obligation of the state to ensure same. The High Court issued directions to authorities such as district collector, director General of police etc to look into the matter and initiate criminal proceedings against those who are found smoking in public place.

5.9 SHORTAGE OF FOOD AND RIGHT TO HEALTH

The supreme court of India in many of its decision have reiterated that right to life guaranteed under Article-21 of the constitution includes basic right to food, clothing and shelter[76]. It is indeed surprising that the justifiability of the specific Right to food as an integral right under Article-21 had never been articulated or enforced until 2001! Prior to the big Right to food petition filed by PULC in 2001, the only other case concerning specifically the right to food, went up to the supreme court in 1989 was the case of Kishen Pattnayak v. State of Orissa[77]. In this petition, the petitioner wrote a letter to the Supreme Court bringing to the court's notice the extreme poverty of the people of Kalahandi in Orissa where hundreds were dying due to starvation and where several people were forced to sell their children. The letter prayed that the State Government should be directed to take immediate steps in order to ameliorate this miserable condition of the people of Kalahandi. This was the first case specifically taking up the issue of starvation and lack of food. In this judgment, the Supreme Court took a very pro-government approach and gave directions to take macro level measures to address the starvation problem such as implementing irrigation projects in the State so as to reduce the drought in the region, measures to ensure fair selling price of paddy and appointing of a Natural Calamities Committee. None of these measures actually directly affected the immediate needs of the petitioner - i.e., to prevent people from dying of hunger. More importantly, the Supreme Court did not recognize the specific right to Food within this context of starvation.

Again, in the State of Orissa there was a massive drought in 2001. Due to the drought, lack of access to food grains and poverty people were starving in large numbers. While the poor were starving in the drought hit villages, the Central Government had excess food grains in its storehouses, which were not being disbursed and were rotting! The agitation in the country

[76] Chameli Singh v. State of UP (1996) SCC 549; Paschim Banga Khet Nazdoor Samity v. State of West Bengal (1996) SCC 37.
[77] AIR 1989 SC 677

over lack of access to food grains in the drought hit states took rapid momentum after shocking incidents of people in some of the poorest districts of Orissa dying due to starvation. Slowly, the agitation over access to food became a full-fledged right to food campaign in the country. As part of the campaign a PIL in the supreme court of India was filed by Peoples' union of civil liberties[78]. The case was filed to for enforcement of the right to food of the thousands of families that were starving in the drought struck States of Orissa, Rajasthan, Chhattisgarh, Gujarat and Maharashtra, and where several had died due to starvation. As relief measures, the petition demanded many things, the immediate release of food stocks for drought relief, provision of work for every able-bodied person and the increase in quota of food grains under the Public Distribution Scheme (PDS) for every person. This was the very first time that a distinct right to food was being articulated as encompassed within Article 21 and was sought to be enforced in the Supreme Court. The Supreme Court expressed serious concern about the increasing number of starvation deaths and food insecurity despite overflowing food in FCI storehouses across the country. In its several hearings, the Court directed all State Governments to ensure that all Public Distribution Shops are kept open with regular supplies and stated that it is the prime responsibility of the government to prevent hunger and starvation. On 23 July, 2001, recognizing the right to food, the court said, The Supreme Court, thus recognized a distinct right to food under the Constitution under Article 21 and also sought to broaden the scope of the right to not only encompass the right to be free from starvation, but to also include distribution and access to food and the right to be free from mal-nutrition, especially of women, children and the aged. The Court, again in an unprecedented interim order on 28 November 2001[79], directed all the State Governments and the Union of India to effectively enforce eight different centrally sponsored food schemes to the poor. These food security Schemes were declared as entitlements (rights) of the poor, and the Court also laid down very specific time limits for the implementation of these schemes with the responsibility on the States to submit compliance affidavits to the court. These included the Antyodaya Anna Yojna, the National Old-Age Pension Scheme, the Integrated Child Development Services (ICDS) programme, the National Mid-day Meals Programme (NMMP), the Annapurna scheme and several employment schemes providing food for work. Of the eight schemes, the most significant was the Mid-day Meal Scheme and the direction of the Court to all State Governments to provide cooked mid-day meals in all government schools by January 2002.

[78] Peoples Union for Civil Liberties v. Union of India W.P. (Civil) No. 196/2001
[79] Unreported interim order dated 28th Nov,2001

5.10 MEDICAL NEGLIGENCE CASE

In order to decide the case of medical negligence the court has to see that what standard of care has been applied by the medical practitioners. The test has been provided in an English case of medical negligence applied and accepted by the House of Lords in many cases[80]. Similarly, the Indian cases also apply the same test provided. The question that under what circumstances a medical practitioner can be regarded as rendering service under Section 2(1)(o) of the consumer protection Act, 1986 arose in the case of Indian Medical Association v. V P Santha[81]. The court discussed in length various decisions of the Hight Court, National Commission, supreme court and various landmark foreign cases and finally came to a conclusion that

(i) Service rendered to a patient by a medical practitioner, by way of consultation, diagnosis and treatment, both medicinal and surgical, would fall within the ambit of 'service' as defined in Section 2(1)(o) of the Act.

(ii) Service rendered free of charge by a medical practitioner attached to a hospital/Nursing home or a medical officer employed in a hospital/Nursing home or at a non- Government hospital/nursing home or at a Government hospital/health center/dispensary, where such services are rendered free of charge to everybody, would not be "service" as defined in Section 2(1)(o) of the Act. The payment of a token amount for registration purpose only at the hospital/nursing home would not alter the position.

(iii) Service rendered at a non-Government hospital/Nursing home where charges are required to be paid by the persons availing such services falls within the purview of the expression 'service' as defined in Section 2(l)(o) of the Act.

(iv)Service rendered at a non-Government hospital/Nursing home, Government hospital/health center/dispensary where charges are required to be paid by persons who are in a position to pay and persons who cannot afford to pay arc rendered service free of charge would fall within the ambit of the expression 'service' as defined in Section 2(l)(o) of the Act irrespective of the fact that the service is rendered free of charge to persons who are not in a

[80] Whitehouse v. Jordan (1981) 1 AII ER 267; Maynard v. west Midlands Regional Health Authority (1985) 1 AII ER 635; Sideway.
[81] AIR 1995 SCC 651

position to pay for such services. Free service, would also be "service" and the recipient a "consumer" under the Act.

(v) Service rendered by a medical practitioner or hospital/nursing home cannot be regarded as service rendered free of charge, if the person availing the service has taken an insurance policy for medical care or is an employee/dependent receiving the expenses of medical treatment from the employer would fall within the ambit of 'service' as defined in Section 2(l)(o) of the Act

With this decision the medical profession has been considered to be a service under the Consumer Protection Act, 1986 and hence the following Medical Rights flows from this decision:

(a). RIGHT TO MEDICAL RECORDS which includes right to case papers, clinical notes and diagnostic reports, all medical records that pile up in hospitals. "All medical records made in the course of treatment rightfully and legally belong to patients," If refused, patients can demand their records in writing and hospitals are bound by law to produce copies within 72 hours.

(b). RIGHT TO INFORMED CONSENT wherein it is obligatory for doctors to inform patients and seek their permission before introducing or altering treatment," Patients should rightfully know alternative treatment options or cheaper alternatives. They also have the right to demand a second opinion.

(c). RIGHT TO EMERGENCY CARE wherein the hospitals have to first treat injured person brought to their doorstep and only then can they demand money or complete police formalities.

The Supreme Court laid down certain guidelines in a case of medical negligence in the case of Jacob Mathew v. Punjab[82]. The Supreme Court was also very sympathetic towards the medical practitioners who face an emergency. The court observed that a medical practitioner faced with an emergency ordinarily tries his best to redeem the patient out of his suffering. He does not gain anything by action with negligence or by omitting to do an act. The court further laid down that for an act to amount to criminal negligence, the degree of negligence should be much higher i.e., gross. The court in absence of any kind of guidelines from the Central and the State Government laid down the following guidelines so as to govern the

[82] AIR 2005 SC 3180

prosecution of doctors in future in cases of criminal rashness or criminal negligence. A private complaint may not be entertained unless the complainant has produced prima facie evidence before the Court in the form of a credible opinion given by another competent Doctor to support the charge of rashness or negligence on the part of the accused Doctor. The investigating officer should, before proceeding against the Doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion preferably from a Doctor in Government service, qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion applying the case of Bolam, test to the facts collected in the investigation. A doctor accused of rashness or negligence, may not be arrested in a routine manner, unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigating officer feels satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest may be withheld.

In A.S. Mittal v. State of UP[83]. The Lions Club at Khurja in U.P. organized, as part of its social service programme, an eye camp for the citizens. The club invited a team of eye surgeons from Rajasthan to offer their services. They operated upon the eyes of 108 patients, 88 of them for cataract, which was considered to" be low-risk surgery. Though the intention was laudable, the programme proved a “disastrous medical misadventure” for the patients. 84 patients lost their eyesight and so two social activists filed a public interest petition and the Supreme Court issued notices to U.P. government, the medical officers, the Lions club, the Central Government and the Indian Medical Council. The Supreme Court considered only two questions: (a) whether the guidelines issued by the Central Government prescribing norms and conditions for the conduct of eye camps are sufficiently comprehensive? And (b) what relief, monetary or otherwise, should be afforded to the victims? Regarding the guidelines the court noted that the Central Government had revised the guidelines in the wake of the Khuija Catastrophe and with a few modifications, they would be satisfactory. Regarding compensation, it was argued for the petitioners that the State must be held liable as the eye camp was held “pursuant to and under the authority of the government.” The court however rejected the doctrine of vicarious liability of the state as the present petition had limited scope. The State Government had submitted that it was not taking an adversary posture but is participating in the litigation in the spirit of exploring relief to the victims. The Court stated that the facts have to be established by the criminal court. But on humanitarian

[83] AIR 1989 SC 1570

grounds the Court directed the State Government to pay to each victim Rs. 12500 in addition to Rs. 5000 already paid. The amount was not compensation but was on humanitarian ground. Though the judgment is not having a legally binding effect but may have force in similar circumstances.

In another case of negligence in tort against surgeon the Supreme Court in Laxman Balakrishna Joshi v. Trimbak Godbole[84] has held: "the duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz., a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives right to action for negligence to the patient. The practitioner must bring to his task a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law require. The doctor no doubt has discretion in choosing treatment which he proposes to give to the patient and such discretion is relatively ampler in case of emergency'

5.11 UNQUALIFIED MEDICAL PRACTITIONERS AND RISK TO PUBIC HEALTH

A writ petition before the High Court of Allahabad in public interest praying for writ of mandamus directing the respondents to initiate action against persons who are unqualified and unregistered but carrying on medical profession unauthorisedly in the district of Agra, Uttar Pradesh in the case of D.K. Joshi v. State of UP[85]. The Court issued directions for the entire State of U.P. and directed the all-District Magistrates, Chief Medical Officer of the state to identity all unqualified/unregistered medical practitioner and to initiate actions against these persons immediately. They were also directed to monitor all legal proceedings initiated against these persons. The court directed the Secretary, Health and Family Welfare Department to give due publicity of the names of such medical practitioners so that people do not approach such persons for medical treatment.

A contempt petition was initiated to enforce and monitor the orders passed in the above-mentioned case by the Hon'ble Supreme Court in Rajesh Kumar Shrivastava v. A.P.

[84] AIR 1969 SC 128
[85] AIR 2000 SCC 80

Verma[86]. In this case the Supreme Court had taken notice of the distressing situation of public health in the State of U.P. and inaction of the State Government to stop the menace of the unqualified and unregistered medical practitioners proliferating all over the State.

Sri Rajesh Kumar Srivastava, a Public-Spirited Citizen and a Reporter of National Daily (Rastriya Sahara) approached the Court wherein the proceedings of about 20,000 unregistered medical practitioners were initiated. These medical practitioners were identified and criminal prosecutions had been started against them. During the course of proceedings, the Court has issued orders for registration of all the qualified and authorised medical practitioners in the State with the Chief Medical Officers of the concerned Districts and has passed several orders in the last two years for identifying and to stop the unauthorised medical practitioners. Directions were also issued to improve the public health - facilities with special emphasis to health care system in rural areas as the surveys and reports demonstrated that wherever the public health system has failed the quacks have proliferated. The Court was called upon to consider and decide whether 'Faith Healing' practiced by the unqualified and unregistered persons with no fixed identity and qualifications at all at a public place after charging consideration amounts to unauthorised medical practice (quackery) and whether such practice is permissible under our Constitutional and Legislative scheme. An organization known as 'Lai Mahendra Shiva Shakti Sewa Sansthan, Kotwa Kot, Allahabad' was holding weekly congregation which was attended by thousands of disease afflicted persons. Each prospective patient was required to obtain a card on a charge of Rs. 30/-. On the back of the card, it is proclaimed that the society has remedies for all kinds of diseases except Leprosy. The persons are required to continuously chant 'Om Namoh Shivai' and this treatment is required to continue for at least 15 weeks. The patient is advised to walk on a machine every day and to give up all kinds of intoxication. Sri Ajay Pratap Singh proclaimed himself to be a doctor and the persons attending the congregation as patients. He used a loud speaker which runs throughout the day creating deafening noise. The court was called upon to decide the question whether the 'Faith Healing' amounts to unauthorized medical practice i.e. quackery and is permissible under our Constitutional and legislative scheme, and whether such a practice is violative of the right to health guaranteed to the citizens of the Country. The court observed that in our country there are different legislations for different systems of medicines. The scheme of these Acts is to regulate the medical practice in various disciplines. Where a branch of medicine is neither established nor has proved its methods in curing and

[86] AIR 2005 ALL 175

healing the persons professing such medicine are not authorized to practice such branch of medicines in public. There is a common feeling with where medicines are not prescribed or where no particular form of treatment is preached or practiced, such practice or form to cure ailments is not required to be regulated, and that there cannot be any law which may restrict such persons from using these methods and practices, and that every person has a right to cure himself, which the person may decide for himself. It is also commonly believed that faith in the Almighty by whatever name or form of belief is the cure to all ailments, and that no law can stop the persons, who have fundamental right to choose, practice and profess the religion in adopting such methods. The Court in this case was not concerned to decide whether a person has right to choose any form and method for himself and to have any belief or faith in curing his ailments. The question to be considered is whether the persons professing such form and method which include 'Faith Healing' can practice and preach such forms or methods for curing ailments, in a public place after charging a fee or taking consideration for such practices. The court decided that the fundamental right to profess practice and propagate religion, guaranteed under Article 25 of Constitution of India is subject to public order, morality and health. Where health of the citizens is involved the right of such practice to profess, practice and propagate religion gets controlled and is subservient to the powers of the State to regulate such practice. No person has a right to make a claim of curing the ailments and to improve health on the basis of his right to freedom of religion. Every form and method of curing and healing must have established procedures, which must be proved by known and accepted methods, and verified and approved by experts in the field of medicines. It is only when a particular form, method or path is accepted by the experts in the field of medicine that it can be permitted to be practiced in public. The right to health included in Article 21 of Constitution of India does not come in conflict or overlap with the right to propagate and profess religion. These two are separate and distinct rights. Where the right to health is regulated by validly enacted legislation the right to cure the ailment through religious practices including 'Faith Healing', cannot be claimed as a fundamental right. The Court, therefore, found that the propagation, practice and profession of 'Faith Healing' in public on charging consideration is violative to the Constitutional and Legislative scheme, and that such 'Faith Healing' based on a person's faith in the religious practices, in public for consideration is not permitted and is violative of the legislations detailed as above.

5.12 EFFECT OF DRUGS AND MEDICINES ON HEALTH

In Common Cause V. Union of India[87] the petitioner organization highlighted the serious deficiencies in the matter of collection, storage and supply of blood through the various blood centres. It asked the court to direct the Central and State Governments to ensure that proper and time-bound steps are initiated for stopping the malpractices, malfunctioning and inadequacies of blood banks. Blood is treated as drug under the Drugs and Cosmetics Act and rules under it. In 1990, a study of blood banks was conducted by a management consultancy firm at the instance of the Central Government. It found serious deficiencies like unlicensed blood banks, flourishing blood trade with poor people like unemployed, rickshaw pullers, drug addicts and alcoholics, no medical check-up was done on the blood sellers. No tests were conducted for the quality of blood and up to 85% of blood collected weren't screened for AIDS. Storage facilities were also found to be unsatisfactory and unhygienic. The court in this case directed the establishment of a National Council of Blood Transfusion as well as State Councils to look after licensing of blood banks and elimination of professional donors within two years. It also directed the government to strengthen the machinery under the Drugs law to enforce the law. The drug inspector was directed to inspect the banks periodically. It is also relevant to note the judgment of the Supreme Court in Vincent Panikurlangara v. Union of India[88], wherein the court observed that "In a welfare State, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health." In this case a public interest litigation was filed by Mr. Vincent Panikulangara, a lawyer for seeking a ban on the import, manufacture, sale and distribution of drugs which have been recommended for banning by the Drugs Consultative Committee. He sought cancellation of all licenses authorizing import, manufacture, sale and distribution of drugs. He asked for the setting up of a committee to study the hazards suffered by the people on account of such drugs. The petitioner alleged that the drug industry in this country was dominated by multi-national corporations, which make huge profits as the Indian Government exercises very little control over them. Those drugs banned in the western countries are freely circulated in India. The Supreme Court agreed that the issues raised in the petition were of vital importance to the citizens. But it said: "Having regard to the magnitude, complexity and technical nature of the enquiry involved in the matter and keeping in view the far-reaching implication of the total ban on certain medicines, we must at the outset clearly indicate that a judicial proceeding of the nature initiated is not an appropriate one for determining such matters." The technical aspects which arise for consideration in a matter of

[87] AIR 1996 SCC 753
[88] AIE 1987 SC 990

this type cannot be effectively handled by the court. It also involved the question of policy. It is for the government to take a decision, keeping the best interest of citizens in view. No final say in regard to such aspects come under the purview of the court. The court passed some general observations about the duty of welfare state to maintain the health of its citizens, and asked the government to broad base the existing institutions which watch over public health. The court also remarked that in public interest litigation, statutory bodies should not be reluctant to come forward and assist the court. They have a duty to join the proceedings. Referring to many bodies which failed to appear in the court, the court said "an attitude of callous indifference cannot be appreciated."

5.13 NEGLECT OF DUTY BY THE PUBLIC AUTHORITIES

Niyamakendran V. Corporation of Kochi[89] is a case relating the menace of mosquitoes in the city of Kochi. The court referring Ratlam Municipality v. Vardhichand[90], pointed out that a responsible local body constituted for the purpose of preserving public health cannot run away from its duty by pleading financial inability. The court was of the firm opinion that it should step in and find out ways and means to bail out the Corporation out of its present precarious position in order to protect the health of the citizens which has been declared by the Apex Court as a part of fundamental right to life and liberty of every person. The court reminded the public authorities that health and wellbeing of the people is imperatively implicit in the right to life guaranteed under Article 21 of the Constitution. The court called upon institutions, establishments and organisations who were impleaded as respondents to come forward and make generous, practical and humanist contributions to the "Mosquito Control Programme" the proceeds of which was to be utilised for spraying chemicals, purchase of pesticides, machines, etc.

In Mahendra Pratap Singh v. State of Orissa[91] a writ petition was filed on behalf of public to the gram panchayat of Pacchikote to run primary health centers providing all amenities and facilities for proper running of the said health centre. The court in its verdict said, "Life is a glorious gift from god. It is the perfection of nature, a master-piece of creation. Human being is the epitome of the infinite prowess of the divine designer. Great achievements and accomplishments in life are possible if one is permitted to lead an acceptably healthy life. Health is life's grace and efforts are tube made to sustain the same. In a country like ours, it

[89] AIR 1977 KER 152
[90] AIR 1980 SC 1622
[91] AIR 1997 Orissa 37

may not be possible to have sophisticated hospitals but definitely villagers of this country with in their limitations can aspire to have a primary health centre. The government is required to assist people, and its Endeavour should be to see that the people get treatment and lead a healthy life Healthy society is a collective gain and no government should make an] effort to smother it. Primary concern should be the primary health cento and technical fetters cannot be introduced as subterfuges to cause hindrances in the establishments of health centers.

In Ambala Urban Estate Welfare Society v. Haryana Urban Development Authority[92] the court ordered the Urban Development authority who hac sold plots with a promise that the purchasers would be provided with all modern facilities. The authority failed to provide basic facilities like proper roads, sewerage, community buildings, parks and hygienic conditions. The court held that all these are basic for the life and health of the residents of the locality. The authority was directed to provide basic amenities like drainage, sewerage, adequate potable water and parks so as to protect right to life as guaranteed under the constitution.

Suo Motu v. Ahmedabad Municipal Corporation[93] is a case wherein the Gujarat High Court had taken the action suo motu. The court observed that the city of Ahmedabad is growing by leaps and bounds and because of this the areas on its periphery are fraught with many problems pertaining to public health, hygiene and sanitation. The civic bodies including the A.M.C. were found hopelessly lacking in solving these problems due to various reasons. In monsoon the situation gets worsened as the undisposed garbage gets soaked in the water causing grave problem to public health. Over and above large number of industrial houses discharge their effluent in totally unregulated manner which poses a grave danger not only to the human health but even to the domestic animals. All these chaotic conditions cause various dangerous diseases. Taking the cognizance of the matter suo moto the court issued notices to various civic bodies and appointed a committee to look into the matter and report. The court observed that under Article 21 of the Constitution of India the right to life is guaranteed in any civilized society. Article 21 with the expansion of its scope has now imposed a positive obligation upon the State to take steps for ensuring to the individual a better enjoyment of his life and dignity. Such obligations include maintenance and improvement of public health, elimination of water and air pollution and providing hygienic conditions, within the area under them. Like the State, every civic authority is clothed with power and equipped with

[92] AIR 1994 P & H 288
[93] 2006(2) GLR 1129

means to ensure the citizens better enjoyment of life and dignity and if it fails to provide them, it would violate Article 21. The court while pointing out the failure of the civic authorities for discharging their functions gave several directions to hospitals run by the management administered by the Government, semi-government or local civil bodies, civic bodies, railway department, police department, A.U.D.A, education department and the Government to protect the fundamental rights of the citizens.

5.14 COVID-19 AND COURT IMPARTING THEIR DUTY

In India the virus hit so hard that people were not getting beds to be admitted to the hospital. In case they were admitted to the hospital the authorities failed to provide them proper treatment due to unavailability of oxygen support and other medical facilities. This clearly depicted the arbitrary conduct which has been adopted by the hospital administration and states being regular authority was just mute spectator in the whole scenario due to reason best known to them. This conduct of the hospital authorities is completely against law laid down by the Hon'ble Supreme Court in the matter of Balram Prasd v. Kunal Saha[94]. In this case the court held that right to life and personal liberty under Article-21 of the Constitution of India also include right of patient to be treated with dignity as observed by the court. The Supreme Court gave a judgement which would benefit the public at large in the matter of State of Andhra Pradesh v. M/s Linde India Ltd[95]. The court held that Medical Oxygen IP and Nitrous Oxide IP fall within the ambit of Section 3(b)(i) of The Drugs and Cosmetic Act, 1940.

The Hon'ble Madhya Pradesh High Court acted as a catalyst in reminding the state of its duties in a Suo moto proceeding in the matter of Re: (Sup Moto) v. Union of India & others[96]. The court stated that ordinally these matters lie in the domain of the executive, who has the responsibility to resolve all the identified problematic issues. However, despite being cognizant of its jurisdictional limitations, the court in an extraordinary situation like this when issues are brough to its notice it cannot play a silent spectator. Therefore, the court laid down certain guidelines which was required to be followed by the state and hospital administration in letter and spirit. The court delt various issues like availability of beds and the need for increasing the same, supply of Remdesivir injections, fixing time limit to

[94] (2014) 1 SCC 384
[95] Civil appeal No. 2230 of 2002, SLP(C) No.19208 of 2016
[96] W.P. No.8914/2020

produce results of RT-PCR and rapid antigen test, continuous supply of medical oxygen, charging reasonable and not hefty amount for treating COVID-19 patient etc.

The court dealt with the matter of oxygen in the capital region in the case of Maharaja Agrasen Hospital Charitable Trust v. Union of India & others[97]. In this case a plea was filed by hospital administration for want of medical oxygen vide order dated 24.04.2021 held that, since hospital has several patients in ICU, and their lives are at stake and the hospital is demanding for oxygen on immediate basis, their requirements have to be noted duly by the concerned offices of state including the Nodal Officer appointed for COVID-19. The court also fixed responsibility on Delhi police to prevent any untoward incident.

In the matter of Rakesh Malhotra v. Government of National Capital Territory of India and others[98], the court directed the central government to dynamically review the distribution of Remedesivir injections in the States and Union Territories on a daily basis and in respect of other drugs required for the proper treatment of patient from Covid-19 such as Tocilizumab, Favipiravir, Ivermectin, Dexamathasone, Methylprednisolone, Dalteparin, Enoxaprin, HCQ and Baricitinib. It was directed that central government must immediately reach out to the manufacturers/patent holders/licensees of such drugs, so as to forthwith ramp up the production capacities.

The Gujarat Hight Court also took Suo moto action due to the prevailing condition of COVID-19 in State[99]. The court laid down a 14-point guideline to be followed by the state government at various hospitals operating within Gujarat to fight COVID-19 pandemic. The court held that availability of beds should be displayed by the hospital on real time basis which means that as soon as the bed is occupied the number of vacant beds should be down and as soon as the patient is discharged the vacancy must be immediately displayed. State must ensure that availability of oxygen is sufficient to cater to the demand of COVID-19 patient. To court further provided that real facts and figures must be provided to public at large.

The High court of Jharkhand at Ranchi bench also dealt with Suo moto proceedings[100]. The court directed the state government to maintain the adequate supply of the lifesaving drugs to treat the persons affected from COVID-19 to maintain the adequate supply of oxygen in

[97] W.P. No.6000/2011
[98] W.P. No. 3031/2020
[99] W.P.(PIL) No. 53 of 2020
[100] W.P.(PIL) No. 1310 of 2020

different hospitals both private as well as government and steps must be taken to put a control on black marketing of life saving drugs in the interest of public at large.

The High court of Karnataka also took Suo moto action to make the hunt for a hospital easer[101]. The court directed the state government to create a help desk outside COVID hospitals in various cities for helping the patients who cannot be admitted in that particular hospital. The help desk will also provide information regarding the availability of Ramdesivir medicine in the cities.

In the case of Rishi v. State of Haryana[102], the court reiterated that had the government strengthen the health system in the past one year, people would not have scrambling for hospital neds, ventilators, oxygen and medicines. Court impleaded states due to grave situation arising in view of non-availability of essential drugs such as Remdesivir and Tocilizumab.

The Patna High court also dealt with oxygen shortage in the state in the case of Shivani Kaushik v. Union of India[103]. The court stated that deficient healthcare facilities and acute shortage of oxygen in the state due to COVID-19 pandemic. Admittedly, acute shortage of oxygen is one of the greatest challenges Which the healthcare system in the state of Bihar is presently facing in the wake of sudden upsurge of COVID-19 cases. The court directed the state of Bihar to ensure that continuous supply of oxygen in the hospital is maintained and officials/ doctors of the said hospital are not made to beg oxygen before the officials of the state government. Any lapse on the part of the state, having consequence of irregular/short supply of oxygen in the hospital, shall be viewed seriously by the court.

The Allahabad High Court addressed the inhuman condition at quarantine centres in the case In-Re human conditions At Quarantine Centres and for providing better treatment to corona positive dealt with the acute paucity of oxygen, beds, injections including Remdesivir and further deteriorating in conditions of patient by introducing painstaking mechanisms. The court strictly addressed that if even after seven decades of our attaining freedom with so many heavy industries set up, we are not able to provide oxygen to our citizen, it’s a matter of shame.

[101] W.P.(PIL) No. 6435 of 2020
[102] CRWP-242/2021
[103] Civil Writ Jurisdiction Case No. 353 pf 2012

The Bombay High Court also took Suo moto action towards prevailing conditions of COVID-19 in the state[104]. The court showed disappointment towards towards Union of India and stated that in a region which accounts for almost 40% Covid patients of the entire nation, the communication from the ministry of health and family affairs should have been to the effect of increasing the supply of liquid oxygen to the state of Maharashtra from the present practice of 110 metric tons per day to somewhere between 200 to 300 metric tons per day. The court further directed the state government to ensure uninterrupted supply of Ramdesivir drug and other life saving drugs to the state of Maharashtra.

The Uttarakhand bench at Nainital was pleased to issue various directions to the state government of Uttarakhand in the matter of Anu Pant v. state of Uttarakhand[105]. In this case the court directed the state authority to update the availability of beds at online portal on real time basis which means that as soon as the bed is occupied or vacated by a patient. The court directed the government to motivate the people to undertake the plasma donation.

The movement of judicial view from the early discussions on health to the late nineties clearly shows that the right to health and access to medical treatment has become part of Article 21. A corollary of this development is that while so long the negative language of Article 21 was supposed to impose upon the State only the negative duty not to interfere with the life or liberty of an individual without the sanction of law, judges have now imposed a positive obligation upon the State to take steps for ensuring to the individual a better enjoyment of his life and dignity. In Paschim Banga, the State has been placed, despite financial constraints, under an obligation to provide better-equipped hospitals modernised medical technological facilities. The substantive recognition of the right to health as essential to living with human dignity has thus allowed the judiciary to directly address human suffering by guaranteeing the social entitlements and conditions necessary for good health. Hence the above narrative judgments suggest a potential role for a creative and sensitive judiciary to enforce constitutional social rights. The analysis of the litigations reaching the Supreme Court as described above, have given rise to the Court articulating and recognising the specific rights to food, education and health. These judgments show that the Supreme Court has refashioned its institutional role to readily enforce social rights and even impose positive obligations on the State. There has been some concern about the legitimacy and accountability of such overt judicial activism but the Court, however, continues to justify its

[104] PIL No.4 of 2020
[105]WP (PIL) No. 97/2019

interventions by asserting that it is temporarily filling the void created by the lack of strong executive and legislature branches the judicial activism shows that constitutional and human rights interpretation is a dynamic process that involves the creativity and commitment of individuals to the underlying values of society. In addition, the Supreme Court has shown that judges have the enormous potential to effect change in society when they so desire. Therefore, despite being non-justiciable in the Constitution, the social rights in the Directive Principles have nevertheless been made enforceable and have been treated as justiciable by the Supreme Court. However, the sad part is that the implementation of judicial orders still remains a big issue.

CHAPTER-6

CONCLUSION AND SUGGESTIONS

The right to health falls under the rubric of economic, social and cultural entitlements with human rights law. The right to health for the very first time was internationally recognized as the enjoyment of highest attainable standards of health as one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions. This recognition was further retreated in several international and regional human rights instruments such as the UDHR and ICSCER. Health as a human right is increasingly being used as a focal point of discussion in international conferences, meetings and councils. This highlights the growing importance of the synergy between health and human rights in addressing pressing social injustices in today's world. Thus, it is arguable that human rights are changing from narrow, legalistic focus on civil and political rights to a broader right approach encompassing economic, social and cultural rights. The affirmation of the right to health is an undeniable attainment of recent decades and is clearly observed at all levels of international and national legal order. However, the early efforts to protect public health were surrounded with the controversies of human rights violations. To protect the citizens from infectious disease, European states passed the Quarantine law, which were notorious for the ill treatment and cruelty to the patients and sometimes used to be reinforced by the threat of execution. This anti- human right approach to health later changed with the birth of WHO, an international organization with the responsibility of protecting health of the people of the world. The formal declaration of health as a basic human right found place in the UDHR recognizing everyone the right to a standard of living adequate for the health and wellbeing of himself and of his family.

The health problems that India faces are highly complex and challenging. Given the diverse cultures and economic levels of India, it is hard to envision a mandate that would implement the right to health appropriate in all parts of the country. It is still struggling with health hazards of communicable diseases. AIDS, cancer etc are further aggravated by widespread poverty, malnutrition, illiteracy and ignorance. These negative forces are reinforced by the rate at which the large population is growing. The full realization of Human Right to health is more a matter of improving the cultural, economic, environmental and socio-political conditions that determine health status than it is a matter of treating illness or injury. Therefore, several factors, determining health status causes obstacles in the realization of

health. The enunciation of a national health policy by the government of India in 1983 raised hopes among those concerned with India's poor health that the government is serious about its commitment to provide Health for all. The policy was broad in its approach to health needs and possibilities and ambitious in its goals. Besides acknowledging many of the mistakes of the past and calling for their redress, it embodied concepts of social justice and demonstration which have been eclipsed in the process of health development to date. Health care as a right is considered desirable universally. Yet all over the world, the private sector dominates the provision of health care. Today health care is fully commodified and people are left to the mercy of the market. What is worrisome about the health care market is that it works as a supply induced demand market. This means that the providers of the care dictate the terms of the market. In the developed countries, while health care may not be stated as a fundamental right, access has been made more or less universal by legislation or some special provisions for those who do not have the purchasing power. Thus, fiscal mechanisms have been created in these countries, with an overwhelming proportion of contributions from the state, to assure basic access although the providers may be from the private sector. In a country like India, where three fourth of the population still lives in the villages, providing universal access for health care, becomes even more difficult. While public health facilities are reasonably well developed in urban areas, the infrastructure in the rural areas is grossly inadequate. This puts a lot of pressure on the urban facilities, thus imposing their efficiency. In conditions of widespread poverty, where family earning is barely adequate to meet two square meals, seeking care from the market becomes a luxury. Yet that is where the poor are often pushed to seek health care because public facilities are ill equipped to serve their needs. Often this has led to serve indebtedness wiping out the few assets a family may own. The national sample survey data shows that after loans for agriculture, the second largest cause of indebtedness is for health care. This is a serious matter and needs urgent attention.

In a country like India, where poverty is the core concern of the political economy, establishing health care as a human right, becomes even more important. The new economic policies had a negative impact on the health sector with declining state investments in health care. Rapid increasing prices of medicines and further consolidation of the private health sector with the corporate sector entering the fray in a big way. With the state under pressure to reduce its participation directly in the economy, it is important that the social sectors like health care do not get diluted, but on the contrary strengthened. The state must take the lead in recognizing the health care system as a public- private mix wherein a planned and

organized system as of financing is provided and not the market determines how health care is accessed by people. This will only be possible if health care becomes a human right.

The state must take the lead in recognizing the health care system as a public- private mix wherein a planned and organized system as of financing is provided and not the market determines how health care is accessed by people. This will only be possible if health care becomes a human right. Advocacy for health is equally important. The aim of advocacy is to generate public demand, place health issues high on the public agenda and effectively convince those who are influential- policy makers, elected representatives, professionals, political and religious leaders and interest groups- to act in support of health. Advocacy directed at policy makers and decision makers should aim at strengthening political commitment to health, promoting social policies conducive to positive action for health and supporting systems that are responsive to peoples need and aspirations. It focuses on creating supportive environments, facilities and conditions that make people's health choice easier and more feasible. Advocacy directed at professionals, public figures and service providers should seek to make them sensitive to peoples need and demands as well as to the desirability of reorienting health systems and services accordingly. Advocacy directed at the public should help to create interest and support for positive health action. It should aim to make health a higher public priority, to stimulate discussion and debate, and to generate public demand and pressure for healthy policies and a healthy environment. Advocacy directed at academic leaders should aim to stimulate interest in study of the aspects of policy and other factors that facilitate progress in health. Academic leaders can be important allies in providing sound scientific backing, with facts and figures, for making a persuasive case for health and health supportive policies.

Social support for Health should also be emphasized. Strategies for strengthening social support should aim at two important targets. The first consists of community organizations and institutions that encourage healthy lifestyles as a social norm and foster community action for health. The second target comprises systems that provide the infrastructure for health care services and related development activities that have an influence on health. So the health sector must use all channels through which people express their concerns and demand for health. The media can also play an important role in increasing both public awareness and support for publication. A wide variety of social institutions, professional association and voluntary organizations are also engaged in health-related activities at community level and in promotional efforts at political and professional levels. Strategies for

social support should aim to initiate and maintain close partnership with these organization and groups, fostering working alliances between them for complementary and coordinated action for health protection and promotion.

The strategies of empowerment equip individuals, families and communities with the knowledge and skills that will enable them to take positive action for health and make sound health choices. Individual and collective choices depend on a supportive physical, social and economic environment as well as accessible services and facilities. Information, communication and health education is at the heart of the empowerment process. Strategies of empowerment for health should be directed at the public and policy –makers alike. They should also use available and credible channels to stress the social and personal values of health. Strategies should be implemented at local and national levels, as well as in the home, school, workplace and other community settings. Empowerment strategies should help people to learn how specific choices of behaviour can affect their own health, as well as the health of their families and communities. This includes not only communicating health knowledge but also helping people to recognize beliefs, attitudes, opinions and skills that influence healthy lifestyles. These skills help people to mobilize resources to meet their needs and aspirations and to influence the physical, social, cultural and environmental conditions that affect their health.

Policy level advocacy for creation of an organized system for universal healthcare and research to develop the detailed framework of the organized system: 'policy-making process' is necessary for the implementation of health and human right. Both preventive and curative health policies are being devised at the community, national, regional and international levels all over the world without the application of this very insightful approach. We must generalize the role of human right activists and health specialists working together to practice a public health policy from both the human right and health perspective in order to optimize both sets of concerns.

Priorities and approaches to health solutions must be individualized and must be contextualized within local realities. Since health right has little meaning without availability of health care infrastructure in adequate quantity as per the need and location of the population, at least the basic requirements to maintain a reasonable standard of health must be provided. Furthermore, if infrastructure is in place, it may not necessarily mean that it is accessible to the people, especially the poor. Thus, differences based on location (rural-urban

and distance), purchasing power (pricing), ethnicity, race and caste, gender etc. must also be eliminated so that access is not hampered due to any form of discrimination or conditionality.

Access to health care must exist irrespective of the capacity to pay. Often it is seen that infrastructure is in place and access too is reasonable, but user charges/fees prevent use of such services by the poor. The success of health care as a right is critical to the condition of affordability and hence any direct payments at the point of receiving care will necessarily be discriminatory. Any charges for health care must be collected indirectly on the principle of payment according to capacity that is through direct progressive taxation and charges, and/or insurance premiums. Further, availability, accessibility and affordability have little meaning if the quality of care provided is compromised in any way. Quality of care not only means in terms of well-defined standards and good practices but also satisfaction of the client". For example, health practitioners must not allow economic incentives to result in the over or under treatment of patients and must comply with all codes of medical ethics, including guidelines for medical or genetic research in human subjects612. Hence health care services must be sensitive to this, including being culturally appropriate or acceptable.

Public health measures must respect basic civil and political rights. The main purpose of health profession is to provide relief to suffering; the prevention and treatment of illness and the promotion of health. So, the health care reform efforts must be oriented towards responding to the needs of population and the pursuit of corporate profit and personal fortune should not distort priorities in care-giving. The privatization and corporation of health care must not be allowed to result in the destruction of national health care systems. Thus, the provision of health care must be excluded from the commercial model that seeks to commodity health.

The wide margin between public resources for health and the demands of the population is a common challenge to health authorities in developing countries. In some of the advanced developing countries, which have enjoyed economic boom in recent years, the health services have grown and are meeting many of the public demands. In poorer nations, especially those that have experienced marked economic decline, there is increasing pressure on public spending for health and other social sectors. Under these circumstances, policy-makers are exploring approaches to increase the resources available for health, allocate the limited resources to target priority conditions and groups, and promote equity. In the least developed countries, it is critically important to increase the financial resources if the health sector is to

provide basic essential services. Many countries that previously offered health services at no cost or highly subsidized rates are now imposing fees on users at the point of delivery. The aim should be to generate additional income for use by the public sector, to enable the public sector to redistribute resources in favour of the poor, and to achieve increasing self-reliance for sustainable community health programs. The main objective of user fees should be to generate resources that can be used to expand the quantity and improve the quality of health services. User charges would enable the public sector to allocate the resources by withdrawing subsidies from those who can afford to pay and redirect the savings to expand cost effective public health services to the poor. In progressively increasing the funds allocated for health, the governments should give first priority to the extension of primary health care to the under-served communities. It should encourage and support various ways of financing primary health care and also take measures to maximize the efficiency and effectiveness of health-related activities in all sectors". It is the time to realize that health is a global issue. It should be considered as an essential component of the continuing globalization process that is reshaping interaction between countries in terms of world trade, services, foreign investment and capital markets. A wonderful opportunity now exists to build a new international partnership for health based on social justice, equity and solidarity, which the world in the 21st century will so urgently need. Therefore, the entire world community, all governments, the political parties, the organizations of various section of the people, the NGO's and the medical professionals should unite to achieve 'Health for All', without any discrimination, during the first quarter of the 21st century i.e., by the year 2025.

Apart from the above concrete suggestions following steps may also be undertaken to achieve the target of 'health for all' -

(i) Lobbying with the medical profession to build support for universal healthcare and regulation of medical practice.

(ii) Filing public interest litigations on right to healthcare to create a basis for constitutional amendment.

(iii) Lobbying with parliamentarians to demand justifiability of directive principles.

(iv) Holding national and regional consultations on right to healthcare with involvement of a wide array of civil society groups.

(v) Running campaigns on right to healthcare with networks of people's organizations at the national and regional level.

(vi) Bringing right to healthcare on the agenda of political parties to incorporate it in their manifestoes.

(vii) Pressurizing international bodies like WHO, Committee of ESCR, UNCHR, as well as national bodies like NHRC, NCW to do effective monitoring of India's state obligations and demand accountability.

(viii) Preparing and circulating widely shadow reports on right to healthcare to create international pressure.

The above is not an exhaustive list. The basic idea is that there should be widespread dialogue, awareness raising, research, documentation and legal/constitutional discourse. India has developed an action plan towards facilitating the realization of this agenda collaboratively with a range of civil society actors through a national initiative on right to health and healthcare in India. To make the above-mentioned recommendations feasible a number of policy decisions have to be taken. In our endeavour to achieve the ultimate objective of universal access to basic health care for all, there is a need to spell out structural requirements or the outline of the model, which will need support of the legislation. The structure, terms and conditions should be clearly incorporated in the legislative framework.

Can the goal of 'Health for All' can be achieved in the present socio-economic system, in the context of systemic exploitation responsible for massive poverty and structural inequities, in the broader setting of large-scale global expropriation, mediated by trade and facilitated by global financial institutions? One answer would be, 'Health for All', in its fullest and most humane sense – requiring, among other conditions, comprehensive nutritional and food security (linked to livelihood security), universal access to safe drinking water and sanitation, provision of healthy housing and local environments, universal healthy working conditions and a safe general environment, access to health related education and information for all, and an equitable, gender just social milieu, free from violence - should remain our larger vision. While definite progress can be made towards achieving these goals in the present socio- economic situation, this is unlikely to be achieved in entirety within the globally defined, economic and social framework prevailing in India today.

The achievement of a strengthened public health system, which is more accountable to ordinary citizens, is a potentially achievable goal to fight for within the existing system. Similarly, the health movement must lend it strength and voice to movements for improving health related entitlements such as nutritional services and food security, clean drinking water, sanitation and safer environmental and working conditions, which may be achieved to certain extent. Such struggles can lead to some concrete improvement in the situation of the working people, and of various deprived and marginalized sections of society. It can also be one channel for people to assert their strength, by demanding that public institutions work for them effectively. This can become one of many arenas of public organization and mobilization, of assertion of people's power.

In this broader context, the right to health care and certain other health related rights are potentially at least partially achievable in the current social framework. However, achievement of the right to health for all, in its fullest comprehensive sense, which constitutes our larger vision, is inextricably linked with larger social transformations. Hence the struggle for public health, in its deepest sense necessitates that health activists also engage with such a larger vision and broader struggles. Keeping this in mind, the struggle for health rights must move on to link with several other struggles for the rights to food, water, education, housing, livelihood and social justice in various forms, not only because these rights are extremely germane to the improvement of health, but also because the struggle for health rights must form one strand of a much larger struggle to challenge the dominant social order. Establishing people's Right to health care, even in a partial form, may be one of the platforms for developing people's awareness and strength, and for beginning to shape certain incipient models of the future within the present. But moving further, a broader movement needs to take shape, to present coherent alternatives in myriad spheres of life, to give people capacity and hope, to challenge the dominant system, and to nurture the tender saplings of the future, even in the harsh world of today. Only such a movement can also dream of replacing the current unhealthy and inequitable socio-economic system, by one that is far more just, humane and healthy, in the world of tomorrow.

COVID-19 is an unprecedent global threat, and human rights should be at the core of the global response as states have legally binding obligation to do so and there is evidence that human rights-based policies strengthen public health. Where human rights are inextricably linked to public health outcomes and interconnected in the COVID-19 response, government should adopt laws and policies that proportionate, necessary and non-discriminatory towards

societies most vulnerable member and should ensure that laws alleviate the worst impact of the crisis on vulnerable groups.

To conclude, it is evident that the neglect of the public health system is an issue larger than government policy making. The latter is the function of the overall political economy. Under capitalism only a well-developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy (which directly benefit capital accumulation) is more urgent (from the business perspective) than the social sectors, hence the latter get only a residual attention by the state. The policy route to comprehensive and universal healthcare has failed miserably. It is now time to change gears towards a rights-based approach. The opportunity exists in the form of constitutional provisions and discourse, international laws to which India is a party, and the potential of mobilizing civil society and creating a socio-political consensus on right to healthcare. There are a lot of small efforts towards this end all over the country. Synergies have to be created for these efforts to multiply so that people of India can enjoy right to healthcare.

The right to health in India is not enshrined as a Fundamental Right, but is included within the ambit of the Directive Principles of State Policy. What is needed to ensure Health for All on an equitable basis is the political will, which would necessitate a constitutional amendment and incorporate health within the ambit of Fundamental Rights. At the international level of analysis, there is an urgent need to ensure that there is a consensus to include health within the ambit of civil and political rights, as the fulfilment of either the civil and political rights as well as the economic, social and cultural rights are mutually reinforcing. Health as a human right needs to be justifiable under international law. The eradication of small pox in the late 1970s has shown that a strong political commitment and adoption of country specific strategies is bound to yield rich results, and would pave the ultimate road to achieve the dream of health for all.

BIBLIOGRAPHY

Agarwal HO. Human Rights. 11th Ed. Allahabad: Central Law Publication; 2008

Anil Kumar. Health Education. 1st Ed. New Delhi: International Scientific Publishing Academy; 2005

Anthony MJ. Social Action Litigation. New Delhi: Indian Social Institute; 2000

Asher J. Right to health: A Resource Manual for NGOs. London: Commonwealth Medical Trust; 2004

Balan K. Health for all: by 2000 AD. New Delhi: Ashish Publishing house

Beotra. The Mental Health Act. 2nd Ed. Kolkata:R. Cambray 8s Co. Pvt. Ltd; 2000

Brownlie I, Goodwin GS. Basic Documents on Human Rights. 1st Ed. Kolkata:R. Cambray & Co. Pvt. Ltd; 2003.

Chakrabarty G. The Law of Negligence. Kolkata:R. Cambray & Co. Pvt. Ltd; 1996.

Chandra U. Human Rights. Allahabad: Central Law Publication; 1999

Chatterjee B. Environmental Laws: implementation Problems and Perspectives. Kolkata:R. Cambray & Co. Pvt. Ltd; 2007.

Chaudhary. Commentaries on the law of Fundamental Rights. 4th Ed. Kolkata:R. Cambray 8s Co. Pvt. Ltd; 2004.

Desai M, Mahabal KB, editors. Healthcare Case Law in India— A Reader. Mumbai: Center for enquiry into health and allied themes

Dutta PK. Drug Control-Desk Reference. 3rd Ed. Kolkata:R. Cambray 8s Co. Pvt. Ltd; 2003.