

Tracing Human Rights In Health

Vivek Neelakantan

The Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

First Published in October 2006

By
Centre for Enquiry into Health and Allied Themes
Survey No. 2804 & 2805
Aaram Society Road
Vakola, Santacruz (East)
Mumbai - 400 055
Tel. : 91-22-26673571 / 26673154
Fax : 22-26673156
E-mail : cehat@vsnl.com
Website : www.cehat.org

© CEHAT

ISBN : 81-89042-47-5

Printed at :
Satam Udyog
Parel, Mumbai-400 012.

FROM THE RESEARCH DESK

Health and Human rights has explicit intrinsic connections and has emerged as powerful concepts within the rights based approach especially so in the backdrop of weakening public health system, unregulated growth of the private sector and restricted access to healthcare systems leading to a near-total eclipse of availability and accessibility of universal and comprehensive healthcare. A rights-based approach to health uses International Human Rights treaties and norms to hold governments accountable for their obligations under the treaties. It recognises the fact that the right to health is a fundamental right of every human being and it implies the enjoyment of the highest attainable standard of health and that it is one of the fundamental rights of every human being and that governments have a responsibility for the health of their people which can be fulfilled only through the provision of adequate health and social measures. It gets integrated into research, advocacy strategies and tools, including monitoring; community education and mobilisation; litigation and policy formulation.

Right to the highest attainable standard is encapsulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights. It covers the underlying preconditions necessary for health and also the provisions of medical care. The critical component within the right to health philosophy is its realisation. CEHAT's main objective of the project, *Establishing Health as a Human Right* is to propel within the civil society and the public domain, the movement towards realisation of the right to healthcare as a fundamental right through research and documentation, advocacy, lobbying, campaigns, awareness and education activities.

The Background Series is a collection of papers on various issues related to right to health, i.e., the vulnerable groups, health systems, health policies, affecting accessibility and provisions of healthcare in India. In this series, there are papers on women, elderly, migrants, disabled, adolescents and homosexuals. The papers are well researched and provide evidence based recommendations for improving access and reducing barriers to health and healthcare alongside addressing discrimination.

We would like to use this space to express our gratitude towards the authors who have contributed to the project by sharing their ideas and knowledge through their respective papers in the Background Series. We would like to thank the Programme Development Committee (PDC) of CEHAT, for playing such a significant role in providing valuable inputs to each paper. We appreciate and recognise the efforts of the project team members who have worked tirelessly towards the success of the project ; the Coordinator, Ms. Padma Deosthali for her support and the Ford Foundation, Oxfam- Novib and Rangoonwala Trust for supporting such an initiative. We are also grateful to several others who have offered us technical support, Ms Sudha Raghavendran for editing and Satam Udyog for printing the publication. The cover page has been designed by Jhanvi Graphics. We hope that through this series we are able to present the health issues and concerns of the vulnerable groups in India and that the series would be useful for those directly working on the rights issues related to health and other areas.

Chandrima B.Chatterjee, Ph.D
Project In-Charge (Research)
Establishing Health As A Human Right

ABOUT THE AUTHOR

Tracing Human Rights In Health

Vivek Neelakantan holds a First Class Masters Degree in History from the University of Mumbai and M.Phil in International Relations from the University of Madras, Chennai. He has worked extensively on Public Health Policy in Indonesia. His research interest includes history of medicine, health and human rights, globalization, health systems and health policy. He is currently doing his doctoral studies on the history of medicine from the Department of History, University of Iowa, USA. He prepared this background paper while working as an Intern with CEHAT.

CONTENTS

1. Introduction	1
1A. The Rationale for State Intervention in Health Systems	3
2. Public Health: Its Genesis since the Dawn of History	4
3. Health within the broad framework of Human Rights	11
4. The Right to Health in the light of International Law	14
5. Human Rights issues affecting the enjoyment of the Right to Health	17
6. The Experience of Developing Countries in Implementing the Right to Health: The Road Ahead	23
7. The Indian Experience	27
8. Conclusion: Some Reflections on the Right to Health	41
<i>References</i>	48

Tracing Human Rights In Health

1. Introduction

The enjoyment of the highest standard of human rights is one of the fundamental human rights of every human being, without distinction of race, religion, political belief or social condition. Of the 30 Articles of the Universal Declaration of Human Rights, Article 25 is concerned with the right to health. According to this Article, everyone has the right to a standard of living, adequate for the health of himself, including food, clothing, housing, medical care and necessary services. The preamble of the World Health Organization, states that the enjoyment of the highest standard of health is a fundamental right of every human being. In one of her speeches as the Director General, Gro Harlem Brundtland reiterated the central message that health is central to development. Viewing good health as a means to further economic development is a useful strategy to elevate the status of health related investment.¹ An alternate view sees health as both intrinsically and instrumentally an end in itself. It recognizes the interrelatedness of health and other valuable social ends and emphasizes the value of health for individual agency². Good Health enables individuals to be active agents of change in the development process. The

Aristotelian philosophy is based on the principle that it is society's obligation to maintain and improve people's health. Therefore, public health should focus on the individual's capacity to function, and health policy should aim to maintain and improve this capacity by meeting health needs. The relationship between health and economic development is two-directional. Health affects labor productivity, investments in physical and human capital and savings rates. In the other direction, income can affect health and demography by improving the ability to obtain food, sanitation and housing and by providing incentives to reduce the family size.

The World Health Report, 2003 reveals that a baby born in Afghanistan today is 75 times more likely to die before the age of five, than say a child born in Iceland or Singapore. The Antiretroviral drugs routinely prescribed for people with HIV/AIDS have greatly extended and improved the life for many. But of the 4.1 million people living in Sub-Saharan Africa who are in urgent need of such drugs, fewer than 2% have access to such drugs. Effective public health action needs to have an ethical stand as well as technical skills. The World Health Organization's core

¹ Article of Ruger Jennifer Prah, 'Health and Development', The Lancet, Volume 362, No. 9385, 30th August 2003.

² Agency refers to the people's ability to live a life they value.

values are those stated in the Constitution of 1946. In the 1940s as of today, the world was concerned about the core security questions, which were delegated to the United Nations. But the founders of the United Nations saw a clear relationship between security and justice. The preamble of the United Nations Charter states that security depends on the conditions under which justice can be maintained. The founders of the United Nations as well as the World Health Organization realized that there is a linkage between health, understood as a state of complete physical, mental and social well-being, and the core values of justice and security.³ The threat of new infections arising as a result of human action demands new forms of co-operation between human security and public health.

Although in the twentieth century, the global health indicators have improved, gross inequalities in health persist. Over the last fifty years, the life expectancy at birth has risen from 46.5 years in 1955, to 65.2 years in 2002. However life expectancy at birth in 2002, ranged from 78 years for the women in the developed countries to less than 46 years for men in Sub-Saharan Africa.⁴ In 2002, despite the declining burden of communicable diseases, HIV/AIDS was the biggest cause of mortality and the single largest contributor to the burden of disease. The outbreak of SARS reminded humankind of the shared vulnerability to new infections. The outbreak inflicted heavy economic

damage and the tourist industry in Southeast Asia had to bear the brunt. The Asian Development Bank estimated that the total damage inflicted on the Southeast Asian economics due to the SARS outbreak was \$ 60 billion. To shape a better tomorrow, the health inequities between the rich and the poor need to be redressed. Although public health in developing countries has registered considerable progress, the pace of progress remains uneven. In Indonesia as well as Ghana in the 1960, one in every five children died before reaching the age of five, a child mortality rate archetypical of many developing countries.⁵ However in Indonesia by 1990 the child mortality rate had fallen to one-half the 1960 level, whereas in Ghana it had declined only slightly. The main public health achievement in the twentieth century has been the eradication of smallpox, and the reduction of polio to an insignificant disease.

The problems faced by the health systems are as follows:⁶

- A. Misallocation: Public money is spent on health interventions of low cost effectiveness such as surgeries for most cancers, whereas critical cost-effective measures such as the treatment of tuberculosis remain grossly under funded.
- B. Inequity: The poor lack access to basic health services and receive substandard care. The government spending on health is disproportionate—it goes to the

³ Lee Jong Wook's, 'Global Health Improvement and the World Health Organization: Shaping the Future', *The Lancet* 2003; Volume 362, pp.2083-2088.

⁴ The World Health Organization, *The World Health Report 2003: Shaping the Future*, 2003. Geneva.

⁵ The World Bank, *The World Development Report 1993: Investing in Health*, 1993, Washington D.C.

⁶ Ibid.

affluent groups, such as free or below cost care in sophisticated tertiary level hospitals and subsidies to public and private insurance.

- C. **Inefficiency:** Much money spent on healthcare is wasted. Brand name pharmaceuticals are purchased in the place of essential drugs. There is a gross underutilization of health personnel.
- D. **Exploding Costs:** Worldwide health expenditure is growing faster than income. The increasing number of specialists, the availability of cutting edge technologies, the expansion of medical insurance linked to the fee for service payment generates a demand for costly tests and treatment. Developed nations such as the United States of America spend approximately 12% of their gross national product(GDP) on health, whereas less affluent states spend less than a thirtieth of this amount. In the developing countries public health spending is highly skewed towards high cost hospital services that tend to benefit urban groups. In Indonesia for instance, in 1980, despite the government's best effort to improve the health conditions of the poor, the government subsidies to the richest 10% of the households were three times the subsidies going to the poorest 10% of the households. In middle income countries, the government frequently subsidizes the social insurance that protects the relatively wealthy section of the population. In South Africa for instance, a small affluent minority

is protected by social insurance. The bulk of the poor rely on out of the pocket payments for medical services and the government health services may be inaccessible to them. In Peru for instance, over 60% of the poor have to commute at least an hour to avail themselves of primary healthcare facilities, in contrast to 3% of the better-off. The patient waiting time is indefinite and wrong diagnosis is common.

1.A The Rationale for State Intervention in Health Systems⁷

- a) A number of health related services, such as the information and control of infectious diseases have been instituted for public good. Malaria Control measures for instance, benefit an entire community. Private markets provide very little of the public goods crucial for health. Other health services have large externalities. Immunization of a child against measles slows transmission. Provision of basic health services is a cost effective way of poverty reduction. Access to basic healthcare is viewed as a basic human right in most nations. This perspective is embodied in the Health for All Declaration at Alma Ata hosted jointly by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Private healthcare will not give the poor much needed access to basic healthcare.

⁷ Ibid.

- Public financing of the basic health services is justified to alleviate poverty.
- b) Government action may be needed to compensate for the uncertainty of the insurance market. Private sector health insurance firms have their own shortcomings. Health risk creates an incentive for insurance companies to refuse to insure the people who are already ill. Private health insurance also faces the danger of moral hazards. These companies do not provide incentives to individuals to remain healthy. A ripe opportunity is created for doctors and hospitals to provide patients more care than they need.
- i) Evolution of public health.
 - ii) Evolution of human rights.
 - iii) Important milestones in global public health since the founding of the WHO.
 - iv) Justifiability of health as a human right from the angle of International Law.
 - v) Human rights issues impeding the realization of health as a human right, such as reproductive health, family planning as a human rights issue, AIDS as a human rights issue, the right to safe drinking water, the right to food and access to essential drugs.
 - vi) Realization of the right to health in developing countries with a special focus on the Constitutional provisions related to the human right to health.
 - vii) Realization of the right to health in the Indian context

There is asymmetry of information between the provider and the patient regarding the outcome of intervention. Providers inform patients about the choice of treatments, but when provider's income is linked to this, excessive treatment may result. In unregulated private markets, health costs escalate without any appreciable benefit to the patient. It is the State's role to regulate privately provided insurance. If governments intervene, they need to do so intelligently. When providing for the public health policy programs, the policymakers are faced with the dilemma of allocation of scarce public funds.

This paper is an endeavor to situate the evolution of Right to Health in a historical context. The various highlights of the paper are :

The conclusion reflects on the aspects of operationalizing right to health through Civil Society Initiatives, the People's Health Movement. It highlights the debates within the newly emergent discipline of Health and Human Rights.

2. Public Health: Its Genesis since the Dawn of History

By inventing agriculture, humans cultivated disease. According to McNeill William, the American historian, humans share 50 diseases with cattle and twenty-six with poultry. Irrigation in the early river valley civilizations such as the Nile and the Hwang Ho was responsible for schistosomiasis and archaeologists have unearthed the evidence of this disease in

the kidneys of 3000-year-old Egyptian Mummies. In the Peloponnesian War of the 5th century B.C Thucydides describes Athens war with Sparta, and the sudden outbreak of smallpox that decimated some 25% of the Athenian population. The Roman Empire knitted the Western World and most of its deadly pathogens by embracing Seleucid Asia, Macedonia, Egypt and Greece. Between AD 165 and A.D 180, the scourge of plague eliminated 33% of the Roman population.⁸

The Roman practicality was shown in their public works and sewers and in the provision of hospitals. Hypocrites' dictum, 'A doctor is a philosopher first', began to be accepted. The Christian view of the sick was based on philanthropy. With the advent of Christianity in Europe and Asia, there was inclusion of the poor and the old into the health services. The Christian contribution to the idea of public health was the hospital.⁹ In Medieval Europe, the church and the state organized care for the lepers in residential hospitals. In the 14th century, plague ravaged Europe, and the republican city-states of Florence and Venice saw the advent of Health Committees. A number of Italian States implemented Health Boards by the 16th century, whose chief task was to gather health information about the foreign states, in the light of which, health magistrates would take strong action such as imposing quarantine.¹⁰ However Great Britain can be regarded as the birthplace of Public Health, from where the idea of

public health was diffused to Australia and other settlements overseas. In the 17th century, the concept of Mercantilism taught that to maximize state power, a state had to grow a healthy population. The health of the people became a key philosophy of the state.¹¹ The Age of Enlightenment in the 18th century Europe would apply collective responsibility for the prevention of disease. Medical environmentalism supported a new interest in preventive medicine. The eighteenth century health philosophers began to co-relate dirt with disease. John Bellers (1654-1725) a Quaker cloth merchant who lived in London, wrote extensively on the health of towns in 1714, emphasizing the importance of population density to the transmission of disease. In Enlightenment England, the campaign to avoid disease was based on social and environmental analysis, and only sporadically was it translated into public policy through haphazard proliferation of urban development commissions. Philanthropic individuals set up commissions for street lighting in local areas. No central government policy was developed.¹² By far, the most important ideological influence on the health and the political state was the philosophy of democratic citizenship. The Democratic Revolutions in USA and France, asserted new principles regarding the state and the health of its subjects. According to Thomas Jefferson, sick populations were a product of sick political systems.¹³ He was of the

⁸ Kiple Kenneth F ,in Porter Roy edited, The Cambridge Illustrated History of Medicine,1996,Cambridge History of Medicine Series, Cambridge.

⁹ Ibid.

¹⁰ Lewis Milton J, The People's Health: Public Health in Australia (1788-1950),2003,2 Vols.,Connecticut

¹¹ Ibid.

¹² Porter Dorothy, Health, Civilization and the State, 1999,U.K, p.5.

¹³ Ibid.

firm belief that Democracy was the source of people's health. However it was the French Revolutionaries who added health to the Rights of Man and asserted that health citizenship should be the characteristic of a modern democratic state. In 1792, the Constituent Assembly's Committee on Salubrity declared that health was the state's obligation to its citizens. The 1830s witnessed the foundation of the English Public Health. The growth of public health legislation during this period was unrelated to its implementation, as it was haphazard and piecemeal.¹⁴

The Public Health Act of 1848, legislating the sanitary conditions of England and Wales is regarded as a great milestone in the history of public health. It heralds the advent of proactive rather than reactive public health¹⁵. For the first time the state became the guarantor of the standards of health and environmental quality and provided resources to local units of government to achieve the minimum public health standards. It empowered the local health boards to deal with water supply, control of offensive trades, quality of foods, pavement of streets and removal of garbage. The Act is viewed by historians as a response to the social and environmental problems generated by the industrial revolution.¹⁶ The financing of poor relief was a key problem in the nineteenth century. The cholera epidemic had drawn attention to the lack of sanitation in the urban areas in 1832. The relationship

between dirt and disease established by Chadwick, clarified the need for sanitary reform. Chadwick had established the co-relationship between black lung disease and poor working conditions in the industrial cities. Sanitary measures were needed on grounds of economics and humanitarian considerations. In 1848, a new wave of cholera swept across Europe. It provided the momentum for the establishment of the general board of health. Historiographical research has shed light on the political confusion in nineteenth century England; there were no clear answers as to how legislative measures could achieve sanitary ends. The Act can be viewed as a powerful catalyst for the development of local self-government and the governmental responsibility in health. It was a marker, to sort out jurisdictional levels of government and to solve questions of ethics, rights and responsibilities in relation to public health.¹⁷

From 1866, The Sanitary Act in UK, acquired an ever greater vocabulary of systematic enforcement. In 1853, Great Britain took the unprecedented step in making smallpox vaccination mandatory for infants under the age of one year. In the nineteenth century, medicine grew international, indeed global. The Red Cross was established through the Geneva Convention of 1864. The international medical congresses were inaugurated in Paris in the 1870's. In the USA, in the 19th century, medicine was largely a matter of

¹⁴ Article of Pickstone John, *Medicine, Society and State* in Porter Roy ed. Cambridge Illustrated History of Medicine, 1996, Cambridge.

¹⁵ Fee Elizabeth and Theodore Brown, *The Public Health Act of 1848*, Bulletin of the World Health Organization, November 2005, 83(1), pp.866-867.

¹⁶ Article of Pickstone John, *op.cit.*.

¹⁷ Fee Elizabeth and Theodore Brown in Bulletin of the World Health Organization, *op.cit.*, November 2005, 83(1)

free market on a fee for service basis. The poor were covered under the statutory welfare system. In Germany in the 1880's the National Program of Health Insurance For Employees was introduced. The international agreements between states on quarantine regulation began in 1851, with setting up of the International Sanitary Conference in Paris. In 1912, the Office International 'd Hygiene Public was established in Paris. It was described as a club of senior public administrators whose primary responsibility was to protect their countries from the importation of exotic diseases.

There was considerable conflict about health philosophies between states. The conflicts occurred not only between different states, but also between different international organizations. There were contentions at the level of political theories regarding the role of the state in the provision of essential goods and services. The Rockefeller Foundation affirmed the importance of the partnership between the state and the private sector in the provision of health services. Between 1918-1920, the USA exercised considerable influence on the development of health organizations.¹⁸ Foundation for the establishment of the League of Nations Health Organization was laid in the period 1918-1920.

The Charter of the Health Organization of the League of Nations Health Organization Article 23, provides that state members of the League will endeavor to take steps in matters of international concern, for the prevention and control of disease.

In the post First World War period, the Health Organization coordinated with the states of Poland and Russia in combating cholera. The Health Organization of the League of Nations, established in 1923, attempted to establish closer relations between the administrative health authorities of various countries. It consisted of higher officials of public health services and public health experts. It set up many commissions. The Malaria Commission recommended the so-called primary measures, which included the thorough and prolonged treatment of malaria, tracking down of cases and instruction to the population regarding the means of prevention. The Health Committee of the League of Nations appointed a commission of experts on Leprosy who advocated humane treatment of lepers, voluntary diagnosis and early treatment of cases in outpatient dispensaries.¹⁹ In 1926, the Health Organization of the League of Nations summoned experts to investigate the problem of infant mortality. They resolved to make an international enquiry on uniform lines to determine the causes of infant mortality among infants below the age of 12 months. In all its undertakings, the League of Nations endeavored to respond to the universal need of prevention of disease and it extended its operation to all corners of the globe. The International Labor office tackled ill health arising from poor working conditions. The post World War I period witnessed the emergence of Soviet Social Medicine, which provided positive welfare measures such as maternity benefits and negative

¹⁸ Ibid.

¹⁹ Ibid.

measures such as compulsory sterilization. The emerging interpretation of the League of Nations Technical Agencies in the light of historical evidence is that their achievements were more durable than their diplomatic failures of the League, which were based on the false notion of collective security. The policies of the Health Organization were conceptually flawed as undue emphasis was placed on the training of public health administrators who required elaborate institutional structures in order to dispense medical solutions to problems of chronic diseases.²⁰ In contrast to the United Nations special agencies such as the World Health Organization, United Nations Population Fund or the Food and Agricultural Organization of the post World War Second period, the League of Nations emerges as excessively Eurocentric, scientized, professionalized and gender biased in its strategies.²¹ Franklin Delano Roosevelt's New Deal (USA) established social security measures through comprehensive legislation such as The Social Security Act of 1935, which provided for federal funds for the public health services in the rural areas.²²

In 1945, a United Nations Conference was held at San Francisco which explored the possibility of setting up an international health organization. The health of all the peoples in the world was considered pivotal for the attainment of peace and global security. In 1946, the responsibilities of

the Office International'd Hygiene Publique were transferred to the new World Health Organization(WHO). On 7th April 1948, the Constitution of the WHO was accepted by twenty-six states. The First World Health Assembly was held at the Palais de Nations, Geneva in 1948. The prevailing health problems were divided into six groups based on priority - malaria, maternal and child health, tuberculosis, venereal diseases, nutrition and sanitation, public health administration, parasitic and viral diseases mental health and other activities.²³ It soon appeared that this classification did not correspond to the actual health needs. The decentralization of the health services was a dicey problem faced by the first World Health Assembly.²⁴ The main aim of establishing the Regional Offices of the WHO was to provide effective contact between the WHO and the National Governments. The World Health Organization's first Director General supervised the creation of a new international organization, Dr. Candau who served as the second Director General from 1953-1973, made his mark in the application of and the extension of the principles as enunciated in the Constitution of the WHO to real life situations. In the 1960s cholera, yellow fever and yaws persisted. Mass campaigns limited the transmission of malaria, poliomyelitis, yellow fever, tuberculosis and typhus. In the field of medical technology breakthroughs such as the invention of the freeze and dried smallpox

²⁰ Wiendling Paul, 1995, op. cit.

²¹ Ibid.

²² The New Deal refers to the comprehensive social security legislation enacted by US President Roosevelt (1933-1945) to deal with the fallout of the Great Depression of 1930. For more details on the New Deal refer, Abrams Robert K article :New Deal Medicine-The Rural Health Programs of Farm Security Administration, Journal of Public Health Policy, 2002.

²³ The World Health Organization, The World Health Report 1998, 1998, Geneva.

²⁴ Ibid.

vaccines brought optimism. There were developments in chemotherapy. The 1970s witnessed the beginning of a new awareness of the health rights of women which led to the greater emancipation for women and their increased participation in the social and economic life. There was considerable emphasis on the evaluation of developmental progress in general and social progress in particular and there was a shift towards the measurement of social indicators by non-monetary indicators such as literacy and life expectancy.²⁵ Hafdan Mahler took over as the WHO's third Director General in 1973. During his tenure, there was a new awareness linking health to human development. The United Nations (UN) designated 1974 as the World Population Year and 1975 as the International Women's Year. The concept of health development as distinct from medical care assumed significance during the 1970s. The WHO elaborated a number of principles for health development, for instance, the fact that the governments have a responsibility for the health of their people, and that at the same time, people had the right as well as the duty to participate individually as well as collectively in the development of their own health.²⁶ These principles further led to self-reliance in health matters at the individual, community and national levels. In the late seventies, there was an eye on the inequities in healthcare within and between countries. There was a call to integrate preventive, curative and the rehabilitative health measures. Policies were aimed at orienting research to the solution of health problems in the context

of basic needs. An important watershed in the development was the International Conference on Primary Healthcare held at Alma Ata, erstwhile USSR, in 1978 attended by delegates from 134 countries. The Conference declared that the health status of hundreds of millions of people in the world was unacceptable and called for a new approach in healthcare that would shrink the health-gap between the haves and the have-nots, to attain an equitable distribution of health resources, and attain a level of health for all citizens of the world that would permit them to lead a socially and economically productive life.²⁷ In 1981, the World Health Assembly formulated the Global Strategy of Health for All and invited the member states to formulate strategies in the achievement of Health for All. The Action Program on Generic Drugs was adopted in 1981 to promote the development of national drug policies and essential drug lists. The period from 1985 to 1990 was characterized by changes in the political as well as the economic landscapes. On the positive side, there was a movement towards greater democratization of political systems and greater participation of the people in determining their own future. Human Rights, equity and social justice became burning issues in the late Eighties of the Twentieth Century in the political decision making process. However, within the broad ambit of health and human rights, ethnic tension, increased violence in countries such as Afghanistan remained a grave concern as far as the realization of the ideal of health for all was concerned. The least developed countries during this

²⁵ See Also The World Bank, *The World Development Indicators 1997*, Washington D.C

²⁶ The World Health Report, 1998, *op.cit.*, p.15.

²⁷ The World Health Organization, *From Alma Ata to the year 2000, Reflections at Midpoint, 1988*, Geneva.

period faced a financial crunch due to the structural adjustment programs, which constrained their public health expenditure. In the developing countries, there was a dual burden of communicable as well as non-communicable diseases linked to changes in lifestyle. In developed countries the accident casualties as well as suicides showed some worrying trends. All these considerations have to be borne in mind while implementing Public Health Action geared towards achieving the goal of *Health for All* through Primary Health Care. Dr. Hiroshi Nakajima was elected the Director General of the World Health Organization in 1988, which was a turbulent period because, the civil wars and regional strife had made it incumbent for the WHO to participate in Humanitarian Emergency Relief and involvement in the Human Rights issues.

“Humans share fifty diseases with cattle and twenty-six with poultry,” said McNeill William, the American historian.

By inventing agriculture, humans cultivated disease. A quick glance at the genesis of disease and public health shows that while irrigation in the early river valley civilizations was responsible for schistosomiasis, post-war afflictions in the Roman Empire and the neighboring states included the dreaded smallpox, plague and host of deadly pathogens. While the Romans were pioneers in building public works and sewers, the Christian contribution to public health was the hospital and Great Britain was the birthplace of Public Health. However, it was the French Revolutionaries who included health to the Rights of Man. Some landmark

events in the history of public health are:

- | In 1792, the Constituent Assembly's Committee on Salubrity declared that health was the state's obligation to its citizens.
- | The Public Health Act of 1848 legislated the sanitary conditions of England and Wales, where the state became the guarantor of the standards of health and environmental quality.
- | Sanitary reform by Chadwick who established the relationship between dirt and disease.
- | Establishment of the general board of health after the cholera epidemic swept across Europe in 1848.
- | The Sanitary Act in UK and its systematic enforcement from 1866.
- | The establishment of the Red Cross through the Geneva Convention of 1864.
- | The International Medical Congress in Paris in the 1870s.
- | The introduction of the National Program of Health Insurance for Employees in Germany in the 1880s.
- | The establishment of the Office International'd Hygiene Public in Paris in 1912 to protect their countries from the importation of exotic disease.
- | Foundation for the establishment of the League of Nations Health Organization between 1918 and 1920.
- | The establishment of the Health Organization of the League of Nations in 1923 to foster close relations between the administrative health authorities of various countries.

- | United Nations Conference at San Francisco in 1945 to explore the possibility of setting up an international health organization.
- | The transfer of responsibilities of the Office International'd Hygiene Publique to the new World Health Organization in 1946.
- | The first World Health Assembly at the Palais de Nations, Geneva in 1948.
- | Awareness of the health rights of women in the 1970s.
- | The International Conference on Primary Health Care at Alma Ata in 1978 attended by delegates from 134 countries.
- | The formulation of the Global Strategy of Health for All by the World Health Assembly in 1981.
- | The adoption of the Action Program on Generic Drugs in 1981.

The burden of wars, civil strife and epidemics in their wake were dealt with by both developed and developing countries, each in their own way. Financial crunches due to structural adjustment programs constrained the public health expenditure of some developing countries. Non-communicable diseases linked to changes in lifestyle posed additional problems. During times of civil war and regional strife, especially in the late 1980s, Dr.Hiroshi Nakajima, as the Director General of the World Health Organization in 1988 was a turbulent period, as the civil wars and regional strife had made it incumbent for the WHO to participate in

Humanitarian Emergency Relief and involvement in the Human Rights issues.

3. Health within the broad Framework of Human Rights

The Rights based approach is not embedded in charity or simple economic development but is a process of enabling and empowering. One human rights activist described the rights based approach as the understanding of the conceptual difference between right and need.²⁸Right is an entitlement as a person and can be enforced in a court of law and entails an obligation on the part of the government to protect it, whereas needs reflect the aspirations of the people, and do not necessarily entail the government to satisfy it. Rights are associated with being, whereas needs are associated with having. The development of human rights and fulfillment reflect a fundamental commitment to protect the well-being and dignity of individuals in all societies. The idea of human development focuses on the individual well-being and augmenting basic capabilities such as basic freedoms,i.e being able to meet body requirements, the ability to avoid starvation, or to escape premature mortality. On the other hand, human rights focus directly or indirectly on the claim one person has over others.²⁹

All claims on human rights aim at securing the basic freedom for humans. The first paradox of human rights is that the power of the state is used for curbing the power of

²⁸ The International Human Rights Internship Program, Circle of Rights: Economic, Social and Cultural Rights Activism-A training resource,2000.Asian Forum for Human Rights and Development.

²⁹ United Nations Development Program,The Human Development Report 2000,2000,New York,cf. Amartya Sen's Capability Approach.

the state. For the weak, human rights are a means for curbing the influence of the strong.³⁰

The Aristotelian view is that inequality and oppression can breed revolution. Notions of equality are found in the Greek City States, but rights were limited to male free citizens. In the Medieval period, rights were limited to certain groups such as freemen. Rights were used against the absolute powers of the king. In the seventeenth century, Locke developed the theory of the consent of the government by those who were governed. In the eighteenth century the philosopher Paine included social security for the aged in the Rights of Man. In the nineteenth century, there was a conflict of interest between the middle class and the factory worker against the interests of the landowners. The aim of the middle class and the working class was the extension of the ballot. The civil and political rights embody such notions as equality, freedom from cruel and degrading treatment. These rights recognize the inherent worth of the individual as a citizen. The economic and social rights are the rights, which are related to improvement of the standard of living. They cannot be enforced in a court of law. In 1948, the United Nations adopted the Draft Declaration on Human Rights.

The United Nations Charter is at the pinnacle of the human rights system in the world today. The UN charter on Human Rights is a positivist instrument. It does not invoke the theory of Natural Rights or any other philosophy to justify human rights. It treats the rights as self-evident. It

has however recognized that the relationship between a state and its inhabitants are a matter of international concern.³¹ The International Covenant on Civil and Political Rights feature the Rights of the Individual. Duties characteristically attach to the state.

Article 5 of the Universal Declaration of Human rights bans cruel or degrading treatment.

Article 2 of the Universal Declaration of Human Rights states that everyone is entitled to the rights enunciated in the charter without any distinction as to race, sex or color.

The right of an individual not to be subject to cruel or inhuman treatment is a negative right, whereas positive rights are affirmative duties imposed upon the state, for example, the duty to provide food stamps and subsidies to realize the human right to food. Thus economic, social and cultural rights are positive rights which have entailed financial expenditure on the part of the state for their realization. The historicity of the economic, social and cultural rights can be contextualized within the religious injunctions concerning the needy, philosophies as diverse as Thomas Paine, Rawls, the Fabian Socialists of Britain, Chancellor Bismarck's social security cover in Prussia, the Mexican Constitution of 1911, The Soviet Constitution of 1919, The Social Insurance Schemes under the New Deal (USA) and John Maynard Keynes General Theory of Employment, Interest and Money. In the Indian context, the

³⁰ Rendel Margherita, *Whose Human Rights*, 1997, London.

³¹ Steiner Henry and Philip Alston, *International Human Rights in Context*, 2000, Oxford.

Economic, Social and Cultural Rights are embodied in the Directive Principles of State Policy in contradistinction to the Fundamental Rights embodying the Civil and Political Rights which can be enforced in a court of law. For instance, Article 39A of the Constitution (Directive Principles of State Policy) states that the citizens both men and women equally have the right to an adequate standard of living.

Article 25 of the Universal Declaration of Human Rights states that everyone has the right to an adequate standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing, medical care and necessary social services and the right to security in the advent of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The Declaration of the Rights of the Child states, "The child shall enjoy the benefit of social security. He shall be entitled to grow in health to this end, and special care shall be provided to him and his mother, including adequate pre natal and post natal care.

The International Covenant on Economic, Social and Cultural Rights states :³²

Article 12.1-The state parties to the present covenant recognize the enjoyment of the highest attainable standard of physical and mental health. Some steps shall be taken by state parties to achieve the full realization of rights as enumerated in the Covenant:- ³³

- i) The reduction of the still-birth rate and infant mortality rate and ensure the healthy development of the child.
- ii) The improvement of all aspects of environmental and industrial hygiene.
- iii) The prevention, control and treatment of epidemic diseases.
- iv) The creation of conditions, which would ensure to all medical service and medical attention in the advent of illness.

The Declaration of the Rights of the Mentally Retarded Persons of 9th December 1971, states that the mentally retarded persons have a right to proper medical care and physical therapy and to such training, education and rehabilitation that would enable him to develop his ability to the fullest.

The Declaration of the Rights of the Disabled Persons of 9th December 1975, states that the disabled people have a right to medical, psychological as well as functional treatment including access to prosthetics..., vocational training and rehabilitation that will hasten their process of social integration .

The Convention on the Elimination of Discrimination Against Women, of 18th December 1979, Article 14.2 B states that state parties shall take adequate measures to ensure that women have access to adequate healthcare facilities including information, counseling and services in family planning.

³² Lawson Edward, Health as a Human Right, in Encyclopedia of Human Rights ,pp.356-370,1996, Washington D.C.

³³ Ibid.

The International Conference on Primary Healthcare was convened in Alma Ata in September 1978 under the sponsorship of the UNICEF and the WHO. It was endorsed by the World Health Assembly in 1979. The World Health Assembly called upon every competent UN body to co-ordinate with the WHO in achieving Health for All. The International Conference on Primary Healthcare at Alma Ata expressed the following points in relation to primary healthcare:³⁴

- i) Health which is a state of physical, mental and social well being and not merely an absence of disease is a fundamental human right and the attainment of the highest standard of health is a social goal.
- ii) The existing inequality in health status between the developed and developing countries as well as within countries is politically, socially and economically unacceptable.
- iii) The promotion of and protection of the health of the people is essential to sustained social and economic development.
- iv) People have a duty to participate individually as well as collectively in the planning and implementation of healthcare.
- v) Primary healthcare reflects and evolves out of the economic conditions of the people addresses the main health problem in the community by establishing Promotive, preventive and rehabilitation services.

- vi) All governments should adopt national policies to launch primary healthcare as a part of the comprehensive national system.
- vii) An acceptable level of health can be attained through the fuller utilization of World's resources.

4. The Right to Health in the light of International Law

The Right to Health is embedded in a number of international human rights instruments. It is defined in the preamble of the WHO. The WHO envisages the highest attainable standard of health as a fundamental human right of everyone and includes a number of governmental obligations, which include commitment to healthcare and also the creation of conditions development of a high standard of occupational health, environmental health, clean drinking water and sanitation. In addition there are a number of treaty provisions related to the right to health, Art 12 of the international covenant on Economic, Social and Cultural rights .In addition to this there are a number of treaty provisions such as women, children, racial minorities, migrant workers and indigenous population.³⁵ The documents produced at Vienna and Beijing elaborate on the meaning and scope of the international human right to health. A number of National Constitutions include Right to Health or stipulate the State duties with regard to health. For example, Art 10 of the 1925 Chilean Constitution, states that it is the duty of the state to oversee the

³⁴ Ibid

³⁵ For detailed information on disadvantaged groups refer Art.of Mullen Kenneth and Lisa Curtice, The Disadvantaged, Their Health Needs and Public Health Incentives, in Detel Rogers et.al.eds., The Oxford Textbook of Public Health, Vol.3, 1997, New York, pp.1517-1535.

Public Health, hygiene and well being of the country.³⁶ Thus it can be seen in the light of international health that there is not so much an absence of consistent codification, rather the absence of consistent implementation practices through reporting procedures and the lack of understanding related to the meaning and scope of right, makes it difficult to implement.³⁷ The international treaty bodies are ambiguous about the implementation of the right to health. The International Covenant on Economic, Social and Cultural Rights addresses the broad framework of topics within the right to health, such as National Health Policies, accessibility of safe drinking water, adequate sanitation, availability of health related information, occupational health and the accessibility of health services for various vulnerable groups. The binding commitment on the state parties is the adoption of the primary healthcare strategy enunciated at Alma Ata by WHO. There is some overlap between the rights contained in the International Covenant on Economic, Social and Cultural Rights with the right to food, clothing and housing. The availability of adequate, nutritious and culturally acceptable food affects the enjoyment of the human right to health. Thus the right to food is a key in the realization of the right to health. The International Covenant on Economic, Social and Cultural Rights seeks to address the issue of the deteriorating environment only insofar as it affects human health. As far as the health needs of the vulnerable groups are concerned, health specific

subjects have emerged in the reporting mechanism of the Economic, Social and Cultural Rights. With regard to the inhabitants residing in the rural areas the state parties have an obligation to ensure that the imbalance in healthcare facilities between the rural and the urban areas is addressed.

At the United Nations there are no specific complaint procedures making health and other economic and social rights justifiable. The development of complaint procedures for the economic, social and cultural rights has proceeded somewhat at the regional level rather than the UN. The Right to Health is contained in the African Charter and is likely to be invoked and reviewed by the African Commission. The inter-American protocol at San Salvador, states that health shall not be subject to judicial review. Nevertheless, it is possible to submit complaints to the inter-American Commission on Human Rights on basis of the Right to Health as provided for in the American Declaration. For instance, in the case of the Yanomani Indians of Brazil, the Inter-American Commission on Human Rights ruled that the Right to Health in Article 11 was violated. The Brazilian government failed to protect the indigenous population from the deleterious effects of rainforest exploitation.³⁸

The inspiration for the justifiability of the Right to Health can be drawn from the national level. In some countries, either the Constitution or the domestic courts give effect to the International Right to Health.

³⁶ Toebes Brigit, Towards an Improved Understanding of the International Human Right to Health, *The Human Rights Quarterly*, 21, 1999, pp.661-679.

³⁷ Ibid.

³⁸ Ibid.

With regard to environmental health, in 1993 the Philippines Supreme Court in the famous *Minors Oposa Case* ruled that the state should revoke logging licenses in order to protect the health of the present and the future generations. The decision of the Filipino court was based on Article 2 of the Declaration of the Principles of State Policies, of the 1987 Constitution, which sets forth the right to health and ecology.³⁹

One may derive inspiration from the civil and political rights for the justifiability of the right to health, for example, the position adopted by the Indian Supreme Court which states that based on the Right to Life, Article 21 of the Constitution, the claimant had the right to emergency medical treatment.

Scholars and activists delineate the core obligations pertaining to the right to health. The so-called core content consists of the set of elements that the states have to guarantee irrespective of the available resources.⁴⁰ The core content related to the right to health draws inspiration from the Primary Healthcare Strategy of the WHO. Irrespective of the available resources, the state parties are obliged to provide access to maternal and child health, including family planning, immunization against infectious diseases, appropriate treatment of common diseases and provision of essential drugs. The analysis of the *Right to Health* according to Brigit Toebes, should be based on the tripartite typology of duties which assumes that the obligations to

protect, respect or fulfill can be derived from the human rights obligations on part of the states.

At the national or state level, the government enacts law to protect the health of the population. This was seen during the medieval period in Europe, in the Guilds of the fifteenth century, which controlled the production, distribution and the purity of drugs. Quality Control was the brainchild of the London Pharmacopoeia which acquired the force of law in 1875. Health Law is concerned with the protection and advancement of the health of the population.⁴¹ The Constitution contains a broad set of principles, intended to establish the power of the government and the right of individuals. Health protection may be defined as social welfare or public good. There is a vast diversity of statutes enacted for the protection of health purposes. A government may issue a detailed regulation in the form of official regulations which may have the force of law, such as the statute on public water supplies. Laws may be enforced through judicial intervention such as the decision of the American Supreme Court in the *Roe versus Wade* case which established the legality of abortion.⁴² Health law is the function of the government at the national, provincial or local levels. The scope of health legislation may vary from generic to specific. We have the example of the health legislation of Kenya, in the post independence period, which carried forward the colonial legacy, but the specific regulations in the ministry of health were

³⁹ Ibid.

⁴⁰ Ibid,cf. Chapman Audrey's Violations based Approach .

⁴¹ Roemer Milton I, National Health Systems of the World, Vol.2,1991,New York,pp.173-203.

⁴² Ibid.

issued by the Health Ministry.⁴³ One of the important milestones in the twentieth century was the eradication of smallpox. There was a rigorous policy of smallpox surveillance and the reporting of cases in Indonesia, through the use of smallpox recognition cards. The foundation of authority in the case of implementation of the WHO program of smallpox eradication was vested with the national health authorities.

The historicity of the legislation on health promotion can be traced to the Maternal and Child Welfare Act of Britain in 1918. The public health law of Iraq devotes a major section of its legislation, intent and strategy for achieving a balanced diet for all citizens. The relationship between lung cancer and smoking became evident in the twentieth century, and Italy became the first country in Western Europe to prohibit the advertising of tobacco. The right to healthcare is spelt out in the Constitutions of Italy, Hungary, Ireland and Poland. In 1982, the Constitution of the Netherlands proclaimed healthcare and social protection to be fundamental social rights.⁴⁴ In the Constitution of the United States of America, there is no reference to healthcare per se, however legislation pertaining to Right to Health may be enacted by police power of state. In Sweden, The Healthcare and Medicare Act of 1982, affirms that the entitlement of medicate and health is a social right.⁴⁵

5. Human Rights issues affecting the enjoyment of the Right to Health

- i) **Family Planning as a human right:** The International Conference on Human Rights in Tehran, in 1968 affirmed that parents have a basic human right to determine freely and responsibly the spacing of their children. The Bucharest Conference affirmed that family planning was the right of all couples. However its discussion about reducing high rates of fertility was not grounded in woman's rights.⁴⁶ In 1984, the International Conference on Population in Mexico City added that men should share the responsibility with women for family planning and child rearing. The International Conference on Population and Development at Cairo, in 1994 emphasized that reproductive rights embrace certain other human rights that are already recognized in law. These rights rest on the recognition that it is the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children. It also includes the freedom to make a decision concerning reproduction free from coercion and violence.
- ii) **Maternal health as a human rights issue:** The creation of public health

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ United Nations Population Fund, State of the World's Population, 2004, New York.

programs to improve the health of women has its origins in Europe at the close of the nineteenth century.⁴⁷ Healthy mothers and children were seen by politicians in nineteenth century Europe to be a resource for political ambitions. The emerging social reform movements at the time provided an impetus in the twentieth century to the institution of embryonic form of maternal and child health services. World War 1 accelerated the movement. In 1919, the League of Nations proposed legal standards for the protection of maternity at work. In the 1930s, the New York Times published a series of articles on maternal mortality and by 1938, the Mother's Charter was proclaimed by 60 local associations in the UK. Backed by a large number of official reports maternal and child health became a priority for ministries of health and a public health paradigm alongside the battle against infectious diseases. Global events such as the Universal Declaration of Human Rights secured the government obligation to provide special care and assistance for mothers. One of the core functions assigned to the WHO was the promotion of maternal and child health and welfare. By the 1950s the national health plans and policy documents from development agencies stressed that mothers and children were vulnerable groups and therefore priority targets for public health action. The notion of mothers

and children as vulnerable groups was also central to the primary health care movement launched at Alma Ata. The plight of women and children soon began to be seen more than a problem of biological vulnerability. The 1987 Call to Action for Safe Motherhood believed that the plight of women was structural and was rooted in their lack of decision making, unequal access to employment, education and poor nutrition. The shift to focus on rights of women was seen at THE International Conference on Population and Development at Cairo and the most noteworthy feature at Cairo was the 20 year plan of action that focused on universal access to reproductive health services grounded in individual choices and rights. This change was significant as it allowed for a rationale to invest in the health of women and children⁴⁸. Today predictably, maternal mortality is greatest in the poorest regions of Africa and Asia. In sub-Saharan Africa the risk of a woman dying from pregnancy related complications is one in sixteen!⁴⁹ In the twentieth century, countries as diverse as Egypt and Bolivia managed to halve maternal mortality. The World Health Report 2005 has observed that the health and survival of a newborn is closely linked to the health of its mother. The report has statistically shown that the percentage of maternal mortality reduces with the availability of skilled attendants at

⁴⁷ The World Health Organization, The World Health Report 2005-Make Every Mother and Child Count, 2005, Geneva.

⁴⁸ Ibid.

⁴⁹ Ibid.

the time of delivery. The progress in reducing maternal mortality is made in countries that have already reduced maternal mortality. Many countries are showing signs of reversal⁵⁰. Malawi is one country in Africa that has witnessed a sharp increase maternal mortality from 752 per100000 live births in 1992 to 1120 in 2000 according to the Malawi Demographic and Household Survey. The investigation revealed that the rise of maternal mortality deaths was due to AIDS. According to the WHO estimates, the national HIV prevalence rate has crossed 8.4%. There was a shortfall of public health personnel, related to the AIDS epidemic. The deficient hospital care accounted for 38% of the deaths according to the investigations and could be prevented.

Obstetric complications are the leading causes of death for women in the reproductive age group in the developing countries and constitute an intractable health problem. It is recognized that reducing maternal mortality is a moral and human rights imperative as well as a crucial international development priority. The maternal mortality in the world today averages 529000 annually or approximately one death per minute. These deaths according to the United Nations Population Fund are preventable. The choices inhibiting

the realization of safe motherhood include the lack of choice of obstetric care for women, poverty conflict and natural disasters.

Ensuring the human right to health for mothers has become a moral and political imperative and has a strong rationale. The WHO has termed the investment in the healthcare of mothers as a positive externality. The health of mothers affects their children and has an indirect bearing on human capital. Healthy children lie at the heart of human capital. Motherless children are vulnerable to malnutrition according to the WHO. The babies of ill or malnourished pregnant women are at a high risk of low birth weight, and impaired development which may inhibit their economic productivity. Improving maternal and child health is one of the cornerstones of the Millennium Development Goals. They are thus prime candidates for public funding.

- iii) AIDS as a human rights concern: Discrimination of people suffering from HIV/AIDS is a complex issue. The chief bone of contention in the realm of Human Rights related to AIDS in legislation is the word High Risk Group.⁵¹

There is a diversity of approaches in dealing with HIV/AIDS. In Bavaria, Germany female prostitutes are

⁵⁰ Ibid

⁵¹ Jayasuriya D.C, Health Law: International and Regional Perspectives, 1997, New Delhi. High-risk group in the context of AIDS related legislation include prostitutes, homosexuals, bisexual men, drug injecting persons and persons receiving blood products, who are discriminated by legislation. In the context of HIV/AIDS related laws references to women and infant are found in screening, occupational hygiene, breast feeding, abortion and adoption.

presumed to be HIV carriers.⁵² In Bavaria, the law prohibits HIV positive women from breastfeeding their infants. Norway in 1986 mandated the screening of breast milk. In the US under the Ryan White Comprehensive AIDS emergency act, of 1990, the Secretary For Health, and human services may suspend Federal grants to a state unless it has criminal laws which prosecute persons donating breast milk knowing that they are HIV positive is likely for prosecution..⁵³ Women are not problems in themselves when it comes to HIV/AIDS. The thrust should be on the education of the public to avoid high-risk activities leading to AIDS and not focus on high-risk groups. For risk assessment it is wrong to characterize all women under one umbrella. Women bear the brunt of the pandemic as mothers. It has imposed onerous duties on women. In many male dominated societies, a HIV positive woman faces social stigmatization, if her HIV positive status is widely known. Mandatory testing requirements should not be introduced, unless it assures the confidentiality of the HIV status. Of particular importance should be the school medical records. They should prevent the access of these records unless there is a valid reason to do so.

iv) Water as a human rights issue:
According to the UN Secretary

General Kofi Annan, access to safe drinking water is a fundamental human need and a basic human right. Contaminated water jeopardizes the physical and social health of all. Over the past 10 years, diarrhea has killed more children than all those lost to armed conflict since the Second World War.⁵⁴ It is estimated by the World Health Organization that one child dies every 15 seconds due to poor sanitation or water supply. In 1998, it was estimated that in Africa alone, over 2 million died due to diarrhea alone. In 2000, the UN Committee on Economic, Social and Cultural Rights adopted a general comment on the Right to Health inclusive of not only extending timely and appropriate medical care, but also to the factors that determine good health such as access to safe drinking water, adequate sanitation and sufficient supply of safe food. Regardless of their available resources, the state parties are to ensure that a minimum essential level of a right is realized. In the case of water the minimum level includes fulfilling the people's access to water and preventing disease. The defining of water as a human right makes a difference and entails the following obligations on the part of the state:⁵⁵

- a) Fresh water is a legal entitlement and not a commodity provided on a charitable basis.
- b) Achieving better access

⁵² Ibid.

⁵³ Ibid

⁵⁴ World Health Organization, The Right to Water, 2003, Geneva.

⁵⁵ Ibid.

- c) Ensuring that the least serviced areas in terms of water supply are targeted.

General comments relating to the Economic, Social and Cultural rights pertaining to water proscribes any discrimination on the grounds of race, sex political belief, national or social origin, property, birth, physical or mental disability, health status, Civil/Political or any other status which has the capacity of nullifying or impairing the enjoyment of the exercise of the right to water. The General Comment 15 was adopted on November 2002 by the Committee on the Economic, Social and Cultural Rights.

- v) Freedom from Hunger: According to the Food and Agricultural Organization, hunger like poverty is still a rural problem. It is clear that reducing hunger is not about the increasing of food production in the developed countries, but facilitating the accessibility of food for the poor countries. Persistent starvation is not a question of fate. It is manmade and a flagrant violation of the right to food.

The General Comment 12 of the Economic, Social and Cultural Rights states that the right to adequate food is realized when every man, woman or child alone or in association with others has physical access at all times to adequate food.⁵⁶ The right to food entails certain core obligations on

the part of the government, namely the obligation to respect. The government should refrain from eviction of people from land. It needs to protect the poor from price fluctuations. To fulfill the right to food the government needs to provide an enabling environment for people to feed themselves. According to the Food and Agricultural Organization, nearly 38 million people in Sub Saharan Africa, are at the risk of hunger. The number of undernourished in the world is approximately 840 million, 799 million in the developing countries. It is estimated by the food and agricultural organization that 2 billion people worldwide suffer from nutritional deficiencies.

In India, a writ petition was submitted to the Supreme Court by the People's Union of Civil Liberties, agitating for the right to food, in the wake of a drought in Rajasthan, Madhya Pradesh and Orissa.⁵⁷ It is alleged that the starvation deaths occurred despite the presence of surplus food stocks. Initially, the case was brought against the Government of India, the Food Corporation of India and six state governments in the specific context of inadequate drought relief. Subsequently, the case was extended to the larger issue of chronic hunger with all states and union territories as respondents. Relying on the expansive interpretation of Article 21 to mean the right to live with dignity and all that goes with it, the petition

⁵⁶ United Nations Economic and Social Council Report NoE/CN.4/2003/54, 10 January 2003.

⁵⁷ South Asia Human Rights Documentation Center, Introducing Human Rights-An Overview of Gender Justice, Environmental Law and Consumer Law, 2006, New Delhi, pp.23-24.

argues that the right to food be placed within the broader purview of Right to Life under Article 21 of the Constitution. The petitioners alleged that the breakdown of the public distribution system, indicated the negligence on the part of the state, and the monthly quota of provisions per family failed to match the standards set forth by the Indian Council of Medical Research. Although the Government of Rajasthan had a famine code it was not complied with nor was it implemented. People's Union of Civil Liberties moved the Supreme Court for the court orders against the Government of Rajasthan, requiring it to provide immediate open ended employment at the legal wage rate to at least one member of the family in the village in all villages for at least six months. The Supreme Court has passed orders calling for the state to identify the below the poverty line and raise the public distribution entitlement per family. It sought direction from the Supreme Court to release free food free of cost to the Rajasthan Government .to the extent possible to cover relief measures.

- vi) The Access to Essential Drugs: The Right to Health is clearly protected in the WHO Constitution and in the International Covenant of Economic, Social and Cultural rights. The World Trade Organization does not place restriction on the member states to set out their own standards in the sphere of health policy. It

however limits national autonomy in the sphere of health policy.⁵⁸ There is a link between trade, genetically modified food, health, food safety as well as TRIPS(Trade Related Intellectual Property Rights), which may limit the access of the member states to generic drugs. The human right to health involves the highest standards of healthcare, and barriers to access include the high prices of the pharmaceuticals. According to the WHO, one-third of the world's population lacks access to essential drugs.

The TRIPS regime as it currently operates, impedes the member states access to essential drugs. Whether the TRIPS actually has a deleterious impact on the right to health is a debatable issue. Prior to the Uruguay Round of the World Trade Organization, different countries had different patent laws suited to their health requirements. Many did not grant patents to pharmaceutical companies per se. The WTO agreement on TRIPS is one of the three main pillars of the WHO, the other two being goods and services. The WTO accommodates the principle of non-discrimination, transparency and establishes the main standards for the protection of intellectual property. It covers inter alia, trade marks, copyrights, geographical indicators, and plant variety protection. The TRIPS imposes obligations on the member states to follow uniform patent laws. The

⁵⁸ Article of Dommen Caroline, Raising Human Rights Concerns, Human Rights Quarterly Vol.24, No 1, February 2002, pp. 1-50.

developed countries have claimed that the lax patent laws in the Third World have distorted free trade and have caused them millions in export earnings. The Intellectual Patents Discussions were more likely to be successful at the WTO as the developing countries not willing to accept the TRIPS would accept it as a tradeoff for concessions in other areas such as tax and agriculture.⁵⁹At the Uruguay round of the World Trade Organization, there was a contention by the developing countries that the greater intellectual protection would result in the augmentation of the Multinational Companies and would have a deleterious effect on the poor countries by raising the price of life saving generic drugs. Article 27 of the TRIPS states that the obligation of patent protection can be excluded to protect human life or health in case of an emergency. To illustrate the implementation of the TRIPS, South Africa, in 1997 passed a legislation which would allow parallel imports of generic drugs.

However South Africa is not able to apply this law due to foreign pressure. It has been forecast in the Economist, that the patent laws would make life saving drugs beyond the purchasing power of the poor. Even though the TRIPS stimulate innovation in the pharmaceutical sector they are unlikely to solve the problem of accessibility of drugs. Indeed what

many nations such as South Africa with high level of AIDS prevalence need is access to essential drugs and the TRIPS as it currently operates is likely to hinder this.

The Pharmaceutical companies do not invest as much in development on the research of tropical diseases as much as they do on coronary diseases. The TRIPS agreement has no provision on differential pricing depending on the state's need and ability to pay.⁶⁰

6. The Experience of Developing Countries in Implementing the Right to Health: The Road Ahead

Developing nations, the groups of nations defined by their low level of per capita income share some similar experiences.⁶¹ They gained independence from the colonial powers in the period succeeding the Second World War. Colonial health coverage was uneven and was geared to serve the strategic interests of the colonial empire, rather than the health of the population in the colonies.⁶² No uniform policies were developed with regard to traditional medicine. Colonial medical services augmented medical knowledge and discovery and control of tropical diseases. In the post independence period, in the developing countries there was a demand for curative services. Before the Alma Ata Declaration in 1978, the health policies of these countries reflected the colonial bias. The health system was skewed in favor of the urban areas. There

⁵⁹ Ibid.

⁶⁰ Ibid.

⁶¹ Article of Lucas Adetokunbo, Public Health Policies and Strategies in Developing Countries, Oxford Textbook of Public Health, Volume 1,2002,New York, Oxford University Press,pp.271-283.

⁶² Ibid

was a shortfall of preventive services. Events such as the Asian fiscal and monetary crisis of 1998 have had a deleterious effect on the government spending on health.

The large inequalities in health outcomes for the developing countries do not just reflect different health preferences or needs. They arise due to the constraints in the ability of the individual to achieve good health. Ethnicity, race and location also influence the health outcomes of the developing countries.⁶³ In South Africa, statistics have shown that the infant mortality rate in South African Blacks is 5.5 times greater than the Whites. In rural China, the life expectancy is six years lower in contrast to the urban areas. A lack on information related to the prevention and the treatment of diseases has inhibited the realization of health for all.

Malaria kills nearly one million children in Africa annually. Empowering mothers to take action at home is a cost effective way of curbing the disease. In the Tigray region of Ethiopia, mothers were selected from the community, to educate other mothers about the symptoms of malaria. They were provided chloroquine and information on how to administer the drug.⁶⁴ By educating the mothers regarding the symptoms and the cost-effective measures of prevention, Tigray showed the way forward, and there was a fall in under-five mortality by 40%. On October 1977, Ali Maow Maalin, a 23 year old cook living in the town of Merca, Somalia developed smallpox.

Vaccination teams immediately descended on the town of Merca and in a span of 3 weeks had vaccinated over 50000 people. Between 1977 and 1979 the WHO initiated smallpox surveillance throughout the Horn of Africa, eradicated the last vestiges of the disease. In 1967, when the program of smallpox eradication was started, approximately 15 million people died of the disease. The program of smallpox eradication cost the WHO \$300 million. The intensified program of smallpox eradication highlights the fact that the eliminating the burden of disease has become affordable for the poorest countries on earth.⁶⁵

Investments in health augment the national income of the developing countries as illustrated by the Sri Lankan Malaria Eradication Program. The near eradication of malaria during the period from 1947 to 1977 correspondingly witnessed a growth in the national income by 9% in 1977. The cost of the program was \$ 52 million compared to the \$ 7 billion gain in national income.⁶⁶

In the Indian Subcontinent, which includes Pakistan, Bangladesh and Sri Lanka, with the notable exception of Sri Lanka, the Bhore Committee report provided the blueprint for the development of health policies in the post independence period. In Sri Lanka, the public health system enjoyed widespread support. According to Mills public action and state responses had politically and socially constructed healthcare as a public good

⁶³ The World Bank, The World Development Report 2006, Equity and Development, 2005, Washington D.C

⁶⁴ Ibid.

⁶⁵ The World Bank, The World Development Report 1993, Investing in Health, 1993, Washington DC, refer Chapter 1.

⁶⁶ Ibid.

and as a basic right to be enjoyed by all citizens. From the time of independence, the Sri Lankan government had provided for universal and free welfare services that included the provision of free rice, education and healthcare to all its citizens. Scholars have commented that the healthcare system in Sri Lanka received support across the social groups. From 1945 to 1960, there was an expansion of the public health services with a considerable emphasis on maternal and child health, food security and expansion of the public health services at the primary, secondary and the tertiary levels of care.⁶⁷ The public health expenditure was 5.5% of total government expenditure in 1977, which declined to 3.2% in 1981, till it peaked to 6.5% in 1989.⁶⁸ In Sri Lanka the health services were evenly distributed with good connectivity. However, the chief concern related to the right to health realization in Sri Lanka is the indirect costs in terms of transportation, which are a cause of concern for the poor. The structural reforms programs were implemented in the Sri Lankan economy in the late 1970s and all the universal public health programs became targeted ones.

As far as Pakistan and Bangladesh were concerned healthcare was determined by the political contexts of the two countries. During the 1960s the healthcare investments were largely skewed in favor of West Pakistan. The rate of growth of public hospitals for West Pakistan was 16% from 1959-1966, whereas for erstwhile East Pakistan it was 7 percent⁶⁹. The health

services were underdeveloped in former East Pakistan, now known as Bangladesh. After independence, the government of Bangladesh assumed state responsibility for health. The regimes of Mujib ur Rehman and Zia ul Haq invested in public health services. It was during the Ershad regime that the famous drug policy of Bangladesh which gave a stimulus to the traditional systems of medicines was passed. The percentage of public spending on health has shown a decline.⁷⁰ The health policy document of Bangladesh in the 1990s was based on the World Bank prescription and from the health policy document it becomes clear that the state is unable to provide for the health services. In Pakistan, the investments in public health have been minimal in the post independence period and have shown an urban bias. Government expenditure on public health has never crossed 1.3% of the GNP and there has been a steady decline as far as the public health spending is concerned. The numbers of unemployed doctors have been rising. According to one estimate, 45% of the population does not have access to basic health services. According to Taylor Associates, only 18% of the public health services are located in the rural areas.

Out of the pocket health expenditure is the extant feature in many low income countries. In Vietnam, prior to the establishment of the social insurance in 1998, 30% of the poor households' income on non food budgets went towards health costs, whereas the richest 20% spent only

⁶⁷ Baru Rama V, Privatization of Health Services, A South Asian Perspective, Economic and Political Weekly, October 18 2003, pp.4433-4437.

⁶⁸ Ibid.

⁶⁹ Ibid.

⁷⁰ Ibid.

15% of the non food budgets on medical expenses.⁷¹In Cambodia, a single hospital could absorb as much as 88% of an average household's expenditure. In Thailand, in 2002 the Government introduced a 95 Baht scheme aimed to guarantee healthcare to every Thai citizen. It combines previous health insurance schemes targeted at the poor and allocates the budgetary resources to the providers of care on a capitation basis.⁷² The tuberculosis control program in China is an example of how the charging for the provision of public health services can lead to failure of public health program.⁷³ In the 1960s, China had made considerable progress in the eradication of tuberculosis due to the long-term free antibiotic therapy made available at the health centers. However, in the year 1981, the government began to levy user fees and the repercussion was that the poor opted out of treatment, as a result the death toll due to tuberculosis had risen to 3,60,000 in the early nineties. The developing countries have limited resources to provide large risk pools to cover vulnerable groups. They face a trade-off between providing a package of healthcare and extending financial protection.

The Constitution of the Republic of Colombia, dated 6th July 1991 contains health related provisions. *Article 17* deals with the realization of right to health. *Article 44* of the Columbian Constitution states that the rights of children have priority over all others .⁷⁴

⁷¹ The World Development Report 2006, op.cit.

⁷² Ibid.

⁷³ World Development Report 1993,op.cit

⁷⁴ The World Health Organization, International Digest of Health Legislation, Vol 56, No 5, 2002.

⁷⁵ Ibid.

⁷⁶ International Digest of Health Legislation, Vol 57, No 1, 2006.

⁷⁷ Ibid.

The Constitution of China states that (Chapter 1, Article 21) the state develops health services, promotes modern and traditional Chinese medicine and supports the establishment of the medical facilities by the rural collectives. The state promotes mass sanitation activities of a mass character to promote people's health. *Article 21* of the Constitution of the People's Republic of China further states that the state develops physical culture and promotes mass sporting activities to promote people's health.⁷⁵

The Constitution of the Republic of Costa Rica dated 7th November 1949, has the following provisions related to health:⁷⁶ *Article 21* recognizes the inviolability of the right to life. *Art. 46* states that the consumers of healthcare are entitled to protection, inter alia their health and environment and receive truthful information. *Article 50* of the Constitution of Costa Rica states that every person has the right to a healthy and ecologically balanced environment and right for redress in case of any damage caused.

The Constitution of the Republic of Niger contains the following Health Related Provisions:⁷⁷

Title II deals with the Rights and duties of the human person. *Art. 11*, states that everyone has the right to life, health, safety, mental and physical integrity and education as conditions laid down by law. *Article 18* of the Constitution, which states

that it is the duty of the state to provide for the physical, mental and moral health of the family, mothers and children in particular. *Article 19* of the Niger's constitution states that everyone has the right to a healthy environment.

Thus, in the constitutions of developing countries, the right to healthcare is frequently stated, but regarded as general intention rather than legal reality.⁷⁸

7. The Indian Experience

The established colonial powers were reluctant to undertake wholesale medical interventionism that would undermine the already precarious status quo.⁷⁹ The tension between the need to control communicable diseases which affected the general population and the imperative to establish clinical medicine and its practice without jeopardizing the tenuous support of the nationalist middle class led to the peculiar structure of the medical establishment in India according to David Arnold. This diarchy between curative and preventive medicine is an extant feature of health organization of post independent countries.

In contrast to the development of public health and medical science in Britain which was organic, in India due to the compulsions inherent in the colonial situation, it was not organic.⁸⁰ The East India Company in 1764 constituted the

Indian Medical Service (IMS). Mortality from disease was a serious threat to the health of the British soldier even before the Indian Mutiny. The three presidency towns of Bombay, Madras and Calcutta were centers of government. By the nineteenth century, the European settlements in India were well planned and were vaccinated against smallpox. After the 1857 Mutiny, the army was the single largest force in the empire and was pivotal for the safeguard of Britain's eastern possessions. Therefore, the health of the military assumed paramount importance. Sanitary Commissions were set up in the three Presidencies in 1864 and were to advise and assist in all matters related to the health of the army and were to supervise the introduction of sanitary improvements in Barracks and hospitals on a continuing basis. The basis of the functioning of these Commissions was the systematic generation of facts about disease, which would be incorporated into the Annual Sanitary Report. In 1861 the Government of India conducted the first systematic enquiry of cholera. The Constantinople Convention urged the Government of India to institute sanitary reforms at pilgrim centers. It was the question of pilgrims taking back cholera with them which provided the catalyst for raising the demand of extending the public health machinery for the general population on a continuing basis.⁸¹ The McKenzie Committee reported that the progress on sanitary reforms could not be enforced as

⁷⁸ Roemer Milton I, op. cit.

⁷⁹ Arnold David, *Colonizing the Body: State Medicine and Epidemic Disease in 19th century India* 1993, Berkeley, University of California Press.

⁸⁰ Ramasubban Radhika, *Public Health and Medical Research in India: Their Origins Under the Impact of British Colonial Policy*, SAREC (Swedish Agency for Research Co-operation with Developing Countries) Report R4:1982, Stockholm.

⁸¹ Ibid

any element of compulsion would offend the religious sensibilities of the people. It sought Indian opinion on sanitary matters at pilgrim centers. The introduction of the railways could be co-related with the unsanitary conditions of pilgrim movement. The report of the United Provinces Pilgrim Committee 1913, recommended that the government regulate the conditions of pilgrim movement. Indian society was seen by the colonial administration as '*tabula rasa*' to be recast in Western mould.⁸²

The *colonial* period in the History of Indian Medicine was a witness to contradictory trends. On one hand, there was an intensification of trade and commerce and on the other hand there was a neglect of health measures of the masses in British India. The plague epidemic of 1896 could have provided as a takeoff point for a far-reaching public policy.⁸³ The haphazard urbanization exacerbated the epidemic. As a result of inoculation drives and epidemic control, there was a stimulus for sanitary reform. Representations were made by the Indians requesting the government initiative to maintain the struggle against plague and widening the scope of sanitary reform. Public opinion formed the basis of the sanitary movement in India according to Radhika Ramasubban. The various international conferences as well as the British Plague Commission pressurized the colonial government to focus on public health. However the draconian measures enunciated by the colonial government caused stiff resistance from the public and

there was a need to place emphasis on the voluntary control measures. The Indian Nationalists emphasized the extremely limited purview of the Indian Medical Service and its preoccupation with the army and its lack of practical commitment to the health needs of the populace. Recent historiography has thrown light on the fact that there was a mismatch between the ideological importance given to medicine in imperial rhetoric and the extent to which medicine was perceived as one of the rationales of colonial rule and the low levels of actual achievement.⁸⁴ There was a large scale application of the germ theory of disease. Waldemar Haffkine contributed to the popularization of the vaccine against plague. In 1897, Ronald Ross discovered the mode of transmission of malaria.

The smallpox vaccination in the nineteenth century also met with popular resistance.

Towards the close of the nineteenth century, the growing number of hospitals and dispensaries founded by the Indian philanthropists such as the Parsis of Bombay Presidency diluted the alien presence of Western medicine, a trend exemplified by increased Indian participation and the Indianization of the Indian Medical Service.⁸⁵ Another important landmark of Colonial India was the growth of the Women's Medical Movement. In the 1880s the Dufferin Fund was created for the employment of women doctors and it can be observed that the Dufferin Fund was an important landmark

⁸² Ibid.

⁸³ Ibid

⁸⁴ Arnold David, The Rise of Western Medicine in India, The Lancet 1996; Vol.348:pp.1075-1078

⁸⁵ Ramanna Mridula, Gauging Indian Response to Western Medicine, Hospitals and Dispensaries, Bombay Presidency :1900-1920 in Deepak Kumar ed. Disease and Medicine, 2001. See also Arnold David, op.cit.

in the history of colonial public health of India and marked the involvement of women both as doctors and patients.

In 1872, responsibility for medical care was transferred to the local government. Lord Ripon's resolution of 1882 ignited the spark of local self-government. However the benefits accruing from decentralization did not percolate toward the grassroots level. The Sanitary Resolution of 1912 was a concrete step undertaken by the Government of India, to take preventive measures against the spread of diseases. Health became a provincial subject under the Government of India Act of 1919. The Government of India Act of 1935 granted provincial autonomy. Provincial legislatures were able to formulate and implement health policies with autonomy. There was a separation between the preventive and curative components of healthcare.

The Rockefeller Foundation began public health intervention against the backdrop of devolution of public health to provincial governments. The activities of the Rockefeller Foundation included disease control and the establishment of rural health units.

The Indian National Movement provided a boost to the revival of traditional medicine. Since 1920, there were attempts made to find common ground between the indigenous and the Western systems of medicine. Training of health personnel was undertaken. Efforts were undertaken to

use local people as the bottom tier of medical service. Schemes for training village nurses were implemented by the British government doctors. By the 1930's the health of the women and children was of concern to the local reform societies. The rise of the women's medical movement marked a drift from major epidemic diseases such as smallpox, plague to conditions such as tuberculosis and anemia which were ignored in mainstream medical research.⁸⁶ Despite introduction of the Vaccination Act in 1880, it was discovered in 1941 that vaccination was compulsory only in 81% of the towns and 62% of the villages.⁸⁷ The politics of health were much more powerful during the freedom movement. The Sokhey Committee of the National Planning Committee of the Indian National Congress recommended a Community Health Worker for every thousand of village population. It also recommended that the private practitioners of Unani and Ayurveda be drawn into the state health systems.⁸⁸

According to Roger Jeffrey's argument public health in India was a qualified failure during the colonial period. The European areas enjoyed the benefits of civic concern, the Indians gained little as preventive health campaigns were never fully addressed. Poverty made it difficult to treat diseases. There is a continuity of the past with the present. As in the past the eradication of communicable diseases has persisted as a public health problem.⁸⁹ Hugh Tinker, an eminent historian has argued that the British officials undertook

⁸⁶ Arnold David, *op.cit.*

⁸⁷ *Ibid*

⁸⁸ Banerji Debabar's Article, 'The Politics of Rural Health in India', Accessible via <http://phm.india.org>, Accessed on 29/6/2006.

⁸⁹ Ramasubban Radhika, *op.cit.*

public health activities in India out of a sense of duty and not due to people's needs. The prevalent social attitude inhibited the full-fledged development of public health in India. Western medicine was essentially curative in nature. Political exigency necessitated that the state adopt preventive health measures. Public Health was a low priority for the colonial government. The government applied the policy of laissez faire to health. There was a dichotomy between preventive and curative health.⁹⁰ The impact of western medicine was slight, and was confined to the larger cities and enclaves of the white community and the army according to the historian David Arnold.

At the time of partition, in 1947, India experienced contradictory health trends.⁹¹ The Bengal famine produced the greatest increase in mortality. An estimated 3 million died. The health services were disrupted by partition and there was a resurgence of malaria and dysentery. On the other hand, owing to mass public vaccination programs during the colonial period, smallpox and plague were on the brink of being wiped off. In 1946, DDT promised a major breakthrough in the fight against malaria.

The Bhore Committee reflected the equivocal standing of Western Medicine in India in 1946.⁹² The Committee reasoned that healthcare should be available to all, regardless of their capacity to pay. It pointed out that the death rate of 22.4 per

thousand was twice that of England and the infant mortality was significantly higher. The report recommended that any plan for the improvement of the health of the community should pay special attention to the development of measures for the protection of mothers and children. It attributed India's health problems to an unsanitary environment. The report underlined that at least 50% of the mortality existing in the country was preventable and should be prevented. To quote the Bhore Committee, "If it were possible to evaluate the loss which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency through malnutrition and preventable morbidity, we feel that the results would be so startling that the whole country would be aroused and would not rest until radical changes had been brought about".⁹³ Great emphasis was placed by the Bhore Committee on the creation of primary healthcare units. The Committee claimed that far from being affordable, Western medicine could meet the demands of the new nation states. India was in need of state hospitals, doctors and nurses. It recommended a health service based on the needs of the people. It emphasized the role of the state in the provisioning of basic health services. It pointed out the need to invest in the pharmaceutical sector and develop indigenous capabilities. Though the Committee felt that it was upto the government of the future to decide whether

⁹⁰ Kavadi Shirish N, 'The Rockefeller Foundation and Public Health in Colonial India (1916-1945), 1999, Pune /Mumbai, FRCH.

⁹¹ Arnold David, op.cit .

⁹² Ibid.

⁹³ 'Primary Healthcare in India: Review of Policies, Plans and Committee Reports', Accessed via [http://whoindia.org/commission on macroeconomics and health _primary healthcare in India _review of policy plans and committee reports](http://whoindia.org/commission_on_macro_economics_and_health_primary_healthcare_in_india_review_of_policy_plans_and_committee_reports), Accessed on 5/7/2006.

or not medical services should remain free for all classes of people there was unanimity among the Committee members that no one should be denied curative or preventive care because of their inability to pay for it. The Committee recommended that the government must spend 15% of its revenues on health activities. It sought to institutionalize the British model of healthcare in independent India. It took cognizance of Western medical changes and excluded from its purview the Indigenous Systems of Medicine. There was a contention between the Bhole Committee and the National Planning Committee regarding the levy of hospital fees. The key question posed by the Bhole Committee was whether the public health service should be free.⁹⁴ The other dilemma posed by the Bhole Committee was whether the public health service should be based on the full time service of the doctor or of the private practitioners. It was equivocal on the issue of whether the funding for the special facilities should come from the community. It also observed that health of the nation was the single most potent factor in determining the character and extent of its development. It also advocated the amalgamation of the medical relief and curative departments.

The Chopra Committee under the chairmanship of Colonel Sir RN Chopra opined that the Bhole Committee failed to take note of the indigenous systems of medicine. It advocated scientific methods for the investigation of indigenous systems of medicine. It recommended the introduction of Comparative History of

Western Medicine in India.

India has substantial achievements to its credit in the post independence period. Life expectancy has risen from 32 years at the time of independence to 66 years in 2004. Infant mortality rate has fallen by 70% points between 1947 to 1990. Smallpox and Guineaworm have been totally been eradicated, whereas leprosy and polio are nearing elimination. Over the last 5 years, over 500,000 deaths from tuberculosis have been averted due to the DOTS program. However the health situation in India presents a paradoxical situation.⁹⁵ Currently the life expectancy rate and the under five mortality rate are worse than those in Bangladesh and Sri Lanka. Although India accounts for about 16.5% of the world's population, it accounts for one fifth of the world's total burden of disease a quarter of all cases of maternal mortality, a fifth of the world's nutritional deficiencies and the second highest AIDS population after South Africa. India is facing the double burden of both communicable and non communicable diseases.

The First Five Year Plan accorded full priority for disease control measures such as the control of malaria, preventive healthcare of the population through health units, health services for mothers and children and self-sufficiency in drugs and equipment. Starting with the First Plan, vertical programs became the center of attention. There was a failure to introduce an integrated approach of healthcare.⁹⁶ In 1952, there was a start to set up Primary

⁹⁴ Report of Health Survey and Development Committee, Government of India(1946).

⁹⁵ Ministry of Health and Family Welfare, Government of India, National Commission on Macroeconomics and Health, 2005, New Delhi.

⁹⁶ Primary Healthcare in India-Review of Policy Plans..., op.cit

Health Centers to provide integrated promotive, preventive, curative and rehabilitative services to cover rural populations as an integrated component of inter-sectoral action.

A study of the of health policy in India suggests that in the post-independence period upto the sixties, the entire focus of public health was on the management of epidemics. There was a countrywide campaign launched against malaria, leprosy, smallpox and tuberculosis. The policy of mass campaigns against communicable diseases was an inheritance from the colonial legacy.⁹⁷ However, during the early years of India's independence, the social causes of diseases were overlooked. During the first two five year plans the health policy remained unchanged. Urban areas received 75% of the medical care resources whereas the rural areas received assistance under the Community Development Program. The Mudaliar Committee admitted that healthcare had not reached even half the nation. The fact of doctors moving into private practice after training under public expense loomed large. The individual communicable diseases were prioritized over public health centers. The rural areas had little or no access to public health centers. One of the major achievements of the 3rd Five Year Plan was the establishment of the AIIMS (All India Institute of Medical Sciences). During the Third Five Year Plan, family planning received attention of the policy makers for the first time.

In the 1960's the National Institute of Communicable Diseases, National Institute of Health Administration and Education, Malaria Institute of India and the National Tuberculosis Institute were established. Between 1961 and 1964, the interdisciplinary research done at National Tuberculosis Institute received worldwide attention.⁹⁸ Its most outstanding contribution was the imparting of a sociological dimension to epidemiological issues, developing people oriented technologies and formulation and use of operational research in public health.

During the *Fourth Plan* (1969-1974), efforts were made to provide an effective base for the health services in the rural areas by strengthening the Primary Health Centers. The vertical campaign against communicable diseases was intensified.

The *Fifth Five Year Plan* envisaged the increasing the accessibility of health services under the Minimum Needs Program. The Minimum Needs Program became an instrument through which the health infrastructure in the rural areas was expanded. It called for the integration of the peripheral staff of vertical public health programs, but the population control program received a further impetus during the emergency (1975-1977). In the year 1977, a major innovation was the creation of the community health worker. In the 1970s the government envisioned the idea of a Community Health Worker per 1000 people to entrust people's health in people's hands. In the 1970's the health situation

⁹⁷ Duggal Ravi, Historical Review of Health Policy Making, Gangolli Leena and Ravi Duggal.ed.s, Review of Healthcare in India, 2005, Mumbai.

⁹⁸ Banerji Debabar, op.cit.

of India was comparable with countries having a similar socio-economic situation. There was one Traditional Birth Attendant and Community Health Volunteer per 1000 people, a sub center and a male and a female multi-purpose worker per 5000 ,a Primary Health Center per 30000 and a Community Health Center per 0.1 million people with referrals that went right upto the national level. These services were offered free. India was thus on the threshold of implementing the Primary Health Care Strategy as enunciated by the Alma Ata Conference on Primary Healthcare.⁹⁹

The *Sixth Five Year Plan* was influenced by the idea of primary health care. The plan had stressed on the horizontal as well as vertical linkages to be established between inter-related programs such as water supply, sanitation, hygiene, education, family planning and maternal and child health.

However the Alma Ata Conference on Primary Health Care was countered by Selective Primary Health Care which recommended a cost effective approach of dealing with diseases, by the developed countries who argued that the developing countries were too poor to afford a comprehensive Primary Health Care package.¹⁰⁰The approach of Selective Primary Healthcare was the exact antithesis of Primary Health Care and changed the equations within and between nations. The rich countries persuaded the international organizations such as the World Health Organization as well as the

UNICEF to promote Selective Primary Healthcare. This has led to a virtual barrage of international initiatives in health, such as immunization, AIDS, and tuberculosis which are donor driven vertical programs in the case of Indian public health and were extremely expensive and difficult to sustain.

The National Health Policy of India has been framed in accordance with the principles of the Directive Principles of State Policy. It recommends universal comprehensive healthcare services which are relevant to the needs of the community and at a cost which people can afford.¹⁰¹ *The National Health Policy 1983* is an important landmark in the history of India, because for the first time since the Bhore Committee recommendations the government was talking in terms of primary healthcare which would be universal.

The salient feature of the 1983 Health Policy was that it was critical of the Western model of healthcare based at the curative level of care. It emphasized on the preventive, curative and the rehabilitative measures. It recommended the decentralization and the deprofessionalization of the healthcare worker through the employment of medics and paramedics and community participation. It called for the expansion of the private sector that would reduce the governmental burden. It recommended the integration of various healthcare interventions and set up targets for the achievement of the same for achieving targets that were primarily

⁹⁹ Ibid

¹⁰⁰ For details on Selective Primary Healthcare refer Walsh J.A and Warren K.A ,*Selective Primary Healthcare, an Interim Strategy for Disease Control for Developing Countries*,New England Journal of Medicine, Vol.301,pp.967-974,1979.

¹⁰¹ Duggal Ravi,op.cit.

demographic in nature. An introspection into the National Health Policy of 1983, would lead on to ask as to whether the policy reflected the grassroots reality. Was it successful in attaining its goal? It was argued that the rural health care received a special boost in the decade following the National Health Policy and a massive expansion of healthcare facilities took place in the Sixth and Seventh Five Year Plan periods to achieve a target of a public health center per 30000 people. The studies researching rural healthcare in contemporary India indicate that the rural healthcare infrastructure is grossly underutilized. The community involvement in healthcare has remained a distant dream and has not taken into account ground realities. The healthcare programs following the National Health Policy of 1983, continue in their disparate forms. As far as the National Health Policy's targets are concerned, only the crude death rate and life expectancy have been on schedule.¹⁰² With regard to the private sector the National Health Policy clearly enunciates privatization of curative care. It talks of a cost that everyone can afford, thereby implying that health services would not be free. The state remained peripheral in the domain of primary healthcare without adequate curative services. The period succeeding the National Health Policy of 1983 has seen a surge in the lifestyle diseases. Another conspicuous shortcoming of the National Health Policy was the shortage of resources.¹⁰³ Since the launch of the

National Health Policy, there has been a gradual fall in the public health investment from 1.3% of the GDP in 1990, to around 0.9% today. The current per capita expenditure on health, around Rs.200 is far from adequate.

India has always had a very large private healthcare sector, especially at the curative level. Hospitals that were hitherto a public monopoly till the mid 1970's were gradually overshadowed by the private sector. The growth of the private sector in healthcare could be attributed to the late Seventies, when the state provided incentives such as tax breaks and other incentives for the setting up of private hospitals. The private sector pharmaceutical industry in India received a massive boost during the same period, when the state granted protection for the fledgling industry through process patent laws, subsidized bulk drugs from public sector companies and protection from multinational companies. The health outcomes of the country made a giant leap forward between the Fifth and the Seventh Five Year Plans.

However, the great leap forward in achieving healthcare in the Eighties, received a setback during the 1991 economic crisis and the subsequent reforms carried out by the Indian government and commandeered by the World Bank. The compression of spending in the health sector is caused by inefficient allocation.¹⁰⁴ As per the recommendations of the Fifth Pay Commission, the non-salary components

¹⁰² Ibid

¹⁰³ <http://www.unpan.un.org/NationalHealthPolicy2002/India> ,accessed on 5/4/2006.

¹⁰⁴ Duggal Ravi, Public Health Expenditure: Expenditure and Financing Under the Shadow of a Growing Private Sector in Leena Gangolli, Ravi Duggal and Abhay Shukla ed.s, Review of Healthcare in India, 2005, Mumbai, CEHAT

of the public health system have shrunk. The levy of user fees has meant that there has been a fall in the use of health services from 60% in 1980s to 45% in 1995-96.¹⁰⁵When we relate health outcomes to expenditures, we notice that India's health outcome is paradoxically low, although it has among the highest expenditures in the region.¹⁰⁶Health expenditure in India is chiefly in the form of out of pocket expenditures. The public resources geared up to meet the public health needs have been low and is corroborated by the acknowledgement of this fact by the National Health Policy of 2002. The poor spend a larger proportion of their income on health, as a result they may have to forego other basic needs such as education and nutrition. In such a situation, the chances of improvement of the standard of living of the people remain slim and there is a distortion of equity. Another dimension of the reform process by the state is the disinvestments process by the state in economic activities, which is slated to release economic resources for the social sector including health. While the disinvestments of public enterprises have taken place, there is no evidence to prove that it has bolstered investment in public health. Moreover, Public Sector Units which contributed so substantially to the state exchequer prior to the Structural Adjustment Program implemented by the Government of India and the World Bank following the economic crisis of 1991 have

been privatized, thereby eroding the capital base for undertaking social sector activities. There is a shrinking of revenues due to cuts in the tax rates, excise duties, and declining tax-GDP ratios from 16% in the mid 1980's to 13% today, for the state government exchequer, ironically although 80% of the public funding for healthcare comes from the exchequer of the state governments.¹⁰⁷

At the root of the problem lies the fact that private healthcare in India is a business. There is no mechanism for monitoring the standards of private physicians once licenses are issued. Moreover, there is a lack of guidelines for ethical standards as far as the private healthcare providers are concerned. Private health insurance is unregulated. The overwhelming presence of the private sector should not be misinterpreted as exercise of choice by individuals; rather it reflects the non availability of primary health services and or poor quality services. There is thus an under-utilization of health infrastructure set up by the government at considerable cost.¹⁰⁸ To prevent the commoditization of healthcare, it is imperative to ensure that healthcare is accessible to all on an equitable basis, irrespective of their ability to pay. Universality of primary healthcare is highly recommended along with Universal Healthcare Insurance provided by the state. For risk-pooling something like a cross-subsidy system would augur

¹⁰⁵ Duggal Ravi, Tracing Privatization of Healthcare in India, Express Healthcare Management, Accessible via <http://www.expresshealthcaremgmt.com/20040415/edit02.shtml>, Accessed on 2/7/2006

¹⁰⁶ Duggal Ravi, op.cit.p.227.

¹⁰⁷ Ibid.

¹⁰⁸ Article of Prabhu Seeta K, Structural Adjustment and Health Sector in India in Mohan Rao Edited, Disinvesting in Health: The World Bank Prescriptions for Health, 1999, New Delhi, Sage Publications.

well, ie. Those who are able to pay would do so, through taxes and premiums which would cover all sections of society.

The paucity of public health investment is a stark reality. The National Health Policy of 2002 has planned to increase the health sector expenditure to 6% of the GDP, with 2% as public health investment by 2010.¹⁰⁹ It seeks to address the deficiencies of health disparities among various states, in the availability and the accessibility of health services and seeks to reduce the rural urban divide. It sets forward 55% of the public health investment for the primary health sector.

It seeks to create a policy structure, which would address the needs of the disadvantaged sections of society and give them a fairer access to healthcare. It defines the role of the central as well as the state government in the functioning of the public sector of the economy. It envisions the convergence of all health programs under a single field administration. Vertical programs for the control of tuberculosis, malaria, HIV/AIDS ,reproductive and child health as well as universal immunization need to be continued till moderate prevalence levels are reached. The integration of the programs would bring about the desired optimalization of the outcomes and convergence of health inputs. The policy envisages that the program implementation be effected via autonomous bodies at state and district levels. Intervention of the state departments be limited to the overall monitoring of the program target.¹¹⁰ It also recommends the scientific designing of public health projects suited to local needs.

It recommends setting up of Medical Grants Commission that would lay down medical standards. This policy recommends

- | Continued medical education and updating of skills of working health professionals.
- | The need for specialists in public health as well as in family medicine.
- | The need for specialists in Public Health and Family Medicine.
- | An increase in the number of post-graduate seats in these disciplines.
- | The improvement of the ratio of nurses vis- a -vis doctors and beds.
- | The need for the Central Government to subsidize the setting up of training facilities for nurses on a decentralized basis.

India has a vast reservoir of the traditional as well as the allopathic systems of medicine and seeks to use both these practitioners in the reaching out of basic health needs. It seeks to address the future health security of the country. India has the reputation of developing process based patents for an array of drugs within the ambit of existing patent laws. The experience has shown that the introduction of TRIPS in India would result in the escalation of the price of the drugs. The National Health Policy 2002 seeks to address the accessibility of essential drugs in the post TRIPS era. The policy recommends the periodic review of generic drugs.

A substantial portion of primary healthcare consists of the dissemination of information related to public health. The

¹⁰⁹ <http://www.mohfw.nic.in/NHP2002>, Accessed on 4/7/2006

aim of the Information, Education, Communication initiative is to bring about a behavioral change and prevent lifestyle diseases.

This Policy has recognized that the private sector contributes significantly to the secondary and tertiary levels of care. There seems to be an apprehension that the private sector is exploitative. With the increasing role of the private sector, since the Structural Adjustment Programs were implemented, the monitoring of minimum standards of the diagnostic centers becomes imperative. The National Health Policy 2002, addresses the issue of maintenance of adequate standards by the diagnostic centers.

It recognizes the fact that disease information is not flowing in an integrated manner from the public health facilities to the government administration. The absence of disease surveillance is a major handicap in providing cost effective healthcare. Timely information on the focal outbreak of cholera, and the seasonal diseases is pivotal to ensure timely intervention and the containment of epidemics. It recognizes the imperative of setting up of National Disease Surveillance Network.

The principal common feature covered by the National Population Policy of 2000 and the National Health Policy of 2002 is related to the prevention and control of communicable diseases, containment of HIV/AIDS, universal immunization of children against infectious diseases, and

addressing the unmet needs of basic and reproductive health services.¹¹¹ The synchronized implementation of National Policy of 2000 and the National Health Policy 2002 is the cornerstone of any structural plan to improve the health standards of the country.

The Policy envisages the consolidation of the documented knowledge contained in Ayurveda, Siddha, Unani, and Homoeopathy and protects them from attack against commercial entities by way of malafide action under the patent laws of other countries. It has envisioned the eradication of polio, leprosy by 2005, achieve 0 % growth of AIDS by 2007, halve the mortality rate attributed to malaria by 2010, reduce the infant mortality to 30 per 1000 and the maternal mortality rate to 100 per 100000.

To solve the financial crunch in the health sector, the National Health Policy 2002 advocates the gradual convergence of programs related to Malaria, Aids, and TB and universal immunization till moderate prevalence levels are reached.¹¹² Another important observation of the National Health Policy 2002 is that mental health disorders do not significantly contribute to mortality. However, they are treated as a spiritual affliction, as a result unlicensed medical institutions adjunct to religious institutions have sprung up. Instead of hospitalization of the cases of serious mental disorders, reliance is placed on faith. Mental institutions are woefully deficient in terms of physical infrastructure and skills of the personnel.

¹¹⁰ Ibid.

¹¹¹ Ibid

¹¹² Ibid.

Medical Ethics is a neglected frontier area of research involving gene manipulation, human cloning, visceral issues related to the sanctity of human life. This Policy recognizes the moral dilemma inherent in genetic engineering. It addresses the issue of chronic morbidity, marked in the case of child labor. It prescribes that there should be an increase in government funded health research from 1% in 2005 to 2% in 2010.

In an encapsulated form, it can be stated that the National Health Policy does not claim to be a roadmap to meet all the health needs of the population.¹¹³ It recommends emphasis on the different program components of healthcare. It focuses on the diseases contributing to the burden of disease such as tuberculosis, malaria as well as on the newly emerging threats such as HIV/AIDS. One nagging imperative of the policy is that equity in health stands out as an independent goal.¹¹⁴ It attempts to provide a guideline for prioritizing health expenditure thereby facilitating rational resource allocation. The National Health Policy needs to be lauded for incorporating the accountability of the private practitioners and for recognizing the growing importance of the private sector in healthcare.

The Ninth Five Year Plan reviews the population policy and family planning program. It reiterates the Bhore Committee message that the core of the program is maternal and child health services.¹¹⁵ In the midst of the Ninth Five Year Plan was

launched the National Health Policy 2000¹¹⁶. The goals of the National Population Policy is demographic, that is, population control, and not population welfare. The Tenth Five Year Plan focuses on primary health care. It states that the national health programs must continue free of cost, but people above the poverty line should pay user fees.

The National Rural Health Mission (NRHM) was launched under the aegis of the United Progressive Alliance (UPA) leadership in 2005 as a part of the National Common Minimum Program. It adopts a systematic approach related to health to determinants of good health such as nutrition, sanitation, safe drinking water. It aims to mainstream the Indian Systems of Medicine to facilitate healthcare. The plan of action includes the increase of public expenditure on health, reducing the regional imbalance in the health infrastructure, risk pooling, integration of organizational structures, optimization of health manpower, decentralization at the level of management of health program and community participation.¹¹⁷ The lack of community ownership of public health programs inhibits levels of accountability. There is a lack of integration of sanitation, hygiene, nutrition and drinking water issues. There are striking regional inequalities. Population stabilization is still an issue in states with weak demographic indicators. It has been indicated that for every Re.1 spent on the poorest 20% of the population, Rs.3 is spent on the richest 20% of the Indians. Only

¹¹³ Ibid.

¹¹⁴ Ibid.

¹¹⁵ Duggal Ravi, Historical Review of Health Policy Making, op.cit p 38

¹¹⁶ The 9th plan covered the period 1997-2002.

¹¹⁷ <http://www.mohfw.nic.in/NationalRuralHealthMission> ,Accessed on 2/7/2006.

10% of Indians have recourse to some form of health insurance. Hospitalized Indians spend approximately 58% of their total annual expenditure. Over 25% of Indians fall below the poverty line due to hospitalization expenses.¹¹⁸

The National Rural Health Mission aims to provide effective healthcare to rural populations in 18 states with weak public health indicators. It is an articulation on the part of the government to raise the public spending on health from 0.9% of the GDP to 3% of the GDP. It aims to undertake architectural correction of the health system to enable it to handle effective increased allocation as promised under the National Common Minimum Program. Among its key components are a female health activist in every village, a village health plan prepared by the health and the sanitation committee of the Panchayat, strengthening the rural curative care, ensuring the accountability of the community through the Indian Public Health Standard. It also seeks to revitalize local health and integrate AYUSH into the public health system. Its chief goals include the reduction of infant mortality, universal access of women to public health services, prevention and control of communicable diseases and non-communicable diseases, access to comprehensive integrated primary healthcare, population stabilization, gender and demographic balance, revitalize local medical traditions as well as the promotion of healthy lifestyles.

Its core strategies include the augmentation of the capacity of the Panchayati Raj institutions, promote

access to improved healthcare at the household level through the female health activist (ASHA), health plan for every village through Village Health committee of the Panchayat, strengthening sub centers, strengthening Primary Health Centers, provision of 24 hour service in 50% of the Primary Health Centers by addressing the shortage of doctors in the high focus states, strengthening of the Community Health Centers for the first level referral care, codification of the Indian Public Health Standards, setting the norms for the norms for the infrastructure management of the Community Health Centers, developing statistics of services and costs in hospital care, the district plans to be amalgamation of field responses through village health plans, converging sanitation and hygiene, strengthening disease control program (National Disease Control Program for Kala Azar, tuberculosis, blindness and iodine deficiency shall be integrated into the Mission for improved program delivery), strengthening disease surveillance at the village level, supply of generic drugs, provision of mobile medical unit at the district level for improved outreach, regulation of private sector, risk pooling for hospital care, reorienting the medical education to support rural health services, constitution of the District Health Mission, decentralization for improved governance, empowerment of communities, establishment of Health Trust of India for reviewing health legislation, prioritization of State Health Action Plan, funding in terms of addressing the inter state as well as intra-state health disparity, special focus on the Northeast States through upgradation of health infrastructure and state specific health initiatives, ASHA's would be

¹¹⁸ Ibid.

accountable to the Village Panchayat, Village Health Committee would prepare village plans and NGO's to monitor, evaluate and social audit the activities of the various public health programs.¹¹⁹ The budget outlay for the years 2005-2006 is approximately Rupees 6700 crores.

At the National Level, the expected outcome of the NRHM is the reduction of infant mortality to 30 per 1000 live births, reduce maternal mortality rate to 100 per 0.1 million live births, reduce malaria mortality by 50% by 2010, eliminate Kala Azar completely by 2012, reduce dengue mortality by 50% by 2010, reduce leprosy prevalence rate from 1.8 per 10,000 in 2005 to less than 1 per 10,000 thereafter, maintenance of 85% cure in case of tuberculosis, upgrade Community Health Centers to Indian Public Health Standards, and increase the utilization of first referral units from 20% to over 75%.¹²⁰

At the Community Level, there should be

- | availability of Community Level Workers at village level, with drug kits for essential drugs,
- | availability of generic drugs at the sub-center for common ailments, improved access to universal immunization,
- | improved facilities for institutional delivery through Janani Suraksha Yojana for below poverty line families,
- | availability of assured healthcare at reduced financial risk through

Community Health Insurance,

- | provision of household toilets and
- | improved outreach service through mobile medical unit at district level.¹²¹

The external evaluation is to be implemented through NGO's. Health Information System is expected to be developed upto the Community Health Center level and web enabled for citizen scrutiny. Sub Centers would be reporting on performance to Panchayats, District Health Mission and Zilla Parishads.

The NRHM emerged after tremendous lobbying for the rural poor in a context where a pro-poor strategy was engineered as a result of failure of slogans such as India Shining.¹²² One of the NRHM aim was to make architectural corrections in the rural health infrastructure by providing universal access to equitable, affordable quality of care. Several members of Jan Swasthya Abhiyan (JSA), a people's movement dealing with public health had participated in the discussions preceding the drafting of the document, and were disappointed that the concerns reflected by them have not been adequately reflected.¹²³ According to the JSA, the NRHM lacks conceptual clarity and the budget for all family planning activities have been clubbed together as the budget for NRHM. The NRHM had proposed to create a band of community based functionaries or Accredited Social Health Activist(ASHA) who would play a pivotal role in the

¹¹⁹ Ibid.

¹²⁰ Ibid

¹²¹ Ibid.

¹²² Rajalakshmi T.K, Out of Focus:An Appraisal of Healthcare Promised by National Rural Health Mission Launched in April 2005,Frontline, April 6 ,2006,pp.93-94.

¹²³ Ibid.

mobilization of the community in local health planning and facilitate the accountability of the existing healthcare services. During the discussion with the JSA it was revealed that insisting on a minimum qualification for ASHA would imply that socially committed women from deprived groups would be excluded.

The Central Government's expenditure in the health sector has risen rapidly, whereas the grants to the states have stagnated, and in such a paradoxical situation the overall public health expenditure remains below 1% of the GDP.¹²⁴ There is a question as to what extent is the NRHM meeting the demand side of rural health. One glaring gap as far as the NRHM is concerned is the issue of neglect of medical care. There is a danger of centralization of rural health programs through the NRHM. Another demerit is the issue of allocation of health resources by the NRHM. It needs to take into cognizance the specific needs of the Community Health Center, rather than rationing resources across the board.¹²⁵

8. Conclusion: Some Reflections on the Right to Health

Some forty years ago, the activities in the realm of international public health were the domain the WHO, Governments and NGOs. Today however new players such as the World Bank, the World Trade Organization have a dominant influence on international public health. Overall the

international development aid to the health sector of the developing countries has plummeted by 17% from 1992 to 1997.¹²⁶ Today the campaign against polio has called for the spearheading of a global leadership to eradicate the disease. The old scourge of diseases namely malaria and TB continue to raise their ugly heads. There are new ethical questions emerging within the right to health with increased longevity such as euthanasia. The co-ordination between the WHO and WTO to exempt tobacco from the provisions of free trade is necessary. The deterioration of the environment is a pressing health concern such as the increased vulnerability of the population to respiratory diseases. Today there are contending views regarding the WHO's role in global health.¹²⁷ The Essentialist view is that the WHO should focus on international health activities and the member states will not fulfill them acting in isolation. International Organizations have a comparative advantage over the national health organizations, in disease surveillance. The social justice approach holds the view that the government and the international agencies should play an interventionist role such as the health sector advocacy, based on the principle of social justice as the world's conscience by focusing on the monitoring of the violation of human right to health. The lack of conceptual clarity has complicated the monitoring of the right to health.¹²⁸ Is the notion of health identical to the definition proposed by the WHO that is, the broader

¹²⁴ Duggal Ravi, Is the Trend in Health Changing?, Economic and Political Weekly, Vol. XLI No 14, 2006 April 8-14 2006, pp. 1135-1138.

¹²⁵ Ibid.

¹²⁶ Walt Gill, Globalization of International Health, The Lancet, Vol. 351, 7th Feb. 1998, pp. 434-437.

¹²⁷ Kelly Lee's Article, Shaping the Future of Global Health Co-operation, The Lancet, 1998, Vol. 351, pp. 899-902

¹²⁸ Chapman Audrey and Sage Russell, Building a Framework for Economic, Social and Cultural Rights, 2002, New York.

ideal of well being or the mere restrictive definition set forward by the international covenant on economic, social and cultural rights ,where it is set forward as the highest attainable standard of physical and mental health.¹²⁹ Public health may involve the restriction of human rights, for instance the quarantining of epidemics may be necessary in the larger social good but it may interfere with the individual freedom of the person concerned.

Activities taken up for improving the determinants of health taken up for their own sake such as struggle for higher wages may not be regarded as part of the health movement per se, however a struggle for securing the right to clean drinking water with the aim of improving people's health can be termed as a part of the health movement.

A broad based health movement operates at two levels, namely health determinants and healthcare ideology.¹³⁰At one level the health movement struggles against environmental pollution, which has a negative bearing on people's health. There is a necessity for the healthcare system to be responsive to the needs of the people. The main thrust of the Health Movement is the fact that it articulates the health needs of the disadvantaged sections of society, and empowers them in decision-making. Social Movements such as the movements launched to establish health as a human right are an essential component of public policy and provide feedback as to what extent the policy has effectively addressed basic needs. They also document and

monitor the human rights violations related to health. These movements generate pressure to bring about changes from below. They thus act as the 'looking glass self' for the policy makers, in gauging the pulse of public opinion related to the efficacy of a particular public health program.

The Alma Ata Declaration on Primary Healthcare put community participation at the center of health planning. Primary healthcare has strong socio-political implications, namely the universal accessibility and coverage based on need.¹³¹ Post Alma Ata, there have been interesting international initiatives such as the Essential Drugs Strategy undertaken by the World Health Organization as well as the elimination of small pox and guinea worm. Over the last fifty years the world has registered considerable health gains, the average life expectancy has risen from 46 years in the 1950s to 65 years today. In aggregate terms the health outcomes have improved. However the disaggregating of statistical data has indicated that the gap between the rich and the poor countries has widened as far as the achievements of health outcomes are concerned. As far as Sub Saharan Africa is concerned, in fact during the 1980s there was a resurgence of infant mortality, attributed to droughts, civil wars, AIDS epidemic and economic recession, which caused a slide in the public health spending. The Alma Ata approach of Comprehensive Primary Health Care was countered by the developed world, who argued in favor of cost-effective health

¹²⁹ Gruskin Sofia and Tarantola Daniel, Health and Human Rights, Working Paper no.14 2003, Francois Xavier Bagnoud Center for Health and Human Rights.

¹³⁰ Drs Shukla Abhay and Anant Phadke, Health Movement in India, Health Action, Vol.12, No 12, 1999.

measures as a sustainable alternative to the Primary Healthcare approach for the developing countries. Many of the cost-effective Selective Primary Healthcare Programs were highly influenced by foreign aid and suffered bureaucratic centralization. The Health for All approach received a setback with the global economic recession between 1979 and 1981 in the aftermath of the oil crisis. The export value of goods exported from the developing world plummeted. The reduced forex earnings meant a fall in real public health expenditure the world over. The levy of user fees has been particularly disastrous for the economically disadvantaged sections of society.¹³²¹³² Global Health Watch 2006: An Alternative World Health Report, 2005, Published Simultaneously by the People's Health Movement (Bangalore), Medact (London), Global Equity Gauge Alliance (Durban) and

The poor have been trapped in a vicious poverty cycle due to off pocket health expenditures leaving them with little investment in education and nutrition. The middle class leaves out the poor state of public health service. There is a distortion of equity.¹³³ The prevailing health system in many countries tends to mirror the socio-economic inequities. In Bangladesh, although the public health services are free on paper, in reality the informal user charges eat away approximately 50-100% of the user's

salary.¹³⁴ Susan Rifkin and Gill Walt have argued that the Selective Primary Healthcare Approach in contrast to the Comprehensive Primary Healthcare Approach does not focus on the socio-economic determinants of disease, or in other words the root causes of deprivation have not been addressed. Listening to and articulating the voices of the marginalized sections of society should be a key role for civil societies worldwide. In 1999, at the insistence of the World Bank, the Bolivian Government awarded a contract to a private company, a subsidiary of Bechtel to supply water to Cochabamba, Bolivia. However on the takeover of the water company, the water prices were hiked threefold. In 2000, for four straight days a strike led by academics and trade unions paralyzed Cochabamba. The Civil Society was successful in halting the privatization of water supply in the city of Cochabamba and the Bolivian government had to revoke the contract.¹³⁵

The People's Health Assembly was convened in Savar, Bangladesh in December 2000, and the People's Health Movement that evolved from it is a Civilian Society effort to counter the global Laissez Faire doctrine and challenge the policy makers with a 'Global Health Campaign for Health for All Now.'¹³⁶ The People's Charter for Health was endorsed by the People's Health Assembly. It is used as a tool of advocacy for people's health. The

¹³¹ Unnikrishnan P.V.ed., Health For All Now: Revive Alma Ata ,2003, Bangalore, People's Health Movement.

¹³² Global Health Watch 2006: An Alternative World Health Report, 2005, Published Simultaneously by the People's Health Movement (Bangalore), Medact (London), Global Equity Gauge Alliance (Durban) and Zed Books (London).

¹³³ Ibid. See also World Development Report 2006, op.cit.

¹³⁴ Ibid.

¹³⁵ Ibid.

¹³⁶ <http://www.phmovement.org>, Accessed on 15/3/2006.

significance of the global People's Health Charter is that it endorses health as a social, political and an economic issue and a fundamental human right. It identifies inequality, poverty, exploitation, violence and injustice as roots of preventable ill health. It brings forward the voices of the marginalized people, and encourages people to develop local solutions. The vision of the charter extricates health from the myopic biomedical, technical and managerial approach as seen in the last two decades.¹³⁷

The People's Health Movement started promoting a wide range of approaches and initiatives that combated the three evils of globalization, liberalization and the privatization of health. It calls for the reform of the World Trade Organization and make it more responsive towards poverty alleviation. It also calls for the writing off debts by the international agencies as well as the developed countries against the developing countries and using its equivalent in poverty alleviation. Putting health in the development agenda of the government is an important priority. It also advocates the promotion of health of the minority people. Unconditional access of the poor to health services regardless of their ability to pay is also essential to achieve 'Health for All Now.' It envisages the exercise of greater vigilance about water and air pollution, soil erosion and attacks on the environment and holding the perpetrators of environmental crimes accountable to the people. The Charter opposes war in all its form. It recommends the promotion of independent drug policies centered round essential drugs. It

endeavors to make sure that the World Health Organization remains accountable to the Civil Society. Keeping the World Health Organization free of corporate interests is an important objective of the People's Health Movement.

For the first time since 2000 health and non-health networks have come together to work on global solidarity issues in health. The Third World Network, The International People's Health Council, Gonoshasthya Kendra (Bangladesh), Global Equity Gauge Alliance as well as the Social Forum Network are strengthening the movement. The themes of the People's Health Movement include:

- | Health in an era of globalization.
- | Equity and inequity in health.
- | Medicalization of Healthcare and the challenge of achieving Health for All.
- | Environmental crisis and the threat to health.

Taken together these documents represented an unprecedented global consensus.¹³⁸

The first People's Health Assembly convened in 2000 in Bangladesh, was a golden opportunity for people engaged in human rights, environment, health and development to converge, share ideas and continue the process of building coalition to drive social change.

The Second People's Health Assembly was convened in 2005 at Cuenca, Ecuador and witnessed the participation of 1492 delegates from 82 countries. This

¹³⁷ Ibid.

¹³⁸ Ibid.

declaration brought to the fore that economic and political inequalities had increased; yet the root causes of diseases have not been effectively addressed. It advocated the achievement of the right to health through popular mobilization. It stressed that the People's Health Movement would initiate or support struggles related to the right to water, food security, healthy environment, dignified working conditions, safe housing, and gender equity, since the people's health depended on the fulfillment of these basic rights. It would also document the violation of the right to health. The Cuenca declaration opposed the privatization of health services. The People's Health Movement would campaign to end TRIPS, and remove it from the World Trade Organization. The People's Health Movement at the Cuenca Declaration, advocated that governments use the Doha agreement to provide people with generic drugs. It would continue to monitor and provide inputs for the World Health Organization Commission on the Social Determinants of Health to ensure that it would effectively address the political and economic causes of poverty and ill health and that engaged in a meaningful dialog with the civil society.

Prior to the convening of the First People's Health Assembly there was an extensive mobilization of 30000 villages in India, and more than 2000 organizations nationwide participated in this mass mobilization in 300 districts in 20 states. The campaign was led by 18 national network organizations and for the first time India witnessed the coming together of many diverse organizations and movements.¹³⁹ Based on the village primary health center

priorities, many districts drew up local health priorities. The culmination of this nationwide process was the convening of the National Health Assembly in Kolkata on December 1, 2000. It drew up a 20-point charter known as the Indian People's Health Charter, outlining a critique of the Indian health scenario in the era of globalization. Jan Swasthya Abhiyan (JSA) emerged from the People's Health Assembly process in India as a coalition of various organizations. The People's Health Campaign is a unique grassroots to global campaign for better health. Since July 1999, this campaign has investigated into current state of health services and has demanded better care. The activities in India since 2000, has involved mass awareness on the right to healthcare through street plays, posters, booklets, organizing block and district level campaigns, advocacy at the national, regional and the local level for strengthening the public health system, monitoring the local health centers, conducting the local level health surveys, regulation of the private sector, critiquing the National Health Policies and building a national campaign on right to healthcare. The Jan Swasthya Abhiyan is the Indian arm of the People's Health Movement and its secretariat is housed in CEHAT, where the author of this background paper interned for a brief while in 2006.

More importantly, JSA developed a critique of the National Health Policy of 2002, launched a crusade against sex selective abortions, engaged in a dialogue on the national and state level health and population policies, state level dialog on human rights, formulation of a National

¹³⁹ <http://www.phm.india.org>. Accessed on 29/6/2006.

Hunger Watch Group to investigate into the hunger related deaths and the launch of the National Right to Healthcare Campaign.¹⁴⁰ In March 2004, the JSA organized a dialogue with the political parties on the eve of the national elections and the political parties shared the charter of demands prepared by the JSA. As a process of establishing health as a human right, a series of '*Jan Sunwais*' or public hearings were organized by the National Human Rights Commission in collaboration with the JSA in 2004. Based on the joint collaboration, the National Human Rights Commission, brought about the recommendations of a national plan to operationalize the right to healthcare in India.¹⁴¹ It recognized the citizen's right to healthcare, delineation of essential services related to private medical sector, enshrining of the right to healthcare by the enactment of the Public Health Services Act, and Clinical Establishment Regulation Act, to regulate the private sector, operationalization of the right to healthcare by the formulation of a broad timetable of activities by the union as well as the state governments, initiation of joint mechanisms for the joint monitoring of human rights at the district, state and national levels by the civil societies as well as the health department of the government, functional redressal of the right to health at the district, state and national levels, delineating the rights of the rights of the citizen, the duties of the private healthcare providers, recognition of and protection of the population with special health needs such as women, children, people facing displacement and

persons facing mental problems by the enactment of the National Public Health Service Act, formulation of the patients rights, setting up of the Health Services Regulatory Authority, which broadly sets forth the guidelines as to what constitutes ethical practices, issuing national operational guidelines on essential drugs and measures to integrate national health programs with primary healthcare would be implemented in a decentralized manner.¹⁴²

In keeping with the spirit of the National Population Policy of 2000, steps would be taken by the National Human Rights Commission to eliminate the coercive two-child norm that targets the vulnerable sections of society. The people's access to emergency healthcare is an important facet of achievement of health as a human right. The Dave Committee of the National Human Rights Commission advocated the enunciation of a National Accident Policy. Both the JSA as well as the National Human Rights Commission have recommended the enactment of state protection acts which would lay down the norms for the establishment of nutritional security, drinking water, and sanitary facilities.

The most noteworthy achievement of the Jan Swasthya Abhiyan has been the mustering of the political will to address the shortcomings of the Indian public health system.

Networks, organizations and individuals in the People's Health Movement work on a wide range of issues from the very generic to the very specific and operate at a number

¹⁴⁰ Ibid.

¹⁴¹ <http://www.nhrc.nic.in/operationalization> of the right to healthcare, Accessed on 8/7/2006, (Website of the National Human Rights Commission, India).

¹⁴² Ibid.

of levels: local, national, regional as well as international. The chief unresolved issue of young movements and networks such as the People's Health Movement is the question of leadership.¹⁴³ Movements and networks respond to situations as they arise, such as a public policy that needs to be challenged. People need to be mobilized in the light of a strategic framework in order to enshrine the right to health in their respective constitutions as a fundamental right.

According to Professor Jeffrey Sachs, the rich countries should set aside 0.1% of their GNP on behalf of the health services for the world's poor. Several of the Millennium Development Goals, enunciated at the United Nations Millennium Summit are related to health, particularly the control of epidemic diseases, and the reduction of maternal and child mortality. Malaria accounts for 3% of the global disease burden, however only 0.16% of the research and development outlays are targeted against malaria.¹⁴⁴ However the picture is not so grim. The effort to contain African river

blindness and leprosy by Novartis has yielded some fruit.¹⁴⁵

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 fulfillment 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.

¹⁴³ <http://www.healthcomms.org>, Accessed on 8/7/2006.

¹⁴⁴ Professor Sachs Jeffrey's Article, Health for All is Wealth (Editorial), The Economic Times, 9/2/2002.

¹⁴⁵ Ibid.

REFERENCES

Aginam Obijifor, 2005, *Global Health Governance: International Law and Public Health in a Divided World*, University of Toronto Press, Toronto.

Annas George J, 1998, *Human Rights and Health: The Universal Declaration of Human Rights at 50*, The New England Journal of Medicine, Volume 339 No.24, Australia. Accessible via <http://www.cme.nejm.org>. Accessed on 14/5/2006.

Arnold David, 1996, *The Rise of Western Medicine in India*, The Lancet, Volume 348, UK. Accessible via <http://www.lancet.com>, accessed on 15/3/2006.

Beaglehole Robert and Ruth Bonita, 2004, *Public Health at the Crossroads: Achievements and Prospects*, Cambridge University Press, Cambridge.

Bok Sissela, 2004, *Rethinking the World Health Organization's Definition of Health*, Volume 17, Number 7, Harvard Center For Population and Development Studies, USA.

Chapman Audrey R and Sage Russell, (Edited) 2002, *Core Obligations: Building a framework for Economic, Social and Cultural Rights*, Intersentia, New York.

Dommen Caroline, 2002, *Raising Human Rights Concerns*, in *Human Rights Quarterly*, 24(1), February, USA.

Fee Elizabeth, and Theodore M Brown, 2005, *The Public Health Act of 1848*, *Bulletin of the World Health Organization*; 83(1), November, Geneva. Accessed via <http://www.who.int/bulletin>, data accessed on 7/4/2006.

Gangolli Leena V, Ravi Duggal and Abhay Shukla ed., 2005, *Review of Healthcare in India*, CEHAT, Mumbai.

Gruskin Sofia and Daniel Tarantola, 2003, *Health and Human Rights*, Working Paper Number 14, Boston. Francois-Xavier Bagnoud Center for Health and Human Rights.

Lawson Edward, 1996, *Encyclopedia of Human Rights*, Washington D.C : Taylor and Francis Group and the United Nations High Commissioner for Human Rights, wa

League of Nations, 1931, *League of Nations Health Organization*, Information Section, Geneva: League of Nations.

Mann Jonathan, Sofia Gruskin, Michael Grodin and George J Annas, 1999, *Health and Human Rights –A Reader*, Routledge, UK.

Marcos Ceuto, 2005, *The Promise of Primary Healthcare*, Bulletin of the World Health Organization, May, Geneva, 83(1). Accessed on 7/4/2006 at <http://www.who.int/bulletin>.

Ministry of Health and Family Welfare, Government of India, 2005, *National Commission on Macroeconomics and Health*, New Delhi.

Mullen Kenneth and Lisa Curtice, 1997, '*The Disadvantaged, their Health Needs and Public Health Initiatives*', *The Oxford Textbook of Public Health, Volume 3*, in Detel Roger et.al. ed., Oxford University Press, New York.

People's Health Movement, 2005, *Global Health Watch 2005-2006: An Alternative World Health Report*, The People's Health Movement, Medact, Global Equity Gauge Alliance and Zed Books.

Redden Candau, 2002, *Healthcare, Entitlement and Citizenship*, University of Toronto Press, Canada.

Rendel Margherita, 1997, *Whose Human Rights*, Trentham Books Limited, London.

Roberts Marc J and Michael Riech, 2002, *Ethical Analysis in Public Health*, *The Lancet* Volume 359, UK, Accessible via <http://www.lancet.com>. Accessed on 15/3/2006.

Roemer Milton, 1991, *National Health Systems of the World (Volumes 1 and 2)*, Oxford University Press, New York.

Roy Porter ed., 1996, *History of Medicine*, Cambridge University Press, Cambridge.

Steiner Henry J and Philip Alston, 2000, *International Human Rights in Context*, , Oxford University Press, Oxford.

The World Bank, 1993, *The World Development Report 1993, Investing in Health*, The World Bank and Oxford University Press, Washington D.C.

The World Bank, 2006, *The World Development Report 2006, Equity and Development*, World Bank and Oxford University Press, Washington D.C.

Toebes Brigit, 1999, *Towards an Improved Understanding of the International Human Right to Health*, *Human Rights Quarterly*, 21, USA.

United Nations Development Program, Human Development Report, 2000, Human Rights and Development, United Nations Development Program, New York. (Accessible via <http://www.hdr.undp.org/reports/global/2000>, data accessed on 9/5/2006).

United Nations Population Fund, 2000, The State of the World's Population 2000: Lives Together, Worlds Apart, New York.

United Nations Population Fund, 2002, State of the World's Population 2002- People, Poverty and Possibilities: Making Development Work for the Poor, New York.

United Nations Population Fund, 2004, State of the World Population 2004-The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty, New York.

Walt Gill, 1998, Globalization of International Health, The Lancet Volume 351, UK. Accessible via <http://www.lancet.com>, accessed on 15/3/2006.

Wiending Paul, 1995, History of International Health Organizations and Movements: 1918-1939, Cambridge University Press, Cambridge.

World Health Organization, 1998, From Alma Ata to the Year 2000: Reflections at Midpoint, World Health Organization, Geneva.

World Health Organization, 1998, The World Health Report 1998, Life in the 21st Century -A vision for all, Geneva.

World Health Organization, 1999, The World Health Report, Making a Difference, 1999, Geneva.

World Health Organization, 2000, World Health Report 2000: Health Systems- Improving Performance, Geneva

World Health Organization, 2003, *Right To Water*, Health and Human Rights Publications, Series No.3, Geneva.

Yamin Alicia Ely, 1999, *Defining Questions, Situating Issues of Power in the Formulation of Right to Health under International Law*, Human Rights Quarterly, 18, USA.