NEED FOR A NATIONAL HEALTH LEGISLATION IN INDIA: CONSTITUTIONAL PARADIGM

Aparajita Mohanty, Deemed University
Saksham Kumar, Deemed University

ABSTRACT

The outbreak of the COVID-19 pandemic has presented law and policy makers throughout the world with socio-eco-politico-legal problems at a scale hitherto unseen. The most pressing of these problems is preventing the spread of the contagion. Though India's response in tackling the pandemic, in terms of implementing a national lockdown and other administrative measures is laudable, it cannot be overlooked that the absence of a statute-enabled healthcare apparatus at the Centre and State levels, has made the public sceptical of this success. The question arises as to why India has not enacted a National Health Care Legislation like other common law jurisdictions. One of the plausible answers seems to be the fact that "public health and sanitation" falls under the "State List", making it difficult for the Centre to legislate on it without facing friction from the States, this has consequently led to the shelving of the National Health Bill, 2009. State Autonomy is important and indeed indispensable for India's democracy to function. However, the pandemic has shown us how inept the States are to tackle a situation of this magnitude on their own. One must therefore, consider what is best for the Nation as a whole and better equip it to effectively square up to situations like these in the future. The National Health Bill, 2009, will be a step in the right direction and we will analyse the Constitutional scheme under the Seventh Schedule to see if an amendment therein can usher it in. Shifting public health and sanitation to the concurrent list may provide a viable solution by giving Parliament the power to make a national legislation and at the same time allowing the States the flexibility to supplement it according to their unique requirements.

Keywords: Constitution, Seventh Schedule, Pandemic, COVID-19, Policy, Healthcare

INTRODUCTION

The Covid-19 pandemic is a new phenomenon as it is the first time that a pandemic has been triggered by a coronavirus and not the influenza virus like in the past. A pandemic is defined as the global transmission of a novel disease. Though not caused by an influenza virus, this pandemic shows all the elements of an "influenza pandemic" wherein the contagion (in this case the novel coronavirus) appears and spreads across the globe and is highly infectious as most people are not immune to it (WHO, 2020). By its very nature, the pandemic poses a serious threat to public health. The term public health is very wide and has been defined by CEA Winslow to imply the prevention of diseases in order to improve life expectancy and health through concerted and organized efforts put in by the stakeholders *i.e.,* all those forming part of the society at large (CDC, 2018). One therefore, finds that public health affects all and the concerted efforts, though required from each and every individual and community, must necessarily come from the civil administration. The "organized efforts" mentioned by Winslow are made possible when they are backed by the authority of law.

Health is an important factor in nation building and an equally important parameter for growth and development. Health, being the most basic parameter of human resource development, is inextricably intertwined with economic growth. With the outbreak of the novel coronavirus (COVID-19) being declared as a pandemic, law and policy makers throughout the world have been seized with problems as novel as the virus itself. In a time like this when the government-imposed lockdown is bound to translate into an economic slowdown, a healthy

workforce will be a sine qua non to ensure that economic activity can be sustained for a longer duration. Measures must therefore, be in place to improve and preserve community health. Community health is a direct indicator of individual health. A healthier nation acts as an 'economic engine' (Mirvis et al., 2008) to boost the economy. A report prepared by the Commission on Macroeconomics and Health has presented findings stating that an increase in investment in the health of the population, especially poor people will, in addition to saving countless lives, have a positive impact on economic gains (Khan, 2002). Having a robust health infrastructure, backed by the force of law is a fundamental step for improving community health.

Apart from the obvious economic benefit, health has been recognised as an indispensable human right in various legal instruments. The Constitution of the World Health Organisation (WHO) recognizes health as a fundamental human right accruing to everyone without discrimination on the basis of "race, religion, political belief, economic or social life" (WHO, 2020) and further delineates the objective of the WHO as facilitating the "attainment by all people of the highest possible level of health." Additionally, General Comment 14 (Committee on Economic, Social and Cultural Rights, 2000) states that concrete steps are needed on part of the States to make certain that quality public healthcare services reach their populace, especially the vulnerable sections of the society. Other International Law treatises like Article 12of the International Covenant on Economic, Social and Culture Rights and Article 25 of the Universal Declaration of Human Rights also echo the principle of "highest possible level of health" as embodied in the World Health Organisation's Constitution.

The Directive Principles of State Policy contained in Part IV of the Indian Constitution too, are replete with provisions emphasizing the State's responsibility towards Public Health. It lays a moral responsibility on the State to ensure that the citizens' health is not abused; make provisions for public assistance in cases of sickness; regard improvement of public health as one of its primary duties (Basu, 2020).

Significance of a National Health Legislation

Before one delves into the pertinence of national public health legislation, one must realize that such legislation is not optional. The term 'health infrastructure' encompasses within it, not only the brick-and-mortar establishments and the technical know-how necessary to fight diseases but also the 'legal infrastructure' including laws, rules and regulations which serve the dual purpose of empowering and at the same time obligating the Government to take action related to public health. A health crisis like the COVID 19 pandemic, tests the effectiveness with which the laws of a country embody governing strategies and social contract principles in addition to human rights norms, further putting to test the efficacy of these laws in guiding action (Marks-Sultan et al., 2018). The said action is in furtherance of 'preparedness' and can involve various activities like quarantine, surveillance, social distancing etc. which must be conducted under the ambit of a law. The International Health Regulations of 2005, require Member States to be prepared (Gostin, 2014) and this can be achieved through a comprehensive Health Code in the form of a legislation.

To highlight the necessity of national health legislation, one must look at the problems that will arise in its absence. Such a law will act as a code *i.e.*, a comprehensive legislation, covering all aspects of public health. In its absence, the legislature will have to enact separate legislations, issue notifications, promulgate ordinances [as has happened in the case of India-The Epidemic Diseases (Amendment) Ordinance, 2020] etc. which will lead to the unnecessary burdening of the legislature and multiplicity of legislations, thereby indirectly increasing the burden on the Judiciary owing to the increase in litigation arising out of these laws. By not enacting a national health law, the right to a healthy life, implicit in Article 21 remains half baked. The Apex Court has held that it is the State's responsibility to provide for health services albeit within its financial capacity, (State of Punjab and Others v. Ram Lubhaya Bagga & Others, 1998) which brings us to our next point of the economic sense in enacting a national

health law. As mentioned earlier, enacting one legislation concerning public health is less time consuming and hence cost effective. Furthermore, in the absence of legal infrastructure which clearly defines the roles and duties of the State with respect to the financial liability to be undertaken by it, the State will incur greater costs. The greatest demerit of not having a national public health law is that its absence makes us vulnerable to situations like these which may occur in the future.

A public health act is therefore, of paramount importance for a number of reasons. It would enable measures to prevent a health crisis before it occurs. It provides for a two-tier structure *i.e.,* administrative and legal which facilitates the health system by assigning duties and powers to government and other agencies and sets the source of their funding (Hamlin & Sheard, 1998). The legislation becomes the source of power for the relevant agencies to regulate and investigate incidents that could potentially trigger a public health crisis and sets standards for food, hygiene, environmental health etc. which directly affect public health (Gupta et al., 2010). Each state in India has its unique characteristics and thus, has unique requirements, a central law would allow a non-discriminatory exoskeleton which the states can then modify according to their varying needs. This will ensure the fulfilment of regional requirements along with national responsibility. It will allow the judiciary to develop much needed jurisprudence in the realm of right to health as the national health law will be amenable to judicial review like any other legislation in India. It would further justify the pressing need to pay attention towards existent health inequalities, the role that health undeniably plays in economic and social prosperity and finally, realize the collective dream of "health for all" (Burci et al., 2017). These principles have been enshrined in the Alma Ata Declaration, 1978 (Alma Ata Declaration, 1978), which was recently celebrated for completing 40 years at the Global Conference on Primary Healthcare in Kazakhstan, 2018. The Declaration of Astana was signed here, reinforcing commitment towards primary health care and universal health care (Declaration of Astana, 2018). India is a signatory to both these declarations and must strive to achieve its international commitments and more importantly, its commitment to its people.

LITERATURE REVIEW

Health can be viewed at two levels, the micro level *i.e.,* relating to the individual and at the macro level *i.e.,* relating to the nation as a whole. At the micro level, health is inextricably linked to the inalienable human right to life and at the macro level, it has a bearing on the nation's economy which in the current situation, is experiencing a major setback owing to the health crisis created by the pandemic.

In their article titled Health and Human Rights (Mann et al., 1994), the authors have given a comprehensive view of how health is linked to human rights. They argue that "health" is not synonymous with healthcare facilities, implying that human rights also fall within the ambit of the former. Health at the micro level is jeopardised if there exists no law to establish and regulate a healthcare infrastructure to tackle situations like a pandemic, thereby dispossessing individuals of their human right to live in a healthy and secure environment. We will further explain how health and human rights are linked by examining 3 relationships: (i) health policies and their effect on human rights, (ii) human rights violations and their effect on health and (iii) that promotion of human rights is tantamount to promotion of health. For the purpose of this paper, the first relationship is important to appreciate the necessity of not only a national public health legislation but also of how it should balance the rights of the people. unlike the Epidemic Diseases Act, 1897 which is a colonial law and was designed to benefit the foreign regime, administering India at that time.

In an economy, the workforce is an important factor of production. The more efficient the workforce, the wealthier the nation. Efficacy of the workforce depends greatly upon its health along with other factors like work environment, model of economy, labour laws etc. Anthony Strittmatter & Uwe Sunde, 2013 conducted a study to understand the cause-and-effect relationship between improvement in healthcare and economic growth. They found that

introducing public health care systems led to an instant impact on health which translated into a positive impact on the economy as they observed a rise in both per capita income and aggregate income. Furthermore, in a chapter published under the "World Health Report 1999: Making a Difference", issued under the then Director Gro Harlem Brundtland, the impact of health on macroeconomic and microeconomic indicators of economic growth has been discussed. It states that macroeconomic factors like life expectancy, geography and demography, which are used to compare the performances of different countries in the long term were positively impacted due to improvement in health and that it is this positive impact which accounts for at least one third to half of the economic boom shown by East Asia during the period between 1965 to 1990. Similarly, on the microeconomic front, studies showed that poor health led to a decline in an individual/household's income (WHO, 1999). Therefore, the importance of health in a society is undeniable and a public health care system is a sine qua non to realize the goal of becoming a superpower which India indeed has the potential to achieve.

The literature review would be incomplete if one did not examine the central laws presently being relied upon to tackle the pandemic, *viz*. the Epidemic Diseases Act, 1897, the National Disaster Management Act, 2005 and the Epidemic Diseases (Amendment) Ordinance, 2020. The Epidemic Diseases Act, 1897 is outdated and only dictates what measures must be taken after an epidemic occurs whereas the focus should be on preventing an epidemic in the first place. The 1897 Act is vague and ambiguous with no definition clause defining crucial terms like "dangerous epidemic diseases" etc. To understand why this legislation is inadequate to deal with a pandemic, one must carefully inspect the social context in which the law was passed. Prima facie, the Epidemic Diseases Act, 1897 was passed as a consequence of the bubonic plague which hit the then presidency town of Bombay in 1896. Though the initiative was aimed at preventing the spread of epidemics in the future, what it did was, give arbitrary and unchecked powers to the colonial government in the garb of "public good". Under the provisions of this Act, officials had powers as wide as the authority to demolish buildings of residents if deemed necessary and such acts were protected under Section 4 of the Act. The Calcutta High Court in 1904 while holding a magistrate personally liable to pay compensation for the demolition of the plaintiff's property held the act of demolition in itself to be justified by law (Ram Laul Mistry v. R.T Greer, 1904). Moreover, the Ordinance passed with respect to the Epidemic Diseases Act only adds provisions to safeguard health care worker and attach criminal liability to those who hurt them in any way. While the intention behind this ordinance is noble and well placed, it remains inthe authors' opinion, a short-sighted piece of legislation as it can only be made applicable once an epidemic breaks out. The Ordinance does not change the original provisions of the Act, in fact, it enhances the Central Government's reach which was earlier restricted to inspecting only ships to searching all forms of public transport. On analysis, one finds that the common thread running between the two pieces of legislation is that of excessive delegation. The provisions of the Act and Ordinance allow the Central and State governments to make any 'temporary' provisions which it may deem fit in order to control the spread of disease, thereby giving wide legislative powers to the executive without any tangible restrictions placed upon them by the Act itself. While delegated legislation is permissible and indeed necessary, excessive delegation is a detriment to the principle of separation of powers as enshrined in the Constitution. The Apex Court has also reaffirmed this stance on excessive delegation in the landmark 7 judge-bench judgment (In Re Delhi Laws Act, 1912, 1951).

The other legislation being used to tackle the pandemic is the Disaster Management Act, 2005 (hereinafter DMA) which, in fact, has been invoked for the first time since its enactment. While it is better articulated than the Epidemic Diseases Act, 1897, the NDMA is "substitute" legislation, being used because of the absence of a law on the subject matter. Credit must be given to the law makers for formulating a definition of disaster which is well-defined and yet broad enough to cover a pandemic even though the intention was to prevent and manage disasters like the 2004 Tsunami which hit Southern India in 2004. Though the DMA sets up a two-tier infrastructure at the Centre and State levels to manage disasters, like the Epidemic Diseases Act, it is a preventive legislation and does not deal with the issue of public health as

much as it deals with the issue of "public safety" especially with respect to disasters. It must be reiterated that a national public health legislation is required to create a comprehensive health care system in India which deals not only with handling of situations like the pandemic but more importantly strive to prevent them and improve community health by making health care more accessible. The Preamble of the DMA makes it evident that the Act is targeted at disaster management. Though Section 2(d) while defining disaster uses terms like 'catastrophe', 'calamity' etc. Which incidentally apply to the pandemic, the social context of enacting the legislation cannot be overlooked. It was enacted in the wake of the unfortunate Tsunami which shook India in 2004 and therefore, in light of that context, it becomes clear that the disasters sought to be managed under this legislation are those which are capable of causing widespread physical damage to tangible resources other than human beings.

It is well-established that the importance of health and by extension, health care cannot be emphasised enough. When a subject is so fundamental to nation building, the law regulating it must apply uniformly to the entire country. It thus, was pertinent to study the report published by the Sarkaria Commission (Justice [Retd.] Sarkaria et al., 1988) on Centre-State Relations. The Commission stated that the Concurrent List in the Seventh Schedule is to account for the subjects forming the "grey area" in legislation *i.e.,* those subjects that are common interest areas for both the Centre and the States. There are some subjects where uniformity of law is of paramount importance and a state law by its very nature cannot provide such uniformity as a state only has authority over the people and objects within its territorial boundary. It is interesting to note that over thirty-two years ago, the Commission took the example of an epidemic spreading across state borders and how in such a situation only a law passed by the Union Parliament would able to curb the spread and effectively remedy the situation.

It therefore, stands to reason that public health should be a part of the Concurrent list to balance the need of uniformity of legislation on one hand and state autonomy on the other.

Health-care legislations in select countries: Bird's Eye View and Analysis

The authors deem it necessary to put into perspective the difference a national health care legislation can make in terms of preparedness. It therefore, becomes pertinent to review legislations of countries that have such a law in place and analyse their experience with healthcare.

Singapore

Singapore is a common law country in the Asian continent with one of the best health care systems in the world. It enacted its Environmental Public Health Act in 1987. The Act is divided into 13 parts and is a comprehensive legislation making provisions for a regulatory authority; public cleansing, food establishments, markets and hawkers; public nuisances; sanitation and general health requirements for buildings; swimming pools; funeral parlours, cemeteries and crematoria; purity of water supply; cleaning industry; enforcement; damages and compensation and miscellaneous provisions.

The Act provides for the post of a 'Director General of Public Health' who bears the responsibility of the enforcement and administration of the Act. He has further been given the authority to delegate his functions to an authorised officer. The legislation is not myopic and does not limit its concern only to the specific question of controlling diseases and their spread. Rather, it makes provisions to ensure that potential hotspots of diseases like public restrooms, swimming pools, market areas, cemeteries, buildings etc. are well-regulated and up to the standard of health prescribed in each respective part of the statute. Part IXA added in 2014, specifically sets a standard for cleaning to be strictly followed by the cleaning industries in Singapore. Singapore plays a direct role in the cleaning industry by making it mandatory for cleaning businesses to obtain a license from the Director-General and ensure that all their cleaners are trained and progressively paid. This ensures greater participation by the workforce.

Operating a cleaning business without a license is a punishable in Singapore under the provisions of this Act by way of fine or imprisonment or both.

One therefore observes that in Singapore, the public sector plays a vital role in providing healthcare. This is evidenced by the fact that 70% of hospital admissions are provided by the public sector and 75% of the beds are subsidised (Mundle, 2018). Another noteworthy feature of the Singapore public health care system is its funding schemes. MediSave, MediShield and ElderShield are national health insurance plans based on the provident fund system which covers expenses for hospitalisation, large hospital expenditures like chemotherapy and severe disability at old age respectively.

The United Kingdom

In the UK, there are two main national legislations looking after public health care *viz*. the National Health Service Act, 2006 and the Health and Social Care Act, 2012. The two acts are complementary and the latter facilitates the former. The National Health Services Act, 2006 (NHS Act) puts a legal imperative on the Secretary of State, to endorse comprehensive health services in the UK. This NHS Act provides for the functions of health services bodies like the National Health Service Commissioning Board, clinical commissioning groups (which was inserted in this Act by the Health and Social Care Act of 2012), NHS foundation trusts etc. It lays emphasis on cooperation with the local authorities under Part 3 to ensure more effective distribution of healthcare services and puts impetus on the active participation of the end beneficiaries of this legislation *i.e.*, the people itself. Part 12 of the NHS Act provides for "Public involvement and scrutiny" and makes provisions for consultation during planning and development stages of health services etc.

The Health and Social Care Act 2012 is the primary healthcare legislation in the UK and supplements the NHS Act 2006. It reiterates the Secretary of State's obligation to promote healthcare and is responsible for the NHS Commissioning Board's creation. It also makes it mandatory for healthcare providers to be licensed thereby ensuring that a minimum standard of healthcare is met. While the NHS Act looks into specificities like dental care, ophthalmic services, pharmaceutical services etc., the Health and Social Care Act focuses on capacity building by making provisions for the regulation of health and social care workers and their training.

The UK uses the Beveridge Model of health care in which free access is secured to healthcare in hospitals. Medical profession is given high levels of autonomy. Universal health plans cover all citizens but the access to care is regulated by the State (Beckfield et al., 2013).

Australia

Australia has recently compiled its national health legislation on 21 February 2018. This compilation consists of the text of their primary health legislation *i.e.*, the National Health Act, 1953, with all its amendments in force till 21 February 2018. The compilation is broadly divided into four categories *viz*. health services at the national level, monetary benefits for people suffering from continence (known as the Continence Aids Payment Scheme), all aspects relating to pharmaceuticals and miscellaneous provisions covering privacy and breach of privacy provisions, provisions on offences etc. Though Australia has other health related legislations on insurance schemes like the Human Services (Medicare) Act, 1953 etc. These legislations focus on specific aspects of public health. The difference between the National Health Act, 1953 and other health legislations becomes more defined when one finds that the former contemplates not only providing of health benefits and care but also for research, training and teaching for the betterment of health and prevention of contagion. Therefore, a national health legislation as envisaged by us must serve as an enabler and create resources beyond physical infrastructure like this Australian legislation. Another striking feature of the Australian legislation is its regard for a citizen's privacy. Australia has codified right to privacy under the Privacy Act of 1988.

Section 135A of the National Health Act, 1953 imposes a duty on health officers working with private data to not disclose such information to third parties. It is interesting to note that this obligation persists even after a health officer is no longer employed in that position. The punishment for breach of this obligation is up to 2 years of imprisonment or fine (calculated as 'Penalty Units) worth 50 penalty units or both.

New Zealand

New Zealand has garnered praise from all around the globe for its prompt and effective response against the COVID-19 pandemic. While the efficacy of the response came from a multitude of factors, one of the major contributors to New Zealand's success was its legislative framework on healthcare. The Health Act of 1956 is the primary healthcare legislation which covers wide aspects of healthcare in New Zealand. The Act provides for the office of the Director of Public Health who acts in an advisory capacity and renders advice to the Director-General of health on matters relating to public health. The legislation is divided into 7 parts which deal with different aspects of public healthcare in New Zealand. The Act also provides for Medical Officers of Health (MOH) who are appointed by the Director General and do medical practitioners possess the specified qualifications and experience in the field of public health medicine. In the present context, it is pertinent to look at Part 3 of the Act which deals with "infectious and notifiable diseases", under this part;MOHs have been given wide ranging powers in the event of an outbreak of an infectious disease. These powers include prohibiting the use of insanitary buildings/land, requiring medical testing of people if the infectious disease causes public risk, authorising local authorities to use temporary sites as places of isolation or special hospitals if the need arises etc. The MOHs have been granted protection from any personal liability for any act legally carried out under section 70 of the Act. Apart from specifically providing for infectious diseases, the act also makes provisions for drinking water, quarantine, regulations with respect to different aspects of health, penalties for offences etc. which is a testament to the general and overarching nature of the law. The novel coronavirus has been listed as a quarantinable infectious disease as also as a notifiable infectious disease under the Health Act, 1956, thereby enabling the MOHs to exercise their powers under Section 70.

Thus, one sees that New Zealand has a sound national health legislation which acted as a solid base for and enabled the COVID-19 Public Health Response Act 2020, (CPHRA) which is a tailor-made legislation, targeting only the pandemic and will remain in force only till such time period as the pandemic subsists or until the pandemic is adequately dealt with. The CPHRA, 2020 has been extended till April, 16 2021.

Inadequacies of the Ayushman Bharat - PMJAY Scheme

After reviewing the National Health legislations in a couple of common law countries and before delving into what kind of health care legislation India should have, it is important to see the existing policies relating to health care that function at the national level. Pursuant to the National Health Policy of 2017, the Ayushman Bharat scheme was launched in 2018, consisting of two components. It was done in a bid to fulfil the goal of Universal Health Coverage as also the Sustainable Development Goals. The first component was the establishment of 1 lakh 50 thousand Health and Wellness Centres which was announced in February 2018 and second component was the Pradhan Mantri Jan Arogya Yojana (PMJAY) which was launched on 23rd September, 2018. It has subsumed the Rashtriya Swasthya Bima Yojana (2008) (RSBY) and gives health cover worth Rs. 5 lakhs annually to poor and vulnerable families forming the bottom 40% of the Indian population along with those covered by the erstwhile RSBY.

While the scheme is a national level scheme, it has given states the flexibility of using this framework to implement their own health assurance schemes. Noble and well-structured as the scheme is, it unfortunately suffers from certain shortcomings. The scheme, despite having a pan India character does not provide complete uniformity which a national health legislation will

be better equipped to provide. Furthermore, as benevolent as the intention may be, it is susceptible to the changes in the political landscape of the country and is therefore, volatile. For example, while most of the states have implemented the scheme in some form or the other, West Bengal and Odisha have rolled the scheme back. Their reasons for doing so may be multiple but one cannot rule out political rivalry as one of them. While the scheme is primary health care centric, it focuses on the financing of the health care system and partly on prevention of diseases by aiming to set up wellness centres and improve medical infrastructure. It however, fails to address and cater to requirements like establishing Public Health Boards at the Centre and State Levels under one regulatory framework, delineating their composition and functions. Furthermore, the scheme does not include any monitoring framework, health information system, redressal mechanism, offences and their remedies and does not impose any legal obligation on the Government to see to the implementation of the scheme.

The PM-JAY policy brief 8 (Smith et al., 2020) states that due to the Covid 19 pandemic, there has been a decline in planned surgeries and "significant declines in the admissions for child delivery and oncology." It is the authors' opinion that a public health legislation would have helped the Government tackle the situation better if community monitoring provisions were present as that would have improved efficacy of the home quarantine system greatly and reduced the stress the hospitals in our country faced, at least in the initial stages of the pandemic. It must be noted that according to the Economic Survey, 2019-2020 carried out by the Finance Ministry, out of the total 1,50,000 health and wellness centres to be made by 2022, only 28,005 have been set up as on January 14, 2020. This amounts to merely 18.67 percent of the total wellness centres aimed to be set up by 2022.

The Ayushman Bharat-PMJAY scheme thus, falls short of meeting the requirements of a comprehensive health legislation an cannot be relied upon to meet all the needs of a robust healthcare system.

Amendment of the Seventh Schedule – Pathway to a National Health Legislation

At the outset, it is necessary to understand in brief, the division of law-making powers between the Central and the state legislatures before making an argument for amending the Seventh Schedule to pave the way for national health legislation. These powers are divided in a two-fold manner (i) on the basis of territory and (ii) on the basis of subject matter. For the purpose of this paper, the latter will be considered. A federal constitution focuses on the allocation of powers between the centre and the states. India's Constitution is no exception, it however, must be kept in mind that the Indian Constitution is quasi-federal in nature and provides for a strong Centre. The Government of India Act, 1935 acted as an inspiration for the Constitution to adopt a federal structure but the structure laid down in the Act itself was not incorporated without changes (Prof. Yashpal *vs.* State of Chhattisgarh, 2005). The scheme of distribution of powers between the Central and state legislatures under the Constitution was devised after a careful analysis of provisions in other federations. Consequently, the framers came up with an elaborate scheme of "Federal-State allocation of powers (Jain et al., 2019)." Accordingly, three lists were created, demarcating three functional areas – one exclusively for the Centre, one exclusively for the States and a common area where both Centre and the states have the competence to legislate, with the proviso that the Centre is supreme in cases of dissonance between the two. These Lists are part of the Seventh Schedule of the Constitution.

The Centre and states derive their authority to make laws on subjects present in the Concurrent List, by virtue of Article 246(2) of the Indian Constitution. The Honourable Supreme Courthas clarified that the division of subjects amongst the lists does not follow any scientific or logical method but is rather done by merely enumerating broad categories (State of W.B. *vs.* Kesoram Industries, 2004). The primary reason for having a concurrent list is to provide for uniformity throughout the country and at the same time, allow the states to tweak the legislation to suit their indigenous requirements. The states can also pass new laws to complement the ones made by the Union Parliament on subjects mentioned under the concurrent list. The most

relevant example would be the Civil and Criminal Procedure Codes which are within the ambit of the concurrent list, thereby allowing for national uniformity along with regional flexibility.

Repugnancy

One must understand that Article 246 elucidates the principle of the supremacy of the Union. This means that when a conflict arises between the law made by the Centre and the one made by the states, the former will prevail. Though it might look like a principle which defeats the purpose of state autonomy, it must be understood that the Apex Court has narrowly interpreted as to what comprises a "conflict". Article 254(1) provides for 'repugnancy' between laws made by the Union Parliament and the state legislatures with respect to a subject enshrined in the Concurrent List. The Apex Court in Deep Chand v. State of Uttar Pradesh, 1959has held that repugnancy arises only in cases of direct conflict. Direct conflict is a specific situation where the statutes are "fully inconsistent", contain "absolutely irreconcilable provisions" and happen to operate in the "same field." Even then, all attempts are first made to resolve the direct conflict and avoid repugnancy. The Apex Courtemphatically laid down that the direct conflict must exist on the basis of discernible facts and cannot be claimed on a mere possibility of conflict between the two statutes. If they occupy different fields without any friction with one another, repugnancy is not made out (Bharat Hydro Power Corpn. Ltd. *vs.* State of Assam, 2004). One therefore, sees that the test of repugnancy has been well established and cannot be invoked in vain, thereby, protecting the interest of the states and allowing them flexibility on subjects mentioned in the Concurrent List.

42nd Amendment – Shift of 'Education' to the Concurrent List

The Sarkaria Commission Report has very articulately summed up the rationale behind shifting education from the List II (State) to the List III (Concurrent) as Entry 25. This shift was made pursuant to the Forty Second Constitutional Amendment, 1976 along with 4 other subjects *viz*. "forests, protection of wild animals and birds, weights and measures and administration of justice, constitution and organisation of all courts except the Supreme Court and the High Courts".

Even though the 42nd Amendment Act did not mention the reason behind this move in its Statement of Objects and Reasons, one can logically infer that education has a clear nexus in the socio-economic growth of the nation, much like health. Education required uniformity in the sense of the standards so as to reduce disparity between different states in terms of syllabi and educational development and promote national integration. Like education, health is also an area which requires enthusiastic co-ordination between the Centre and the states. The Supreme Courthas defined 'co-ordination' as "harmonising or bringing into proper relation in which all the things co-ordinated participate in a common patter of action" (emphasis added) (Gujarat University *vs.* Shri Krishna Ranganath Mudholkar, 1963).

Health and education are equally important in the process of nation building. There are glaring disparities among states when it comes to health and a national legislation is required to provide basic uniformity to bring the states at a level footing and allow them to make changes according to their specific requirements. The Right of Children to Free and Compulsory Education (RTE) Act, 2009 which was passed pursuant to the entry of Article 21A in the Constitution by virtue of the Eighty Sixth Constitutional Amendment Act, 2002, became a reality and was not met by any opposition as the Union Parliament was competent to make such legislation. This legislation has made education accessible to all children between the ages of six to fourteen by making it a fundamental right which would not have been possible if it would have been a state legislation as it would have affected only the children living in a particular state.

CONCLUSION

There has always been a tussle between the Centre and the States over many things and indeed, such a tussle is necessary to an extent in a democracy. However, when it comes to issues that affect the nation as a whole and are integral in its development, the needs of an individual state must give way to the needs of the nation. In a 2016 news article, the then country coordinator of the International Budget Partnership, Mr. Ravinder Singh Duggal stated that while the spirit of the National Health Bill, 2009 was commendable, the Bill's formulation itself was faulty because it did not acknowledge that "health" was a state subject ("High Time India", 2016). Other critics have rejected the National Health Bill, 2009 by stating that different states have different need and a national level legislation would fail to cater to indigenous requirements of the states.

Critics who have said that health is a state subject and that a national health legislation will fail to cater to the precise needs of different states are only partially correct. The National Health Bill, 2009 in its 'Statement of Objects and Reasons' lists down the various facets of right to health as recognised by the several international covenants as also by the Indian Constitution by virtue of a combined reading of Articles 14, 15 and 21. It would however, be incorrect to assume power of legislation solely on the basis of Item 14 in List I which related to the authority of the Union Parliament to enact statutes to fulfil international obligations (National Health Bill, 2009), one such obligation being the implementation of the International Health Regulations, 2005 propounded by the WHO. While a compelling reason in itself, making a law pursuant to item 14 of the Union List would deprive the state legislatures of any control over such statute as only the Centre has jurisdiction over subjects mentioned in the Union List. This would defeat the purpose of having national health legislation as along with uniformity, the ultimate goal of the legislation has to be public welfare, a goal which, by denying the states any authority over the statute will ipso facto be compromised. Furthermore, with an amendment to the Seventh Schedule, adding health to the Concurrent list, the question of the Union Parliament encroaching upon the states' jurisdiction would never arise as both the Centre and the states would be stakeholders with a say in that subject.

One must strive to learn from the experience of this global pandemic, unprecedented in terms of its spread and effect, not only on the world population but also on institutions both international and domestic. India must equip itself with the requisite tools to fight such a situation in the future and enacting a national health law is the first step in that direction and an amendment to the Seventh Schedule of the Indian Constitution is a possible way of moving towards that first step.

RECOMMENDATIONS

India has shown remarkable resilience and grit in tackling the pandemic and has been successful in sustaining itself during the most testing curve of the pandemic. While this success is owed in part to the administrative and legislative response of Union and State governments, the experience of the pandemic has shown that there is a dire need for the Centre to actively participate in the sphere of public health. Health plays an important role in the life of an individual and it stands to reason that it forms an integral part of the Right to Life as enshrined under Article 21 of the Indian Constitution. In light of the importance of health to not only an individual but also to the nation at large, the authors have the following recommendations to make:

1. One of the ways in which the Centre can play an active part in formulating a public healthcare legislation without taking away the State governments' right to administer healthcare in its territory is by shifting "health" as a subject from the State List to the Concurrent List. This can be done by way of a formal constitutional amendment of the Constitution of India as was done with "education" pursuant to the 42nd Amendment of the Constitution. It is imperative to make a reference to the 2019 report of the HighLevel Group on Health Sector which was formulated by the 15th Finance Commission in the year 2018. In this

report, the High Level Group (HLG) while focusing primarily on medical education in India suggested that "health" as a subject should be shifted to the Concurrent List and stated that this recommendation needed further deliberation by the Niti Ayog and the Inter State Council.

2. The Centre also has the option of choosing the recourse under Article 249 of the Indian Constitution. Under Article 249 the Parliament is empowered to make laws on those subjects which are enumerated in the State List if two conditions are fulfilled *viz.* – i) that it is necessary or in national interest to make laws on the state subject and ii) that the Council of States *i.e.*, the Rajya Sabha passes a resolution in that regard with two thirds of the majority present and voting in the house, authorising the Union Parliament to legislate on subjects mentioned in the State List. Once such resolution is passed, the Parliament assumes the power to legislate on the said subject for the entirety of India's territory. The only caveat to this provision is that once the resolution is passed, it remains in effect only for a period of one year and must be renewed annually to ensure that the law passedpursuant to the resolution remains intra vires the legislative powers of the Union Parliament. Since health is of paramount importance for the nation as has been made abundantly clear by the experience of this pandemic, the Centre can use the mechanism mentioned under Article 249 to bring in a national public health law. A resolution has already been passed on health pursuant to Article 249 which culminated into the National Health Policies of 1983, 2002 and 2017 and the same recourse can be taken to enact a national legislation.
3. In the event that the Centre assumes the authority to legislate on health, the National Healthcare Bill should be reintroduced and passed with certain amendments. The Bill puts certain obligations on both the state governments as well as the Centre government to ensure that they have sufficient monetary resources to fulfil the duties set forth by the Bill. The Bill also encumbers the governments to provide "free and universal" access to healthcare and forbids them from denying healthcare "to anyone" not only by the State agencies but also by other private players. The Central Government has also been empowered under Section 6 of the Bill to pass laws, rules, regulations etc. especially for a) the prevention of those diseases which are communicable in nature, b) for those health emergencies which have gained international recognition [as is the case for the covid-19 pandemic], c) for birth and death registration, d) for food safety, e) for making drugs available and accessible and ensuring that such drugs follow the required safety standards, f) for those aspects of social security which are related to social security and employment etc. Another path-breaking provision in the Bill was that of providing reproductive and sexual healthcare rights to adult women and adolescent girls alike.

As far as implementation is concerned, the Bill provides for the creation of a National Public Health Board which has been given the primary function of co-ordination, maintaining national uniformity, providing assistance in terms of financial, technical and human resources. Section 18 specifically mentions that the States must be given the maximum extent of power over health and related functions in their territories and only those matters of health which have specifically been reserved for the Centre under the Indian Constitution, have to be exercised by the National Health Board. This is evidence of the fact that a National Health Law will not encroach upon the States' right to administer healthcare within their territories and at the same time will ensure a uniform framework of implementation and administration throughout the country.

It is the authors' humble opinion that while the Bill does a commendable job on providing a decentralised healthcare apparatus and provisions on general aspects of health but the Bill also codifies the right to health, under Section 8 of the Bill, which India is currently not prepared for. The right to health should be made justiciable only when there is a subsequent improvement in health infrastructure as granting a right which is enforceable in spirit will not serve its purpose unless the State possesses the means to ensure that the practical implementation of the right is possible.

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