LAW, POLICY AND ENFORCEMENT CHALLENGES IN HEALTH REGIME WITH SPECIAL RFERENCE TO PANDEMIC (COVID-19): LESSONS LEARNT

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Abstract

Sensitivity towards health ethics during this pandemic requires a transition. COVID-19 has restated the challenges before the health regime in India. This article demonstrates the challenges related to health issues posed to legislative and judicial machinery and their responses. The role of the government in influencing the people is to be visualized in the domain of the health sector. It is an attempt to present a critical survey of legislations and the interpretation of constitutional mandates for ameliorating the health of the people and trying to combat the situation created by a virus known as SARS-CoV-2. The author emphasizes that India needs a comprehensive central legislation and/or the present legislation be infused with proper health care provisions so that even the remotest villager realizes the fundamental right to good health.

I. Introduction

IT IS rightly said that '*Salus populi supreme lexesto'*, which means 'the health of the people should be the supreme law.'[1] As only health of the people can determine the fate of any nation. Healthy people play the most crucial role in achievement of sustainable development goals. Similarly, good health is also considered to be the cornerstone for any sort of development. The health of humans, however, is dependent on the surrounding environment in which they live.

The plans, health schemes and the legal framework could not balance between what was meant for providing good health and the multiple interventions as far as public health was concerned. While we are aware of the dismal status of the health infrastructure at central and state level, COVID-19 has given us the opportunity to rethink our health policy and implementation gap in health laws.

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[1] *De Legibus* by Marcus Tullius Cicero.

This article demonstrates the same as it would be seen that the legislations in vogue are century old or decade old. They were necessitated at the time when they were legislated. The question is, are they adequate to ameliorate the degrading health structure of the country? The article, therefore, focuses on whether we need new legislation for combating health hazards. Did we enforced the existing laws with full vigor. The objective of this article is to present a critical survey of legislations addressing health issues as well as the different plans which were in vogue and are still in vogue. The objective is also to trace the evolution of health jurisprudence in India relevant to the pandemic and to increase the accountability of people as well as the government qua each other and encourage positive implementation by purposive interpretation through the Courts.

The Government of India has time and again framed several policies.[2] The Indian legislative framework goes to show that the Epidemic Diseases Act, 1897, a colonial law, is required to be substituted by law which can give an umbrella legislation. The Epidemic Diseases Act, 1897 and the laws prevailing today like the Disaster Management Act, 2005 give autonomous power to the States to legislate with the right to frame their regulations for the health of the people. However, current pandemic has made us realized that public health facilities need a revolutionary change.

The problem of health has several facets. Initially, it seemed to be super-technical, but with the spreading of environmental pollution, it became socio-technical. The world community finds solace in law to address this issue and therefore it assumes socio-techno-legal character. In other words, there is a linking process as while deciding an issue of health, the Courts will have to take into consideration the social, technical, legal and economic factors so as to give optimum effectiveness to the situational approach[3]. With the advancement in technology, a data bank is required to cater to our health needs in future.[4]

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[2] National Health Policy (1983, 2002, 2017), *available at*: https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf (last visited on Sept. 01, 2020).
[3] A. A. Desai, *Environmental Jurisprudence* (New Delhi Modern Law House, 2nd edn., 2002).
[4] Sahil Deo and Subhodeep Jash, "Heralding a new health data regime in India", *Observer Research Foundation*, July 06, 2020, *available at*: https://www.orfonline.org/expert-speak/heralding-a-new-health-data-regime-in-india-69259/ (last visited on Sept. 01, 2020).

While discussing the aspect of health, the author would be discussing animate as well as inanimate objects. The temperature, wind, electricity which constitutes abiotic components are seen as an essence on which biotic components thrive. The non-living component comprises atmosphere, hydrosphere and lithosphere. This is necessary to be mentioned as COVID-19 has spread through which sphere is unknown. The biotic sphere consists of plants, animals and homo sapiens line on what does animate inanimate mean here. Conservation of our environment which was once protected but now we need to rejuvenate because hazardous substances have caused havoc. Our lives have been brought to a complete standstill, during this year of 2020 due to a virus which originated from Wuhan in Republic of China. The disease brings epidemic which then brings pandemic which causes harm to animate and inanimate. The author has bifurcated the study into regimes; British Regime or Pre-independence period i.e. prior to 1947 and Post-independence era.

The ancient regime and era is important to begin with as the Vedas, Upanishad, Smritis, Dharmas, Rigveda, Manusmrities, Charusanhita, were the first ones to provide us with a code of conduct for protecting our environment. The Arthshashtra of Kautilya, can be said to be Magna Carta for framing comprehensive policy of environment during the ancient Indian period.[5] However, sophisticated laws for environmental protection and conservation can be found only after the advent of British in India.[6]

II. Health regime during the British Period

The British regime would reveal that the Britishers tried to safeguard the community from health hazards. One of the initial attempt in this direction was, the passage of the Shore Nuisances (Bombay and Kolaba) Act, 1853 "to facilitate the removal of nuisances and encroachments below high- water mark in the Islands of Bombay and Kolaba." The removal of filth and safe navigation in public interest was the purpose of this law. The collector was empowered for the removal of nuisance but the rule of natural justice (notice) was acknowledged in the enactment. The aggrieved party was provided with the right to petition in the Court. Similarly the Oriental Gas Company Act, 1857 was passed so that the company can

[5] Hardik Shah, *Environmental Legislation and Administration in India : Critical Appraisal* (2003).
[6] *Ibid.*

open soils, break up any sewers, drains, or tunnels *etc.* for coal gas supply in Calcutta.[7] The Company could incur "liability to indictments for nuisance."[8] To avoid health hazards to the public the Oriental Gas Company Act provided that such places would be fenced and guarded. Once the work is over, the rubbish will be carried away as early as possible. If the company failed to restore the open drainage, pipes *etc*., there was provision for punishment. Indeed there was "Penalty for causing water to be corrupted" by the Company.[9] It was a strict liability offence in certain cases. The Company could be liable for each offence separately making the offence continuing in nature. There was a daily penalty during the gas escape. There was also penalty if water be fouled by Gas.[10] The uniqueness of these provisions rests in (i) both provisions were strict liability offences because they did not require any mental element. (ii) they are consequence neutral offences, *i.e*., even if no injury was caused, the offence could be committed. It can be recalled that in the case of *Rylands* v. *Fletcher*[11] the House of Lord held that "anything that is likely to do mischief if escapes" will be the responsibility of the person who brought it on his land. But the liability under tort will be incurred only if there is a damage. The OGC Act, 1857 is free from such riders of internal element of mental capacity or external element of consequences. This makes the accused more responsible. The criminalisation of such conduct causing health hazards was made under various provisions of the OGC Act, 1857 ten years prior to *Rylands* v. *Fletcher* and three years before IPC, 1860. However, they were in the nature of civil offences because there was no provision for imprisonment and fine was the only punishment.

Next milestone development was the passage of the Indian Penal Code, 1860 which contains several provisions for safeguarding the health of the people. Chapter XIV of IPC is dedicated to the offences affecting "public health, and safety". The other provisions which require a mention and which are being put in action by the government so as to safeguard the people from disasters are; section 269 where 'negligent act likely to spread infection of disease dangerous to life' is made punishable for six months. Section 270 which deals with 'malignant act likely to spread infection of disease dangerous to life.' This was for more serious cases and therefore is made punishable by two years. The concern of the British can be reflected under

[7] The Company was sold and did not work effectively. A case can be traced on the Industrial Disputes Act, 1947, decided in 1954 by the High Court of Calcutta. *Ramdas* v. *K.M. Sen, Manager, Oriental Gas Co. Ltd., Calcutta*, AIR 1955 Cal 517. The Company was nationalized in 1960.
[8] The Oriental Gas Company Act, 1957, s. 21.
[9] *Id.*, s. 15.
[10] *Id.,* ss. 16, 17.
[11] [1868] UKHL 1.

these provisions. The first important conviction under this provision was in *Queen Empress* v. *Krishnappa and Murugappa*,[12] in which a person suffering from cholera had travelled through the train. He was convicted under section 269 and same conviction was upheld by the Madras High Court. The *ratio decidendi* contains points which is as under:

> he was, to his knowledge, suffering from cholera, did an act which he must have known was likely to spread the infection of a disease dangerous to life; and he did so "negligently," that is, neglecting the precautions which would have obviated risk to his fellow passengers in that he gave no notice of his condition to the Company's servants, who would have either provided separate accommodation for him or have lawfully prevented him from travelling.

If we analyze the above passage we find three points. (i) he was aware of his disease, which establishes the knowledge subjectively. (ii) he must have known that he "is likely to spread the infection of a disease dangerous to life." This is objective knowledge based on reasonable person test. (iii) he did not inform the authorities. Such information was a part of his legal duty to take care. Had he informed the authorities, they might have taken action in the interest of his health or health of other passengers.

Section 271 prescribes punishment for disobedience to quarantine rule. However, this is a misnomer in contemporary discussion because this provision is limited to ports only. Therefore, it is clear that the Indian Penal Code which was legislated in 1860 before the Epidemic Act is being extensively implemented where people are flouting the orders passed by police authority so as to have deterrent effect on the people. The people against whom these provisions (section 188, 269, 270) were applied in the wake of COVID-19 and the subsequent lock down 2020 are common persons, Bollywood singers**,** politicians *etc.*[13] However, the executive and the Police have used it in a hurry without understanding the elements of offences. For example, in the case of *Konan Kodio Ganstone* v. *State of Maharashtra*[14] (popularly called

[12] (1883) ILR 7 Mad 276.
[13] Explained Desk, "Explained: Sections 269 & 270 IPC, invoked against those accused of spreading disease?", *The Indian Express*, March 30, 2020, *available at*: https://indianexpress.com/article/explained/explained-what-are-sections-269-270-ipc-invoked-against-those-accused-of-spreading-disease-6336810/ (last visited on Sept. 02, 2020).
[14] 2020 SCC OnLine Bom 869. The charge sheets are filed in these crimes for offences punishable under ss. 188, 269, 270, 290 of Indian Penal Code, ss. 37 (1)(3) r/w. 135 of the Maharashtra Police Act, 1951 and s. 11 of

as *Tablighi Jamaat* case) there was prosecution under various provisions including section 269, 270 of IPC. *Tablighi Jamaat* members were not infected at relevant time. The High Court of Bombay held that "it is not possible to infer under any circumstances that these persons were infected when they arrived to India. It is also not possible to infer that their acts amount to offences punishable under sections 269 and 270 of I.P.C." Therefore, the whole FIR was quashed.

The object of legislating the laws during the colonial era was either to address rapid industrialization or exodus of villages to cities for earning livelihood which continue even today. Later one more law was legislated *i.e.,* the Bombay Village Sanitation Act, 1889 which meant to improve the sanitary condition of villages in the presidency of Bombay and to provide for the constitution of Sanitary Committees. The last decade of the nineteenth century witnessed a very severe threat to public health through the bubonic plague of Bombay in 1896. This led to many legal developments. Three of them were - (a) the enactment of the Epidemic Disease Act, 1897. (b) conviction of Lokmanya Tilak for sedition law and (c) murder of collector Rand. All three are relevant for the year 2020. The plague spread to Pune. Collector RA Lamb of Pune planned "house-to-house search for infected patients and suspects" with the help of soldiers. The British resorted to the "compulsory methods" to ensure isolation of the infected patients. While the intention was to secure the people, the implementation of the plan enraged the mass in Pune and Maharashtra. Three reasons of great disappointment of Indian people against the counter plague drive can be summarized as - (a) "there was wanton and indiscriminate destruction of the property during searches" in order to use disinfectant. (b) "Perfectly healthy" persons were taken to segregation camps, and (c) Certain members of the British administration misbehaved with the female members. They behaved 'disgracefully with native ladies'.[15]The females were compelled to come out of their houses and stand before the public gaze in the open street and were subjected to inspection by soldiers. Bal Gangadhar Tilak was compelled to write in his paper *Mahratta*, as under :[16]

Maharashtra COVID-19 Measures and Rules, 2020, ss. 2, 3 and 4 of the Epidemic Diseases Act, 1897, s. 14 (b) of the Foreigners Act, 1946 and s. 51(b) of the Disaster Management Act, 2005.

[15] Atikh Rashid, "How oppressive containment measures during Poona plague led to assassination of British officer", *The Indian Express*, June 09, 2020, *available at:* https://indianexpress.com/article/research/how-oppressive-containment-measures-during-poona-plague-led-to-assassination-of-british-officer-6450775/ (last visited on Sept. 03, 2020).

[16] *Ibid.*

> Plague is more merciful to us than its human prototypes now reigning the city. The tyranny of the Plague Committee and its chosen instruments is yet too brutal to allow respectable people to breathe at ease.[17]

This became one of the reasons for his conviction under the law of sedition *i.e.,* section 124A of IPC. In Pune the great disappointment of people resulted in the killing of Rand and Lieutenant Charles Ayerst by Chapekar brothers. In light of this, we are obliged to invoke old legislations even today, namely the Epidemic Diseases Act, 1897 and IPC provisions to tackle COVID-19. The State Governments also faced some disappointment from the public in some cities. Health personnel were stopped and attacked.[18] With the help of digital media, aggressive awareness campaign and receptive government officials the pandemic of 2020 could avoid the situation like the Pune of 1897 and the collector Rand like incident. The Epidemic Diseases (Amendment) Ordinance, 2020 was passed to deal with serious violators.[19]

The Epidemic Diseases Act of 1897 was preceded and also succeeded by several other Acts which were meant for protection of the health.[20] Next significant development can be traced to the Government of India Act, 1919 which made express provision for "public health".[21] Under Part 11 public health was a Provincial Subject. However, the central legislature was empowered "in respect to infectious and contagious diseases". If we date back to the Nehru Report of 1928[22] it viewed public health as a constitutional right under the chapter of

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[17] *Available at:* http://dspace.wbpublibnet.gov.in:8080/jspui/bitstream/10689/13311/7/Chapter%208-10-118-180p.pdf (last visited on Sept. 03, 2020).

[18] Vikas Pandey, "Coronavirus: India doctors 'spat at and attacked", *BBC News*, April 03, 2020, *available at*: https://www.bbc.com/news/world-asia-india-52151141#:~:text=Several%20healthcare%20workers%20in%20India,vulgar%20language%20towards%20female%20nurses (last visited on Sept. 04, 2020).

[19] The Epidemic Diseases (Amendment) Ordinance, 2020 (NO. 5 OF 2020), *available at*: http://egazette.nic.in/WriteReadData/2020/219108.pdf (last visited on Sept. 04, 2020).

[20] The Shore Nuisance Act (Bombay) 1853; The Orient Gas Company Act, 1857; The Indian Penal Code, 1860; The Cattle Trespass Act, 1871; The Indian Easements Act, 1882; The Bombay Village Sanitation Act, 1889; The Indian Fisheries Act, 1897; The Criminal Procedure Code, 1898; The Code of Civil Procedure, 1908; The Explosives Act, 1908; The Bombay Smoke Nuisance Act, 1912; The Indian Boiler Act, 1923; The Indian Forest Act, 1927; The Brostol's School Act, 1929; The Dangerous Drugs Act, 1930; The District Vaccination Act, 1932; The Drugs and Cosmetic Act, 1940.

[21] Entry 3. Public health and sanitation and vital statistics ; subject to legislation by the Indian legislature in respect to infectious and contagious diseases to such extent as may be declared by any Act of the Indian legislature. *See also* H. N. Mitra (ed.), *The Govt. of India Act, 1919 Rules Thereunder & Govt. Reports, 1920* (N. N. Mitter, Annual Register Office Sibpur, Calcutta, 1921), *available at*: https://advocatetanmoy.files.wordpress.com/2017/04/govt-of-india-1919-act.pdf (last visited on Sept. 04, 2020).

[22] The mandate of the committee was 'to consider and determine the principles of the Constitution of India along with the problem of communalism and issue of dominion status.' Motilal Nehru (Chairman), Sir Ali Imam, Tej Bahadur Sapru and Subash Chandra Bose. M.R. Jayakar and Annie Besant joined the Committee later. Jawaharlal Nehru, Motilal Nehru' son, was appointed the secretary to the Committee. Hereinafter referred as

fundamental rights. Under article 4, the report provided that the "Parliament shall make suitable laws for the maintenance of health and fitness for work of all citizens."[23] Schedule I contained Central Subjects where entry 15 contained "Port quarantine" and "marine hospitals" while entry 37 covered Industrial matters which contained "Laws relating to Industrial Insurance-General health and accident." Epidemic disease did not find any mention in the report. Public health and sanitation was in the State list.[24] It seems difficult to understand why public health was a provincial subject when the Parliament was mandated to make law. The Government of India Act, 1935 also contains "Public health and sanitation" in the provincial list like the Act of 1919.[25]

III. Constituent Assembly Debates and the Constitution on Public health

In the Constituent Assembly, the Expert Committee on Financial Provisions[26] in 1947 warned that the "sources of revenue allocated to the Provinces were inelastic, and were insufficient ... for ...Medical Relief, Public Health…" During the Constituent Assembly Debates, H.V. Kamath wanted the subject of public health to be shifted to the Concurrent List. He observed as under:[27]

While commending my amendment seeking to transfer public health, sanitation, hospitals and dispensaries to the Concurrent List, I should like to state that public health has been the Cinderella of portfolios in the Cabinet of our country. During the British Regime it was specially so, very sadly neglected and not much provided for : as a result of which the health of the nation has fallen to C-3 standards, it is the object of our government today to raise the health of the nation from C-3 to A-I standard. If this were the aim of our Government we could not do better than make public health a Concurrent subject. It must be accorded top priority if the nation is to rise to its full stature.

Nehru Report, *available at*: https://www.constitutionofindia.net/historical_constitutions/nehru_report__motilal_nehru_1928__1st%20January%201928 (last visited on Sept. 03, 2020).

[23] Nehru Report, art. 4 (xvii).

[24] Schedule II-Provincial Subjects, Entry 16.

[25] Seventh Schedule- Legislative Lists- List II. Provincial Legislative List, Entry 16.

[26] VII, *Constituent Assembly Debates*, Dec. 05, 1947, *available at*: https://eparlib.nic.in/bitstream/123456789/762996/1/cad_04-11-1948.pdf (last visited on Sept. 05, 2020).

[27] IX, *Constituent Assembly Debates*, Sept. 02, 1949.

On the other hand, Sri Brijeshwar Prasad wanted the same to be in the Union List. The reason given was the weak financial earnings of the provinces. However, the Constituent Assembly followed the Act of 1919 and 1935 where public health was with provinces. The Motilal Nehru Report also supported the same but it had made a provision under fundamental rights where the Parliament was required to make laws on public health.

The constitutional mandate under article 246 read with 7th Schedule distribute matters between the Union and the States and their power to legislate. Under the seventh schedule the Union List or List I contains certain provisions dealing with health.[28] Under State List or List II Entry 6 contains "Public health and sanitation; hospitals and dispensaries." The Concurrent List or List III has Entry 23 which is on "Social Security and Social Insurance". A high level committee under the 15th Financial Commission in 2019 has recommended the subject of public health be shifted to Concurrent List.[29] India being a federal structure, the shifting of the provision of health to the concurrent list, strengthen the access to people. The basic law as per the Concurrent List would be public welfare. If the subject of health is shifted to the Concurrent List as per Article 254, subject to rule of repugnancy the State will not lose their competence to legislate. The shifting of the subject of health from the State List to the Concurrent List would be based on the rationale which underlines the common interest of the Center and the State. The main purpose as to why the author suggests shifting from List II to List III is that it is now important to safeguard the fundamental right to good health and to secure implementation of the Constitutional directive. After declaration of the right to health as fundamental right under article 21, it is incumbent upon both, the central as well as state that this right is realized in its spirit. This is possible if public health is shifted to the concurrent list. Arguments have been made that such shifting will weaken the federal structure and will be a step towards further centralisation. Seventy years of our experience has shown that the provinces cannot provide good health infrastructure. They don't have a sufficient budget for it. Instead of centralisation, such shifting will be a new age of the coordination between the Centre and the states.

[28] Entry 28 - Port quarantine, including hospitals connected therewith; seamen's and marine hospitals.
[29] Uday Shankar, Simi Mehta, *et.al.*, "New India? A case for urgent transfer of public health from state to concurrent list", *Counterview*, April 29, 2020, *available at*: https://www.counterview.net/2020/04/new-india-case-for-urgent-transfer-of.html (last visited on Sept. 06, 2020).

Government can also bring in legislation as was done with the Water Act by invoking Article 252 of the Constitution of India. In 2002, the Parliament brought 86th constitutional amendment to incorporate the right to primary education as a fundamental right in pursuance of the Supreme Court decision.[30] Similarly, the right to health and adequate health care in India should be made a fundamental right by amending the constitution.

All other health related provisions which are also important for our purpose need a quick mention. It is now accepted that health is a fundamental right enshrined under article 21. However, health also serves as a restriction under articles 25 and 26. Provisions under directive principles of the state policies are enumerated in Articles 39,41, 42, 43 and 47 of the Constitution of India. The following provisions can also be referred to as they throw light on the health regime in India.

The Disaster Management Act, 2005 is enacted under this entry.[31] On the other hand another committee thinks that "disaster" is not on any list of the schedule. Therefore it should be treated in the Union List.[32] Moreover under article 253 of the Constitution of India the Parliament is empowered to make laws on international conventions, conferences.[33] At the World Conference on Natural Disaster Reduction in the city of Yokohama, Japan in 1994,"[34] deep concern was expressed with a call for a plan of action. It is appreciable to see that the Parliament has taken a view acceptable to the States also which indicates cooperative federalism in India.

Most relevant provision is Entry 29 of the Concurrent List or List III which deals with the "Prevention of the extension from one State to another of infectious or contagious diseases or pests affecting men, animals or plants." The Epidemic Diseases (Amendment)Ordinance, 2020

[30] *J.P. Unni Krishnan* v. *State of Andhra Pradesh*, AIR 1993 SC 2178.
[31] Rajya Sabha, Department - Related Parliamentary Standing Committee On Home Affairs, One Hundred And Fifteenth Report On The Disaster Management Bill, 2005. Para 2.1 of the report reads as "The proposed legislation is relatable to Entry 23 (Social Security and Social Insurance) in the Concurrent List of the Constitution. This will have the advantage that it will permit the States also to have their own legislation on disaster management", *available at:* http://164.100.47.5/rs/book2/reports/home_aff/115threport.htm (last visited on Sept. 07, 2020).
[32] National Centre for Disaster Management, "The Report of the High Powered Committee (HPC) on Disaster Management" 10 (October, 2001), *available at*: https://nidm.gov.in/PDF/pubs/HPC_Report.pdf (last visited on Sept. 08, 2020); *See also* Rajendra Kumar Pandey, "Legal Framework of Disaster Management in India", Winter Issue *ILI Law Review*, 179 (2016), *available at:* http://ili.ac.in/pdf/p13_rajendra.pdf (last visited on Sept. 08, 2020).
[33] Art. 253. Legislation for giving effect to international agreements — Notwithstanding anything in the foregoing provisions of this Chapter, Parliament has power to make any law for the whole or any part of the territory of India for implementing any treaty, agreement or convention with any other country or countries or any decision made at any international conference, association or other body.
[34] *Supra* note 33 at 3.

is passed under this entry. The health related issue extends vertically to the third and fourth level of democratic institutions. Under the 11th schedule the Powers, authority and responsibilities of Panchayats are provided. Entry 23 of the Eleventh schedule deals with "Health and sanitation, including hospitals, primary health centres and dispensaries." Same is provided under the Twelfth Schedule (article 243W) where Powers, authority and responsibilities of Municipalities are provided. Entry 6 of this schedule provides for Public health and sanitation. Sixth Schedule [articles 244(2) and 275(1)] has "Provisions as to the Administration of Tribal Areas in the States of Assam, Meghalaya, Tripura and Mizoram." They deal with Autonomous districts and autonomous regions. Assam under clause(k) places public health and sanitation, hospitals and dispensaries.

In other words, the Constitution of India is conscious that public health is something that has to be addressed at village level. However, the mandate of the Constitution was attended with a halfhearted approach. COVID-19 has given an opportunity to revisit our priorities. The 73th Amendment (1992) envisages the Gandhian dream of empowering Gram Sabha. It conceived a three tier Panchayat Raj System at the village, intermediate and district levels. The Government should focus more on better health care facilities in these three tier Panchayat Raj System either through executive order or facilitating a suitable legislation.

These provisions under various schedules are important as they relate to the powers and responsibility of agencies of State. The municipalities under these provisions carry out what can be said to be giving power to the State and its instrumentality. They strengthen cooperative federalism so that the Central Government determines the national standards and the central authorities oversee the policies regarding these subjects. The author feels that a Central Legislation would strengthen cooperative federalism, provide better health facilities and empower the State to function in a much better way. It is supported by "a high-level group (HLG) on health sector constituted by the Fifteenth Finance Commission." It has made two recommendations:

(i)'Right to Health' be declared a fundamental right on the 75th Independence Day in 2022.

(ii) The subject of health be shifted from the state list to the concurrent list.[35]

For both, constitutional amendments will be required.

[35] Dinesh Narayanan, "Panel seeks 'Right to Health', shift to Concurrent list", *The Economic Times*, Sept. 03, 2019, *available at:* https://health.economictimes.indiatimes.com/news/policy/panel-seeks-right-to-health-shift-to-concurrent-list/70953162 (last visited on Sept. 10, 2020).

A reference to the decision of the Apex Court in *Security Association of India* v. *Union of India*[36] held that constitutional doctrines must be designed to reconcile the legitimate diversity of regional experimentation with the need for national unity, and if such appropriate balance is struck, it would be in pursuance of cooperative federalism. Thus, the Central Government can shift health into the concurrent list which would be more beneficial to meet with such a situation in future.

IV. Right to health : A fundamental right

It is significant to note that in 2017 a private member Bill was proposed to introduce a new article 21B for making the right to health a fundamental right. It says that, "the state shall provide a system of health protection to all citizens, including prevention, treatment and control of diseases and access to essential medicines."[37] The Bill is a good attempt but the financial statement has not been attached with Bill. The Bill says that it was not possible to predict such a financial statement. Without any homework on financial liability, it is not advisable to proceed with the Bill. While fundamental rights cannot be denied for lack of funds, it is hard reality that public health requires huge expenditure. Within the first month of the lockdown in 2020 the Supreme Court passed an order in the case of *Shashank Deo Sudhi* v. *Union of India*[38] where it declined to make all COVID-19 tests free of cost. The Court seemed to be influenced by two reasons, namely –

(a) making health scheme a policy matter, (b) the financial constraints cannot be ignored, (c) poor and needy persons are given COVID-19 treatment and tests free of cost under Aayush and other government schemes.

[36] Stuti Shah and Shashank Atreya, "COVID-19 outbreak refocuses need to shift public health from State to Concurrent List; move won't harm decentralisation but enhance Centre, state coordination", *First Post*, June 15, 2020, *available at*: Https://www.firstpost.com/health/covid-19-outbreak-refocuses-need-to-shift-public-health-from-state-to-concurrent-list-move-wont-harm-decentralisation-but-enhance-centre-state-cooridnation-8483911.html (last visited on Sept. 10, 2020).

[37] Art. 21 B - (1) The State shall provide health protection to all citizens which shall include; (a) prevention, treatment and control of diseases; (b) access to essential medicines; (c) maternal, child and reproductive health; (d) access to basic health services; (e) access to emergency medical treatment; and (f) access to mental healthcare. Provided that the State in such manner as deemed fit, shall provide the above objectives for every citizen by earmarking not less than eight per cent of the annual estimated receipts of the State for healthcare, *available at*: http://164.100.47.4/billstexts/rsbilltexts/AsIntroduced/21B-E-151217.pdf (last visited on Sept. 10, 2020).

[38] 2020 SCC OnLine SC 358.

Right to health as a fundamental right has been briefly referred to in *Pt. Paramanand Katara* v. *Union of India*[39] for medico legal cases (MLCs). The right to health under article 21 was indirectly recognised in MLCs. A clear recognition of right to health can be traced in the case of *Consumer Education and Research Centre* v. *Union of India*[40] where the Court held as under:

> Continued treatment, while in service or after retirement is a moral, legal and constitutional concomitant duty of the employer and the State. Therefore, it must be held that the *right to health and medical care is a fundamental right under Article 21* read with Articles 39(c), 41 and 43 of the Constitution and make the *life of the workman* meaningful and purposeful with dignity of person.

The recognition of the right to health as a fundamental right is limited to a person or patient who is/was a workman.

Consumer Education and Research Centre was a long leap in the direction of fundamental right to health. However, it was limited to workers in hazardous factories. Another mile stone development was *Paschim Banga Khet Mazdoor Samiti* v. *State of West Bengal*.[41] The Supreme court explained in a couple of para why it is a part of article 21. However, it was limited to the right of an *injured person* who was denied admission to a government hospital. *Paschim Banga Khet Mazdoor Samiti* is relevant in context of COVID-19. There are many news articles which report that COVID-19 patients run from one hospital to another. Many hospitals declined admission of COVID-19 patients for one cause or other.[42] Some patients died on the road,[43] some died inside hospitals for lack of facilities. As per the law laid down in *Paschim Banga Khet Mazdoor Samiti* case, patients can be denied admission only if the

[39] 1989 (4) SCC 286.
[40] AIR 1995 SC 922.
[41] 1996 SCC (4) 37. The issue decided by the Court was "whether the non-availability of facilities for treatment of the serious injuries sustained by Hakim Seikh in the various Government hospitals in Calcutta has resulted in denial of his fundamental right guaranteed under Article 21 of the Constitution." The Court answered in strong yes.
[42] Shikha Salaria, "41-year-old Covid patient denied admission by Noida hospital", *The Times of India*, Sept. 13, 2020, *available at:* https://timesofindia.indiatimes.com/city/noida/41-year-old-covid-patient-denied-admission-by-noida-hospital/articleshow/78086348.cms (last visited on Sept. 10, 2020).
[43] Kiran Parashar, "Denied admission, Covid-19 positive patient dies at Bengaluru hospital doorstep", *The Times of India,* July 02, 2020*, available at:* https://timesofindia.indiatimes.com/city/bengaluru/denied-admission-covid-19-positive-patient-dies-at-bengaluru-hospital-doorstep/articleshow/76740196.cms (last visited on Sept. 10, 2020). *See also* Ankita G Menon, "Denied admission by 5 hospitals, 51-year-old Covid-19 patient dies in Thane", *The Hindustan Times*, June 14, 2020, *available at:* https://www.hindustantimes.com/cities/denied-admission-by-5-hospitals-51-year-old-covid-19-patient-dies-in-thane/story-gMvlprhKsuplP5m3LoXLaN.html (last visited on Sept. 10, 2020).

hospital has made enough effort to find suitable beds, facilities like oxygen cylinders, ICU *etc.* in other wards, other floors, and other hospitals.

The *Paschim Banga Khet Mazdoor Samiti* case has a suggestion which was legislative in nature. In the USA problems like that of India were frequent. In the words of the learned advocate:

> Private hospitals were turning away uninsured indigent persons in need of urgent medical care and these patients were often transferred to, or dumped on public hospitals and the resulting delay or denial of treatment had sometimes disastrous consequences. To meet this situation the U.S. Congress has enacted the Consolidated Omnibus Budget Reconciliation Act of 1986 [for short 'COBRA'] to prevent this practice of dumping of patients by private hospitals. By the said Act all hospitals that receive medicare benefits and maintain emergency rooms are required to perform two tasks before they may transfer or discharge any individual.

It is understandable that the population of the USA and the financial as well as human resources cannot be compared with India. COVID-19 has made us learn that it is high time we should seriously think on such suggestions like COBRA made twenty five years ago. The experiences of seven decades suggest that the Parliament has to do it for which it is empowered to do under concurrent list.[44] While finances are a serious concern, the Court reiterated that the matters of constitutional obligations (here article 21) to provide adequate medical services to the people, "whatever is necessary for this purpose has to be done." On the financial aspect of fundamental right to health the *dicta* of the Supreme Court in the case of *State of Punjab* v. *Mohinder Singh Chawla*[45] is relevant The Supreme Court held that a government servant referred to another hospital by a government hospital for adequate treatment, all medical expenses including rent of staying in the hospital or hotel during treatment will be covered under medical Bills. The directions in *Consumer Education and Research Centre* as well as *Paschim Banga Khet Mazdoor Samiti* uphold that article 21 contains the fundamental right to health of every person. However, the needy, poor, workers, injured *etc.* can enforce their fundamental right to health and access to health care is unqualified. Lack of finances cannot be a justification for it. On the other hand, for the rest of the citizens, the fundamental right to health is not unqualified and state resources do play a crucial role.

[44] List III, entry 23. Social security and social insurance; employment and unemployment.
[45] AIR 1997 SC 1225.

One can appreciate two categories of fundamental right to health under article 21, *i.e.,* unqualified and qualified. For COVID-19 test Ayushman Bharat Yojana, the Labs are conducted free of cost.[46] For those not covered under the Yojana the offer rate was Rs. 4500 which was reduced by various States.

According to the author, we will now have to even enforce fundamental duties more vigorously for the benefit of the people who try to save us and are not harmed by us. The Epidemic Diseases Act, 1897 was directed to be invoked by States, Union Territories and the provisions of Disaster Management Act, 2005 were invoked so as to treat this novel disease. The Nodal legislation was supplemented by an Ordinance of 2020.This ordinance as narrated above was an armor for the protector as incidents occurred in all parts of the country which were collectively showing that there was hopelessness, helplessness and resilience. The ordinance was necessitated so that the violent tendencies during the outbreak of the dangerous disease may be controlled. This shows that the argument of the author that we need a new health regime requires to be gone as they show that they are lacking in complete implementation. The vision of a public health legislation would concern the power and duties of the State so that the general public can benefit. An umbrella legislation with the kind of ordinance promulgated in April, 2020 if it is made part of a Statue, it can be immediately brought into effect so that there may be no difficulty in functioning and there would be very little difference. The Epidemic Disease Act, 1897 in the current scenario is to be infused with more regulatory and right based approach. It was also supplemented by invoking penal provisions of the Indian Penal Code. The government will have to enforce and see that the recent health plans are followed with great vigor. The legislations coupled with the legal sanctions and the interpretation given by the Supreme Court would serve the public and guide the government of states to see that the effect of the pandemic is lessened.

Moribund approach has given way to legislative and judicial activism. The conflict between central and state legislations has been curtailed by judicial interventions. Thus, it can be seen that we need legislation which would partake within itself right to an economically viable and balanced health regime. The right to a healthy environment can be said to be based on judicial interpretation.

[46] Pradhan Mantri Jan Aarogya Yojana.

Combating health hazards is a delicate problem. However, judicial activism coupled with PIL and directions by the Supreme Court and the High Court have protected the health of the Citizens. The Constitutional mandates and the judicial activism shown by the Courts with aid of legislative enactments have halted health hazards to a considerable extent. The mission is still not over. The nightmare is still continuing as a reality.

The legislations, the precedents set by the Apex court and High courts show that legislations alone will not help the govt or courts to meet the dangers of the pandemic . It can be noted that recently in a webinar on "*Environment and the Economy: Reimagining Key Concepts & Precepts*" effective guidance was proposed by Surya Kant, J. and road map ahead for the economy with environment protection and concerns in mind.[47]

The judicial orders even before lockdown till date go to show that the Supreme Court is trying to direct the government to see that the damage due to COVID-19 and lockdown is minimized. *In Re : Contagion of Covid-19 Virus in Prisons*[48] the Supreme Court tried to stop contagion spreading in prison houses. The Central Government and State Governments are taking effective measures for stopping the contagion of Novel Coronavirus caused by SARS-Cov-2 (COVID-19). Recently, in the case of *In Re Contagion of Covid-19 Virus In Children Protection Homes*[49] the Apex Court directed the central government for proper treatment of COVID-19 patients and of children in protection homes. The disasters in the past are different from the impact of this pandemic and, therefore, as the name suggests we will also have to have novel ideas to combat the same. The author has refrained himself from discussing any of the pending matters but suggests that a new health regime is required for this Country once the effect of the pandemic dies down.

V. Concluding Observations

The basic theme of good health lies in the will of people to obey the mandate and proper implementation of legislations in vogue. The disasters, epidemics and pandemics have to be combated by combined efforts of governments, judiciary and above all the people of the polity.

[47] Hon'ble Judge, The Supreme Court of India.
[48] March 16, 2020, Suo Motu Writ Petition (Civil) No.1/2020.
[49] June 11, 2020. Prior to this a detailed order was passed on April 3, 2020, 2020 SCC OnLine SC 354, order dated 03.04.2020.

Bringing one more legislation will not make much difference as the legislative system has assured and reassured people that the courts have respect for life and liberty namely (health of human beings and the habitat in which homo sapiens live. Health of the nation is the backbone of all other activities which rotate around the fulcrum *i.e.,* health, as health gives stability to a person who in turn gives stability to people of the nation which then completes the circle of ensuring good hygiene and hazard free existence. Health and economy are very important for both, legislation as well as governance of democracy and we need to find out innovative ideas to salvage the situation.

Dr. D.Y. Chandrachud, J. rightly observed that "Our Constitution places the individual at the forefront of its focus, guaranteeing civil and political rights in Part III and embodying an aspiration for achieving socio-economic rights in Part IV."[50] Legislations are one means to achieve these rights. COVID-19 has indicated the significance of the right to health and health care. Though legislation alone cannot bring good health to the country, legislation is a step forward. It is high time we should shift public health to the concurrent list, expressly recognise the right to health as a fundamental right and bring a central enactment to enforce it.

[50] (2017) 10 SCC 1 at para 266.