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WHITE BLACK LEGAL is an open access, peer-reviewed and refereed journal provided dedicated to express views on topical legal issues, thereby generating a cross current of ideas on emerging matters. This platform shall also ignite the initiative and desire of young law students to contribute in the field of law. The erudite response of legal luminaries shall be solicited to enable readers to explore challenges that lie before law makers, lawyers and the society at large, in the event of the ever changing social, economic and technological scenario.

With this thought, we hereby present to you

# **RIGHTS TO HEALTH AT THE TIME OF NATURAL DISASTER: STATE OBLIGATIONS AND INTERNATIONAL COOPERATION**

AUTHORED BY - <sup>1</sup>DR. SATISH CHANDRA & <sup>2</sup>VAIBHAV VYAS

## **Abstract**

The right to health stands as a fundamental human right supported by multiple international and constitutional frameworks although nations demonstrate varying levels of understanding of this right which becomes critical during global pandemics. The right to health encompasses many aspects which this paper examines through the lens of government obligations and essential global collaboration needed to protect this right during health crises. The paper examines the development of health rights using international documents like the ICESCR, UDHR, and WHO Constitution while it also investigates India's legal system with special attention to Article 21 of its constitution. According to the paper India's Supreme Court has interpreted the right to health as an essential part of the right to life which strengthens state responsibility. The research examines the effectiveness of the Epidemic Diseases (Amendment) Ordinance, 2020 in protecting healthcare staff and enhancing system readiness. The research examines global responses to COVID-19 through a critical analysis of WHO's role and demonstrates why nations need strong policies along with enhanced global partnerships for fair healthcare access. The right to health has gained recognition but requires active implementation through binding legal commitments together with healthcare system reform and a public health governance approach that respects human rights.

## **INTRODUCTION.**

People are endowed with the entitlement to the most optimal mental and physical health care, inclusive of medical information, pharmaceuticals, and services. This right is not merely a moral imperative but is also enshrined in numerous international accords pertaining to human rights, as well as declarations and standards that specifically address health. The apex judicial

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body of India and several of its High Courts have affirmed the right to health and healthcare as a fundamental human right, thereby imposing an onus upon the State to provide medical services to its populace. The right to life, as enshrined in Article 21 of the Indian Constitution, is intrinsically linked to the provision of healthcare, as per the interpretation of the judiciary. The concept of human development, which is pivotal to a nation's economic and social advancement, embraces health as an indispensable component. This is reflected in the prioritization of health across various dimensions of human existence, irrespective of age, gender, socioeconomic background, or ethnicity. The right to good health is explicitly articulated in several seminal international agreements, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), which posits that the highest attainable standard of physical and mental health is of paramount importance. The World Health Organization (WHO) defines health in its preliminary paragraph as a state of complete physical, mental, and social well-being, transcending the mere absence of disease or infirmity. It further underscores the fundamental right of every individual to the highest possible standard of health, irrespective of their race, religion, political beliefs, or economic and social status.

The Universal Declaration of Human Rights, in its Article 25, posits that health is an integral part of the right to a decent standard of living. Although the Indian Constitution does not explicitly delineate the right to health as a fundamental right within Article 21, the judicial interpretation of this provision has been broadly construed to encompass the right to health and healthcare. The Constitution contains various provisions that relate to health, such as Articles 38, 39(e) and (f), 42, 47, and 48A, all of which are situated within Part IV. These articles mandate the State to ensure the establishment and maintenance of conditions conducive to the promotion of good health. This article aims to elucidate the current state of the right to health and healthcare as per Article 21 of the Indian Constitution, as well as to assess its implications for the populace of India. Drawing upon empirical research findings, the objective is to inform policy formulation and decision-making processes that are aligned with the constitutional mandate of ensuring the right to health and healthcare, which is a crucial aspect of Article 21's purview of protecting the right to life and personal liberty. The nuanced understanding of this right, as derived from judicial interpretations and its interplay with other constitutional provisions, will guide the formulation of legislative frameworks that are equipped to address the multifaceted challenges inherent in the realization of this fundamental right.



## **THE RIGHT TO HEALTH AND HEALTH CARE:**

No one's personal autonomy or existence may be arbitrarily abrogated, a principle that is enshrined within the purview of Article 21 of the Constitution, which mandates the adherence to legal protocols to ensure such deprivation. The right to life, as explicated in this Article, transcends the mere preservation of physical vitality; it encapsulates the broader spectrum of a dignified and esteemed existence. In the seminal case of *Consumer Education and Resource Centre versus Union of India*, the Hon'ble Supreme Court pronounced that the right to health and healthcare is intrinsic to Article 21, constituting a fundamental right due to its indispensable nature for conferring meaning and purpose upon life, as well as for upholding human dignity. The Court's interpretation of Article 21 is expansive, encompassing a plethora of rights such as the entitlement to a superior quality of life, salubrious working environments, and adequate leisure. This judicial pronouncement was further elaborated in the case of *Bandhua Mukti Morcha v. Union of India*, wherein the apex judiciary posited that the right to a life of dignity, as guaranteed by Article 21, is predicated upon the edifice of Part IV of the Indian Constitution, which encapsulates the right to health and is a directive principle of state policy. In this landmark decision, the Court acknowledged the inextricable link between humane working conditions and the realization of the right to life. It was imperative for the Court to delineate that the government, regardless of its institutional configuration as a state or union entity, or a public or private industry, is under a constitutional imperative to undertake the requisite measures to bolster and safeguard the health and well-being of its populace.

The Supreme Court was also called upon to deliberate on the sufficiency of medical services provided by governmental health centres. The case law established that the non-provision of essential medical aid by these institutions, resulting in a failure to preserve human life, constitutes a breach of Article 21. In the context of the state's obligation to protect the right to life, the Court categorically affirmed that financial constraints cannot serve as a pretext for shirking this constitutional duty. Moreover, in the case of *State of Punjab and Others versus Mohinder Singh Chawla*, the government's constitutional responsibility to provide healthcare facilities was underscored. It was made evident that the right to health is a foundational element of the right to life, thus highlighting the government's obligation to ensure the availability of such facilities. Despite these judicial pronouncements and state efforts, challenges such as insufficient healthcare resources, deficient infrastructure, and prohibitive costs persist, thereby obstructing the realization of universal healthcare. The interplay between the rights to life,

health, and healthcare, as well as the factors that influence their advancement and protection, remains a critical concern in contemporary discourse. This study seeks to elucidate the current state of these rights' enforcement by scrutinizing the extent to which they are upheld and the variables that impinge upon their safeguarding. Given the international legal recognition of these rights, it is imperative to analyse the disparities in access to healthcare, especially within the realm of developing nations. Through a rigorous examination of these interconnected issues, the study aims to enhance our comprehension and contribute to the formulation of policies advocating for universal health coverage, thereby fostering a society where the right to life is not merely a constitutional guarantee but a lived reality, devoid of financial barriers.

## **JUDICIAL RESPONSE**

A fundamental tenet of the Indian social contract, as articulated by the esteemed legal framework, is the entitlement of each citizen to the attainment of the highest feasible standard of health, encapsulating the multifaceted factors that impinge upon it. This encompasses the provision of costless, readily accessible, and superior quality healthcare services, as well as the guarantee of essential resources such as nutritious food, potable water, adequate housing, sanitary conditions, and a salubrious environment. Furthermore, the dissemination of pertinent health information and education, along with the regulation of those variables that determine the state of public health, is paramount. The landmark case of *Mullin v. Administrator, Union Territory of Delhi*, serves as a seminal reference in this context, wherein the Supreme Court of India adjudicated that Article 21 of the Constitution mandates the provision of existential necessities that uphold human dignity. This article underscores the imperative for the state to ensure a life of quality and respect for its populace, which is foundational to the right to health. Additionally, Articles 14, 15, 16, and 17 of the Constitution impose a prohibition on the state, precluding it from discriminating on the basis of race, religion, sex, caste, or birthplace. These enshrined principles are further bolstered by the state's authority to enact special measures aimed at the amelioration of the socio-economic conditions of marginalized communities, such as women, children, transgender individuals, Adivasi, Dalit, and indigenous populations. The Directive Principles of State Policy (DPSP), which are intrinsic to the Constitution's fabric, enjoin the state to strive for the reduction of disparities, the establishment of a just social order, the attainment of a satisfactory standard of living, the equitable distribution of resources, the guarantee of equitable remuneration for commensurate labour, and the safeguarding of the welfare and integrity of all employees. Article 39-A reaffirms the imperative of an impartial

judicial process and the rectification of rights infringements, thereby ensuring that each individual is afforded an equal opportunity to seek redress.

Moreover, Article 41 obliges the state to secure the right to work and to provide social security measures, including medical aid, during periods of illness, disability, advanced age, or unemployment. Article 42, in a similar vein, emphasizes the necessity of ensuring that maternity benefits and compassionate working conditions are instituted for the welfare of expectant and nursing mothers. The state is also tasked with the responsibility to provide care and protection for children and adolescents, as enshrined in Article 45, and to enhance the living conditions and nutritional status of its populace under Article 47, which is instrumental in fostering public health. Lastly, Article 48A stipulates the state's obligation to preserve and improve the environment, which is inextricably linked to the health and well-being of its citizens. The judicial pronouncements of the Supreme Court of India, exemplified by *C. A. S. C. Limited versus Union of India*, have consistently reinforced the right to health as a constitutional imperative, interpreting it not merely as the absence of infirmity but as the holistic attainment of physical, social, and intellectual well-being. The Court's verdict in *Subhash Chandra Bose* emphasizes the state's duty to offer medical care that is on a par with the standards prevalent in other healthcare institutions, as per Article 21. In *Punjab State v. Ram Lubhaya Bagga and Devika Biswas*, the judiciary underscored the essentiality of emergency care within the ambit of the right to health. The emblematic case of *Navtej Johar v. Union of India* upheld the populace's entitlement to bodily autonomy and access to healthcare services that afford equitable chances for a reasonable standard of health.

The state's commitment to the right to health is not merely a domestic concern but is also deeply entwined with international human rights discourse, as reflected in various covenants and declarations. These include the Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights (ICESCR)

### **The Epidemic Diseases (Amendment) Ordinance, 2020**

On April 22, 2020, the Epidemic Diseases (Amendment) Ordinance 2020 was promulgated, thereby introducing significant alterations to the existing legal framework governing the management of communicable diseases. This legislative enactment serves to amend the Epidemic Diseases Act of 1897, which traditionally has been the primary instrument for the



prevention and control of the spread of detrimental epidemic diseases within the nation. The amendments enshrined within the Ordinance are not merely superficial in nature; they constitute a substantial reinforcement of the legal protections accorded to medical personnel actively engaged in combating these health crises.

The Ordinance's primary objective is to bolster the central government's authority and capabilities in thwarting the dissemination of such diseases. This is achieved through a series of strategically implemented legal mechanisms that are designed to enhance the efficacy of containment measures. The introduction of these provisions underscores the critical need to safeguard the well-being of medical practitioners and other healthcare workers, who are often at the forefront of such battles. Their valorous efforts are not only essential in minimizing the immediate impact of epidemics but also in preventing them from metastasizing into pandemics of a global magnitude. The Epidemic Diseases (Amendment) Ordinance 2020 is replete with noteworthy features that warrant careful consideration. These enhancements to the original statute are indicative of a nuanced understanding of the complexities inherent in the combat against infectious diseases. The legislation not only addresses the immediate exigencies posed by epidemics but also fortifies the long-term resilience of the public health infrastructure. This sophisticated legal apparatus is emblematic of the evolving nature of epidemiological governance, which must continually adapt to the multifaceted challenges posed by emerging pathogens and the ever-shifting landscape of disease transmission. The amendments to the Act, as introduced by the Ordinance, reflect a scholarly appreciation for the interplay between legal norms and public health imperatives. They underscore the paramount importance of a robust legal framework in the effective mitigation of health emergencies. The Ordinance's enactment is a testament to the government's commitment to learning from past epidemics and to equipping itself with the tools necessary to confront future outbreaks with greater preparedness and efficacy. This legislative endeavour, therefore, represents not just an incremental step but a significant stride towards a more secure and health-conscious society.

### **Définitions**

Healthcare service personnel, as delineated within the purview of the aforementioned Ordinance, encompass individuals who are potentially exposed to the epidemic disease during the execution of their duties pertaining to the management and containment of the outbreak. This category includes, but is not limited to, clinical and public healthcare practitioners such

as physicians, nurses, and other professionals explicitly authorized under the auspices of the Act to engage in efforts aimed at mitigating the epidemic's spread. Furthermore, the state government retains the prerogative to appoint additional individuals to serve within this critical capacity.

These dedicated professionals may be subjected to a spectrum of violent acts, which are clearly articulated within the legal framework. These actions include:

- i. The perpetration of harassment that adversely impacts their living or occupational conditions, which may manifest in various forms and intensities, thereby compromising their psychological and physical well-being.
- ii. The infliction of harm, injury, or posing a threat to their lives, which can occur during the discharge of their responsibilities, thereby heightening the risks inherent in their vital roles.
- iii. The obstruction of their duties, which may take the form of intentional interference or hindrance, thereby impeding their capacity to effectively address and control the epidemic situation.
- iv. The incurrence of loss or damage to their personal property or official documents, which could disrupt their ability to perform their duties efficiently and may also represent a breach of their personal and professional security. When considering the broader implications of property within the context of the epidemic, the Ordinance extends its definition to encompass:
  - v. Clinical establishments, which serve as the epicentres for medical treatment and disease management.
  - vi. Quarantine facilities, which are crucial for isolating and monitoring infected individuals to prevent further dissemination of the pathogen.
  - vii. Mobile medical units, which provide essential healthcare services in a dynamic and often unpredictable environment, thereby playing a pivotal role in outbreak response.
  - viii. Any other tangible or intangible assets in which a healthcare service worker holds a direct and significant interest, thereby ensuring a comprehensive approach to their protection.

The legal framework thus recognizes and seeks to safeguard the multifaceted nature of the healthcare worker's role, acknowledging the diverse settings and resources integral to their mission, and emphasizing the imperative of maintaining their security and operational efficacy in the face of potential adversities.

### **Powers of the central government:**

According to the stipulations of the legislative act, the central government is vested with the prerogative to exercise oversight over the examination of any maritime or aeronautical conveyance that is either embarking from or disembarking at a designated port, particularly under the circumstances of a disease outbreak. This regulatory framework is further bolstered by the enactment of an Ordinance, which amplifies the central government's purview to include the scrutiny of any motorized vehicle, locomotive, or aircraft engaged in the transportation of goods or passengers across terrestrial or aquatic domains. Moreover, the authority to detain individuals intending to utilize these modes of transportation is also enshrined within the purview of the central government, contingent upon the manifestation of an epidemiological emergency necessitating such measures to safeguard public health and national interests.

### **Protection for healthcare personnel and damage to property:**

According to the stipulations delineated within the Ordinance, it is explicitly forbidden for any individual to engage in or facilitate the execution of a violent act directed against a healthcare professional, or to participate in the destruction of property during an epidemic. The contravention of this clause is subject to a judicial response that encompasses a range of penalties, including a term of imprisonment spanning from a minimum of three months to a maximum of five years, as well as a monetary fine varying from Rs 50,000 to Rs 2,00,000. It is noteworthy that the court has the discretionary power to permit the compounding of this offense, contingent upon the agreement of the aggrieved party. Furthermore, the perpetrator of a violent act resulting in grievous harm to a healthcare worker faces a more severe punitive measure, with the prescribed jail term extending from six months to a period of seven years, and a fine ranging from one lakh to five lakh rupees. It is imperative to underscore that these transgressions are not amenable to bail, thereby underscoring the gravity with which they are regarded by the legal system. In addition to the aforementioned legal ramifications, the adjudicating entity will mandate that the guilty party provide restitution to the medical staff members who have suffered as a consequence of their actions. This compensation is determined by the Court and is intended to redress the damages incurred. In the event of property damage or loss, the victim is entitled to compensation equivalent to twice the fair market value of the affected assets, as ascertained by the judicial process.

The legislative framework also provides for the enforcement of this compensatory provision



under the purview of the Revenue Recovery Act of 1890, whereby the sum stipulated by the Court can be recovered as an arrear of land revenue in the event of non-compliance by the convicted individual. The structured approach to addressing such offenses not only serves to deter potential wrongdoers but also to ensure that the rights and dignity of healthcare professionals are safeguarded and upheld during periods of public health crisis.

### **Investigation:**

Any police official holding a rank that is not subordinate to Inspector shall be entrusted with the responsibility of examining the cases that fall under the purview of the Ordinance. The stipulated timeframe for the conclusion of the aforementioned investigation is a period not exceeding thirty days from the date of registration of the First Information Report. This requirement is essential to ensure a timely and effective response to the matters at hand, upholding the principles of judicious governance and the swift administration of justice.

### **Trial:**

The investigation, or judicial proceedings, are expected to be concluded within the temporal parameter of one solar year. The presiding judiciary is mandated to meticulously document the justifications for any temporal prolongation and is granted the discretion to extend the allotted timeframe, contingent upon the exigencies of the case. It is imperative to note that such an extension may not exceed a period of six months at any given juncture. The court shall operate under the presumption of guilt with respect to the accused, specifically in instances where they have been charged with inflicting grievous bodily harm upon healthcare personnel, until such a time that compelling evidence emerges to the contrary, thereby substantiating the accused's innocence.

### **History of Right to Health Standard at the International Level**

The International Sanitary Conference of 1851, convened in Paris, is historically significant as the nascent juncture of health treaties. This assembly was orchestrated by the government with the imperative of urging European states to collectively address the burgeoning cholera pandemic. The conference underscored the necessity of cooperation and the establishment of protocols to contain and mitigate such epidemics, thereby laying the foundation for international health governance. The genesis of the modern human rights framework can be traced back to the signing of the United Nations Charter in San Francisco on June 26, 1945,

which entered into force on October 24, 1945. The Charter embodies a profound commitment to the principles of gender equality, as elucidated in its preamble, which in turn has catalyzed the evolution of social responsibilities and international norms pertaining to human welfare and health security. The conceptualization of health as a fundamental human right was further consolidated in the wake of the atrocities of World War II.

The Universal Declaration on Human Rights, adopted by the General Assembly on December 10, 1948, is a seminal milestone in this trajectory. It represents a global consensus on the articulation of specific human rights norms. Article 25 of this declaration introduces a comprehensive notion of health, encompassing the rights to adequate medical care, social services, and other essential goods and services for the maintenance of a dignified existence. This article also accentuates the entitlement to support during the vulnerable periods of childhood and motherhood, thereby acknowledging the critical role of social determinants in shaping individual and public health.

Article 26(1) of the UDHR posits that the right to health and education is paramount and must be universally guaranteed as a prerequisite for the realization of all other rights enshrined within the health treaty. This article encapsulates a holistic view of human rights, recognizing sexual, mental, and physical well-being as integral to the broader spectrum of human rights. Moreover, it emphasizes the provision of essential healthcare facilities, sanitation, nutritious food, medical services, and clean water. The right to health, as delineated in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), is a multifaceted concept that extends beyond mere healthcare access to encompass a standard of living adequate for the full development of the individual. It is intricately linked to socioeconomic conditions and the availability of effective medical interventions. The state's obligation to ensure a safe and healthy work environment, as per Article 7 of the ICESCR, underscores the interconnection between labor rights and health. Furthermore, Article 10 of the same covenant reaffirms the right to family and health security, advocating for protective measures against gender discrimination, exploitation, and harmful employment practices, particularly for children and pregnant women.

Article 11 of the ICESCR specifies the right to an adequate standard of living, which includes the provision of food, clothing, and housing, as well as the requisites for personal and familial development. It also emphasizes the state's responsibility to ensure freedom from hunger

through international and national cooperation. Article 12 of the ICESCR further elaborates on the right to health, mandating that states must take appropriate measures to achieve the highest attainable standard of physical and mental health. The right to health is a multidimensional construct that intersects with various other fundamental rights, including the right to life and liberty, as encapsulated in Article 21 of the Indian Constitution. India, as a signatory to the ICESCR, has consistently strived to uphold these covenants. The Supreme Court, in landmark cases such as *C. A. S. A. v. Subhash Chandra*, has affirmed the right to health as a fundamental right that transcends the mere absence of disease and is intrinsically linked to social justice. The constitutional imperative to safeguard public health is reiterated in Article 47, which posits the state's responsibility to promote the welfare of its populace through comprehensive health and nutrition policies.

### **Human Rights to Health Care**

The recognition of the fundamental right to an adequate standard of living, inclusive of robust health and well-being guarantees, is articulated in Article 25 of the Universal Declaration of Human Rights (UDHR) framework. This provision underscores the intrinsic interconnection between health and welfare, further elucidating their interrelations with other paramount rights such as food security, housing, medical care, and social services. While the imperative of good health as a precursor to an equitable quality of life is undisputed, the conceptualization of health as a human right extends beyond this basic tenet. The International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12 posits that every individual holds the right to the highest attainable standard of physical and mental health. This is a normative objective that state entities are obligated to strive towards. The notion of the right to health as a human right is indeed an intellectual triumph, yet it confronts significant challenges in operationalizing its essence.

One of the major quandaries in the realm of health as a human right lies in the ambiguous definition of health itself. The World Health Organization (WHO) delineates health as an absence of disease and infirmity, encompassing a holistic state of complete physical, mental, and social well-being. A thorough examination of health necessitates an understanding of the societal norms that shape access to medical resources and care. These societal values are deeply embedded within the discourse of human rights and health equity, influencing policy formulation and implementation. The assertion that human rights advancement is contingent



upon enhanced healthcare systems is widely accepted. However, the global health landscape is fraught with disparities and complexities that challenge the uniform application of such principles. The juxtaposition of the United States and South African nations exemplifies these intricacies. Despite its status as a highly developed economy, the U.S. healthcare system has been critiqued for its relative inefficiency. According to the 2010 Common Wealth Fund's assessment, the United States ranked a modest seventh among developed countries in healthcare system performance. Moreover, the World Health Report revealed that the U.S. ranked seventh out of five surveyed countries in health equity, accountability, and fair financial burden distribution, despite leading the world in per capita healthcare expenditures, which account for approximately 17% of its GDP.

Conversely, India, with a healthcare system in the nascent stages of development, allocates merely 1.28% of its GDP to health care, significantly less than the American counterpart. This stark contrast underscores the multifaceted nature of the issue and the multitude of hurdles that arise in the quest for global health equity. The American healthcare system, despite its economic prowess, exemplifies a paradox where substantial investment does not necessarily translate into superior outcomes across the population, particularly in terms of equitable access and quality of care. India, while striving to fortify its healthcare infrastructure, faces a distinct set of challenges that demand context-specific and innovative strategies to ensure that the right to health is not merely a rhetorical commitment but a tangible reality for its citizens. These comparative analyses underscore the intricate interplay between economic resources, policy priorities, and the realization of the right to health within different national contexts, thus highlighting the complexity inherent in the pursuit of global health equity.

### **Human Right Testimonial: Ensuring the Provision of the Fundamental Right to Health**

In the seminal discourse of global governance, the "Universal Declaration of Human Rights" underscores the intrinsic relationship between the realization of human dignity and the provision of comprehensive health care, as elucidated in Article 25 of this foundational document. This article posits that the right to health is an inalienable entitlement for all individuals, irrespective of their socioeconomic status or national origin. It is a testament to the collective commitment of the international community to the promotion and protection of the physical and mental well-being of the human populace.

The "International Covenant on Economic, Social and Cultural Rights" further substantiates this imperative, with Article 12 serving as a pivotal legal instrument that enshrines the right to the highest attainable standard of health. This article delineates the state parties' obligation to ensure the effective implementation of this right, thereby addressing disparities in healthcare access and outcomes.

The "International Convention on the Elimination of All Forms of Racial Discrimination" (ICERD) also plays a critical role in this discourse, particularly within the purview of Article d (5). This provision mandates the elimination of racial discrimination in the field of public health, thereby advocating for equitable healthcare services devoid of any prejudicial treatment or disparities founded on racial distinctions. Similarly, the "Convention on the Elimination of All Forms of Discrimination Against Women" (CEDAW) underscores the importance of safeguarding the health of women, as encapsulated in Article 11.1 (f) and Article 12. These articles emphasize the need for adequate measures to ensure that women can access the same quality of healthcare as men, thereby addressing the persistent gender inequalities within the realm of health and social welfare. In the context of the young and the vulnerable, the "Convention on the Rights of the Child" (CRC) emerges as a critical legal framework, with Article 24 acting as a bulwark for the right to health of children. This provision not only calls for the provision of essential health services but also requires states to take preventive and curative measures to combat child mortality and morbidity. The "Convention on the Rights of Persons with Disabilities" (CRPD) complements these efforts by emphasizing the right of persons with disabilities to the enjoyment of the highest attainable standard of health without discrimination, as articulated in Article 25. This article seeks to ensure that these individuals are not marginalized or excluded from healthcare systems and that their specific health needs are met with due consideration. Turning our gaze to regional human rights instruments, the "African Charter on Human and People's Rights" reinforces the right to health in Article 16, reflecting the continent's commitment to the holistic well-being of its citizens and the importance of this right within the African human rights framework. Likewise, the "European Social Charter" also accentuates the right to health, as detailed in Article 16, thereby fortifying the legal architecture that guarantees equitable healthcare provision across European societies. Finally, the "American Declaration of the Right to Duties of Man" and the "Additional Protocol to the American Convention on Human Rights in the area of Economics, Social and Cultural Rights," particularly Article 10, echo the global consensus on the right to health. These texts reaffirm the interdependence of economic and social rights with civil and political rights,

thereby highlighting the multidimensional nature of the right to health in the Americas. In summary, these interconnected international and regional human rights declarations and conventions collectively form an edifice that supports the universal provision of the right to health, embodying a scholarly consensus that transcends disciplinary boundaries and reflects a profound understanding of the intricate relationship between human rights and public health.

### **Existing International Health Care Rights Legislation**

Medical care and an array of health-related activities are intrinsically encompassed within the broadly acknowledged conceptualization of the right to health, which has experienced a significant expansion in the realm of international law in the past few decades. This multifaceted principle is posited to offer a robust foundation for the examination of issues that span the spectrum from social justice to the quality of healthcare provision. The international legal framework for health has not only propelled the evolution of the right to health but also underscores the intrinsic nature of these rights within the social fabric of societies. The hypothesis that social interactions exert a profound influence on health and well-being, transcending the purview of mere biological and natural determinants, is supported by an extensive body of epidemiological research. Social norms are frequently identified as a primary factor contributing to the exacerbation of health disparities, which are pervasive across numerous global contexts.

The genesis of the right to health in international law can be traced back to the seminal Universal Declaration of Human Rights, wherein it is initially articulated. The United Nations has since affirmed this as a fundamental human right, enshrining it within the purview of a global consensus. Article 25 of the Declaration, while addressing the imperatives of protection and healthcare, omits a comprehensive delineation of the constituent elements of the right to health. This omission is notable in light of the multidimensional nature of the right, which extends beyond medical intervention to encompass socioeconomic security, including safeguarding individuals and their families from the negative impacts of illness, disability, and unforeseen circumstances that may impair their ability to maintain a sufficient standard of living. In the pursuit of fostering social and economic progress on a global scale, the United Nations has instituted a series of specialized organizations. One such emblematic entity is the World Health Organization (WHO), which is not only mandated to promote health but also empowered to formulate and implement international health legislation. The WHO

Constitution, which serves as the foundational charter for global health governance, posits health as a holistic state of complete physical, mental, and social well-being, extending beyond the mere absence of disease or infirmity. It underscores the importance of this right within the broader context of human rights, emphasizing the commitment to ensure the highest attainable standards of health for all inhabitants of the planet. Several international conventions and agreements have been established to further elucidate and substantiate the right to health. These legal instruments encompass a spectrum of health-related provisions, including those pertaining to healthcare and safety, as well as the collective obligation to protect and promote public health on a worldwide basis. These conventions not only delineate the scope of the right to health but also provide a platform for accountability, thereby shifting the focus from a predominantly analytical discourse to the practical implementation of policies that address the underlying social and institutional factors that influence health outcomes. In essence, the right to health is understood not merely as an aspirational goal but as an inherent and enforceable entitlement that is essential to the functioning of a just and equitable international order.

### **International Provision on Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12**

The States Parties to the prevailing Covenant on Economic, Social and Cultural Rights affirm their commitment to the intrinsic principle that each individual is endowed with the inalienable right to the highest attainable standard of physical and mental health. This multifaceted right encompasses not only the absence of disease but also the presence of positive conditions that promote a state of complete well-being. The realization of this right necessitates the implementation of a comprehensive array of measures by the States Parties, which are delineated below.

Initially, the States Parties are tasked with the imperative of reducing infant mortality and stillbirth rates, as well as fostering the healthy development of children, who are the cornerstone of any society's future. This endeavour requires a concerted effort to enhance the quality of healthcare services available to new-borns and their mothers, including pre- and post-natal care, nutrition, and sanitation. Moreover, the promotion of child health is an essential component of the broader objective of advancing overall public health. Secondly, the enhancement of industrial and environmental hygiene in a holistic manner is paramount. This encompasses the implementation of stringent regulations to prevent the dissemination of diseases and the



contamination of the environment, thereby safeguarding the health of the populace from the pernicious effects of industrialization and environmental degradation. It is incumbent upon the States Parties to adopt and enforce standards that ensure a salubrious work environment and protect against the emergence of occupational diseases that may arise from various industrial processes and practices. In addition, the prevention, treatment, and management of occupational endemic and epidemic diseases are of paramount concern. The burgeoning global health crisis underscores the urgency of developing and enforcing effective strategies to combat such maladies. States must ensure that the healthcare infrastructure is adequately equipped to respond to these challenges, thereby mitigating the disproportionate impact of such diseases on vulnerable populations.

Furthermore, the establishment of a healthcare system that guarantees medical services and attention to all individuals in the event of illness is a fundamental obligation of the States Parties. This necessitates the creation of conditions that allow for equitable access to medical facilities and personnel, regardless of one's socioeconomic status or geographic location. The San Salvador Protocol (Article 10) further elucidates the right to health as a multidimensional concept, comprising physical, mental, and social well-being. It is essential that the States Parties recognize health as a public good and undertake measures to ensure its universal accessibility and quality. To this end, the Protocol advocates for the provision of primary healthcare to all members of the community and their families, thereby serving as a foundation for a more equitable healthcare framework. The adoption of a national public health strategy, informed by epidemiological evidence and crafted through a participatory and transparent process, is a cornerstone of this endeavour. This strategy must be periodically reviewed and revised to reflect the evolving health needs of the population and to incorporate the right to health indicators and benchmarks that facilitate the monitoring of progress. In the interest of advancing comparative health accountability, it is imperative that the States Parties prioritize the needs of children, mothers, and reproductive healthcare providers. This entails the provision of prenatal and postnatal care, as well as the promotion of maternal and child health through immunization programs targeting the prevalent infectious diseases within the community. Moreover, healthcare workers must receive appropriate training that integrates human rights principles and education on the primary health issues affecting the community, thereby empowering them to prevent, treat, and control these conditions effectively. The equitable distribution of medical facilities, supplies, and expertise is another critical component of the right to health, as is the provision of essential medications as outlined by the WHO Action

Programme on Essential Drugs. This program serves as a critical guidepost for ensuring that all individuals have access to lifesaving medications, irrespective of their economic means or social status. The right to an adequate standard of living, including food, water, and housing, is inextricably linked to the right to health. Therefore, the States Parties must guarantee the availability of safe and nutritious food to prevent hunger and ensure that all citizens have access to a sufficient supply of potable water and sanitary living conditions.

### **The Status of the Right to Health Care on the Global Scale**

During the tumultuous era of the First World War, spanning from 1914 to 1918, the League of Nations proposed the establishment of an international health organization to mitigate the pandemic challenges that transcended national borders. Despite the initial discourse culminating in an impasse, this period bore witness to the emergence of two significant entities that would leave an indelible mark on global health governance. The South Asian landscape, a mosaic of British colonial influence, comprised India, Bhutan, Nepal, and what would later become Bangladesh and Sri Lanka. India, as the "Jewel in the Crown," and Bhutan, adhering to British foreign policy, exemplified the broader colonial dynamics of the region. In contrast, Nepal, though not formally colonized, engaged in a treaty with the British, delimiting its sovereignty. The pre-WWII health conditions within these territories were deplorable, with the overwhelming majority of the populace grappling with severe maladies. The oppressive climatic conditions, characterized by intense heat and humidity, facilitated the rapid dissemination of diseases. The prevalence of malnutrition, poverty, illiteracy, unsanitary living environments, and overpopulation further exacerbated the health crisis. The widespread lack of access to medical facilities meant that only a privileged few could avail themselves of the rudimentary health services available, leading to an alarmingly high mortality rate. Post-WWII, the health status in these regions did not exhibit substantial improvements, as the ravages of war had depleted resources and infrastructure. The spectre of starvation loomed large, a direct consequence of the persistent food scarcity. Compounded by the dearth of medical care and pharmaceuticals, diseases such as cholera, plague, and malaria grew endemic. The vulnerable, particularly children, bore the brunt of these maladies, with high mortality rates serving as a grim testament to the inadequacy of healthcare provision. The failure of global surveillance mechanisms, including the two-point check system, underscored the urgency for a more robust international response. The World Health Organization (WHO), cognizant of these systemic shortcomings, pledged to implement rigorous campaigns aimed at eradicating a spectrum of

diseases with pandemic potential. The dawn of the twenty-first century heralded an era where the pursuit of universal health became a paramount objective, a quest that WHO was poised to lead by leveraging international law to safeguard the right to health for all inhabitants of the global community. This legal framework would serve as a bulwark against the pervasive inequities that continued to undermine public health efforts. The organization's strategic commitment to enhance and expand its health programs on a global scale signalled a pivotal shift in the approach to disease management and prevention. By harnessing the power of legal instruments, WHO sought to create a world where access to healthcare would no longer be contingent upon one's socioeconomic status or geographic location, thereby laying the foundation for a more equitable and health-secured future.

### **The Functioning of W.H.O**

The United Nations' seminal embrace of health as an integral aspect of its charter is largely attributable to the advocacy of the esteemed Brazilian delegate, Dr. Oswaldo Aranha de Paul Souza. His vision underscored the profound interconnection between socioeconomic progress and the amelioration of human health, emphasizing that the pursuit of health is not merely an absence of disease, but encompasses a triadic conceptualization of physical, mental, and social well-being. The preamble of the World Health Organization (WHO) reflects this comprehensive perspective, positing that health is an inalienable right that transcends the confines of nationality, ethnicity, religion, political orientation, and socioeconomic status. The organization's primary objective is to operationalize this right by fostering a global commitment to public health, grounded in internationally recognized principles and standards that resonate with mutual respect among nation-states. Founded in 1948 as the International Office of Public Health, the WHO's mandate has evolved into a multifaceted framework that encompasses the promotion of wellness, prevention of diseases, and the establishment of a robust infrastructure for healthcare delivery, especially in less developed regions. The organization's guiding principles are encapsulated within its charter, which posits that genuine peace and security are contingent upon the collective health and well-being of humanity. It is a universally acknowledged truth that the fullest expression of human potential is contingent upon robust health, which in turn necessitates a concerted effort by governments to safeguard the physical and social welfare of their citizens. The WHO's constitution, a veritable Magna Carta of global health, is predicated on the notion that health is a fundamental human right. This right extends beyond the mere absence of illness and includes the provision of essential

medical, psychological, and informational resources to facilitate holistic well-being. The organization's strategic objectives are manifold, encompassing the promotion of child welfare, environmental health, and the prevention of pandemics, among others. The efficacy of these initiatives is contingent upon the collaborative engagement of international law, including trade regulations, human rights statutes, environmental protocols, and bioethical guidelines, as well as the international legal frameworks governing global humanitarian law and the control of dangerous chemical and biological agents. The interdependence of national and international legal systems in the realm of public health necessitates the WHO's continuous development of legal frameworks capable of addressing the complexities of global health governance. As the guardian of this vital human right, the WHO is charged with orchestrating a harmonious interplay between these legal domains, ensuring that the pursuit of health equity and security is both robust and equitable. The organization's commitment to this endeavor is underscored by its multidisciplinary approach, which integrates legal, scientific, and ethical considerations to optimize the health and safety of the international community, as codified by its signatories on January 12, 1948, under Article 57 of the United Nations Charter.

### **World Health Organization's focus**

The focus of the World Health Organization (WHO) is the holistic attainment of optimal global health, as per its constitutional mandate. Beyond merely the absence of disease and disability, this encompasses the integration of physical, mental, and social well-being. This multifaceted approach involves collaborating with international bodies to ensure equitable access to essential services, including nutrition, housing, sanitation, recreation, economic opportunities, and suitable work environments. Additionally, WHO establishes and enforces international health standards, formulates pharmaceutical and medical supply requirements, and implements rapid-response strategies for disease management and pandemic prevention, thereby addressing the multidimensional nature of global health imperatives.

### **Human Rights and Health under W.H.O.**

In WHO, the safeguarding of human rights and welfare is paramount, embodying a distinctive convergence of economic, intellectual, and socio-political dimensions, exemplifying its specialized mandate as a bastion for human rights and well-being advancement.



## **Role of W.H.O during Covid-19 Pandemic**

The specialized UN agency, the World Health Organization (WHO), has played a pivotal role in the global combat against the COVID-19 pandemic. Following the outbreak's emergence in Wuhan, China, the WHO has been unwavering in its commitment to prevention strategies and therapeutic intervention proposals. Its swift, comprehensive response, embodying a sense of urgency akin to a wartime effort, has significantly shaped international health policy and collaborative endeavours.

## **Préparations and Prevention Initiative by W.H.O.**

The World Health Organization (WHO) has meticulously orchestrated a comprehensive framework of responses and guidelines, informed by rigorous scientific inquiry, to navigate the complexities of the ongoing Covid-19 pandemic. This global entity has been disseminating pertinent data on the virus's genetic composition and characteristics in a systematic manner to ensure uniform comprehension and strategic implementation. The WHO's collaborative approach extends to its six international regional offices and an expansive network encompassing 150 countries, fostering a synergistic endeavour that transcends national boundaries. This initiative has been instrumental in harmonizing the mitigation efforts of governments, regardless of their developmental status, and has been underpinned by the timely distribution of accurate information through various media channels. Moreover, the WHO's establishment of the "UN COVID-19 Supply Chain Task Force" on April 8, 2020, exemplifies its commitment to global solidarity, as it seeks to equitably allocate protective gear and diagnostic resources to the 133 nations that are part of this unprecedented coalition. This scholarly-driven organization has been pivotal in providing not only epistemological clarity but also tangible support to combat the pandemic's multifaceted impact.

## **Mobilizing and Training of Health Workers**

The aim of the World Health Organization (WHO), a specialized agency of the United Nations established in 1946, is to facilitate the instruction and preparation of frontline health professionals and personnel in vital life-preserving practices. The emergency medical team constitutes a pivotal component in the global health apparatus, possessing extensive training that enables them to autonomously manage an array of critical health scenarios in diverse settings. The WHO's mandate extends to deploying these skilled professionals to regions struck by emergencies and disasters, thereby fortifying the global response to health crises. At the core

of the WHO's mission is the establishment of a substantial research contingent dedicated to the investigation of pandemic diseases, such as the multifaceted nature of epidemic illnesses, viral and bacterial pathogens, and associated matters that threaten international health security. This research focus is operationalized through an extensive network of projects currently active in over 40 countries, involving the collaboration of approximately 130 scientists who have conducted comprehensive studies on the entire spectrum of COVID-19-related concerns. Their collective endeavor has not only bolstered our understanding of the coronavirus but also significantly contributed to the international pool of knowledge regarding pandemic management, resource allocation, and global health governance. The WHO's commitment to the principle of "equitable service to all individuals, irrespective of their socioeconomic or cultural background" is underscored by its strategic emphasis on Universal Health Coverage (UHC). The objective of UHC is to extend safe and high-quality health services to an additional one billion people within the next five years. This ambitious target is integral to the realization of the Sustainable Development Goals (SDGs), which are predicated on the premise that equitable access to healthcare is a fundamental prerequisite for sustainable development. The attainment of these goals' hinges upon the universal commitment to overcome financial barriers to health service provision, thereby ensuring that no one is left behind in the quest for optimal human development. The intricate challenges confronting global healthcare systems are manifold, ranging from disparities in infrastructure and resource distribution to systemic inefficiencies and the persistent burden of communicable and non-communicable diseases. The WHO plays a critical role in setting and upholding global health standards, which, despite the heterogeneity of demographic, epidemiological, and economic contexts across nations, serves to establish a relatively uniform foundation for the evaluation of healthcare systems. The organization's guidance transcends national borders and informs the policies and practices of its 194 member states, thereby contributing to a more equitable landscape of healthcare provision.

The COVID-19 pandemic has starkly illuminated the vulnerabilities of healthcare systems worldwide, leading to a significant reduction in the availability of essential services such as diagnostic facilities, ventilators, oxygen supplies, and personal protective equipment for medical staff. In particular, marginalized communities within various countries face formidable obstacles in accessing these services due to insufficient healthcare infrastructure. The imperative to provide adequate care to these populations is paramount, as it is intrinsically linked to the respect and protection of the right to health.

The state's increased investment in public health and the subsequent provision of these services at subsidized rates reflect the broader imperative to safeguard the health and well-being of its citizens. The implementation of stringent measures such as lockdowns, school closures, and restrictions on non-essential activities, while undeniably infringing upon individual liberties, are justified as necessary interventions to preserve human life during a public health emergency. The right to health, enshrined in international law, comprises a multitude of interconnected elements including, but not limited to, access to adequate healthcare, sanitation, nutrition, housing, and protection from violence. These rights are interdependent and mutually reinforcing, demanding a holistic approach to healthcare provision and policy formulation.

The WHO's involvement in public health extends beyond the provision of guidance during emergencies. It also advocates for the active participation of community groups in bolstering national and local responses to health crises, thereby amplifying the effectiveness of public health interventions. Furthermore, independent evaluations of judicial, legislative, and regional health system performance are crucial in ensuring accountability and fostering a culture of continuous improvement.

## CONCLUSION

The courts of India, acting as the custodians of the constitutional edifice, have affirmed the intrinsic relationship between the right to health and the right to life as enshrined in Article 21 of the Indian Constitution. This article delves into the nuances of this nexus, examining the judicial discourse surrounding the right to health within the purview of the Directive Principles of State Policy, and elucidates the imperative for a constitutional amendment to explicitly categorize health and medical care as a fundamental right. The ensuing analysis, grounded in a comparative perspective of international legal frameworks, aims to provide a robust foundation for stakeholders such as policymakers, jurists, and medical practitioners to advocate for the unassailable recognition and enforcement of these rights.

The right to health, an inalienable facet of the right to life, has been the subject of judicial interpretation and legislative debate in the Indian context. The Supreme Court, in a series of landmark decisions, has explicated that the state is under an obligation to safeguard and promote the health of its populace, thereby extending the ambit of Article 21. This article posits that the current legal paradigm, while progressive, necessitates a more pronounced articulation

of health as a fundamental right to ensure governmental accountability for any infringements.

The discourse on the right to health as a fundamental right is not confined to the Indian jurisdiction. It is a global concern that has found resonance in various international human rights instruments and national constitutions. The Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the Constitution of the World Health Organization all underscore the centrality of health to human dignity and the state's responsibility to ensure its provision. India, as a signatory to these covenants, is implicitly bound to uphold these principles.

In the realm of constitutional law, the right to health has been recognized as a fundamental right in various countries, such as South Africa, where the Constitution explicitly guarantees this right, and obligates the state to take progressive measures to achieve the full realization of this entitlement. The South African model, exemplified by its constitutional provision, provides a salient example of how a clear legal mandate can serve as an impetus for the government to prioritize healthcare and allocate resources accordingly.

The Indian Supreme Court, while acknowledging the symbiotic relationship between health and life, has often refrained from explicitly categorizing the right to health as a fundamental right. Instead, the Court has approached the issue through the prism of the Directive Principles, which, despite their non-justiciable nature, have been instrumental in shaping socio-economic policies and guiding the interpretation of fundamental rights. However, the distinction between direct and indirect enforceability often leads to a situation where the right to health is not given the same priority and protection as other fundamental rights.

The argument for constitutional amendment to explicitly enshrine the right to health as fundamental is multifaceted. It is predicated on the premise that such a move would serve as a catalyst for the government to prioritize healthcare, allocate resources more effectively, and be held accountable for the delivery of quality medical care to all citizens. Moreover, it would provide a stronger legal basis for citizens to seek redress for the violation of their health rights and ensure that the state's obligation to provide healthcare is not merely rhetorical but is translated into tangible action.

Several judicial pronouncements have illustrated the importance of this right. For instance, in



the case of Paschim Bango Khet Mazdoor Samity vs. State of West Bengal, the Supreme Court held that the right to health is a fundamental right, stating that the right to life would be meaningless without the right to live with human dignity, which includes the right to health. Similarly, in the case of Consumer Education and Research Center vs. Union of India, the Court recognized the right to health as a fundamental right under Article 21 and emphasized the government's duty to provide safe and effective healthcare services.

However, the lack of explicit constitutional recognition has led to inconsistencies in the interpretation and implementation of this right. This ambiguity often results in a situation where the government can evade its obligations, especially in the context of resource allocation and the provision of adequate healthcare facilities. A constitutional amendment would remove this ambiguity and establish a clear legal framework for the enforcement of the right to health.

