

**National seminar on the *'Human right to health'***  
**Organized by the Madhya Pradesh State Human Rights**  
**Commission (At Bhopal) - September 14, 2008**

**Address by Justice K.G. Balakrishnan, Chief Justice of India**

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Ladies and Gentlemen,

I am here today since I feel that it is my duty to participate in this seminar which touches on an issue of fundamental importance in our society. The responsibility to respect, protect and fulfil the 'right to health' lies not only with the medical profession but also with public functionaries such as administrators and judges. In this context, the present programme is important since it seeks to highlight the inter-linkage between the promotion of healthcare and the language of human rights norms.

In this speech I would like to discuss the evolving understanding of the 'right to health' in the domain of international human rights norms. The 'right to health' had been accorded the status of an aspirational right in prominent international instruments, but in recent years the understanding of the same has evolved to incorporate specific obligations for implementation by states. I would also like to dwell on the recognition of the 'right to health' in some prominent decisions given by the Supreme Court of India. Subsequent to that, I would like to present an overview of the contemporary challenges to the understanding of the 'right to health'.

The traditional notion of healthcare has tended to be individual-centric and has focused on aspects such as access to medical treatment, medicines and procedures. The field of professional ethics in the medical profession has accordingly dealt with the doctor-patient relationship and the expansion of facilities for curative treatment. In such a context, healthcare at the collective level was largely identified with statistical determinants such as life-expectancy, mortality rates and access to modern pharmaceuticals and procedures. It is evident that such a conception does not convey a wholesome picture of all aspects of the protection and promotion of health in society. There is an obvious intersection between healthcare at the individual as well as societal level and the provision of nutrition, clothing and shelter. Furthermore, the term 'public health' has a distinct collective dimension and has an inter-relationship with aspects such as the provision of a clean living environment, protections against hazardous working conditions, education about disease-prevention and social security measures in respect of disability, unemployment, sickness and injury. Special emphasis is laid on elements such as women's reproductive health and the healthcare of children.<sup>1</sup>

There is a foundational logic for health concerns to be addressed through the language of human rights. While professional ethics in the medical profession have retained an individual-centric focus on curative treatment, the evolution of international human

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<sup>1</sup> See: Benjamin Mason Meier and Larisa M. Mori, 'The highest attainable standard: Advancing a collective human right to public health', *37 Columbia Human Rights Law Review* 101-146, Fall 2005

rights norms pertaining to health has created a normative framework for governmental action.<sup>2</sup> It may be useful to quote Jonathan Mann, a doctor who led the efforts to develop the interface between health and human rights:

*“Modern human rights, precisely because they were initially developed entirely outside the health domain and seek to articulate the societal preconditions for human well-being, seem a far more useful framework, vocabulary, and form of guidance for public health efforts to analyze and respond directly to the societal determinants of health than any inherited from the biomedical or public health traditions.”*<sup>3</sup>

The incorporation of health concerns in the ‘rights’ discourse, both at the international and domestic level – recognises that the legal system bears the responsibility of aiding the medical profession in advancing the ‘right to health’. In fact, the onus on governmental agencies goes beyond aspects like the regulation of the medical profession and support for research and development (R&D) in the medical field. It also includes policy-choices pertaining to education, housing, environmental protection, labour laws, social security provisions and the protection of intellectual property among others. Since the end of World War II, many such aspects have come to be recognised as part of a ‘right to health’ in international human rights

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<sup>2</sup> See generally: Lawrence O. Gostin, ‘Public Health, Ethics and human rights: A tribute to the late Jonathan Mann’, 29 *Journal of Law, Medicine and Ethics* 121-129, Summer 2001

<sup>3</sup> Cited from: Jonathan Mann et al., *Health and Human Rights: A Reader* (New York: Routledge, 1999) at p. 444

instruments, but there has been considerable disputation regarding the scope and nature of this right. Article 25 of the *Universal Declaration of Human Rights, 1948* (UDHR) encapsulated the 'right to health' in the following words:

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

*2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection."*

While this declaration articulated the core elements of public health concerns, it did not create any binding obligations on the members of the United Nations. In subsequent years, the right to health came to be incorporated in the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) which was presented before the UN General Assembly in 1966 and adopted in 1976. While Article 12(1) of the ICESCR referred to the 'right to health' in aspirational terms, Article 12(2) mandated specific measures on part of the state parties to the covenant. Its language reads as follows:

*“1. The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*

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

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

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

*(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.”*

It must be remembered that the rights enumerated in the ICESCR were subject to ‘progressive realisation’ and further contingent on the ability of State parties to muster adequate material resources for fulfilling the same.<sup>4</sup> This condition was at the heart of the difference between rights enumerated in the ICESCR and those enumerated in the *International Covenant on Civil and Political Rights* (ICCPR) which could be specifically enforced against State parties. The hierarchy between the rights enumerated in the two covenants

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<sup>4</sup> Article 2(1) of the ICESCR reads as follows: *“Each State Party to the present covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by appropriate means, including particularly the adoption of legislative measures.”*

reflected the cold-war politics over the prioritization of the same. Some of the rights enumerated in the ICCPR were given a 'non-derogable' status and individual complaints mechanisms have been created for the protection of the same. In comparison, the economic, social and cultural rights were not made the subject of any means of specific enforcement at the international level and have retained an aspirational character, in a manner akin to the Directive principles in the Constitution of India.<sup>5</sup>

There are provisions relating to the protection and advancement of health in several conventions formulated under the aegis of the United Nations. Specific reference can be made to provisions in the *Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)*, the *Convention on the Rights of the Child (CRC)* and the *International Convention on the Elimination of all forms of Racial Discrimination (ICERD)*.<sup>6</sup> Apart from this several regional treaties and instruments have touched on issues pertaining to health.<sup>7</sup> Part IV of our Constitution which deals with

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<sup>5</sup> In this regard an interesting reading is: Yuval Shany, 'Stuck in a moment of time: The International Justiciability of Economic, Social and Cultural Rights', *Research Paper No. 9-06, August 2006 (Law Faculty, Hebrew University of Jerusalem)*, Paper available from <www.ssrn.com>

<sup>6</sup> See: Articles 11(1)(f), 11(2), 12 and 14(2)(b) in the *Convention on the Elimination of all forms of Discrimination against Women (CEDAW)*;  
Articles 3(3), 23(3), 23(4) and 24 in *Convention on the Rights of the Child (CRC)*;  
Article 5(e)(iv) in *International Convention on the Elimination of all forms of Racial Discrimination (ICERD)*

<sup>7</sup> Refer: Articles 11 and 13 of the *European Social Charter*;  
Article 35 of the *Charter of fundamental rights of the European Union*;  
Article XI of the *American Declaration on the rights and duties of man*;  
Article 16 of the *African Charter on Human and People's rights*;  
Article 14 of the *African Charter on the Rights and welfare of the Child*;

Directive principles of State policy has several provisions that touch on the subject of health and one can refer to the text of Articles 39(e), 39(f), 42 and 47.<sup>8</sup>

It is evident that the main problematic issue in the evolution of the 'right to health' in international human rights norms is its non-justiciable character. This problem pervades into domestic enforcement as well since states are reluctant to assume liability in respect of the failure to provide adequate healthcare facilities. However, some developments in recent years have not only expanded the scope of the 'right to health' but have also called on state parties to the ICESCR to 'respect, protect and fulfil' their citizens' right to the same. 'Respecting' the right to health means that the government must refrain from taking actions that inhibit or interfere with people's ability to enjoy their right. 'Protecting' the right

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<sup>8</sup> The text of the Directive Principles dealing with health, is as follows:

Article 39(e): *“that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength.”*

Article 39(f): *“that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment.”*

Article 42: *“The State shall make provision for securing just and humane conditions of work and for maternity relief.”*

Article 47: *“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 bring about prohibition of the consumption except for medicinal purpose of intoxicating drinks and of drugs which are injurious to health.”*

to health means that the State must seek to protect the people from having their rights infringed by third parties, such as healthcare providers, private industry, pharmaceutical companies, researchers or vendors. 'Fulfilling' the right to health means that the government is required to take positive action to implement the right to health by adopting policies which allocate public resources to correct deficiencies in health facilities, goods and services.<sup>9</sup> In this regard, one can make a special mention of General Comment 14 issued by the *UN Committee on Economic, Social and Cultural Rights* in 2000. The said Committee made the following observations:

*“The notion of the ‘highest attainable standard of health’ in Article 12.1 of the ICESCR takes into account both the individual’s biological and socio-economic preconditions and a State’s available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual’s health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods,*

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<sup>9</sup> Cited from: Patricia C. Kuszler, 'Global health and the human rights imperative', *Asian Journal of WTO and International Health Law and Policy*, Vol. 2(1), March 2007, p. 99-124, at 111-112

*services and conditions necessary for the realisation of the highest attainable standard of health.*"<sup>10</sup>

The Committee also recognised that the understanding of what constitutes 'health' had changed considerably since the drafting of the ICESCR in 1966. General Comment 14 adopted a broader definition of health which includes social determinants such as access to safe water and food, adequate nutrition and housing, healthy environmental conditions, access to health-related education and information.<sup>11</sup> It also acknowledged global changes such as rapid population growth, the emergence of infectious diseases such as HIV/ AIDS and the fact that chronic diseases have become more widespread.<sup>12</sup> In this respect, General Comment 14 also enumerated a set of universal minimum core obligations on State Parties. Most of these resonated with the health-related *Millenium Development Goals* (MDG's) articulated under the aegis of the United Nations.<sup>13</sup>

The broader notion of the 'right to health' emphasizes its interlinkages with rights and regulations relating to the protection of life and liberty, privacy, education, housing, transport, environmental protection and labour standards among others. In this respect, *1993 Vienna Declaration and Programme of Action* had emphasized the fundamental inter-relatedness between civil and political rights on one

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<sup>10</sup> Committee on Economic, Social and Cultural Rights, *General Comment 14 – The Right to the Highest Attainable Standard of Health*, E/C.12/2000/4 at para. 9

<sup>11</sup> *Id.*, para. 11

<sup>12</sup> *Id.*, para. 10

<sup>13</sup> See: United Nations, *The Millennium Development Goals Report 2006*

hand and economic, social and cultural rights on the other hand. The said Declaration specifically provides:

*“All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.”*<sup>14</sup>

The World Health Organisation (WHO) issues the *International Health Regulations* from time to time as a guiding framework for domestic policies. These regulations have further strengthened the link between human rights and health. For instance, Article 3(1) of the same states: *“The new International Health Regulations shall be implemented with full respect for the dignity, human rights and fundamental freedoms of persons.”*<sup>15</sup>

In India, the theory of the inter-relatedness between rights was famously articulated in the *Maneka Gandhi*<sup>16</sup> decision. This became the basis for the subsequent expansion of the understanding of the ‘protection of life and liberty’ under Article 21 of the Constitution of

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<sup>14</sup> Cited from: *1993 Vienna Declaration and Programme of Action*, U.N. GAOR, World Conference on Human Rights, 78<sup>th</sup> Session, UN Doc. A/CONF 157/23 (1993)

<sup>15</sup> World Health Assembly, *Revision of the International Health Regulations*, WHA58.3 (May 23, 2005)

<sup>16</sup> AIR 1978 SC 597

India. The Supreme Court of India further went on to adopt an approach of harmonization between fundamental rights and directive principles in several cases. With regard to health, a prominent decision was delivered in *Parmanand Katara v. Union of India*.<sup>17</sup> In that case, the court was confronted with a situation where hospitals were refusing to admit accident victims and were directing them to specific hospitals designated to admit 'medico-legal cases'. The court ruled that while the medical authorities were free to draw up administrative rules to tackle cases based on practical considerations, no medical authority could refuse immediate medical attention to a patient in need. The court relied on various medical sources to conclude that such a refusal amounted to a violation of universally accepted notions of medical ethics. It observed that such measures violated the 'protection of life and liberty' guaranteed under Article 21 and hence created a right to emergency medical treatment.<sup>18</sup>

Another significant decision which strengthened the recognition of the 'right to health' was that in *Indian Medical Association v. V.P. Shantha*.<sup>19</sup> In that case, it was ruled that the provision of a medical service (whether diagnosis or treatment) in return for monetary consideration amounted to a 'service' for the purpose of the Consumer Protection Act, 1986. The consequence of the same was

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<sup>17</sup> AIR 1989 SC 2039

<sup>18</sup> Commentary cited from: Arun Thiruvengadam, 'The global dialogue among Courts: Social rights jurisprudence of the Supreme Court of India from a comparative perspective' in C. Raj Kumar & K. Chockalingam (eds.), *Human Rights, Justice and Constitutional Empowerment* (New Delhi: Oxford University Press, 2007) at p. 283

<sup>19</sup> AIR 1996 SC 550

that medical practitioners could be held liable under the act for deficiency in service in addition to negligence. This ruling has gone a long way towards protecting the interests of patients. However, medical services offered free of cost were considered to be beyond the purview of the said Act.

With regard to the access and availability of medical facilities, the leading decision of the Supreme Court was given in *Paschim Banga Khet Mazdoor Samiti v. State of West Bengal*.<sup>20</sup> The facts that led to the case were that a train accident victim was turned away from a number of government-run hospitals in Calcutta, on the ground that they did not have adequate facilities to treat him. The said accident victim was ultimately treated in a private hospital but the delay in treatment had aggravated his injuries. The Court realized that such situations routinely occurred all over the country on account of inadequate primary health facilities. The Court issued notices to all State governments and directed them to undertake measures to ensure the provision of minimal primary health facilities. When confronted with the argument that the same was not possible on account of financial constraints and limited personnel, the Court declared that lack of resources could not be cited as an excuse for non-performance of a constitutionally mandated obligation. The Court set up an expert committee to investigate the matter and endorsed the final report of the said committee. This report contained a seven-point agenda addressing several issues such as the upgrading of facilities all over the country and the establishment of a centralized

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<sup>20</sup> AIR 1996 SC 2426

communications system amongst hospitals to ensure the adequacy and prompt availability of ambulance equipment and personnel. Some commentators have argued that by recognizing a governmental obligation to provide medical facilities, the Court has created a justiciable 'right to health'.

Without doubt, considerations of availability and access to medical facilities are the paramount challenge in our country. In recent years, considerable investment has been made for the expansion of the government run-healthcare infrastructure and the establishment of more medical and para-medical educational institutions. However, the enhancement of the scale of medical facilities is not a sufficient strategy by itself. While private sector investment in establishing full-fledged hospitals has to be encouraged, there must be adequate safeguards to ensure that the same also benefits the poorer sections and those in rural areas. The concern with an increasingly privatized healthcare sector is that it may cater largely to urban patients with high purchasing power. In this respect, administrative and legal interventions may be required to ensure proper access to existing facilities. An integrated approach to advancing 'public health' recognises its relationship with policies for economic development and addressing social inequalities. Medical professionals should also take on the responsibility of catering to the needs of the weaker and underprivileged sections. It must be recognised that access to medical facilities is often dependent on determinants of social status such as caste, gender and class.

Prof. Amartya Sen, in his recent Prof. Hiren Mukherjee Memorial Parliamentary Lecture delivered at the Central Hall of Parliament House, said :-

“A government in a democratic country has to respond to ongoing priorities in public criticism and political reproach, and to the threats to survival it has to face. The removal of longstanding deprivations of the disadvantaged people of our country may, in effect, be hampered by the biases in political pressure, in particular when the bulk of the social agitation is dominated by new problems that generate immediate and vocal discontent.

If the politically active threats are concentrated only on some specific new issues (no matter how important they may appear), rather than on the terrible general inheritance of India of acute deprivation, deficient schooling, lack of medical attention for the poor, and extraordinary undernourishment (especially of children and also of young women), then the pressure on democratic governance acts relentlessly towards giving priority to only those particular new issues, rather than to the gigantic persistent deprivations that are at the root of so much inequity and injustice in India. The perspective of realization of justice is central not only for the theory of justice, but also for the practice of democracy.”

The evolving law of medical negligence and consumer protection in India has already put the spotlight on the role of practitioners as well as intermediaries such as hospital managements and government agencies. Medical practitioners should not resent such legal scrutiny, since the same is essential to deter the unscrupulous elements in the profession. In recent years, substantial media attention has been given to controversial issues such as illegal organ trade as well as the widespread prevalence of quackery and the circulation of unsafe traditional medicines. The medical profession should cooperate with administrative and legal efforts to tackle these problems. It must be remembered that there is no distinctive bias against systems of traditional medicine, which is evident from the fact that the government has a full-fledged department devoted to the promotion of alternative systems of medicine such as *Ayurveda*, *Unani*, *Siddhi* and *Homoeopathy*.

With regard to access to drugs, there have been substantive debates about the impact of the changes in India's patent regime. It is argued that the adoption of the 'process patent' standard will impede the capacity of Indian pharmaceutical firms to replicate life-saving drugs in a cost-effective manner. It must be remembered that the changes in the patent regime were necessary to give Indian pharmaceutical firms access to foreign markets as well as the entry of foreign firms in the Indian market. In an environment of open competition, it is the consumer who benefits from wider choice and better pricing. Furthermore, one must also keep in mind that the *Doha Declaration* made in 2001 ensures a vital exception to the *TRIPS*

(Trade-Related Aspects of Intellectual Property Rights) agreement made under the aegis of the *World Trade Organisation* (WTO). Under the said declaration, developing countries retain the right to grant compulsory licences to their pharmaceutical companies for manufacturing otherwise patented drugs in instances of emergencies such as health epidemics.<sup>21</sup>

In an era where health risks assume a transnational character, it is important for all countries to ensure effective engagement at an international level. Over the last decade, we have all heard of the threats posed by infectious diseases such as the Mad Cow disease, SARS and Avian-Flu. The growth of HIV/AIDS continues unabated despite increasing investment in AIDS control measures such as awareness campaigns, the provision of contraceptives and increased supply of Anti-retroviral drugs. In such a scenario, the importance of the international human rights discourse cannot be understated. Governmental and private measures at the domestic level need further support from international collaborations such as the transfer of medical technology, personnel and medicines. The 'right to health' cannot be conceived of as a traditional right enforceable against the state. Instead, it has to be formulated and acknowledged as a positive right at a global level – one which all of us have an interest in protecting and advancing.

Thank You!

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<sup>21</sup> See generally: Frederick M. Abbott, 'The WTO medicines decision: World Pharmaceutical trade and the protection of public health', 99 *American Journal of International Law* 317 (2005)