RIGHT TO HEALTH IN CONSTITUTIONAL PERSPECTIVE: A COMPARATIVE OVERVIEW

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Introduction

In 2020 the health and health care of our citizens could look quite different. We find ourselves today on the threshold of a new era with many opportunities for radical improvements in the way we manage and receive health care. In order to ensure the sustainability of our health care systems, there is a need to tackle considerable challenges.

Health is vitally important for every human being in the world. Whatever our differences may be, health is our most important commodity. A person in bad health cannot really live life to the fullest. The right to health care is primarily a claim to an entitlement, a positive right, not a protective fence. In the 18th century rights were interpreted as fences or protection for the individual from the unfettered authoritarian governments that were considered the greatest threat to human welfare. Today democratic governments do not pose the same kind of problems and there are many new kinds of threats to the right to life and well being. Hence in today's environment reliance on mechanisms that provide for collective rights is a more appropriate and workable option. Social democrats all over Europe, Canada and Australia have adequately demonstrated this in the domain of health care.[1] The researcher in this paper has made an attempt to analyze the right to health and health care from the international perspective.

Right to Health in International Human Rights Law

Under international law, there is a right not merely to health care, but to the much broader concept of health. Because rights must be realized inherently within the social sphere, this formulation immediately suggests that determinants of health and ill health are

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1 AUDREY CHAPMAN, EXPLORING A HUMAN RIGHTS APPROACH TO HEALTH CARE REFORM, AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, WASH. D.C. (1993).

not purely biological or "natural" but are also factors of societal relations.[2]

In the human rights discourse and practice the right to health has been and continues to be a contentious arena. Primarily located within legal frameworks that focus on civil and political rights, the right to health is more frequently being used to challenge abuses of health by invoking social and economic rights, even though this places the right to health on slippery terrain that is not as internationally accepted as civil and political rights. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health has been recognized in different international and regional human rights systems and in the domestic laws of many countries as a fundamental right. The majority of countries have acquired an international obligation to respect, protect and ensure the right to health to everyone under their jurisdiction. It is also recognized as fundamental right in numerous international instruments, including the Universal Declaration of Human Rights (UDHR).

UDHR states that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care."[3] Subsequently, many nations adopted the International Covenant on Economic, Social and Cultural Rights (ICESCR), one of the implementing treaties of the UDHR.[4] Article 12 of ICESCR provides that states parties "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[5] ICESCR also provides enforcement provisions for states parties.[6] Since ICESCR, the United Nations (U.N.) has adopted other treaties that recognize the international human right to health and related health

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[2] U.N. Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health,* U.N. Doc. E/C.12/2000/4, *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument (last visited Dec. 26, 2012).

[3] Universal Declaration of Human Rights art. 25.

[4] G.A. Res. 2200, U.N. GAOR, 21st Sess., Supp. No. 16, at 49, U.N. Doc. A/6316 (1966).

[5] *Id.* at 51.

[6] *See* MATTHEW C.R. CRAVEN, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL, AND CULTURAL RIGHTS 106–51 (1995) (discussing states' obligations in implementing ICESCR); Matthew C.R. Craven, *The Domestic Application of the International Covenant on Economic, Social and Cultural Rights*, 40 NETH. INT'L L. REV. 367 (1993) (discussing problems and possible solutions for enforcing ICESCR, including direct applicability).

questions.[7] In addition, the treaty bodies that monitor the ICESCR, the Convention on the Elimination of All Forms of Discrimination against Women, and the Convention on the Rights of the Child have adopted general comments or general recommendations on the right to health and health-related issues. Numerous conferences and declarations, such as the International Conference on Primary Health Care (resulting in the Declaration of Alma-Ata[8]), the United Nations Millennium Declaration and Millennium Development Goals,[9] and the Declaration of Commitment on HIV/AIDS,[10] have also helped clarify various aspects of public health relevant to the right to health and have reaffirmed commitments to its realization.

The right to health is also recognized in numerous national constitutions,[11] either directly, as in South Africa, or indirectly, as in India. Despite significant improvements, access to health care services-and, in particular, equitable access-remains a major challenge facing developing countries; the desire to achieve universal coverage and the pursuit of the right to health can conflict with resource constraints.

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7 *See e.g.*, International Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106, U.N. GAOR, 20th Sess., Supp. No. 14, at 49, U.N. Doc. A/6014 (1966) (entered into force Jan. 4, 1969) (providing in art. 5(e)(iv) for the right to "public health, medical care, social security and social services); Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 196, U.N. Doc. A/RES/34/180 (1980) (entered into force Sept. 3, 1981); Convention on the Rights of the Child, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, at 169, U.N. Doc. A/44/49 (1989) (entered into force Sept. 2, 1990).
See Susan Kilbourne, *U.S. Failure to Ratify the U.N. Convention on the Rights of the Child: Playing Politics with Children's Rights*, 6 TRANSNAT'L L. & CONTEMP. PROBS. 437 (1996) (supporting adoption of the Convention and highlighting arguments of its opponents in the U.S.); Alison Dundes Renteln, *Who's Afraid of the CRC: Objections to the Convention on the Rights of the Child*, 3 ILSA J. INT'L & COMP. L. 629 (1997) (providing historical overview on the Convention's adoption process in the U.S. and political controversy surrounding it); Egon Schwelb, *The International Convention on the Elimination of All Forms of Racial Discrimination*, 15 INT'L & COMP. L.Q. 996 (1966) (discussing origins of the Convention and providing detailed comparative analysis of its provisions).

8 Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, U.S.S.R., Sept. 1978.

9 *See* http://www.un.org/millenniumgoals/.

10 G.A. Res. S-26/2 (July 27, 2001).

11 Cf. E. Kinney & B. Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INTERNATIONAL LAW JOURNAL 285 (2004).

Right to Health: Development as a Concept

Traditionally health was seen as falling within the private, rather than public, realm. Health was also understood as the "absence of disease". The first laws containing health-related provisions go back to the era of industrialization. The Moral Apprentices Act (1802) and Public Health Act (1848) were adopted in the United Kingdom (U.K.) as a means of containing social pressure arising from poor labour conditions. The 1843 Mexican Constitution included references to the state's responsibility for preserving public health.[12] Besides these there are some specific issues and provisions related to the right to health of specific sectors as follows:

- **Prisoners:** Rules 22-26 of the Standard Minimum Rules for the Treatment of Prisoners refer to health services in prison, minimum health entitlements of prisoners and the general duties of doctors assigned to penitentiary establishments.[13]
- **Disabled persons:** The U.N. Declaration on the Rights of Disabled Persons addresses their rights to health care and rehabilitation services.[14] In addition, ICESCR General Comment 5 is devoted to disabled persons, and establishes the obligation to adopt positive measures in order to reduce the structural disadvantages that affect them.[15]
- **Victims of violence:** The U.N. Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power[16] lays out the health and social services provisions that should be available for victims of violence, including psychological assistance.
- **Mental health:** The U.N. Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care establish a series of standards to safeguard the

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[12] The first nation to formally incorporate guarantees for economic, social and cultural (ESC) rights was Mexico (1917 Constitution), though no specific mention is made of the right to health.

[13] Standard Minimum Rules for the Treatment of Prisoners, *adopted on* Aug. 30, 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, U.N. Doc. A/CONF/611, annex I, ESC Res. 663C, 24 U.N. ESCOR Supp. (No. 1) at 11, U.N. Doc. E/3048 (1957), amended ESC Res. 2076, 62 U.N. ESCOR Supp. (No. 1) at 35, U.N. Doc. E/5988 (1977).

[14] Declaration on the Rights of Disabled Persons, G.A. Res. 3447 (XXX), 30 U.N. GAOR Supp. (No. 34) at 88, UN Doc. A/10034 (1975).

[15] CESCR, General Comment 5, *Persons with Disabilities* (11th session, 1994), U.N. Doc E/C.12/1994/13 (1994).

[16] Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, G.A. 40/34, annex, 40 U.N. GAOR Supp. (No. 53) at 214, U.N. Doc. A/40/53 (1985).

human rights of mentally ill persons, guarantee adequate treatment, care and rehabilitation, and ensure humanitarian and non-discriminatory conditions. The U.N. Declaration on the Rights of Mentally Retarded Persons sets out the rights of such persons to health care, therapy and education.[17]

Constitutional Provisions for Health

The extent to which health rights are neglected or promoted is a major factor in the promotion of health equity in a civilized country. Right to health as a constitutional right provides a bench mark for government, private sector and society to respect, protect, fulfill and promote it. Two thirds of the constitutions in the world have a provision addressing the right to health or to health care.

The right to health is also recognized in numerous national constitutions,[18] either directly, as in South Africa, or indirectly, as in India. Such indirect protection can be effected by judicial pronouncements, incorporating the right to health aspects in other human rights, explicitly guaranteed at the national level.[19] In some countries, where the constitution does not provide specifically for the right to health, elementary health care issues can be deduced from a more generic human rights provision, such as the human dignity provision read in conjunction with a "social state" or solidarity principle, as under the German Basic Law in Articles 1[20] and 20a[21]. These chapeau provisions serve as an umbrella of human rights

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[17] Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, G.A. Res. 46/119, 46 U.N. GAOR Supp. (No. 49) at 189, U.N. Doc. A/46/49 (1991); Declaration on the Rights of Mentally Retarded Persons, G.A. Res. 2856 (XXVI), 26 U.N. GAOR Supp. (No. 29) at 93, U.N. Doc. A/8429 (1971).

[18] Cf. E. Kinney & B. Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INTERNATIONAL LAW JOURNAL 2004, at 285.

[19] *See* H. Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Open Society Institute, Public Health Programme, University of Essex, Human Rights Centre, 2008, app. I, case studies 3 and 4–India, at 33–35.

[20] **Art. 1.** Human dignity–human rights–legally binding force of basic rights.-
1. Human dignity shall be inviolable. To respect and protect it shall be the duty of all state authority.
2. The German people therefore acknowledge inviolable and inalienable human rights as the basis of every community, of peace and of justice in the world.
3. The following basic rights shall bind the legislature, the executive and the judiciary as directly applicable law.

[21] **Art. 20a.** Protection of the natural foundations of life and animals.-Mindful also of its responsibility toward future generations, the state shall protect the natural foundations of life and animals by legislation and, in accordance with law and justice, by executive and judicial action, all within the framework of the constitutional order.

protection, albeit restricted to guaranteeing the survival kit, the existential minimum, without which a life in dignity cannot be led.[22]

Health Care Rights under Constitution of United States of America

More than 70% of national constitutions around the world now provide a right to health care. But the United States (U.S.) Constitution is not among them. It is generally accepted that no right to health or health care exists in the U.S. Constitution.[23] The U.S. Constitution does not explicitly address the question of a right to health care. The words "health" or "medical care" do not mentioned anywhere in the text of the Constitution. The provisions in the Constitution indicate that the framers were somewhat more concerned with guaranteeing freedom from government, rather than with providing for specific rights to governmental services such as for health care. The right to a jury trial, the writ of habeas corpus, protection for contracts, and protection against ex post facto laws were among the few individual rights explicitly set forth in the original Constitution.[24] Even though the U.S. Constitution does not explicitly set forth a right to health care, the Supreme Court's decisions in the areas of the right to privacy and bodily integrity suggest the constitution implicitly provides an individual the right to access health care services at one's own expense from willing medical providers.[25] But some argue that even if a right to health or health care existed, it would not be justiciable because enforcement via the courts would be impossible without exceeding judicial competence, stretching separation of powers, and undermining democratic accountability.[26]

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[22] Eibe Riedel, *International Law Shaping Constitutional Law in* CONSTITUTIONALISM: OLD CONCEPTS, NEW WORLDS 105-121, at 115 (Eibe Riedel ed., Berlin: Berliner Wissenschafts-Verlag, 2005).

[23] Although Shapiro v. Thompson, 394 U.S. 618 (1969), suggests that advocates could use a theory of economic discrimination under the 14th Amendment to require the government to provide welfare benefits, this approach has been undermined by subsequent cases.

[24] W. Kent Davis, *Answering Justice Ginsburg's Charge that the Constitution is 'Skimpy' in Comparison to our International Neighbours: A Comparison of Fundamental Rights in American and Foreign Law*, 39 S. TEX. L. REV. 951, 958 (1998).

[25] *See* Roe v. Wade, 410 U.S. 113 (1973) (constitutionally protected right to choose whether or not to terminate a pregnancy), and Cruzan v. Missouri Department of Health, 497 U.S. 261 (1990) (constitutional right to refuse medical treatment that sustains life), both of which involve a right to bodily integrity that may logically be extended to a person seeking health care services at his or her own expense.

[26] *See* CASS R. SUNSTEIN, THE SECOND BILL OF RIGHTS: FDR's UNFINISHED REVOLUTION AND WHY WE NEED IT MORE THAN EVER 175-176 (2004).

Health Care Jurisprudence in U.S.

In U.S. the health care reform debate raises many complex issues including those of coverage, accessibility, cost, accountability, and quality of health care. Underlying these policy considerations are issues regarding the status of health or health care as a moral, legal, or constitutional right, it may be useful to distinguish between a right to health and a right to health care.[27] An often cited definition of "health" from the World Health Organization (WHO) describes health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity".[28] "Health care" connotes the means for the achievement of health, as in the "care, services or supplies related to the health of an individual".[29] For purposes of this paper, discussion will be limited to constitutional and legal issues pertaining to a right to health care. Numerous questions arise concerning the parameters of a "right to health care". If each individual has a right to health care, how much care does a person have a right to and from whom? Would equality of access be a component of such a right? Do federal or state governments have a duty to provide health care services to the large numbers of medically uninsured persons? What kind of health care system would fulfill a duty to provide health care? How should this duty be enforced? The debate on these and other questions may be informed by a summary of the scope of the right to health care, particularly the right to access health care paid for by the government, under the U.S. Constitution, and under interpretations of the U.S. Supreme Court.[30]

Health Care Rights in South Africa

Pre-1994, South Africa had a highly fragmented and bureaucratic health care system. Administration of health care was fragmented, with 14 separate departments to look after the health of the different

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27 *See* Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39 ST. LOUIS U.L.J. 7 (1994), and Lawrence O. Gostin, *The Right to Health: A Right to the Highest Attainable Standard of Health*, 31 HASTINGS CENTER REPORT 29-10 (2001).

28 WHO CONST. (2006), *available at* http://www.who.int/governance/eb/who_constitution_en.pdf.

29 Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 C.F.R. § 160.10.

30 *See e.g.,* JOHN TOBIN, THE RIGHT TO HEALTH IN INTERNATIONAL LAW (Oxford University Press 2012); Puneet K. Sandhu, *A Legal Right to Health Care: What Can the United States Learn From Foreign Models of Health Rights Jurisprudence?* 95 CAL. L. REV. 1151 (2007); and, Marcela X. Berdion, *The Right to Health Care in the United States: Local Answers to Global Responsibilities,* 60 S.M.U. L. REV. 1633 (2007).

racial groups, the 4 homelands, and 6 "self governing" territories. At an organizational level, there were multiple ministries and departments based on race (the tricameral system) and ethnicity (the homeland governments). Vertical fragmentation was through service differentiation (preventive and curative services) amongst the federal government, the provinces and local authorities. Public health services for whites were better than those for blacks and those in the rural areas were significantly worse off in terms of access to services compared to their urban counterparts. Expenditure on tertiary health services was prioritized above primary health care services.

Subsequently South Africa has been commended by many for giving direction to and recognizing health rights such as the right of access to health care services.[31] When apartheid ended in South Africa, a new populist government, headed by Nelson Mandela, aimed to create a more just and equal society which would seek to address the economic and social rights of its citizens. Article 27 of the Constitution of South Africa includes the right to health care, food, water and social security. It sets forth "the right to have access to" health services, including reproductive health care, and prohibit the denial of emergency assistance to it.[32] The adoption of this Constitution for the Republic of South Africa marked the enactment of one of the world's most liberal constitutions. Besides this the National Health Act, 61 of 2003, provides a framework for a single health system for South Africa. The Act provides for a number of basic health care rights, including the right to emergency treatment and the right to participate in decisions regarding one's health. The implementation of the Act was initiated in 2006, and some provinces are engaged in aligning their provincial legislation with the national Act. Other legislation relating to health care, some recently passed, include laws which aim to:

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[31] A. Snellman, *The Development of a Socio-Economic Rights Jurisprudence in South Africa: A Minor Field Study* (Orebro University (Online) 2002), http://www/afrikagruppema.se/usrd/agm488.pdf.

[32] **§ 27.** Health care, food, water and social security.-

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

- Ensure all health establishments comply with minimum standards through an independent entity (the National Health Amendment Bill, 2010);
- Make drugs more affordable and provide for transparency in the pricing of medicines (the Medicines and Related Substances Amendment Act, 59 of 2002);
- Regulate the medical schemes industry to prevent it from discriminating against "high risk" individuals like the aged and sick (the Medical Schemes Act, 1998);
- Legalize abortion and allow for safe access to it in both public and private health facilities (the Choice on Termination of Pregnancy Act, 92 of 1996);
- Limit smoking in public places, create public awareness of the health risks of tobacco by requiring certain information on packaging, and prohibit the sale of tobacco products to anyone younger than 18 (the Tobacco Products Control Amendment Act, 23 of 2007);
- Provide for the introduction of mandatory community service for nurses (the Nursing Act, 2005);
- Introduce a process to develop and redesign mental health services so as to grant basic rights to people with mental illnesses (the Mental Health Care Act, 2002);
- Allow non-pharmacists to own pharmacies, with the aim of improving access to medicines (the Pharmacy Amendment Act, 2000). This came into effect during May 2003.

Other important developments in health care policy and legislation include the Health Professions Amendment Act.[33]

Health Care Rights in European Countries

European governments face a growing number of major health challenges, which are putting unprecedented pressures on public health systems. As main actors responsible for the delivery and financing of health care, generally based on the principle of social solidarity, they need to identify policy solutions in this and relevant non-health sectors to best address these challenges. Despite its limited competences with regard to health, the European Union (EU) also has an impact, particularly by encouraging cooperation between member states, funding health programmes and reinforcing internal market rules. The Charter of Fundamental Rights of the European Union has caused much debate and controversy since it was

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[33] http://www.southafrica.info/about/health/health.htm#ixzz2Gho4PoAi.

proclaimed in December 2000.[34] Section 2 of this Charter explores the relationship between human rights and the regulation of health and health care. It considers various human rights principles with relevance in health contexts, as developed at the international and Council of Europe level. By reference to selected examples, it explores some of the ways in which human rights have affected health and health care at the member state level. Diverse national approaches to controversial ethical questions may give rise to particular challenges for the EU in attempting to construct health and health care law and policy in the light of human rights principles in the future. The 3rd section of the Charter focuses upon the impact of human rights principles upon the EU itself. That is, in the formulation of health law and health policy in the light of the EU Charter and the recent creation of the European Union Agency for Fundamental Rights. The Charter considers how such fundamental rights principles may be utilized in developing law and policy in this area in the future. It explores whether the EU Charter will really provide radical change or whether, ultimately, the EU Charter is likely to operate more at a rhetorical level, with limited practical effects.

England is one of four countries, along with Scotland, Wales and Northern Ireland that make up the United Kingdom of Great Britain (U.K.) and Northern Ireland. Health care in England is mainly provided by England's public health service, the National Health Service, that provides health care to all permanent residents of the U.K. which is free at the point of use, and paid for from general taxation. Since health is a devolved matter, there are differences with the provisions for health care elsewhere in the U.K.[35] The National Health Services Act in U.K along with the Health and Social Security Act, and the National Health Service and Community Care Act, 1990 are largely concerned with the constitution of services.[36]

Health Care Rights in South East Asia Region

Article 32 of the Constitution of the People's Republic of Bangladesh states that no person shall be deprived of life or personal liberty saves

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[34] *See* ECONOMIC AND SOCIAL RIGHTS UNDER THE EU CHARTER OF FUNDAMENTAL RIGHTS: A LEGAL PERSPECTIVE (T. Hervey & J. Kenner eds., Oxford: Hart 2003); S. PEERS & A. WARD, THE EU CHARTER OF FUNDAMENTAL RIGHTS: POLITICS, LAW AND POLICY (Oxford: Hart 2004). The Treaty of Lisbon changes the position of the Charter from that of soft law to being legally enforceable.

[35] http://news.bbc.co.uk/2/hi/health/7149423.stm.

[36] BRAZIER MARGARET, MEDICINE, PATIENTS AND THE LAW 20-22 (Harmondsworth: Penguin Books 1992).

in accordance with law. The Constitution of Bangladesh mandates that: "[It] shall be a fundamental responsibility of the state to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people with a view to serving its citizens the provisioning of basic necessities of life, including food, clothing, shelter, education and medicine". The government of Bangladesh, since independence, has been investing substantially in the strengthening of health and family planning services in the country, giving special allocation to the population that resides in the rural areas. The main thrust of the health programmes has been the provision of primary health care (PHC) services which has been recognized as a key approach to attain "Health for All by the year 2000". Bangladesh has accepted the goal and reiterated her political and social commitment to achieve it based on the Primary Health Care Strategy declared in Alma-Ata in 1978.[37]

The right to health is not an unfamiliar concept in the other member states of the South-East Asia region. This right is enshrined in the constitutions of Democratic People's Republic of Korea, Indonesia, Maldives, Nepal (interim constitution), Thailand and Timor-Leste. All these constitutions employ the local equivalent of the English language word "right" in describing people's entitlement to health care, and in some cases also to underlying determinants of health. The Constitution of Timor-Leste is the only constitution where the word "right to health" is included. The constitutions of Bhutan, Bangladesh, India, Myanmar and Sri Lanka do not recognize the right to health as a fundamental right but, nevertheless, compel the state to provide health services or in some cases, more indirectly to improve public health. It should be noted that although the right to health has not been included as a positive right in some constitutions of the region, other national legislation guaranteeing this right might be in place, or access to health could be treated de facto as a right. The distinction between the "right to health" or the "right to health care", and the obligation of the state to provide health care may not appear significant as far as the observable outcomes on the ground are concerned, but from the human rights perspective the difference is important. The rights-based approach to health signals a paradigm shift to using human rights as a pervasive human value enshrined in global convention, and not merely constitutional declarations on state

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[37] Omar Haider Chowdhury & S.R. Osmani, *Towards Achieving the Right to Health: The Case of Bangladesh*, XXXIII THE BANGLADESH DEVELOPMENT STUDIES, Mar.-June 2010, Nos. 1 & 2.

policy, as a direction for health development.[38] The assumption is that once people are made aware of human rights as a pervasive value of a democratic society, and assume their role as rights holders, they will take actions to hold the states accountable to improve health service delivery.[39] The right to health may be incorporated in the constitution as a constitutional right (positive right), which can be enforced in a court of law. In contrast, when it is incorporated as a directive principle of the government, the right cannot be enforced by the courts and constitutes rather a socio-economic objective to guide the government's actions.[40]

Health Care Rights in India: Constitutional Provisions

The preamble to the Constitution of India coupled with the Directive Principles of State Policy strives to provide a welfare state with socialist patterns of society. It enjoins the state to make the "improvement of public health" a primary responsibility. Furthermore, Articles 38, 42, 43 and 47 of the Constitution provide for promotion of health of individuals as well as health care.[41] The

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[38] WHO, *25 Questions and Answers on Health and Human Rights*, 1 HEALTH AND HUMAN RIGHTS PUBLICATIONS, GENEVA, July 2002, at 16.

[39] Sofia Gruskin & Daniel Tarantola, *Health and Human Rights in* PERSPECTIVES ON HEALTH AND HUMAN RIGHT 49 (Gruskin et al. eds., New York: Routledge 2005).

[40] M. Mulumba, D. Kabanda & V. Nassuna, *Constitutional Provisions for the Right to Health in East and Southern Africa,* Centre for Health, Human Rights and Development, CEHURD, *in* Regional Network for Equity in Health in East and Southern Africa EQUINET, Discussion Paper No. 81, April 2010, *available at* http://www.equinetafrica.
org/bibl/docs/Diss81%20ESAconstitution.pdf 3 (last visited Jan. 10, 2013).

[41] **Art. 38.** State to secure a social order for the promotion of welfare of the people.-
1. The state shall strive to promote the welfare of the people by securing and protecting as effectively as it may a social order in which justice, social, economic and political, shall inform all the institutions of the national life.
2. The state shall, in particular, strive to minimize the inequalities in income, and endeavour to eliminate inequalities in status, facilities and opportunities, not only amongst individuals but also amongst groups of people residing in different areas or engaged in different vocations.

Art. 42. Provision for just and humane conditions of work and maternity relief.-The state shall make provision for securing just and humane conditions of work and for maternity relief.

Art. 43. Living wage, etc., for workers.-The state shall endeavour to secure, by suitable legislation or economic organization or in any other way, to all workers, agricultural, industrial or otherwise, work, a living wage, conditions of work ensuring a decent standard of life and full enjoyment of leisure and social and cultural opportunities and, in particular, the state shall endeavour to promote cottage industries on an individual or co-operative basis in rural areas.

Art. 47. Duty of the state to raise the level of nutrition and the standard of living and to improve public health.-The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the state shall endeavour to

Constitution of India also enumerates the separate and shared legislative powers of parliament and state legislatures in 3 separate lists: the Union List, the State List and the Concurrent List. The parliament and state legislatures share authority over matters on the Concurrent List, which include criminal law and procedure; marriage, divorce and all other personal law matters; economic and social planning; population control and family planning; social security and social insurance; employment; education; legal and medical professions; and prevention of transmission of infectious or contagious diseases. Laws passed by parliament with respect to matters on the Concurrent List supersede laws passed by state legislatures. The parliament generally has no power to legislate on items from the State List, including public health, hospitals and sanitation. However, two-thirds of the rajya sabha may vote to make parliament possible to pass binding legislation on any state issue of "necessary or expedient in the national interest". In addition, 2 or more states may ask parliament to legislate on an issue that is otherwise reserved for the state. Other states may them choose to adopt the resulting legislation.

Concluding Remarks

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

The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes,

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bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under Article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by states.

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

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

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

Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations

should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should be strengthened to address violations of the right to health.

The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be promoted in all cases. Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to ICESCR.

To sum up it is felt that judges and members of the legal profession should be encouraged by states parties to pay greater attention to violations of the right to health in the exercise of their functions. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

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