LST REVIEW

Volume 16 Issue 219 January 2006

A Draft National Medicinal Drug Policy for Sri Lanka

Charters on Health Rights/Patients' Rights & Responsibilities

Constitutional Incorporation of the Right to Health?

Migrant Workers Rights in the Pacific

LAW & SOCIETY TRUST

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ISSN - 1391 - 5770

Editor's Note ... ...

The Review, for its first publication in the year 2006, offers a collection of articles with an emphasis on the Right to Health in all its manifold aspects.

It commences with a proposed National Medicinal Drug Policy (NMDP) for Sri Lanka put forward by the Peoples' Movement for Rights of Patients. The NMDP is currently undergoing public scrutiny through a process spearheaded by the Ministry of Health and the World Health Organisation (WHO).

Creditably, the initiation of the NMDP was at the instance of a small group of public spirited journalists, concerned health sector and medical professionals as well as activists. This group worked on the Policy voluntarily in the interests of the Sri Lankan public in general. Their efforts were spurred by increased public attention on the need for a comprehensive medicinal drugs policy, given the vulnerability of the disadvantaged sectors in society where access to quality drugs at affordable prices is in issue.

A key element of the proposed NMDP is the appointment of an independent Drug Regulatory Authority who will be empowered to register drugs contingent upon five factors of quality, efficacy, safety, cost and need.

The Review also publishes in this regard, draft Charters on the Right to Health as well as Patient's Rights and Responsibilities put together by ***Dr K Balasubramanium*** with a view to facilitating a broader discussion on bringing about a health system where the well-being of a patient is the first priority. An essential part of this process of this process is the incorporation of a constitutional Right to Health. A draft provision which was worked upon by the Law and Society Trust last year in collaboration with the Peoples' Movement for Rights of Patients is also published.

Providing a useful general context to these discussions in the context of the law and jurisprudence both of Sri Lanka and in other countries is the paper on *The Right to Health as a Socio-Economic Right in Sri Lanka – its Scope and Limits* by ***Dr J de Almeida Guneratne***. The writer examines the existing statutory framework in regard to the right to health as well as case law that has recognised such a right in an extremely limited manner within the context of the constitutionally embodied right to freedom from torture and arbitrary arrest and detention. More extended arguments are advanced in the context of the right to quality of healthcare as emanating from judicial reasoning from the Supreme Court.

While drawing interesting comparisons between development of this right through judicial action as well as social advocacy in countries such as South Africa and Argentina, he suggests that existing statuory provisions must be used to good effect by civil action groups. Undoubtedly however, express constitutional provision regarding the Right to Health needs to be incorporated in Sri Lanka's Constitution as a matter of utmost urgency.

The concluding paper in this Issue, written on the invitation of the Review by an overseas academic, *Dr Dejo Oluwu* draws away from its general theme to present a rights-based approach to migration laws and policy within a sustained analysis of the applicable international human rights frameworks.

His paper looks at the implications of such global standards and mechanisms for legal and policy initiatives in the smaller states of the Pacific in particular, and the Pacific region as a whole. Specifically, he points to the importance of the Pacific states fashioning their domestic and regional agendas on migration generally (and labour migration in particular), to be in consonance with global standards.

The issues that he has raised in his analysis are important for Sri Lanka as well. Readers of the Review who are interested in the topic of migrant workers' rights may also avail themselves of the benefit of the incisive examination of Sri Lanka's Bureau of Foreign Employment Act, No. 21 of 1985 by *Nura Maznavi* in LST Review, Volume 14, Issue 201, July 2004.

This paper urged a wholesale reform of Act, No 21 of 1985 by highlighting critical weaknesses in its provisions. In particular, Maznavi opined that Sri Lanka should forthwith make provision for the voting rights of migrant workers along the lines of similar legislation, for example, in the Phillipines.

It is a matter of regret that such legislative reform has yet not been carried out.

Kishali Pinto-Jayawardena

A DRAFT NATIONAL MEDICINAL DRUG POLICY FOR SRI LANKA

Proposals from the People's Movement for Rights of Patients (PMRP) [♠]

Introduction

Sri Lanka has had a 'partly written' Drugs Policy from the 1960s. The elements of a policy were "written in" as a result of developments commencing at the early stages, from the selection of drugs for the government drug supply and the Ceylon Hospitals Formulary in early 1960s to the Bibile-Wickremasinghe report in 1971 and the Cosmetics Devices and Drugs Act (1980).

There were attempts to develop a National Medicinal Drug Policy (NMDP) in 1991 and 1996. However, while these documents were accepted by the Ministry of Health, they did not reach the final stage of cabinet approval. Many health service activists attribute this failure to efforts by giant pharmaceutical companies who were unhappy about a medicinal drugs policy coming into effect in Sri Lanka.

It was as an effort to remedy this lacunae that a group of activists and public-spirited health sector and medical professionals focussed, in recent times, on agitating for a policy based on rational drugs principles. The end result brought together, the elements of a National Medicinal Drug Policy (NMDP) in one document which was developed based on World Health Organisation (WHO) documents through discussion with all concerned persons. It is hoped that this effort will see a formal NMDP being adopted by the Cabinet for Sri Lanka.

Effectively, the NMDP will constitute the government's commitment to a goal and guide for action in the area of good drug regulation. It will express and prioritize the medium to long term goals set by the government for the pharmaceutical sector and identify the main strategies for achieving them. It will cover both the public and private sectors and involve all the main actors in the field.

It is relevant to note that the NMDP, drafted through a vigorous social action process, was accepted by the consensus of all the stakeholders in both the public and private sectors at two workshops in February and July 2005.

Ideal Elements of an NMDP

An NMDP should be buttressed by the following underlying values:

- To present a formal record of values, aspirations, aims, decisions and medium to long-term government commitments;
- To define the national goals and objectives of the pharmaceutical sector and set priorities
- To identify the strategies needed to meet these objectives, and identify the various actions responsible for implementing the main components of the policy;
- To create a forum for national discussions on these issues;

[♠] The PMRP consists of a group of dedicated activists, medical professionals, journalists and consumers working voluntarily on fundamental concerns affecting the health sector in Sri Lanka.

The Objectives of an NMDP

These should be as follows;

1. To ensure the availability and affordability of efficacious, safe and good quality medicines relevant to the health care needs of the people in a sustainable and equitable manner;
2. To promote the rational use of medicines by healthcare professionals and consumers;
3. To promote local manufacture of Essential Medicines;

The NMDP should be within the overall health policy of the country, should be based on the Essential Medicines Concept and should be focused on the health sector but also include/coordinate with relevant areas such as education, finance, agriculture, veterinary, pharmaceutical industry and trade. Crucially, it should safeguard the rights of the patients/consumers.

Ideally, it should cover all systems of medicine including allopathic, homeopathy, ayurveda, sidda, unani and any other systems recognised in the country. While the primary target of this policy should be allopathic medicines, policies for the others systems of medicines should be developed later in consultation with stakeholders of those systems.

The Sri Lankan NMDP

The proposed NMDP for Sri Lanka has the following elements; Selection of essential medicines, Affordability and Equitable Access, Financing options, Supply systems and Donations, Regulation and quality assurance, Quality Use of Medicines, Research, Human resources, Viable Local Pharmaceutical Industry and Monitoring and evaluation

There shall be a National Standing Committee appointed by the Minister on the recommendation of the DGHS, comprising all stakeholders to oversee the implementation of the National Medicinal Drug Policy.

Selection of Essential Medicines

The selection of an Essential Medicines List prioritises the medicines that are important. The medicines will be selected according to valid scientific evidence, the disease pattern in the country and cost-effectiveness.

A Standing Committee comprising all stakeholders will be established to define and regularly update the National Essential Medicines List. It will formulate, review and update Standard Treatment Guidelines, Drug Index, the Sri Lankan Formulary and Government Drug Procurement Documents.

Undoubtedly, the selection of essential drugs and its use by both the public and private sector is the cornerstone for a successful NMDP. The multinational drug corporations fear that adoption of the concept of essential drugs will cut into their profits. They carry out skillful unethical promotion through the health profession to the effect that limiting selection to to essential drugs denies clinical freedom to doctors and will result in a negative impact on the health of the people.

The essential drug concept is central to the NMDP because it promotes equity and helps to set priorities for the healthcare system. The concept of essential medicines is based on universal concepts of equity, commonsense and sound evidence based medicine: when a competent scientific committee draws up a list of essential drugs, every drug listed has a weight of scientific evidence behind it and is

the best product the country can afford. These essential drugs are not cheap, inferior medicines. They will be as effective for the treatment of diseases such as cancer and cardiovascular disease as they are for common of childhood illnesses such as diarrhoeal disease and acute respiratory infections.

The concept of essential medicines encourages health systems to focus on regular access to those medicines that represent the best balance of quality, safety, efficacy and cost to meet the priority health needs within any given healthcare setting. Over the last 25-30 years, the concept has proven to be a global necessity for countries from the poorest to the wealthiest.

The centralized bulk procurement of few items in the national list of essential drugs by the State Pharmaceuticals Corporation results in increased price competition and economies of scale. Quality assurance, procurement, storage, distribution and dispensing are all easier with a limited number of drugs. Training of health workers and drug information in general can be more focused; prescribers can gain more experience with fewer drugs and are more likely to recognize drug interactions and adverse reactions.

Affordability and Equitable Access

It is essential in this regard that a Pricing Policy/Mechanism is adopted to ensure affordability. Retail pricing should be based on a dispensing fee rather than cost+markup. Legislation requiring generic prescribing and allowing cost-effective generic substitution with the consent of the patient (and where possible informing the doctor) should be enacted. There should be a policy for licensing pharmacies which among others would incorporate the needs and requirements of the communities.

Medicines including raw materials (both local and imported) should be free of any taxes, other tariffs and excise duties. The public health provisions of the Doha Declaration (Parallel Imports, Compulsory Licensing) should be incorporated into the national legislation to ensure affordability of needed medicines. These activities should be authorised by the Regulatory Authority.

Rational self medication should be facilitated by appropriate scheduling of the medicines.

Financing options

The State should provide sufficient funding for procurement and supply of necessary medicines with priority for essential medicines, monitor appropriate use and prevent waste. Public and private sector health insurance schemes will be encouraged to develop re-imbursable lists of medicines.

Supply systems & Donations

The responsibility for ensuring a continuous availability of Essential Medicines in the country is a shared public/private sector responsibility. The State should continue centralised bulk purchase and supply to its institutions. Preference should be given to local manufacturers in supply of medicines to the state sector. Good pharmaceutical procurement practices and management of the supply chain should be enacted for both the public and private sector.

There should be a private/public mix of suppliers to the private sector. A policy for acceptance of donations of medicines should be developed based on WHO Guidelines for Drug Donations. Until this policy is developed, the WHO guidelines should be followed.

The state should take the responsibility for the availability of "Orphan" Drugs and incentives to be given to suppliers of such items.

Regulation and Quality Assurance

Legislation should be enacted to provide a sound legal basis for regulating activities in medicines. A statutory body titled the National Medicinal Drug Regulatory Authority (NMDRA) which is accountable to the Minister of Health through the National Standing Committee should be established. This Authority will be solely responsible for regulation and control of manufacture, importation, registration, promotion, sale and distribution of medicinal drugs and devices, nutraceuticals and functional foods. It should have transparent mechanisms and adequate human resources.

Medicines should be registered based on the criteria of quality, safety, efficacy, need and cost-effectiveness. These criteria should be established by the NMDRA. The NMDA should have the authority to limit the number of new chemical entities of a particular class of drugs, as well as the number of products of a particular chemical entity. Such limitation of numbers will not apply to locally manufactured products.

Official drug information will be instituted through approval of Product Information Leaflets/Summary of Product Characteristics and where relevant Patient Information Leaflets. The Authority should be funded by the state and through statutory levies on services rendered. An accredited Drug Quality Assurance Laboratory should function within the Authority with appropriate fees for services. Good Manufacturing Practices (GMP) compliant with WHO Guidelines should be required for registration of medicines. Good Pharmacy Practices (GPP) and Good Distribution Practices (GDP) should be developed and implemented.

The promotion of medicines should be regulated based on the Sri Lanka Medical Association Ethical Criteria for Medicinal Drug Promotion. Promotion and sale of medicinal drugs based on financial or other incentives should be prohibited. Post-marketing surveillance and Pharmacovigilance systems should be established.

Quality Use of Medicines

Appropriate education in the quality use of medicines should be included in the training of healthcare professionals. The state should fund a national medicines information centre and Drug Information Bulletins through the medicines budget, to provide independent and unbiased information to healthcare professionals and consumers.

The rational use of drugs should be promoted and irrational use should be discouraged. There should be public education programs about medicines especially through the school curricula.

Research

There should be resources and incentives for operational research on issues such as access to medicines, pricing mechanisms, cost-benefit, cost-effectiveness and other areas of pharmacoeconomics, quality, storage and utilisation. The research findings should be incorporated into clinical practice. Clinical research into drugs for neglected diseases which are prevalent in Sri Lanka should be encouraged and funded. Contract research in drug development should be in keeping with WHO Good Clinical Practice Guidelines.

Human Resources

There should be a special focus on the development of the pharmacy profession with degree programs in pharmacy. The Pharmacy Council should be established as a priority with sole responsibility for accreditation of pharmacists. The NMDRA should undertake human resource development of it's staff.

There is a need for external technical cooperation for the development of human resources in the pharmaceutical sciences. Expertise in Clinical Pharmacology/Clinical Pharmacy needs to be developed and utilised in the health care sector.

Viable Local Pharmaceutical Industry

The state should encourage and facilitate a viable sustainable local pharmaceutical industry by fiscal and other incentives. This will allow better monitoring of quality, improve availability, affordability, employment of skilled personnel and development of technical and human resources.

The State Pharmaceuticals Corporation (SPC) and the State Pharmaceuticals Manufacturing Corporation (SPMC) should be amalgamated into one Corporation and solely owned and managed by the state. There should be one Board of Directors comprising of technical experts in the relevant fields and officials from the Ministry of Health and Treasury. This corporation should facilitate training for the pharmaceutical sector. The Medical Supplies Division should give preference to pharmaceuticals manufactured by this Corporation at procurement.

The local pharmaceutical industry should be given priority over imports in state procurement.

Monitoring and evaluation

An inspection system should be established at the NMDRA for GPP, GMP, GDP by the appropriately qualified personnel. Regular monitoring of the pharmaceutical sector through indicator-based surveys should be conducted by the National Standing Committee.

Implementation

Once the NMDP is adopted, it will be the responsibility of the Minister of Health on the recommendation of the Director General of Health Services, to appoint the National Standing Committee within three months to oversee the implementation of the Policy.

This policy will be reviewed and revised if necessary in five years.

The Sri Lankan Peoples' Health Charter[♠]

Preamble

While acknowledging that one of the most fundamental human rights is the assumption that each person has intrinsic value and everyone deserves to be treated with dignity and that this is the tenet from which all other human rights derive their substantive content and that those who are most vulnerable deserve special protection;

While also acknowledging that the recognition of the inherent dignity and equal and inalienable rights of every citizen is the foundation of freedom, justice and peace in Sri Lanka, that Sri Lanka should emerge as a country in which all its citizens shall enjoy freedom of speech and freedom from fear and want, that this should be the highest aspiration of the common people;

And while affirming our faith in fundamental human rights, in the dignity and worth of the human person and in equal rights for men and women and are determined to promote social progress and better standards of life, we declare as follows;

- The Fundamental Right to Health is a social, political and economic issue:
- While Health is a fundamental human right indispensable for the exercise of all other rights, health and ill-health are themselves the outcome of social, economic and political influences. Without sustained improvements in socio-economic conditions and consequent improvements in standards of living, optimum health for all is unlikely to be achieved and maintained;
- Inequality, poverty, exploitation, violence and injustice are at the root of ill health;
- Every one has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices;
- Every one has the right to a standard of living adequate for the well being of himself/herself and of his/her family, including food, clothing, housing, medical care, necessary social services and the right to social security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his/her control;
- The right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life and extends to the underlying determinants of health including food and nutrition housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment;
- Poverty is the deadliest disease and hunger is the commonest cause of death, clearly demonstrating that the Ministry of Health and the Department of Health Services alone cannot ensure the right to health but which is instead a cumulative responsibility of all other government Ministries and Departments and the State as a whole;

Substantive Contents

Acknowledging that the Right to Health exists in all its forms and at all levels described above, the Charter declares the following as interrelated and essential elements of the Right to Health;

[♠] Drafted by Dr K Balasubramaniam, Advisor and Co-ordinator, Health Action International Asia - Pacific.

a. *Availability*

Well functioning public health and healthcare facilities, goods and services as well as programmes have to be available in sufficient quantities within the government institutions.

b. *Accessibility*

Health facilities, goods and services have to be accessible to every one without discrimination. Accessibility has four overlapping dimensions.

i. Non-discrimination
Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population.

ii. Physical accessibility
Health facilities, goods and services must be within safe physical reach of all sections of the population, especially the vulnerable or marginalized groups.

iii. Acceptability
All health facilities, goods and services must be respectful of medical ethics and culturally appropriate.

iv. Quality
Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

Right to participate in Planning Processes

People will have the right and duty to participate individually and collectively in the planning and implementation of healthcare.

The Role of the State

The State has the responsibility for the health of its entire people. These responsibilities can be fulfilled only by provision of appropriate and adequate health and social measures.

The realization of the right to health can be achieved by formulation and implementation of national health policies based on the concepts of Primary Health Care as outlined in the Alma Ata Declaration on Primary Health Care as the key to Health for All. Sri Lanka, along with other Members States of the World Health Organization, adopted the Alma Ata Declaration at the International Conference on Primary Health Care in September 1978. This conference reaffirmed that health was a fundamental human right. The WHO member states, including Sri Lanka, gave a solemn promise to the world community that they would introduce national health policies based on Primary Health Care in their respective countries.

The constraints faced by the government due to the limits of available resources are acknowledged. However, there are minimum core obligations of the government which include the following:

a. Ensuring the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
b. Ensuring access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

c. Ensuring access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
d. Providing essential drugs as, from time to time, defined under the WHO Action Programme on Essential Drugs;
e. Ensuring equitable distribution of all health facilities, goods and services;
f. Adopting and implementing a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored and evaluated; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.
g. Ensuring reproductive, maternal and child healthcare.
h. Providing immunizations against the major infectious diseases occurring in the community.
i. Taking measures to prevent, treat and control epidemic and endemic diseases.
j. Providing education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.
k. Providing appropriate training for health personnel including education on health and human rights.
l. Providing a Public Complaints Mechanism where complaints in relation to the standards specified in this Charter can be recorded, investigated and redress recommended.

Constitutional Enshrining of the Right to Health

Health for all Sri Lankans can be achieved only when the Right to Health is protected by the laws of the country and enshrined in the Constitution. The obligation of the State to fulfil the various requirements for the Right to Health includes the enshrining of the Right to Health in the Constitution and the adopting of appropriate legislative, administrative, budgetary and judicial measures towards the full realisation of the right to health.

Annexure

Guidelines for implementing the Sri Lankan Peoples' Health Charter

The dissemination and application of the contents of this Charter will have to be carried out at national, regional and local levels.

Information and Education

As a means of informing and educating the public and healthcare workers this charter may be promoted in all health institutions, mass media, in universities, schools and other appropriate public places.

Support

Support for and subscription to the Charter need to be gathered from the Ministry of Health, healthcare workers and civil society organizations. The special commitments of those health services and professionals that subscribe to the Charter should be defined.

Dialogue

It will be important to initiate a dialogue among the various stake-holders on the basis of the contents of the final version of the Charter in order to work out policies, programmes and action plans for the protection of and promotion of people's health. Such a dialogue will take place among governmental authorities, public and private sector institutions involved in healthcare, professional associations of doctors, dentists, nurses, pharmacists, trade unions of healthcare workers and civil society organizations.

Legislation

The Charter may be incorporated into national laws and regulations in full or in part to make the goal of protecting promoting peoples' health an ordinary part of public policies.

Charter of Patients' Rights and Responsibilities[♠]

Introduction

Patients' rights refer to what is owed to the patient as a human being by the healthcare providers and the State. Patients' rights and responsibilities vary in different countries and in different jurisdictions. Prevailing cultural and social norms will determine the set of patients' rights and responsibilities in a particular country.

Undoubtedly, assuring that the rights of patients are protected requires much more than educating policy makers and healthcare providers. It requires educating citizens about what they should expect from their governments and their healthcare providers.

The Sri Lankan national health system should put in place, systems that guarantee the rights of patients, consumers, users, family members, weak populations and ordinary people at risk. We are at a stage where the public will not accept that patients' rights can be affirmed in theory, but then denied in practice, because of financial limits. Financial constraints, however justified, cannot legitimize denying or compromising patients' rights.

A. Patients' Rights

Right of Access to Healthcare Services and Right to Humane Treatment

- The right to receive medical advice and treatment which fully meets the currently accepted standards of care and quality regardless of age, sex, ethnic origin, religion, political affiliation or social class. The currently accepted standards are those adopted by a responsible body of the profession in the light of accepted medical practice.
- Healthcare services shall be available on the basis of clinical need regardless of the ability to pay. It shall be the responsibility of the government to ensure that every person has access to essential health services whenever the need arises.
- Right to a second opinion at any time.
- No patient care is abandoned by a healthcare professional worker or a health facility which initially takes responsibility for one's care.
- Healthcare providers shall display a positive disposition that demonstrates courtesy, human dignity, patience, empathy, tolerance, respect and which shall be without discrimination of any kind.
- All drugs prescribed and dispensed shall be of acceptable standards of quality, safety and efficacy as determined by the Drug Regulatory Authority of Sri Lanka.
- The right to prompt and timely emergency care in the nearest government or private sector health facility regardless of one's ability to pay.
- There shall be provision for special needs in case of new born infants, young children, pregnant women, the aged, disabled, and patients in pain, persons living with HIV/AIDS.
- The right to ready access to palliative care that is effective and affordable in cases of incurable or terminal illness.

[♠] Drafted by Dr K Balasubramaniam, Advisor and Co-ordinator, Health Action International Asia - Pacific.

Right to Information and Consent

- The right to information about what healthcare services are available and how to obtain them.
- The right to be given a clear description of a patient's medical condition with diagnosis, prognosis (ie. an opinion as to the likely future course of that illness) and of the treatment proposed including common risks and appropriate alternatives.
- The right to know the names of medications prescribed; the prices of the brand names and the prices of the generic equivalents of the medications prescribed.
- The right of the patient to choose between the brand name and its generic equivalent.
- All medications shall be labelled and shall include the generic or international non-proprietary name (INN). The labelling should also provide the following information.
  - The dosage and how often to be taken
  - The purpose of the medicine
  - Potential side effects
  - The avoidance of any food, beverages or other drugs
  - Duration of a course of treatment
- The right to an itemized account for the fees paid for consultation and treatment and to have this explained.
- Where it is appropriate to a patient's continued care and management, the patient shall be given advice about self-care, continued drug treatment, special precautions, life styles which may be necessary or desirable and the existence of special associations, facilities, aids or appliances which may be of assistance.
- The right to be given full and accurate information about the nature of one's illness, diagnostic procedures, the proposed treatment and the costs involved, for one to make an informed decision that affects any one of these elements.
- The right to choose whether or not to take part in medical research programmes.

Right to Privacy and Confidentiality

- The right to have one's privacy, dignity and religious and cultural beliefs respected.
- The right to ensure the details of the patient's condition, treatment, prognosis, and all communications and other details relating to the patient's care to be treated as confidential, unless
  - authorized in writing by the patient or parent or guardian in case of children
  - The information is required by due legal process.

Right to Complain

The right to complain about healthcare services whenever a patient has suffered a harm; to have such complaints investigated and the right to receive a response or other feed back.

For this purpose, a Public Complaints Bureau should be established and a Health Ombudsman appointed with overall responsibility of inquiring into complaints and recommending appropriate remedial action including redress to be taken in law in respect of both complaints of patients as well as in respect of the satisfaction of standards specified in the Charter on Health.

The health services ought to guarantee the exercise of this right, providing (with the help of third parties) patients with information about their rights, enabling them to recognize violations and to formalize their complaint. A complaint must be followed up by an exhaustive written response by the health service authorities within a fixed period of time.

The complaints must be made through standard procedures, facilitated by independent bodies and/or citizens' organizations and cannot prejudice the patients' right to take legal action or pursue alternative dispute resolution.

Right to Compensation

Each individual has the right to receive sufficient compensation within a reasonably short time whenever he or she has suffered physical, moral or psychological harm caused by a health service treatment.

The health services must guarantee compensation, whatever the gravity of the harm and its cause (from an excessive wait to a case of malpractice), even when the ultimate responsibility cannot be absolutely determined.

Right to Preventive Measures

- The right to a proper service in order to prevent illness. The health services have the duty to pursue this end by raising peoples' awareness, guaranteeing health procedures at regular intervals free of charge for various groups of population at risk, and making the results of scientific research and technological innovation available to all.

B. Patients' Responsibilities

The patient shall:

- ensure that she/he knows and understands what patients' rights are and shall use these rights reasonably and responsibly
- keep appointments, be on time and shall inform the health professional in advance if unable to do so.
- Give her/his health provider as much information as she/he can about the present health, whether consulting with or under the care of another healthcare provider or traditional healer in connection with the same complaint or any other complaint
- Use the healthcare system properly and not abuse it, not waste medical resources unnecessarily.
- Take good care of all health records in her/his possession.
- Comply with prescribed treatment or rehabilitative processes.
- Show consideration and respect for the rights of other patients and healthcare providers by following the hospital rules concerning patient conduct.
- Have a regular family doctor, dentist and pharmacist to ensure that there is continuing healthcare for the patient and patient's family.
- Seek a consultant's advice only when referred to by the family doctor or general practitioner.

Annexure

Guidelines for Implementing the Charter of Patients' Rights and Responsibilities

The dissemination and application of the contents of this Charter will have to be carried at national, regional and local levels.

Information and Education

As a means of informing and educating the public and healthcare workers this Charter may be promoted in all health institutions, mass media, in universities, schools and other appropriate public places.

Support

Support for and subscription to the Charter need to be gathered from healthcare stake-holders and civil society organizations. The special commitments of those health services and professionals that subscribe to the Charter should be defined.

Dialogue

It will be important to initiate a dialogue among the various stake-holders on the basis of the contents of the Charter in order to work out policies, programmes and action plans for the protection of patients' rights. Such a dialogue will take place among governmental authorities, public and private sector institutions involved in healthcare, professional associations of doctors, dentists, nurses & pharmacists, trade unions of healthcare workers and civil society organizations.

Legislation

The Charter rights and responsibilities may be incorporated into national laws and regulations in full or in part to make the goal of protecting patients' rights an ordinary part of public policies.

DRAFT CONSTITUTIONAL PROVISION ON THE RIGHT TO HEALTH*

1) **Everyone has the right of access to;**

   a) **Healthcare facilities;**

   b) **Essential goods and services of adequate scientific and medical quality including emergency medical treatment irrespective of the citizen's ability to pay for the same;**

   c) **sufficient food and water;**

   d) **appropriate social assistance**

2) **The proper organisation and administration of health care and adequate control and treatment of diseases shall be made available by the State through adequate budgetary provision which shall not be reduced for whatever reason;**

   Provided that, nothing in this article shall prevent an increase in the health share of the budget as and when such a need or demand may arise.

* Drafted by the Law and Society Trust with the People's Movement for Rights of Patients (PMRP), 3/11/05

The Right to Health as a Socio-Economic Right in Sri Lanka – its Scope and Limits

Dr. J de Almeida Guneratne[♦]

Introduction – Scope and Objects of the Paper

The Committee on Economic, Social and Cultural Rights of the United Nations in its General Comments identified four essential elements of the right to health:

(i) Availability – public health and health care facilities, goods and services and programmes should be available in sufficient quantity.

(ii) Accessibility – health facilities, goods and services have to be accessible to every one without discrimination.

(iii) Acceptability – all health facilities, goods and services must be respectful of medical ethics and culturally appropriate.

(iv) Quality – health services must be scientifically and medically appropriate and of quality.

An initial question one would be prompted to ask is whether the Sri Lankan constitutional cum statutory regime adequately responds to the said four elements and secondly, whether there is an adequate institutional cum administrative framework in place necessary to implement that statutory commitment.[1]

Bearing in mind that the Constitution of Sri Lanka does not expressly recognise the right to health as a fundamental right or otherwise[2] and having regard also to the fact that there is no authoritative judicial pronouncement either on such a right, whether expressly or impliedly, the primary object of this paper is to examine the options that could be pursued to promote recognition of a right to health.[3]

Towards that objective, the existing statutory regime as well as relevant judicial precedents will be examined and commented upon, drawing inspiration from international standard setting norms and from initiatives taken by other jurisdictions. This chapter will also address certain consequential issues that arise from the concept of a right to health.

♦ President's Counsel; PhD; M. A. (Int. Rel.); LL.M; M.A. (Budd. Studies); LL.B. Consultant, Law & Society Trust. This article is excerpted from a chapter in *Sri Lanka; State of Human Rights, Law & Society Trust*, 2005

[1] this latter question is not discussed here, falling as it is, outside the scope of this paper

[2] As opposed to a statutory right.

[3] In the sense of 'justiciability' of such a right.

The Right to Health and Constitutional Provisions

Neither in the chapter on fundamental rights in the Constitution nor in the chapter on Directive Principles of State Policy, is there any reference to the right to health. This stands in contrast to some other socio-economic rights such as housing, which finds expression at least in the Directive Principles of State Policy.[4]

A strained argument perhaps may be advanced in the context of Article 27(2)(c) that the said directive principles acknowledge the State's commitment to environmental health, which may be regarded as an aspect of the broad concept of the right to health on account of the phrase 'the continuous improvement of living conditions' employed in the said Article. Article 27(2)(14) may be used to buttress such an argument. That Article decrees that "The State shall protect, preserve and improve the environment for the benefit of the community."[5]

The Right to Health and International Norms

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises in explicit terms the right to health. Apart from the ICESCR, there are a host of international covenants recognising the right to health. Article 5(e)(iv) of the Convention on the Elimination of Racial Discrimination, Article XI of the American Declaration on the Rights and Duties of Man and Article 25 of the Universal Declaration of Human Rights serve as examples.[6] Although Sri Lanka has ratified the ICESCR, it has not been incorporated into domestic law either in any statute or in any provision in the Constitution as noted earlier. Against that background, first, the statutory regime and then authoritative judicial decisions impacting on the right to health and medical care in Sri Lanka will be examined.

Sri Lanka's Statutory Regime relating to Health

The Penal Code

Under the Penal Code,[7] the unlawful or negligent[8] or malicious spreading[9] of any infectious disease dangerous to life is made punishable with imprisonment or fine. These provisions not only reveal a statutory right to life but also establish a clear link between the right to life and the right to health. Thus, sometimes when it is argued that the Constitution does not expressly recognise the right to life, what is meant is that the Constitution does not expressly recognise the right to life as a right in the fundamental rights Chapter for the violation of which an application under Article 126(1) read with Article 17 of the Constitution might or might not be brought.

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[4] Article 27(2)(c) of the Constitution.
[5] Other provisions carrying an implied impact are discussed later in this paper.
[6] See also the Preamble to the Constitution of the World Health Organisation (W.H.O.)
[7] Vol. II, Chapter 25, Legislative Enactments of Sri Lanka (LESL) 1980 (Revised)
[8] Section 262, *Ibid.*
[9] Section 263, *Ibid.*

It is that right that was in effect recognised by the Supreme Court decisions of *Silva v. Iddamalgoda* [10] and *Wewalge Rani Fernando v O.I.C. Seeduwa Police Station*[11] in construing Articles 11 and 13(4) of the Constitution as implying the right to life itself.

When one takes into consideration the opening words of Article 13(4) that,

> *"no person shall be punished with death or imprisonment except by order of a competent Court made in accordance with procedure established by law..., "*

and compare the same with the wording in Sections 262 and 263 of the Penal Code that,

> *"whoever unlawfully or negligently (or maliciously) does any act, which is likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment ... or fine,"*

it becomes clear that just as much as Articles 11 and 13(4) could be construed (as the Supreme Court did)[12] as implying the right to life in the Constitution enabling a victim's heirs to file an application for violation of Article 11, Sections 262 and 263 of the Penal Code lend themselves to the proposition that there is clear statutory recognition of the right to life.[13]

On account of the demonstrable nexus between that right and the acts contemplated in the said Sections of the Penal Code relating to health, it is submitted that there is little room for doubt that the right to health is statutorily recognised in the law of Sri Lanka. That proposition is buttressed by the provisions of Sections 264 to 271 of the said Code, which make several acts hazardous to the health of persons punishable offences.

The question that remains to be addressed is, (like in the case of the right to life), whether an argument could be addressed that the right to health could also be regarded as being impliedly recognised in the Constitution, thus making the same amenable to the fundamental rights jurisdiction of the Supreme Court? Then, if not, what measures ought to be pursued to achieve that objective and further, what purpose it would serve in the context of the Constitution and law of Sri Lanka in a rights related sense? With that objective in mind, other pieces of legislation and subsidiary legislation may now be examined.

Classification of Legislation Impacting on Health Concerns

Besides the provisions contained in the Penal Code, legislation impacting on health concerns may be conveniently classified into four broad categories, namely:

(1) Legislation pertaining to the regulation of different systems of medicine
(2) Legislation directed at the organisation and administration of health care
(3) Legislation relating to the control and treatment of diseases, and
(4) Legislation dealing with inter-sectoral cooperation.

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[10](2003) 2 SLR 63 per Justice (Dr.) Mark Fernando. (See also the judgment of Justice (Dr.) Shirani Bandaranayake on a preliminary ruling – (2003) 1 SLR 14)
[11] SC/FR/700/2000, SC Minutes of 26.7.2004.
[12] *Ibid.*
[13] Sections 293 to 298 of the Penal Code throw further light on this proposition.

Legislation pertaining to the Regulation of Different Systems of Medicine

The Homeopathy Act, No. 7 of 1970,[14] the Medical Ordinance No. 26 of 1927 (as amended)[15] and the Ayurveda Act, No. 31 of 1961 (as amended)[16] fall into this category.*

Through provisions regarding development and encouragement of measures for the investigation of diseases and for the improvement of public health, the Homeopathy Act has shown a legislative commitment to the right to health. Section 23(h) in particular, which provides that the Council (established under the Statute) is empowered to suspend or withdraw recognition to any recognised homeopathic institution which is not conducted in accordance with such conditions as are required under the Act, is of special significance.[17] The same legislative commitment is depicted in the provisions of the Medical Ordinance dealing with the erasure of names from the relevant registers of medical practitioners,[18] dentists,[19] midwives,[20] pharmacists[21] and nurses.[22] The Ayurveda Act is to a like effect.[23]

Legislation Directed at the Organisation and Administration of Health Care

The Health Services Act, No. 12 of 1952 (as amended),[24] the Nursing Homes (Regulation) Act No. 16 of 1949 (as amended),[25] the Medical Wants Ordinance (as amended),[26] the Food Act,[27] the Cosmetics, Devices and Drugs Act, No. 27 of 1980[28] and the Poisons, Opium and Dangerous Drugs Ordinance No. 17 of 1929 (as amended)[29] may be accommodated under this heading.

While positive health care is the underlying theme behind the first three statutes referred to above, the latter three are specifically directed at preventing injury to health of a user of any item of food[30] or device[31] or dangerous drug[32] resulting in penal consequences to any person who may cause such injury to health.[33]

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[14] Vol. VI, Chapter 117, (LESL) 1980 (Revised).
[15] Vol. VI, Chapter 113, (LESL) 1980 (Revised).
[16] Vol. VI, Chapter 116, (LESL) 1980 (Revised).
* The valuable research material made available in the preparation of this paper in this regard by Ms. Chithralega Thavachelvan, LLB. (Col.) and Attorney-at-Law, Project Coordinator – Right to Health (Law & Society Trust, Colombo) is hereby acknowledged.
[17] This aspect will be commented on later.
[18] Section 33(c).
[19] Section 45(c).
[20] Section 52(c).
[21] Section 57(c).
[22] Section 64(c).
[23] Section 57(c).
[24] Vol. XVII, Chapter 550, (LESL) 1980 (Revised).
[25] Vol. XVII, Chapter 551, (LESL) 1980 (Revised).
[26] Vol. XVII, Chapter 558, (LESL) 1980 (Revised).
[27] Vol. XVII, Chapter 544, (LESL) 1980 (Revised).
[28] Vol. XVII, Chapter 545, (LESL) 1980 (Revised) as further amended by Act No. 38 of 1984.
[29] Vol. XVII, Chapter 549, (LESL) 1980 (Revised) as further amended by Act No. 13 of 1984.
[30] Section 2(1)(a) of the Food Act.
[31] Section 5 of the Cosmetics, Devices and Drugs Act.
[32] The Poisons, Opium and Dangerous Drugs Act in general. See also Sections 265 to 269 of the Penal Code.
[33] For example, Section 26 of the Cosmetics Act and Section 18 of the Food Act.

Legislation Relating to the Control and Treatment of Diseases

Diseases (Labourers) Ordinance No. 10 of 1912 (as amended),[34] Venereal Diseases Ordinance No. 27 of 1938,[35] Lepers Ordinance No. 4 of 1901 (as amended),[36] Mental Diseases Ordinance No. 1 of 1873 (as amended),[37] Contagious Disease Ordinance No. 8 of 1866 (as amended)[38] and the Quarantine and Prevention of Diseases Ordinance No. 3 of 1897[39] together with Section 264 of the Penal Code fall into this category.

The ground common to these statutes is that they all address both preventive as well as curative aspects of medicines and thus leave no room for any doubt in so far as the legislative recognition of the right to health.

Legislation Dealing with Inter-Sectoral Cooperation

The Inter-Sectoral National Consultative Council Act of 1987, which was brought about as an amendment to the Health Services Act,[40] the National Health Development Fund Act No. 13 of 1981 (as amended by Act No. 17 of 1984) and the National Dangerous Drugs Control Board Act No. 11 of 1984 may be viewed as some of the more recent legislative measures taken under this head. As a broad proposition it may be stated that these statutes have been designed to improve the working and implementation of the laws classified under the three categories discussed earlier in this paper.

Subsidiary Legislation Impacting on the Right to Health

Several provisions of the Local Authorities Ordinance and the Nuisances Ordinance (as amended)[41] recognise both expressly and impliedly the right to health. Section 100 of the Municipal Councils Ordinance[42] imposes a duty on Municipal Councils to cleanse and empty drains that may be injurious to public health. Similar duties are imposed in regard to unsanitary buildings,[43] conservancy and scavenging,[44] and nuisances[45] on the said local authorities.[46]

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[34] Vol. XVII, Chapter 557, (LESL) 1980 (Revised).
[35] Vol. XVII, Chapter 556, (LESL) 1980 (Revised).
[36] Vol. XVII, Chapter 560, (LESL) 1980 (Revised).
[37] Vol. XVII, Chapter 559, (LESL) 1980 (Revised).
[38] Vol. XVII, Chapter 555, (LESL) 1980 (Revised).
[39] Vol. XVII, Chapter 553, (LESL) 1980 (Revised).
[40] *Supra*, no. 24.
[41] Vol. XVII, Chapter 562, sections 2(1), (4) and (11).
[42] Vol. XVIII, Chapter 576.
[43] Section 124 of the Municipal Councils Ordinance. Compare section 123 of the Urban Councils Ordinance (Vol. XVIII, Chapter 577) and section 98 of the Pradeshiya Sabhas Act No. 15 of 1987.
[44] Section 129 of the Municipal Councils Ordinance. Compare Section 118 of the Urban Councils Ordinance and Section 93 of the Pradeshiya Sabhas Act.
[45] Section 132 of the Municipal Councils Ordinance. To a like effect is Section 126 of the Urban Councils Ordinance and Section 100 of the Pradeshiya Sabhas Act.
[46] See also Section 137 which imposes a statutory duty on medical practitioners and occupiers of buildings to report on infectious diseases and epidemics for the breach of which penal consequences are provided.

The Right to Health and its Statutory Recognition and Implementation

Criminal Prosecutions and Article 140 Applications

The foregoing analysis of several laws and subsidiary legislation establish firmly a statutory right to health in Sri Lanka. While the Penal Code provisions highlighted in this paper[47] reveal that penal consequences would entail if that right is violated in the circumstances laid down in those provisions, thus resulting in criminal prosecutions, an application under Article 140 of the Constitution of Sri Lanka[48] would be the remedial action or relief available to a person whose health has been placed in jeopardy on account of statutory functionaries failing to discharge their functions and/or duties relating to the regulation of different systems of medicine or the organisation and administration of health care or the control and treatment of diseases or aspects of inter -sectoral cooperation.[49]

Authoritative Judicial Precedents impacting on the Right to Health

At the outset, it must be noted that there is no authoritative express judicial pronouncement on the right to health in Sri Lanka. The observation was earlier made that there are penal consequences visiting any person who violates certain provisions of the Penal Code[50] and certain other statutes[51] relating to another's life and health. Reference was also made to the question as to what remedial action could be taken for the breach of functions imposed on certain functionaries relating to the regulation of different systems of health, the organisation and administration of health care, the control and treatment of diseases and inter-sectoral cooperation. Bearing these considerations in mind, it is proposed to examine certain judicial precedents, though not expressly pronouncing upon a right to health, that could be construed as impliedly acknowledging such a right.

The Supreme Court decision in *SmithKline Beecham Biological S.A. and Another v. State Pharmaceutical Corporation of Sri Lanka and Others*[52]

The rubella viral vaccine is used on pregnant women to immunise their babies, thus carrying the implication that the non-use of it could expose them and newborn babies to risk of health and life. Upon the State Pharmaceutical Corporation (SPC) (on behalf of the Director of Health Services) calling for tenders for the supply of the vaccine, only SmithKline, which was a past supplier and whose products were registered with the Cosmetics and Drugs Authority (CDA), tendered in terms of the government tender procedure and requirements. However, only 2.5 million doses were awarded to Smith Kline. BS, which was not even registered at the relevant time with the CDA, was awarded 2 million doses in breach of tender requirements, allowing it time to obtain registration. The Supreme Court found the SPC's conduct violative of Article 12 (1) of the Constitution in that it offended the principle of equal opportunity.

The following observations may be made as arising from the judgment of the Supreme Court.

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[47] *Supra* nn. 8 and 9

[48] For example, an application for an order in the nature of a writ of Mandamus.

[49] See also Article 154P(3)(b) of the Constitution read with Section 7 of the High Court of the Provinces (Special Provisions) Act, No. 16 of 1990.

[50] *Ibid.*

[51] For example, The Cosmetics Act and the Food Act, supra, n. 33.

[52] (1997) 3 SLR 220.

Acknowledgement of the right to life (and health)

It was noted earlier that the right to life as a constitutional right was recognised by the Supreme Court in the context of Articles 11 and 13 (4) of the Constitution.[53] The Supreme Court decision in the SmithKline case may also be regarded as a decision recognising the right to life in the context of Article 12 (1) of the Constitution. In that case, Justice Amarasinghe observed that, "When any authority is dealing with a product concerned with the lives of the people including the unborn citizens of Sri Lanka, as in the case of Rubella Vaccine, ... would the government compromise, may it gamble? Can it afford to do with less than the best available in terms of efficiency?"[54]

Implied response to imperative concomitants of the right to health

The four elements of the right to health as identified by the United Nations were noted earlier.[55] The availability criterion in regard to health care facilities and goods is seen satisfied in the initial steps taken by the SPC (on behalf of the Director of Health Services) to secure a vaccine under consideration. The judicial response to the criterion of quality is reflected in the words, "... would the government compromise, may it gamble? Can it afford to do with less than the best available in terms of efficiency?"

It is submitted that the SmithKline case is a judicial decision that has in effect or impliedly upheld both the right to life and the right to quality of healthcare.

Sanjeewa, Attorney-at-Law (on behalf of Gerald Mervin Perera) v. O. I. C. Wattala [56]

Consequent to being subjected to torture by the police, the petitioner was medically advised to seek immediate treatment at a leading hospital. He admitted himself to the intensive care unit of a private hospital and later claimed reimbursement for the medical expenses he had incurred. Counsel for the respondents argued that the charges at the private hospital in question were exorbitant and that the petitioner could have sought treatment at a State hospital.

Right to life and its links to a right to quality of health and/or healthcare

Rejecting the argument advanced on behalf of the respondents, the Supreme Court upheld the right to life and the right to medical care as an aspect of the right to health. Having made the observation that many Sri Lankans opt for treatment in private hospitals, however good the standard of treatment in State hospitals may be, because of fear of delays, overcrowding, strikes, shortages of equipment and drugs, Justice M. D. H. Fernando held thus:

> *"Citizens have the right to choose between State and private medical care in order to save (a) patient's life..."*[57]

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[53] *Supra*, nn. 10 and 11.
[54] At p. 237, *supra* n. 52.
[55] *Supra* n, 1
[56] (2003) 1 SLR 317.
[57] *ibid.*

It will be noted that the right to choose between state and private medical care was recognised in the context of a patient's life being in issue, thus upholding a right to quality of healthcare so far as it is linked to the right to life. The question whether a citizen (or a person) would be entitled to quality of health services when life itself is not in issue, however, remains a question that needs to be addressed.

Acknowledgement of Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR)

In declaring the citizen's right to choose between state and private medical care when a patient's life is in issue, Justice Fernando called in aid Article 12 of the ICESCR, which recognises the right of everyone "to the enjoyment of the highest attainable standard of physical and mental health."[58]

Denial of medical treatment (services) of a patient's choice and the right to health

In *Udeni Renuka Gunawardena v. Dr. Guruge Wimalasiri and others*,[59] a government hospital, inter alia, had refused to perform a Caesarean operation, which refusal was against the petitioner's wishes as she desired such an operation. The petitioner had then admitted herself to a private hospital for the birth. Subsequently, the petitioner's application based on an alleged violation of her fundamental rights was dismissed by the Supreme Court. She alleged in her application that at a time she was in a serious condition, the saline tubes had been ripped off her and she had been chased from the labour room to the ward.

The Court found that these factual allegations raised in the context of Articles 11 and 12(1) of the Constitution had not been established. In the process, the Court does not appear to have addressed its mind to a patient's right to choose, particularly a pregnant mother's right to choose a certain kind of medical service (Caesarean delivery) in preference to another (normal delivery) particularly when the same was available at the state hospital in question.

The Committee on Economic, Social and Cultural Rights of the United Nations had identified accessibility as an essential element of the right to health, that is, health facilities, goods and services have to be accessible to everyone without discrimination.[60] In the context of Article 12(1) of the Constitution which postulates non-discrimination and non-arbitrariness, would it not have been arbitrary and discriminatory to deny the petitioner the right to choose between a Caesarean operation as opposed to a normal delivery, particularly in the light of *Gerald Perera's case?*[61] This is another aspect that remains to be addressed in the future in the context of the concept of the right to health.

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[58] *Ibid.*
[59] SC (FR) Special 69/99. S. C. Minutes of 26.01.2004.
[60] *Supra*, n. 1.
[61] *Supra*, n. 56.

The Right to Health – its Scope and Content as Judicially Recognised

The foregoing analysis of the available case law in Sri Lanka reveals that not only has the right to health been recognised statutorily but that it has been upheld in a Constitutional context as well. Availability and quality of health care facilities, goods and services serve as essential elements of the right to health,[62] right to quality of health services and its links to the right to life.[63]

The above, taken cumulatively lend support to the argument that the Supreme Court has impliedly recognised a Constitutional right to health within the framework of Articles 11 and 12(1) of the Constitution. Further, despite the decision of the Supreme Court in *Udeni Renuka Gunawardena v. Dr. Guruge Wimalasiri and others*[64] in which the Court was not called upon to consider the matter from the standpoint of the right to health, the argument that the denial of medical services of a patient's choice could amount to a denial of accessibility to the right to health may possibly be urged in another appropriate case.

Adequacy of the Scope and Content of the Right to Health in Sri Lanka

Although the statutory regime and Constitutional provisions as judicially interpreted surveyed above lend support to the proposition that the right to health is recognised in the law of Sri Lanka, it remains to address the adequacy of its scope and content. Towards that end, the legal and constitutional position of some foreign jurisdictions in regard to the right to health will be examined.

Argentina and the case of *Viceconte v. Ministry of Health and Social Welfare*[65]

The right to medicine

The Constitution of Argentina expressly incorporates, *inter alia*, the ICESCR and permits the direct application of international human rights norms.[66] Furthermore, a liberal approach to the concept of *locus standi* has been accepted within the framework of the Constitution enabling individuals and organisations, in the public interest, to institute proceedings concerning rights violations.[67]

The Pampas region of Argentina was struck by a haemorrhagic fever and the rate of deaths began to increase. The Argentinean Government, which had obtained a vaccine[68] in the past from an American private supplier that could counter the fever, was unable to do so on this occasion because the supplier had stopped production. Consequently, the vaccine was non-accessible. A

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[62] The *SmithKline decision*, n. 52 *supra*.
[63] *Gerald Mervin Perera*, n. 56, *supra*.
[64] *Supra* n. 59
[65] See, for a comprehensive account of the facts of the case, *Litigating Economic, Social and Cultural Rights*, COHRE, Geneva, 2003, pp 60 – 65.
[66] See, Constitution of Argentina, 1853, Article 43 (as amended in 1994).
[67] Called an Amparo action (class action).
[68] Described as the Candid I vaccine.

law student from the affected region instituted an amparo action[69] asking the State to construct its own laboratory to produce the vaccine in order to make it accessible.

Following a response on the part of the Ministers of Health and Economy, who initiated a budget proposal in Parliament, the original Court ruled the question moot and then ruled that it had no jurisdiction to look into the matter, the petitioner's claim for ecological reconstruction (to prevent the disease)[70] also failed for evidentiary complexity.[71] The Federal Court of Appeal, however, upheld the petitioner's claim holding that the government was legally obliged to intervene to provide health care when the same was not forthcoming from individuals and the private sector.

The following features discernible from the judgment and consequential matters arising therefrom may be noted at this point as bearing relevance to the Sri Lankan situation.

Significance of incorporating the terms of the ICESCR relating to the right to health in the Constitution and the concepts of justiciability and locus standi

As noted earlier, the Argentinean Constitution incorporates international treaties relating to the right to health. The Court inferred principally (from the fact of such incorporation) the right of any individual (and not only a person directly affected) to institute proceedings concerning the right to health.[72]

Reflections on the Sri Lankan situation – is there a need to elevate the right to health to Constitutional status?

Article 15(7) recognises "protection of public health" as a provision qualifying the fundamental rights recognised in Articles 12,13 and 14 of the Constitution. Thus, to that extent it could be contended that the said Article recognises impliedly a right to health. Articles 27(2)(g), 27(13) and (14) may be regarded as buttressing that right. Yet, Article 29 reflects precisely the converse of the Constitutional provision in Argentina. However, as demonstrated in an earlier part of this paper, a clear statutory right to health in Sri Lanka is discernible.

Two competing arguments are possible in the wake of this statutory cum constitutional scenario. One argument would be to the effect that whatever statutory right and implied right in Articles 27(2)(g), (13) and (14) of the Constitution there may be, the same is taken away on account of Article 29. The counter-argument to that may be grounded on a three-fold basis. First, that a right to health is not (at any rate expressly) recognised in the Constitution (the reference to "protection of public health" being in the context of and restricted to the applicant claiming rights based on Articles 12,13 and 14) and thus the statutory right that is discernible is not caught up in terms of Article 29 of the Constitution and therefore remains justiciable.

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[69] *Supra*, n. 67.
[70] That is, to rehabilitate those environments where the disease was spreading.
[71] *Supra* n. 65 at p. 61.
[72] Besides the ICESCR, Article XI of the American Declaration on the Rights and Duties of Man and Article 25 of the UDHR.

Secondly, that in any event, Article 29 could not have been intended to set at nought the gamut of statutory provisions that incorporate a statutory right to health which include Sections 262 and 263 of the Penal Code as well,[73] which is further buttressed by the fact that Article 16(1) of the Constitution provides for the continuance of "all existing written law and unwritten law notwithstanding any inconsistency with the preceding provisions of the Constitution" and not the subsequent provisions which would include Article 29.

Thirdly, even if the contrary arguments are possible, given the fact that the issue is one regarding justiciability and therefore consequentially involving the jurisdiction of Courts, a presumption must necessarily be drawn in favour of a jurisdiction which enhances the protection of the rule of law and against an interpretation that undermines it by seeking to take away existing rights.[74]

Thus, upon reflection on the Sri Lankan situation, it is submitted that, even without the need to elevate the right to health to constitutional status, the said right very much exists within the statutory framework of the country. This right, upon an objective and purposive construction of the relevant constitutional provisions referred to above, remains justiciable. This proposition stands further vindicated on the basis of the few available judicial precedents in Sri Lanka which were referred to earlier.[75] Nevertheless, the scope and content of such a right remains to be addressed if it is not accorded constitutional status. For example, could the *Viceconte case* have been decided similarly within the statutory cum constitutional framework of Sri Lanka?[76] This question leads to reflection of other issues arising from the judgement handed down by the Argentinean Federal Court of Appeal.

Personal Obligation of relevant Ministers to implement the Right to Health

Another striking feature in the Argentinean decision is where the Court compelled the government to provide a vaccine to prevent an endemic fever and imposed that obligation personally on the Ministers of Health and Economy within a specified time schedule. How that personal obligation was effected is the significant feature in the judgement. The Minister of Economy was the Minister who had control over the release of budgeted funds. By requiring the construction of a laboratory, the Minister was compelled to reallocate budgeted funds of which he had control and release funds for the said construction. While this became his personal obligation, the obligation on the part of the Minister of Health was to construct the laboratory for the purpose of manufacturing the required vaccine.

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[73] *Supra* nn. 8 and 9

[74] See, by analogy of reasoning Justice (Dr.) Mark Fernando in *Peter Atapattu v. People's Bank* (1997) 1 SLR 208 at p. 222.

[75] *Supra* nn. 51 to 60.

[76] Contra for instance the limited scope within which the Supreme Court of Sri Lanka had to grapple with in the *SmithKline case*, *supra* n. 52

Reflections on the Sri Lankan situation – conversion of undisputed political decisions to legal obligations

It is a generally accepted proposition that courts will not interfere with resource allocation and technical policy decisions.[77] The Argentinean Court was, however, able to overcome this problem on account of the government being forced to admit the need for the vaccine in question to arrest the ongoing epidemic. This was the result of intense lobbying and campaigning. Thus, a political decision having been reached, which acknowledged the need for the vaccine in question, a public policy debate was avoided in court. The Court would anyway not have been inclined in any event to entertain such debate, since issues of jurisdiction would have arisen.[78] On the contrary, what the Court was invited to do in the case was merely transforming or converting an undisputed political decision to a legal obligation.

The decision carries an object lesson for Sri Lanka and focuses attention on the role that civil society as well as stakeholders and the media are required to play in carrying out effective campaigning and lobbying to secure undisputed political decisions on socio-economic and cultural rights, including the right to health, in a bid to prepare the groundwork to have such decisions converted to legal obligations through the interventions of Courts.[79] The practical value to society of such social action is amply demonstrated by the fact that the upshot of the Court's decision in Argentina was the development of a Social Plan to deliver basic medicines.

India and the Right to Health

The case of *Paschim Bangakhet Mazdoor Samity v State of West Bengal*[80] was a case in which a patient died in consequence of denial of emergency medical treatment at a public hospital, which had no facilities including space (a bed) to accommodate the patient. Upholding that the right to life expressly implied in Article 21 of the Constitution had been violated, the Supreme Court held that the obligation on the part of the State to preserve human life and to improve health facilities towards that end exists irrespective of financial constraints.

In *Consumer Education and Research Centre v Union of India*[81], the Court, while reaffirming the connection between the right to life and the right to health, held that it is a fundamental right of a workman not only to be protected from health hazards in the workplace but also to have the State take affirmative action to promote health, strength and vigour of the workman during employment as well as after retirement.

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[77] Subject to the qualification that, where a change of existing policy is sought to be effected, individuals who might be adversely affected must be given an opportunity to be heard. See *Dayaratne v Minister of Health and Indigenous Medicine* (1999) 1 SLR 393. See also *ex parte Asif Mahmood Khan* (1984) 1 WLR 1337 and *ex parte Liverpool Taxi Fleet Association* (obiter) (1972) 2 QB 299. Compare also *Council of Civil Service Unions v. Minister for Civil Service* (1985) 1 AC 374.

[78] In such situations, indirect ways of asserting rights might have to be resorted to, for instance, through the right information and expression, thereby subjecting to public scrutiny governmental inactions or decisions.

[79] Such social initiatives are imperative to make the government publicly accountable in situations that do not under existing procedures compel such accountability through judicial intervention, for example, use of funds for tsunami victims.

[80] (1996) SOL Case No. 169 (S.C. India)

[81] 1995 SOL Case No. 266.

In *Mahendra Pratap Singh v State of Orissa,*[82] the right to health was extended to cover the state's obligation to provide at least primary health care centres in villages.[83]

Advances made in other selective jurisdictions – specific Constitutional incorporation of the Right to Health – South Africa and Venezuela

South Africa and Venezuela fall into the category of countries where their constitutions make express provisions recognising the right to health.[84] While Section 27 of the South African Constitution gives expression to the right in the form of a right of access to health care services including reproductive health care[85] and a right not to be refused emergency medical treatment,[86] the Constitution of Venezuela firmly establishes the right in unqualified terms[87] apart from the fact that the Supreme Court has acknowledged the Venezuelan law which permits the direct invocation of international conventions by a citizen,[88] thus opening up Article 12 of the ICESCR in its application to the right to health.

In pursuance of these positive constitutional provisions, the South African Courts have upheld the obligation of the State to provide health care services, in effect, as including the obligation to increase such services to HIV/AIDS patients by compelling nationwide distribution of the drug Nevirapine (NVP) to be given to mothers during childbirth which had been found to prevent mother to child transmission of the disease.[89]

Likewise, the Venezuelan Supreme Court,[90] rejecting the Government's financial constraints or budgetary inhibitions argument, has held that the right to health had been violated by the state on account of its failure to provide the antiretroviral (ARV) therapies medically proven to prolong the lives of HIV/AIDS patients, to which category the petitioners belonged.[91]

In contrast, having regard to Article 27(2) of its Constitution which states that, "the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights..."[92], the South African Constitutional Court, being influenced by the budgetary constraints the government was subjected to, adopted a restrictive view of the right to health in that the decision of a state hospital which had denied admission to a man who was suffering from chronic renal failure, and whose life could only be prolonged by an ongoing dialysis treatment, was upheld on the reasoning that although the right not be refused emergency medical treatment under section 27(3) of the Constitution would include the State's

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[82] 1997 (Orissa) 37.
[83] These Indian authorities were extracted from an article in *Moot Point* (Volume 7), 2003-04, Centre for Policy Alternatives, pp 112-128, Megan Bremer.
[84] The Argentinean Constitution was referred to earlier.
[85] Section 27(1).
[86] Section 27(3), although section 39 binds the Constitutional Court to take into consideration international law including the ICESCR.
[87] Article 76.
[88] *The Cruz Bermudez case* (July, 1999) discussed at pp. 121-125, n. 82 supra
[89] *Minister of Health and others v. Treatment Action Campaign and others*, CCT 8/02. See further, pp. 121-125, n. 82, *supra.*
[90] Op. cit., *the Cruz Bermudez case.*
[91] See for a fuller discussion, n. 88 supra.
[92] That is, health care, food, water and social security.

obligation not to deny a person remedial treatment that is necessary and available to forestall harm in the case of a sudden catastrophe or emergency, it did not extend to providing on-going treatment of chronic illness for prolonging life.[93] The Court held that, "... to hold otherwise would make it substantially more difficult for the State to fulfil its primary obligations... to provide health care services to everyone within its available resources."[94]

Against the background of the positive developments in other jurisdictions relating to the right to health as recounted above, it is proposed to assess the existing scenario in Sri Lanka with a view to suggesting not only improvements to the existing legal cum constitutional framework but also reflecting upon fresh initiatives that need to be taken by civil society in general and other stakeholders towards making real the right to health.

The need for a more viable framework and fresh initiatives to make real the right to health in Sri Lanka – lack of initiative to have such right enforced or implemented

Statutory Right to Health as distinguished from a Constitutional right

Ever since the formation of the League of Nations and the United Nations followed by the UDHR, the need for recognition and advancement of human rights has been acknowledged and conceded by all developed legal systems, culminating in the ICCPR and ICESCR besides other international conventions. Some countries have incorporated the provisions of these conventions into their constitutions and domestic laws, which has paved the way for a progressive body of human rights jurisprudence to evolve in its wake.[95]

In so far as the right to health is concerned, finding as it does its setting in the context of the ICESCR, it is only by an extended if not strained argument that certain constitutional provisions could be construed as being even tokenly suggestive of a recognition of a Constitutional right to health in Sri Lanka.[96] Nevertheless, a statutory right to health could easily be discerned from the numerous statutes that impact on health and health concerns.[97] The possibility of launching criminal prosecutions and filing applications under Article 140 of the Constitution for violations or breaches of that right was noted.[98] What is lacking presently is initiative to have the said right enforced or implemented.

The need for public awareness campaigns and good governance programmes and test actions regarding the statutory right to health – Role for Non-Governmental Organisations (NGOs) – a prescribed formula

Consequently, there is an imperative need not only to educate the public but also to make relevant statutory functionaries aware of the statutory existence of the right to health. A meaningful and necessary role of NGOs is identifiable in this context where both these demands could be

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[93] *Subramooney v. Minister of Health, KwaZulu-Natal*, (1998) 1 SA 765 (CC).
[94] *Ibid.*
[95] South Africa, Venezuela and Argentina serving as examples, *ibid.*
[96] *Supra* nn. 73 and 74 read with n. 5, op. cit.
[97] *Supra* nn. 14-46
[98] *Supra* nn. 47-49.

addressed respectively through public awareness campaigns with the assistance of the media and good governance programmes in the first instance and through test actions where relevant statutory functionaries fail in the discharge of their duties.

The limits and scope for Supreme Court initiatives in the context of the Fundamental Rights Chapter - Need for express constitutional provisions regarding the right to health

The few decisions of the Supreme Court surveyed in this paper show the limits and scope for Supreme Court initiatives in the context of the Constitution of Sri Lanka. Availability and quality of health care facilities, goods and services being recognised as essential elements of the right to health,[99] the establishment of links between the right to life and the right to quality of health,[100] the implied recognition of the principle that denial of medical services of a patient's choice could amount to a denial of accessibility to the right to health,[101] may lend strong support for the argument that the Supreme Court has elevated the right to health to a constitutional level within the framework of Article 12(1) and/or Article 11 of the Constitution.

Yet, could it be seriously contended that the Sri Lankan Supreme Court would be in a position to respond similarly to the issues that come up for consideration in countries such as India,[102] Argentina,[103] Venezuela[104] and South Africa[105]?

More than any other factor, the budgetary constraints argument linked to the unreviewable policy factor coupled with the absence of an express provision relating to the right to health would stand in the way of such a contention, although the Supreme Court over the years has shown an inclination to recognise, adopt and apply international conventions as being part of the law in the country. This judicial approach has varied from interpreting statutory provisions[106] and constitutional provisions[107] in the light of international norms to the direct application of international norms.[108]

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[99] (1997) 3 SLR 220, (vide) n. 52, *supra.*
[100] (2003) 1 SLR 317 (vide) n. 56, *supra.*
[101] *Supra* n. 59
[102] *Supra* nn. 80-82.
[103] *Supra* n. 65.
[104] *Supra* n. 88
[105] *Supra* n. 93
[106] *Sepala Ekanayake v. AG* (1988) 1 SLR 46 where Articles 2 and 4(2) of the Hague Convention were referred to in interpreting the Aircraft Act No. 24 of 1982 (per Seneviratne, J.)
[107] *Weerawansa v. AG* (2000) 1 SLR 387 where Article 27(15) of the Constitution was read in conjunction with Article 9 of the ICCPR (per Justice M. D. H. Fernando), *CPA and Dr. Saravanamuttu (and Rohan Edrisinha) v. Dissanayake* SC Appeals 26 and 27/2002, C.A. Minutes of 23.06.2003 where Articles 3 and 4(e) were read in conjunction with Article 19 of the ICCPR (sic) (per Justice M. D. H. Fernando)
[108] *Silva v. Iddamalgoda* (2003) 2 SLR 63 (Article 14.1 of the CAT Convention was applied in recognising a deceased torture victim's widow and minor child to sue and seek compensation) (per Justice M. D. H. Fernando); *Sanjeewa v. O.I.C. Wattala* (2003) 1 SLR 317 where Article 12 of the ICESCR was applied. (Per Justice M. D. H. Fernando) and *Bulankulama v. Secretary, Ministry of Industrial Development* (2000) 3 SLR 243.

Conclusion: The Need for Constitutional Amendment and Sensitising the Judiciary

In conclusion, therefore, it is submitted that rather than the 'bottom-up' scenario that prevails at present, a 'top-down' framework would be preferable in regard to the recognition of the right to health.

For this, objective express constitutional provisions must be incorporated in the Constitution,[109] perhaps with additional entrenched provisions providing that the health budget cannot be cut with further provision to increase the health share of the budget should such demands arise. Only then would there be a framework to make real the right to health with all its concomitant connotations.

The other avenues in relation to the right that exist at present are only lesser options. One of the points made in this paper has been that with regard to those lesser options, no initiatives have been taken either by civil society or the media in general or by even public interest groups or public spirited citizens in particular situations where such interventions might have been called for. Indeed unless such a social ethos soon emerges in the terms articulated above, Sri Lanka will surely earn the dubious reputation of a country that does not recognise and implement a constitutional right to health.

[109] See the Draft Constitution of 2000- clause 25(1).

GLOBAL MIGRATION AND THE RIGHTS OF MIGRANT WORKERS: IMPLICATIONS FOR LEGAL AND POLICY RESPONSES IN THE PACIFIC

Dejo Oluwu[*]

Great importance must be given to the promotion and protection of the human rights of persons belonging to groups which have been rendered vulnerable, including migrant workers, the elimination of all forms of discrimination against them...The World Conference on Human Rights urges all States to guarantee the protection of the human rights of all migrant workers and their families. The World Conference...considers that the creation of conditions to foster greater harmony and tolerance between migrant workers and the rest of the society of the State in which they reside is of particular importance....[1]

Introduction

Undoubtedly, one of the most pronounced indices of new age globalisation has been the movement of people, principally skilled and unskilled workers, across national borders. While cross-border migration of workers is not a recent experience in the modern world, it has become a particularly pronounced phenomenon since the increased pace of globalisation began in the 1990s.[2] A largely economic phenomenon, globalisation has emerged as the pivot on which the wheels of migration rotate. Despite its complexities and ambiguities, the globalisation process is crystallising a global market and nurturing a global mass culture – both driven by advances in communications technology, mobility, and more integrated trade. States are yielding to fluid regional constellations and geographical demarcations are giving way to one 'global' space. While avid protagonists of globalisation would readily assert its tremendous contribution to human advancements, it is safe to posit that globalisation has wrought mixed fortunes on and across many people in diverse nations.[3]

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[1] World Conference on Human Rights, 14-25 June 1993, *Vienna Declaration and Programme of Action*, UNGA Resolution 48/121, A/CONF.157/23, Part II, paragraphs 24, 33 and 34. See also Prasad Kariyawasam, *No Excuses for Lack of Realisation of the Rights of Migrant Worker*, UN Press Release, International Migrants Day, 17 December 2004 <http://www.december18.net/web/docpapers/doc2166.doc> (accessed 04 January 2006), for a related inspirational speech.

[2] There have been scholarly indications that globalisation is, after all, not a new phenomenon. See Tomas Larsson, *The Race to the Top: The Real Story of Globalisation* (2001) 9; Matthew J. Rippon, History of Globalisation <http://www.aworldconnected.org/article.php/611.html> (accessed 04 January 2006). See also The World Bank, *Globalisation, Growth, and Poverty* (2002), 23-24, identifying the "new wave" of globalisation of the post-1980s as the third wave of globalisation.

[3] See United Nations Development Programme (UNDP), *Human Development Report 1999: Globalisation With a Human Face* (1999), 32-33, for an analysis of the "uneven human opportunities and uneven human impacts" of migration in the age of globalisation. The divergent views on the theories of globalisation are not of particular interest in this paper. However, for a broad analytical discussion of the unevenness of the "benefits and costs of globalisation", see Paul Streeten, Globalisation: Threat or Salvation? in A. S. Bhalla (ed.), *Globalisation, Growth, and Marginalisation* (1998), 13-46. See also Charles O. Lerche III, *The Conflicts of Globalisation*, <http://www.gmu.edu/academic/ijps/vol3_1/learch.htm>, (accessed 04 January 2006).

There have been winners and losers in the rapidly changing global economic reforms and developments over the last decade. Migrant workers across the globe, their families, and invariably, their rights as human beings have not been left out of the dynamic consequences.

More than ever before, the international community has been at the vanguard in addressing the vicissitudes of life that confront men and women who, either by volition or compulsion, find themselves working for a living in nations other than theirs. As would be seen in the course of this paper, an elaborate body of international human rights standards have been developed to promote and protect the rights of migrant workers anywhere they may be in world.

While there has been a suggestion that the incidence of labour migration from or among the smaller island states of the Pacific region is a recent experience,[4] inter-country migration of workers within, and wider international migration of workers beyond the smaller Pacific states has been quite remarkable since the 1990s.[5] With the phenomenon of workers' migration across the globe not presenting a foreseeable end in the nearest future,[6] and the subject being a less explored aspect of globalisation,[7] it is timely to engage the Pacific dimension of the subject within its broader global context.

The object of this paper is thus to examine the international human rights frameworks for the protection of the rights of migrant workers and to accentuate the implications of such global standards and mechanisms for legal and policy initiatives in the smaller states of the Pacific in particular, and the Pacific region as a whole. An effort is made to highlight some of the key issues that would confront policy makers in the migrant origin, destination, and transit countries of the Pacific region, in the longer and shorter terms. Extrapolating from the emergent paradigm of rights-based approach to other problematic issues connected with development in recent times, this paper advocates the application of this approach in addressing the question of migrant workers. The discussions in the paper draw the trajectories for concerted national initiatives and regional responses, proffering viable modalities and strategies in that regard.

Globalisation and the Dynamics of Migration

Even though there are sufficient empirical and historical reasons to suggest that human migration is a phenomenon as old as humanity itself,[8] the push-and-pull factors responsible for the phenomenon have astoundingly increased since the late 20th century. Ranging from drought, famine, disasters, repression, and poverty, the factors compelling skilled and unskilled workers to migrate to foreign lands have been compounded by the demand for alternative and cheaper labour sources across developed and developing regions such that there is hardly any country of the world today that is not

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[4] Reg T. Appleyard & Charles W Stahl, *South Pacific Migration: New Zealand Experience and Implications for Australia*, (1995) 47-48.

[5] Avelina Rokoduru, Fiji's Women Migrant Workers and Human Rights: The Case of Nurses and Teachers in the Republic of Marshall Islands, (2004) 27(2) *Journal of Pacific Studies*, 205-227.

[6] See The World Bank, above n 2, at 76-81, for an indication that global migration of labour is a phenomenon that has come to stay.

[7] The World Bank, above n 2, at 82.

[8] See, T. J. Hatton & J. G. Williamson, *What Fundamentals Drive World Migration?*, National Bureau of Economic Research Working Paper 9159, Cambridge, Massachusetts, USA, 1-3; and United Nations, Office of the High Commissioner for Human Rights, Fact Sheet No. 24, *The Rights of Migrant Workers*, <http://www.unhchr.ch/html/menu6/2/fs24.htm> (accessed 04 January 2006) (hereinafter referred to as Fact Sheet No. 24).

either a country of origin, or of transit, or of destination in the labour migration chain.[9] While the enumerated factors may not be exhaustive, there is no gainsaying the fact that the most patent motive for migration is the quest for economic gains.[10]

Just as the free flow of capital and goods are readily cited as hallmarks of globalisation,[11] so has there been a seeming consensus among population and development watchers that globalisation has prompted unprecedented movement and circulation of human beings around the globe.[12]

In 1998, the International Labour Organisation (ILO) had estimated that there were some 42 million migrant workers worldwide,[13] and by 2000, the United Nations Development Programme (UNDP) had projected that there were some 175 million migrant workers all over the world, representing 3% of the entire world population.[14] One must however be quick to mention that while statistical data in the sphere of human migration are prone to unascertainability because a vast number of migrant workers are undocumented,[15] the available empirical trends nonetheless confirm the magnitude of human flows in the globalisation age.

Notwithstanding the small sizes of territories and populations of most small island states of the Pacific,[16] the impact of globalisation on workers' migration has been quite remarkable. In their seminal work produced in 1995, Connell and Brown had established four dynamic elements in the labour migration patterns in the Pacific – emigration out of the smaller and remote islands; emigration from mountainous areas to more accessible locations; rural-urban migration; and the boost in international labour migration.[17] Between the late 1980s and the early 1990s, the influx of skilled and unskilled workers from Pacific island countries had been a subject of concern in Australia and New Zealand.[18] Indeed, an empirical survey by Appleyard and Stahl had established that while labour migration in the Polynesian states of the Pacific is international, the incidence involves internal

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[9] See International Labour Office, *Towards a Fair Deal for Migrant Workers in the Global Economy*, International Labour Conference Report VI, 92nd Session, 2004, 3, 8-9 (hereinafter referred to as *Towards a Fair Deal for Migrant Workers*); Fact Sheet No. 24, above n 8.

[10] The World Bank, above n 2, at 43-44; Fact Sheet No. 24, above n 8.

[11] UNDP, *Human Development Report 1999*, n 3 1; Joe Oloka-Onyango & Deepika Udagama, The Realisation of Economic, Social and Cultural Rights: Globalisation and Its Impact on the Full Enjoyment of Human Rights, UN Doc. E/CN.4/Sub.2/2000/13 (15 June 2000), paragraphs 6-10; Adam Higazi, Integrating Migration and Development Policies: Challenges for ACP-EU Cooperation, ECDPM Discussion Paper 62 (2005), 4.

[12] See, The World Bank, above n 2, at 42-46; Stephen Castles & Mark J. Miller, *The Age of Migration: International Population Movements in the Modern World* (3rd ed., 2003), 1.

[13] International Confederation of Free Trade Unions (ICFTU), *Migration and Globalisation: The New Slaves* (1998), 1, quoting the ILO.

[14] UNDP, *International Migration Report 2002* (2002), 2.

[15] See, *Towards a Fair Deal for Migrant Workers*, n 9, at 7. See also *International Migration Report 2002*, n 14 above, at 9, acknowledging the problem of data collection and availability.

[16] At the middle of 2005, the entire population of all the nations located within the Pacific, namely, Australia; Federated States of Micronesia; French Polynesia; Guam; Kiribati; Marshall Islands; Nauru; New Caledonia; New Zealand; Palau; Papua New Guinea; Samoa; Solomon Islands; Tonga; Tonga; Tuvalu; and Vanuatu was estimated at 33 million. When Australia and New Zealand are subtracted from this figure, it leaves 8.5 million for all the smaller Pacific countries. See Population Reference Bureau, *World Population Data Sheet 2005* (2005), 13.

[17] John Connell & Richard P. C. Brown, Migration and Remittances in the South Pacific: Towards New Perspectives, (1995) 4(1) *Asia Pacific Migration Journal* 1-33.

[18] Richard D. Bedford & W Larner, Pacific Islanders in New Zealand in the 1980s, in Paul Spoonley and Andrew D. Trlin (eds..) *New Zealand and International Migration: A Digest and Bibliography No. 2*, (Department of Sociology, Massey University of Palmerston North, 1992), 65-81; Vasantha Krishnan, Penelope Schoeffel & Julie Warren, *The Challenge of Change: Pacific Island Communities in New Zealand 1986-1993*, (New Zealand Institute for Social Research and Development, Wellington, 1994), 100.

workers and their families.[30] Further, the treaty strongly canvasses the humane treatment of all categories of migrant workers and members of their families.[31]

The MWC also requires all its states parties to submit their periodic reports to a committee of experts on the steps they have taken to fulfil their obligations under it.[32] Furthermore, states parties are to submit their initial reports one year after acceding to the Convention and, afterwards, every five years.[33] To monitor the implementation of the treaty, the expert committee of the MWC would consider the periodic reports by states parties to the treaty which will in turn address its concerns and recommendations to a reporting State party.[34]

Apart from the states reports, a stronger mechanism for the implementation of the treaty lies in the power of the committee of experts to receive inter-state or individual complaints – "communications" – (where a state party agrees to that procedure) from another state party or any person who claims that the rights under the MWC have been infringed by a state party.[35] Since the committee has just begun its work, it might be too early assess its efficacy.[36]

While the world waits to see the fulfilment of the promise of this treaty, what has become apparent in the aftermath of its adoption has been a rising international consciousness towards the manifold challenges of global workers' migration since the 1990s. From the International Conference on Population and Development, in Cairo (1994); the World Summit for Social Development, in Copenhagen (1995), the Fourth World Conference on Women, in Beijing (1995), the Second United Nations Conference on Human Settlements, in Istanbul (1996), the World Conference Against Racism, Xenophobia and Related Intolerance, in Durban (2001), the World Commission on the Social Dimension of Globalisation (2004), the UN Global Commission on International Migration, in Stockholm (2004), and lately, the 92nd Session of the International Labour Conference, in Geneva (2004), there have been notable efforts at placing the rights of migrant workers squarely on the global agenda.[37]

Reinforcing the formal commitments of states in this regard is the growing interest of many international human rights groups which had traditionally been reluctant to embrace labour rights and

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[30] The treaties usually referred to as the 'six key international human rights treaties' are the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), 1965 (entered into force January 1969); the International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966 (entered into force January 1976); the International Covenant on Civil and Political Rights (ICCPR), 1966 (entered into force March 1976); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979, (entered into force September 1981); the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), 1984 (entered into force June 1987); and the Convention on the Rights of the Child (CRC), 1989 (entered into force September 1990).

[31] Parts III-VI (articles 8-71), MWC.

[32] Article 73, MWC.

[33] *Id.*

[34] Article 74, MWC.

[35] Articles 76 and 77, MWC.

[36] See articles 72 and 75, MWC, on the appointment, tenure, and composition of the Committee of Experts. The committee held its inaugural session in Geneva between 1-5 March 2005 where it elected its Chairperson and other officers. See Committee on Migrant Workers, Monitoring the Protection of the Rights of All Migrant Workers and Members of Their Families,
<http://www.ohchr.org/english/bodies/cmw/> (accessed 04 January 2006). For an extensive discussion on the promise of the MWC, see Sandesh Sivakumaran, The Rights of Migrant Workers One Year On: Transformation or Consolidation?, (2004) 36 Georgia Journal of International Law 113-153.

[37] Apart from all these enumerated platforms and initiatives, another significant international mechanism in this field was the appointment of a "Special Rapporteur on the Rights of Migrants" by the UN Commission on Human Rights in 1999. For the mandate, functions, tenure, reports, and other matters relating to the work of this thematic mechanism, see
http://www.ohchr.org/english/issues/migration/rapporteur/index.htm.

migration issues in the past,[38] as well as the input of new non-governmental organisations to the promotion of the rights, and the amelioration of the plight of migrant workers.[39] It is significant to note that all these global initiatives are built around the quest for more effective legal and policy collaboration among states.

This paper now shifts its spotlight to the implications of all the foregoing for legal and policy action in the Pacific region.

Challenges and Strategies for Pacific States; Towards a Rights Based Approach

In the *Pacific Human Development Report 1999* published by the United Nations Development Programme (UNDP), the UN agency had noted the significant effect of globalisation on the states of the Pacific region in many respects.[40] Apart from issues related to population, social impact and poverty,[41] the UNDP reported that limited job opportunities in the smaller states of the Pacific have made emigration inevitable.[42]

Compounding the human migration situation in the Pacific region has been the phenomenon of globalisation which, according to the UNDP, threatens employment growth because of the "small" and "vulnerable" nature of the economies of these states.[43] While there might still be disputation as regards how much verifiable impact labour migration has had upon the states of the Pacific in general, there can be no plausible denial of its connotation for the broader development goals of the states in the region.[44]

Although accurate statistics are usually problematic for developing states, the study by Appleyard and Stahl had shown that when balanced against national populations of many of the smaller Pacific states (populations 'at home'), the number of emigrant populations from those states to just three developed states – US, New Zealand, and Australia – has been quite substantial.[45] The study also established that migration in the Pacific region is "either long-term or permanent."[46]

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[38] Some of the remarkable efforts in internationalising and addressing the rights of migrant workers through the MWC are those of the Amnesty International and the Human Rights Watch. See, Human Rights Watch, Migrant Workers Need Protection – UN Treaty Comes into Force, 01 July 2003, <http://www.hrw.org/press/2003/06/mwc063003.htm> (accessed 04 January 2006); The Migrant Workers Convention: A Call for Ratification, HRW Letter to Governments not Party to the Migrant Workers Convention, 30 June 2003, <http://www.hrw.org/press/2003/06/mwc063003.htm> (accessed 04 January 2006); Amnesty International, The Migrant Workers Rights Convention, 01 July 2003, <http://web.amnesty.org/pages/refugees-010703-news-eng> (accessed 04 January 2006); Amnesty International Statement to the 88th Session of the General Council of the International Organisation for Migration, 30 November - 3 December 2004, AI Index: IOR 30/025/2004, 02 December 2004.

[39] Such organisations include December 18, <http://www.december18.net/web/general/start.php>; the International Catholic Migration Commission (ICMC) <http://www.icmc.net/docs/en>; the Global Campaign for Ratification of the Rights of Migrants <http://www.migrantsrights.org>; and Migrants Rights International <http://www.migrantwatch.org>.

[40] See UNDP, *Pacific Human Development Report 1999* (1999), 1.

[41] *Id.*, 2-6.

[42] *Id.*, 17-20.

[43] *Id.*, 73.

[44] See Higazi, note 11 above at 6. See also *Pacific Human Development Report 1999*, 79, noting that as a result of depletion of capital formation in the smaller Pacific states, there has been a growing necessity for the 'importation' of expatriate workers to perform skilled duties.

[45] Appleyard & Stahl, n 4 above, at 27, showing the highest figures of "away" populations to be 75.6% (Tokelau); 65.3% (American Samoa); 62.4% (Cook Islands); 35.4% (Western Samoa); 24.9% (Tonga).

[46] *Id.*, at 31.

In another extensive survey on the size and growth of migrants across world regions, the *International Migration Report 2002*, the first report of its kind, shows that from the figure of 4.7 million migrants in 1990, states of the Pacific had collectively received 5.8 million migrants in 2000, representing 22.8% increase.[47]

The bottom-line of all the foregoing analysis is to show that with the giant strides of globalisation, the migration of workers has become a phenomenon that cannot be ignored or wished away. The smaller states of the Pacific will certainly have a role to play in the short and long run.

This brings into focus, at this juncture, the question of formulating appropriate response by Pacific states to the challenges of human migration in general, and the rights of migrant workers in particular.

With the marked decline in the use of bilateral migration agreements and a noticeable increase in the use of own initiatives by individual states, cross-border labour migration management presents a cacophony of disjointed, if not rancorous, self-regulating legal and policy responses.[48] Apart from the depletion of skilled labour in developing states, the absence of coherent collaborative framework among states has created a lee-way for criminal syndicates and human traffickers.[49]

It has been shown that the attitude of states towards the issue of labour migration in providing appropriate legal and policy responses has mainly been the result of their perceptions about the plight of their citizens abroad: sending countries tend to be more committed to liberal policy initiatives while receiving countries tend to be more tuned to more restrictive policies.[50] However, for the Pacific region, broadly speaking, a new pattern of attitude is discernible – undulating between indifference, passivity and reluctance – towards addressing the question of migrant workers.

As a pointer to this assertion, while there has been a growth in regional migration initiatives across many sub-regions of the world since the 1990s,[51] the Pacific region is yet to fashion a collective policy on the subject. Apart from Australia and New Zealand that have designed comprehensive legal and policy frameworks on the issue of labour migration,[52] no other state in the Pacific has done so.

In terms of the ratification of the pertinent international labour and human rights treaties, the overall picture from the Pacific region is bleak.[53] Furthermore despite the ground-breaking promise of the MWC, no state in the Pacific region has ratified or even signed the treaty.[54]

With global labour migration intensifying, there is no exaggeration in suggesting that the best response by states should be in concerted efforts.

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[47] *International Migration Report 2002*, n 14 above, 3 (Table 1).
[48] *Towards A Fair Deal for Migrant Workers*, n 9 above, 15. See also Reginald T. Appleyard, International Migration Policies 1950-2000, 39(6) *International Migration* 7-18.
[49] See, Silvia Scarpa, Universalism and Regionalism: The Synergy to Fight against Trafficking in Human Beings, (Special Issue 2004) *Nottingham Human Rights Law Review* 4.
[50] *International Migration Report 2002*, n 14 above, 23.
[51] See, *Towards A Fair Deal for Migrant Workers*, n 9 above, 15.
[52] See, Moira Coombs, *Excisions from the Migration Zone – Policy and Practice*, Research Note No. 42, 01 March 2004, Department of Parliamentary Services; Immigration New Zealand, <http://www.immigration.govt.nz/> (accessed 04 January 2006); Australian Government, Department of Multicultural and Indigenous Affairs, *Immigration Fact Sheet Index* – 25 August 2005, <http://www.immi.gov.au/> (accessed 04 January 2006). For relevant analytical papers on the subject see *Immigration Research* <http://www.immi.gov.au/facts/16research.htm> (accessed 04 January 2006).
[53] As at Friday 04 January 2006, no state in the Pacific region was state party to ILO Convention No. 143, and New Zealand was the only state party to ILO Convention No. 97. See ILOLEX, n 26 above.
[54] See United Nations, Status of Ratifications, n 28 above.

All states in the Pacific region, big and small have all things to benefit by acceding to or ratifying all the international human rights treaties relevant to the issue of labour migration: for their own nationals as well as nationals of other states. Beyond simply putting in place strait-jacketed policies meant to safeguard domestic jobs at all costs,[55] states of the Pacific would have joined the global campaign for the humane treatment and well-being of all migrant workers and their families by formally enlisting on universal standards.

While this paper recognises that a human rights approach to the global challenges of labour migration would be inadequate in itself alone, the rights-based thrust of this paper is to outline the trajectory for democratic, people-oriented, inclusive and objective legal and policy planning on the subject in the Pacific region. The rights-based approach works in tandem with international labour migration initiatives and other development targets, focusing on the twin issues of poverty alleviation and human development.[56] With regard to labour migration, *all* human rights are to be perceived as components of holistic response to the pressures of globalisation as well as platforms for maximising its gains.

A rights-based approach to migration laws and policy has the capacity to strengthen the normative agenda for labour migration policies in an objective way and facilitates universally acceptable tools and operational guidance which are pivotal in justifying policy measures and informing their design, implementation and evaluation.[57] The other benefit in applying a rights-based approach to the question of migrant workers is that it subdues the impact of unscrupulous elements and labour syndicates who would rather indulge in exploitative cross-border labour practices. Invariably, when this becomes a mutual approach among the generality of states, a veritable synergy emerges for more effective monitoring of the implementation of migration laws and policies in general.

Since it is at the national and regional levels that the efficacy of global standards will be tested, this paper strongly advocates that the regional clamour for a coherent legal and policy approach in the Pacific must begin at the Pacific Islands Forum ("the Forum").[58] Since the Forum recognises and proclaims that "unity in securing shared interests contributes to the national, regional and global good",[59] it becomes imperative that the Forum translates rhetoric into reality. When the Forum articulates its commitment to the question of labour migration and the rights of migrant workers, it would have provided a springboard for civil society groups to follow-up through lobbying within the appropriate political and legislative arenas of its member-states.

While the Forum is yet to consider migration generally as an issue, the member-states of the Forum cannot continue to ignore this subject. In this age and time, no state can successfully play a game of

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[55] See IOM, World Migration Report 2005: Costs and Benefits of International Migration, (2005), asserting that there have been too many myths about migration, e.g., job losses, welfare entitlement costs, and exploding figures of migrants into richer states.

[56] See Julia Hausermann, A Human Rights Approach to Human Development, in UNDP (ed.) (1998) *Human Rights and Human Development: Report on the Oslo Symposium*; UNDP, *Human Rights & Development—An Emerging Nexus*, <http://www.undp.org/rbap/rights/Nexus.htm> (accessed 04 January 2006), analysing the theoretical importance of the "rights-based approach".

[57] For a general background reading on the "rights-based approach", see Simon Maxwell, Overseas Development Institute (ODI), *What Can We Do With a Rights-Based Approach to Development?*, (ODI Briefing Paper 3, Sept. 1999), 2.

[58] The "Pacific Islands Forum" (previously known as the South Pacific Forum) is the foremost political organisation in the Pacific. It holds an annual meeting of all the heads of government of the sixteen independent and self-governing states in the Pacific region. Australia, Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Republic of the Marshall Islands, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu. See Australian Government, Department of Foreign Affairs and Trade,
<http://www.dfat.gov.au/geo/spacific/regional_orgs/spf.html> (accessed 04 January 2006).

[59] Pacific Islands Forum Vision Statement, Issued at Madang, Papua New Guinea, 14 September 1995, <http://www.forumsec.org.fj/>.

denial with the multidimensional implications of globalisation for its nationals. The danger of not having a coherent policy framework on labour migration in the Pacific region far outweighs whatever political gains would be scored through an ostrich approach. Lessons from the adverse consequences of the erratic approach of states in other regions of the world surely portend implications for more pragmatic initiatives in the Pacific region.[60]

In the mean time, labour organisations and trade unions across the Pacific region must take up the challenge in raising social and political awareness about these issues. There is also need for further multidisciplinary intellectual investigations on the conceptual dynamics that would inform legal and policy drive on this subject in the Pacific region. Non-governmental organisations, especially those of the human rights field, must engage in impact assessment research, monitoring and documentation of hitherto unspoken and latent abuses of the rights of migrant workers.

The gains of the global campaign for the protection of migrant workers' rights thus far must be consolidated through synchronised civil society-inspired and state-led initiatives. In this age of globalisation, the momentum must not suffer a pause towards the formulation of a coherent rights-based approach to the challenges of workers' migration.

Conclusion

It would be apposite to conclude this piece with the statement of the UN Secretary-General before the European Parliament at the beginning of 2004. In his words encapsulating the philosophy behind the protection of migrant workers' rights, "The public has been fed images of unwelcome entrants, and of threats to their societies and identities. In the process, immigrants have sometimes been stigmatised, vilified, and even dehumanised. In the process, an essential truth has been lost. The vast majority of migrants are industrious, courageous, and determined. They don't want a free ride. They want a fair opportunity. They are not criminals or terrorists. They are law-abiding. They don't want to live apart. They want to integrate, while retaining their identity."[61]

All that has been written presupposes that the governments of states in the Pacific region would want their domestic and regional agenda, on migration generally and labour migration in particular, to run in consonance with global standards and objectives. This paper has attempted to show some of the key modalities that should inform the formulation of such agenda.

Since the states of the Pacific region cannot afford to be permanently isolated from multilateral engagements in this area, it is imperative that they begin a conscious debate on the issues canvassed here. Simultaneously, civil society groups should engage themselves in strategising on how human migration and the rights of migrant workers should become vital issues for policy and legal responses in the region.

Far from being an *ex cathedra* pronouncement on all the concerns that should guide the formulation of national and regional policy responses on this subject, this paper would have served its purpose if it stimulates further discussions.

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[60] For views on how the incoherent national and regional approaches to labour migration policies have resulted in more complicated policy situation in Europe and the Americas, see Mark J. Miller, Evolution of Policy Modes for Regulating International Labour Migration, in Mary M. Kritz et al (eds.) *International Migration Systems: A Global Approach* (1992) 300-314; *International Migration Report 2002*, n 14 above, 31; W. R. Böhning & R. Zegers de Beijl, *The Integration of Migrant Workers*, n 20 above, 47-58; *Towards A Fair Deal for Migrant Workers*, n 9 above, 115-116.

[61] Kofi Annan, Secretary-General of the United Nations, *Address to the European Parliament, 29 January 2004*, quoted in *Towards A Fair Deal for Migrant Workers*, n 9 above, 119.

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