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Original Article

Evolution of the Right to Health: From Colonial Public Health Systems to Modern Human Rights Frameworks in South Asia

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Abstract

The paper traces the progression of health rights in South Asia from its beginnings in colonial public health systems to its current status in human rights laws. The study demonstrates that health rights in the region developed over time through multiple factors which included colonial sanitary systems, postcolonial constitutional developments, judges' decisions, and international human rights standards. The research uses doctrinal and comparative methods to study constitutional laws and court decisions together with the different legal systems of South Asian countries while focusing on the particular judicial interpretations of Article 21 in India. The research connects its main topic to Article 25 of the Universal Declaration of Human Rights and to Article 12 of the International Covenant on Economic Social and Cultural Rights and to the WHO rights-based health definition which considers health as a complete and socially connected right. The research shows that South Asian nations have developed constitutional health rights through their constitutional duties and directive principles and judicial decisions yet their implementation process faces challenges. The primary finding shows that legal systems have granted rights to healthcare services at a faster pace than people can access these services because financial problems and weak administration and geographical imbalances and social discrimination still obstruct the achievement of health rights throughout the area.

Keywords: *Colonial Public Health Systems, Postcolonial Constitutional Developments, Article 21 In India, South Asian Nations, Geographical Imbalances etc.*

Introduction

Chronological Context

The right to health in South Asia has progressed through three major stages which begin with colonial public health systems and end with present-day constitutional rights and human rights protections. The colonial era established health regulations which focused on sanitation and epidemic control and military protection and administrative functions instead of providing citizens with universal healthcare rights.

Geographical Extent

Post-independence South Asian countries established health as a fundamental aspect of their constitutional frameworks which they used to advance social welfare and national development and human dignity and social justice[1]. Some states explicitly recognized health-related rights while other states relied on their directive principles and policy commitments and general rights to life and equality.

Primary Goal

The paper demonstrates that South Asia's right to health developed through multiple elements which included colonial institutional legacies and postcolonial constitutionalism and international human rights standards which existed before James Cook first set foot in Australia.

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[1] World Health Organization, The Right to Health in the Constitutions of Member States of the World Health Organization South-East Asia Region.

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The study demonstrates that healthcare access throughout the region suffers from irregularities because legal systems expanded their recognition rights yet people face barriers from inadequate public funding and institutional weaknesses and deep social disparities.

Objective of the Study

The study tracks how the right to health developed from its original public health control framework into a rights-based system which requires governmental responsibility and respect for human dignity and provision of healthcare services. The study uses South Asia as a legal comparison point to demonstrate how constitutional rights and their actual implementation develop at different speeds.

Buildings of Colonial Origin

Governance of Sanitary Matters

The construction of public health institutions in South Asia during the colonial era used control as its main guiding principle instead of providing care for the public. Their primary objective focused on preventing disease outbreaks which would affect European communities and military bases and ports and commercial centers in metropolitan areas that suffered from poor sanitation conditions. The health policy developed into an instrument of colonial control instead of becoming a general social right which should have existed for all people.

The Regulation of Epidemics

The regulation of epidemics emerged as one of the most prominent aspects of the administration of health in colonial settlements. Authorities established quarantine and segregation and surveillance and inspection powers as mandatory requirements to contain the smallpox and cholera and plague outbreaks. The initiatives led to a situation where local inhabitants were treated as objects of control instead of being recognized as rights holders which caused communities to distrust the state for an extended period.

Discrepancies in the Structure

The health infrastructure during the colonial era was quite patchy. Urban areas and strategic locations received better sanitation services and medical treatment facilities than rural areas which remained underserved. The unequal distribution of medical services created permanent structural obstacles that continued to affect South Asian countries after they achieved independence.

The Legacy of Administration

The colonial state created an administrative structure that operated in separate parts which caused hospitals and local health organizations and epidemic laws to work independently from each other instead of creating a unified public health system[2]. The system operated in two ways which resulted in health governance becoming disease-focused which pursued other diseases instead of following preventative measures and fair health access. Public health efforts focused mainly on emergency management while nutrition and maternity care and primary healthcare needs received much less consideration[3].

Impact on the Long Term

Colonial foundations established the postcolonial health system in South Asia. Even after obtaining independence many states maintained weak institutional systems which used centralized decision-making and created unequal access across different regions. The right to health in modern times emerged from a historical period when health functioned as a governance instrument instead of being recognized as a democratic right.

Postcolonial Constitutional Turn

Welfare State Vision

The constitutions of South Asian countries after their independence started to define health as a public health issue which states needed to oversee as a social right. The constitutional change emerged from the postcolonial nation-building process which required states to establish order while they worked to build development systems that would decrease social gaps and enhance citizen living standards[4].

A new set of standards developed through which society recognized health as a requirement for citizenship. Health-related rights existed in most constitutions which included welfare provisions for nutrition labor protection and social security and living standards. Postcolonial constitutionalism established public health rights through its constitutional framework yet it created a legal requirement which states needed to protect public health essentials.

Directive Principles and State Duties

The South Asian countries which established their national constitution adopted directive principles and equivalent policy standards to control government activities in their health systems. The provisions established non-justiciable status for themselves but they maintained strong normative value because they defined the goals of governance and expressed the ethical basis of the welfare state.

[2] Office of the High Commissioner for Human Rights, OHCHR and the Right to Health.

[3] World Health Organization, Human Rights and Health.

[4] World Health Organization, The Right to Health (Fact Sheet No. 31)

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India is the clearest example of this model[5]. The articles 38 39 41 42 47 and 48A require the state to advance public welfare while it creates better public health conditions and protects workers and provides maternity benefits and raises nutrition standards and protects environmental resources[6].

Article 47 establishes public health improvements and standard of living enhancements as state obligations which create a constitutional basis for future judicial development of health rights[7]. South Asia demonstrates similar indirect methods through various channels that operate within the region. The WHO regional constitutional survey found that Bhutan Bangladesh India and Sri Lanka have different health right recognition practices which compel the state to fulfill health-related obligations through its constitutional duties and policy principles and devolved governance structures. The evidence demonstrates that postcolonial constitutional systems used governance responsibilities as their primary foundation instead of relying on rights language only.

Diversity Across South Asia

The postcolonial constitutional turn did not produce a single regional template. South Asian countries created their constitutional systems because their political backgrounds and governmental frameworks and their legal traditions created different constitutional systems. Some constitutions moved closer to explicit recognition of health-related entitlements, while others relied on broad social commitments that allowed later interpretation by courts and legislatures[8].

Nepal demonstrates more direct constitutional evolution through its legal framework. WHO materials and more recent regional health reviews note that Nepal's constitutional framework moved toward recognizing free basic health services and health-related state responsibilities more clearly than many older constitutions in the region. The way Sri Lanka has approached healthcare demonstrates the country views healthcare as a governmental duty that belongs to provincial authorities rather than as a right that should exist for all citizens.

Constitutional Meaning

The postcolonial turn transformed legal approaches to health because it introduced a new understanding of health rights[9]. Health rights extended beyond epidemic control and sanitary regulations because they formed part of constitutional obligations which guaranteed welfare and dignity and democratically governed societies. The theoretical limits of this framework developed through two specific circumstances which showed that constitutional goals advanced quicker than actual healthcare services when state enforcement powers and directive principles stayed[10].

The South Asian postcolonial constitutional movement established a fundamental intellectual separation from colonial public health systems although it failed to achieve complete institutional change[11]. The legal and moral framework established through this process became essential for the development of health rights which emerged through judicial decisions and human rights discussions although the system still faced challenges in delivering welfare benefits to all citizens.

Human Rights Framework

UDHR Foundation

The human rights framework for health rights begins from Article 25 of the Universal Declaration of Human Rights. The article establishes that every person possesses the right to an adequate standard of living which includes food and housing and medical treatment and essential social services. The provision brought about crucial changes because it elevated health issues from their preliminary medical framework to a complete examination of human dignity and social welfare and human rights protection.

ICESCR and Legal Development

The International Covenant on Economic Social and Cultural Rights established a legal foundation for health rights through Article 12 which grants every person the right to achieve their maximum level of physical and mental health. The document establishes specific responsibilities for governments which include decreasing infant death rates and enhancing environmental health and disease prevention and control and delivering medical services during health emergencies. The state became legally required to provide health services to citizens because the right to health evolved into a legally binding duty instead of just a moral requirement.

[5] United Nations, Universal Declaration of Human Rights, Article 25.
[6] Human Rights in the World Health Organization
[7] Judicial Approach towards Right to Health in India
[8] The Legal Right to Healthcare in South Asia.
[9] Reorienting Health Systems towards Primary Health Care in South Asia.
[10] International Covenant on Economic, Social and Cultural Rights, Article 12
[11] Implementation of the Right to Health Through Laws and Policies in India.

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WHO Norms
The World Health Organization established its standards which improved this framework because it defined health as a person who has complete physical mental and social well-being instead of disease-free status. The World Health Organization has established the right to highest possible health standards as a basic human entitlement which exists in national laws and health regulations and institutional obligations.
Rights-Based Approach
The contemporary rights-based approach which exists today requires people to have more than hospital or treatment access rights. The system requires equality together with non-discrimination while people must be held responsible and they should take part in the process which concentrates on fundamental health factors which include water sanitation and nutritional needs and social security. The South Asian framework provides an essential explanation about constitutional rights because it mandates that health entitlements must be supported through functioning institutions and inclusive policies and fair implementation methods to transform health rights from abstract concepts to actual human experiences.
Comparative South Asia analysis
The right to health in South Asia is affected by diverse constitutional systems across the region. The WHO regional assessment shows that Maldives and Nepal approached constitutional health rights while Bangladesh Bhutan India and Sri Lanka treat health as a governmental obligation through their constitutional framework and policy commitments. The SAARC region shows unequal recognition because both constitutional descriptions and practical implementation of rights differ between member states[12].
India presents the clearest case of indirect recognition which shows its most advanced development. Although the Constitution does not expressly provide for a fundamental right to health, the courts have read the right to health into a range of constitutional rights, including Article 21, relating to emergency medical treatment and labor rights and dignity and social protection obligations[13]. The jurisprudential framework in India provides a strong foundation for legal matters, yet the execution of laws faces challenges because various states exhibit different levels of public services and financial resources and healthcare facilities.

Nepal functions as a direct implementation of rights through its established rights system. The regional constitutional assessment shows that Nepal's legal system provides clearer protection for free basic health services than older South Asian constitutions, which establishes a stronger legal foundation for health rights. Research studies show that even there, policy studies identify ongoing disparities between urban and rural communities and different regions and social economic classes, which prove that constitutional recognition fails to eliminate fundamental obstacles to access health services.
The Maldives demonstrates its legal recognition through constitutional provisions yet its island-based population distribution creates difficulties for providing health services which require multiple steps and cost management and treatment continuity. Bhutan, by contrast, does not recognize health as a stand-alone fundamental right in the same way, but it imposes a constitutional duty on the state to provide access to basic public health services, showing a duty-based welfare model rather than a fully rights-based one.
The Pakistani constitution demonstrates which powers the constitution grants to citizens while also showing its limits. The current legal and human rights analysis shows that health does not qualify as a basic constitutional right, which creates unenforceable government policies that fail to deliver essential health services, resulting in significant healthcare disparities. The SAARC comparison demonstrates that legal recognition has value, yet actual implementation depends more on public funding, organizational strength, geographic coverage, and societal fairness, rather than solely constitutional documents.
Judicial Development
The Supreme Court of India together with the judiciary system transformed health from a government policy into a constitutional right which belongs to all citizens under Article 21[14][15]. Since the Constitution does not expressly guarantee a fundamental right to health, courts relied on the broader idea of life and personal liberty to expand the meaning of constitutional protection beyond mere survival. The development came in a series of landmark rulings[16]. The Court in Vincent Panikurlangara v. Union of India linked the right to live with human dignity under Article 21 with the

[12] Right to Health, Constitutional Safeguards and Role of Judiciary.

[13] Right to Health under the Domain of Article 21

[14] Constitution of India, Articles 21, 38, 39, 41, 42, 47 and 48A
[15] Right to Health: The Forgotten Constitutional Mandate
[16] The Right to Health as a Constitutional Mandate in India

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maintenance and improvement of public health. The Court in Consumer Education and Research Centre v. Union of India held that health and medical care of workers are integral to the basic human right of existence. The doctrine received further support in Paschim Banga Khet Mazdoor Samity v. State of West Bengal, which established that government hospitals must provide emergency treatment according to Article 21, and the Court established that state authorities must protect human life as a constitutional duty which persists even during financial emergencies. In Parmanand Katara vs Union of India and in State of Punjab vs Mohinder Singh Chawla the responsibility of the state to provide immediate medical aid has been upheld.

The Indian court system established health as a legal matter which protects human dignity through emergency medical treatment and public welfare programs[17]. The judicial system has not succeeded in resolving fundamental issues because recognition by courts needs administrative activities and financial resources and institutional capabilities to operate.

Conclusion

The right to health in South Asia has progressed through three different stages which began with colonial sanitary control and continued through postcolonial welfare constitutionalism before arriving at the contemporary human rights system which upholds dignity and equality together with state responsibility. Across the region, constitutions and courts have increasingly recognized that health is more than a policy concern and forms part of a broader structure of human rights and social justice. The main result shows that access does not follow from recognition. The right to health benefits from court decisions that extend its boundaries and constitutional protections, but public funding and administrative structures and geographic access and social disparities maintain their negative impact on health system implementation. The South Asian experience therefore shows that the promise of the right to health depends not only on legal recognition, but on the capacity of states to translate constitutional ideals into effective healthcare systems.

[17] Right to Health in India: Constitutional Perspective

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Conflicts of interest

The authors declare that there are no conflicts of interest regarding the publication of this paper

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