NEED TO SHIFT THE FOCUS OF ‘PUBLIC HEALTH’ AS A SUBJECT FROM STATE LIST TO CONCURRENT LIST

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ABSTRACT:
COVID-19 pandemic has exposed the deep vulnerabilities of the health sector in India. A good system of regulations is fundamental to successful public health outcomes. A wide gap exists in the enforcement, monitoring and evaluation, resulting into a weak public health system. This is partly due to poor financing for public health, lack of concentrated power, and commitment of public health functionaries. Revival of public health regulation through concentrated efforts by the Government is possible through upgradation and implementation of public health laws, consulting stakeholders and increasing public awareness of existing laws and their enforcement procedures. The seventh schedule is not cast in stone. Changes in seventh schedule requires ratification of the amendment by the legislatures of at least one-half of the states. The meritorious public health services with inter-state spillovers and their efficient provision requires subsidization. This research paper reviews the constitutional provisions related to health care and health sector, judiciary on state’s role in managing the public health sector, role of the state and centre during COVID-19 and the need to shift public health as a subject from state list to concurrent list.

INTRODUCTION:
“You can’t have public health without the public health system. We don’t want to be a part of mindless competition for resources. We want to build back the capacity in the system.”
- Paul Farmer

COVID-19 pandemic has shown us how the current constitutional framework impedes co-operative federalism on the subject of public health. It has been observed that the centre has been issuing directions across the country to battle with the pandemic, while some states has been issuing directions contrary to those recommended by the centre. Structured governance and sizable allocation of budgetary resources for public health are the apparent fixes to the health crisis before us.\(^1\) Despite this relatively simple solution, India is struggling in its governance of public health, primarily because of the lack of co-operative federalism between the centre and the state, and the limited mandate carved out in the Constitution for the centre to constructively participate in the governance of public health.\(^2\)

The need of the hour is to build a resilient public health system that can prevent diseases, promote good health and respond

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quickly to minimize the loss of life when faced with an outbreak of this magnitude. The other key issue for the condition in India is the extent and nature to which Government will be able to garner support from private partners is actually crucial. At some level there is a thought process we need to improve the infra-structure, public health care infrastructure and the hospitals run by the state needs to be improved and brought to a level where people have trust in public health care as well. There’s a need to realize and re-orient our health system towards public and preventive care. We have been very cure focused historically and that is not feasible at the scale we need to operate. We have too many people and too many diseases to cure with. We really need to focus on preventive and public health and that of course is the primary responsibility of the Government.

CONSTITUTIONAL PROVISIONS RELATED TO HEALTH CARE:
Constitution of India places obligations on the State to ensure protection and fulfilment of right to health to all, without any discrimination, as a fundamental right, by interpretation, under Articles 14, 15 and 21 (fundamental right to equality, non-discrimination and life); Article 23 (prohibition of traffic in human beings and forced labour); and Article 24 (prohibition of employment of children in factories, etc.); and also urges the State, under the Directive Principles of State Policy, to strive to provide to everyone certain vital public health conditions such as right to work, to education and to public assistance in certain cases (Article 41); just and humane conditions of work and maternity relief (Article 42); raised level of nutrition and the standard of living and to improve public health (Article 47); and protect and improve environment and safeguard forests and wild life (Article 48); and identifies certain concomitant fundamental duties like obligating every citizen to protect and improve the natural environment (Article 51).

The Directive Principles of State Policy in Part IV of the India Constitution provide a basis for the right to health. Article 39 (E) directs the State to secure health of workers, Article 42 directs the State to just and humane conditions of work and maternity relief, Article 47 casts a duty on the State to raise the nutrition levels and standard of living of people and to improve public health. Moreover, the Constitution does not only oblige the State to enhance public health, it also endows the Panchayats and Municipalities to strengthen public health under Article 243G (read with 11th Schedule, Entry 23).

Health and health care is now being viewed very much within the rights perspective and this is reflected in Article 12 ‘The right to the highest attainable standard of health’ of the International Covenant on Economic, Social and Cultural Rights. According to the General Comment the Committee for Economic, Social and Cultural Rights states that the right to health requires availability,
accessibility, acceptability, and quality with regard to both health care and underlying preconditions of health. The Committee interprets the right to health, as defined in Article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.\(^\text{14}\)

Given no explicit recognition of the right to health or healthcare under the Constitution, the Supreme Court of India in Bandhua Mukti Morcha v Union of India & Ors,\(^\text{15}\) interpreted the right to health under Article 21 which guarantees the right to life. In State of Punjab & Ors v Mohinder Singh Chawla,\(^\text{16}\) the apex court reaffirmed that the right to health is fundamental to the right to life and should be put on record that the government had a constitutional obligation to provide health services. In a historic judgment in Consumer Education and Research Centre vs. Union of India\(^\text{17}\) held that the right to medical care is a fundamental right under Art.21, it is essential for making the life of the workman meaningful and purposeful with the dignity of person.

In September 2019, a High-Level Group on the health sector constituted under the 15th Finance Commission had recommended that the right to health be declared a fundamental right.\(^\text{18}\) It also put forward a recommendation to shift the subject of health from the State List to the Concurrent List. The recommendation to declare the right to health a fundamental right, if implemented, will strengthen people’s access. At present, the subject of “public health and sanitation; hospitals and dispensaries” falls under the State List of the 7th Schedule of the Constitution of India – which means that state governments enjoy constitutional directives to adopt, enact and enforce public health regulations.\(^\text{19}\)

**JUDICIARY ON STATE’S ROLE IN PUBLIC HEALTH CARE:**

The Indian Judiciary has made an extensive use of the constitutional provisions and developed a new jurisprudence in the protection of public health and sanitation. In one of the earliest instances of public interest litigations -Municipal Council, Ratlam vs. Vardhichand & Ors,\(^\text{20}\) the municipal corporation was prosecuted by some citizens for not clearing up the garbage. The corporation took up the plea that it did not have money. While rejecting the plea, the Supreme Court through Justice Krishna Iyer observed: “The State will realize that Article 47 makes it a paramount principle of governance that steps are taken for the improvement of public health as amongst its primary duties.” In Vincent Panikurlangara vs. Union of India,\(^\text{21}\) the Supreme Court observed “In a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health.” In CESC Ltd. vs.

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\(^{14}\) Article 12.1, International Covenant on Economic, Social and Cultural Rights

\(^{15}\) 1984 AIR 802

\(^{16}\) (1996) 113 PLR 499

\(^{17}\) 1995 AIR 922

\(^{18}\) Finance Commission, India: https://fincomindia.nic.in/

\(^{19}\) 7th Schedule of the Constitution of India

\(^{20}\) 1980 AIR 1622

\(^{21}\) 1987 AIR 990
Subash Chandra Bose, Supreme Court held that, “The term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensure stable manpower for economic development. Facilities of health and medical care generate devotion and dedication to give the workers’ best, physically as well as mentally, in productivity. It enables the worker to enjoy the fruit of his labour, to keep him physically fit and mentally alert for leading a successful economic, social and cultural life.

The medical facilities are, therefore, part of social security and like gilt edged security, it would yield immediate return in the increased production or at any rate reduce absenteeism on grounds of sickness, etc. Health is thus a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. In T. Ramakrishna Rao vs. Hyderabad Development Authority, the Andhra Pradesh High Court observed, Protection of the environment is not only the duty of the citizens but also the obligation of the State and it’s all other organs including the Courts. Environment Pollution is linked to Health and is violation of right to life with dignity. In S.K. Garg vs State of U.P., the Allahabad High Court held that, adequate and quality medical care is part of right to health and right to life. The Petition had been filed raising concerns about the pitiable nature of services available in public hospitals in Allahabad. Complaints were made concerning inadequacy of blood banks, worn down X-ray equipment, unavailability of essential drugs and unhygienic conditions. The Court appointed a committee to go into these aspects and report back to the Court. In State of Punjab vs. Ram Lubhaya Bagga, though the Supreme Court observed that the State had an obligation to provide health care facilities to government employees and to citizens, the obligation was only to the extent of its financial resources for fulfilling the obligation. In the case of Common Cause vs. Union of India, the Supreme Court laid down guidelines regarding operation of blood banks. The issue rose before the court was that the deficiencies and shortcomings in collection, storage and supply of blood through blood centers operating in the country could prove fatal.

CENTRE AND STATE’S ROLE DURING COVID-19:
The COVID-19 pandemic has exposed the shortcoming which plague the public health system in India. On a crucial subject like health, there must be coordination between the centre and states without impeding cooperative federalism – an essential element of the Indian Constitution. The joint response to COVID-19 has demonstrated the need for strong capacities at the district and local levels to contain the spread of the pandemic. Decentralisation of power and funds to states for boosting their respective public health systems is therefore imperative. For example, Uttar Pradesh and Bihar, though they struggled in the beginning, were able to control the Japanese Encephalitis outbreak in 2019. Even in the ongoing pandemic, Maharashtra and Delhi invoked The Epidemic Diseases Act, 1897 before the

22 1992 AIR 573
23 2002 (2) ALT 193
24 (1998) 2 UPLBEC 1211
25 (1998) 4 SCC 117
26 W.P. (Civil) 215 of 2005
central government invoked the National Disaster Management Act, 2005 on March 23.²⁸

Through the Directive Principles of State Policy, the Constitution has made a forceful appeal to the State to provide a decent standard of living. Several legal precedents have dictated that the state is responsible for citizens’ healthcare. India’s commitment to international legal treaties and conventions also binds it, as a state party, to enhance and provide adequate public services and a minimum standard of universal health care.²⁹

Existing constitutional guarantees, legal precedents and global commitments form a solid basis for a fundamental right to health in India. A legislatively guaranteed right will make access to health legally binding and ensure accountability. A constitutional amendment on the lines of the 93rd Amendment to the Constitution which provided a constitutional sanction to the right to education, should be adopted for providing adequate healthcare in India.³⁰

NEED TO SHIFT PUBLIC HEALTH FROM STATE TO CONCURRENT LIST:

²⁸ Power sharing-Why states are failing decentralization:
https://www.financialexpress.com/opinion/power-sharing-why-states-are-failing-decentralisation/1570265/
²⁹ Declaring the right to health a fundamental right:
https://www.orfonline.org/expert-speak/declaring-the-right-to-health-a-fundamental-right/
³⁰ Corona virus impact on public health sector:

Public health and allied subjects, such as sanitation, hospitals and dispensaries, are the exclusive responsibilities of state governments under the Seventh Schedule of the Indian Constitution whereas the prevention of the spread of infectious or contagious diseases from one state to another falls under the Concurrent List of the Constitution, making it the shared responsibility of the Centre and the states.³¹

This demarcation has limited the constitutional role of the Centre in the governance of public health and made states primarily responsible. Whereas in practice, due to the fiscal and institutional constraints experienced by states, the Centre has consistently played an active role in shaping public health policies.³² This has led to an absurd situation where the identification of who is truly responsible for the governance of public health has become difficult.³³

India’s fiscal expenditure on public health has been caught in the tangled mess of the current constitutional framework, with the Centre spending only about 3.6 percent of its
GDP\textsuperscript{34} in the past year on health, leaving India to rank an abysmal 176 out of 191 countries\textsuperscript{35} in health expenditure.

The Central government has attributed this to its lack of constitutional mandate and to the fact that states are the primary custodians of public health under the Constitution. Despite its limited spending on public health, the Centre’s contribution to the states continues to outstrip each state’s individual allocation of budgetary resources to public health.\textsuperscript{36}

The Central government is also technically better equipped to come up with such schemes because it has the assistance of multiple research bodies and departments dedicated to the management of public health. States on the other hand do not have the technical expertise to independently design comprehensive public health policies.\textsuperscript{37}

Basis its expenditure and expertise, the Central government has prepared several schemes on health issues such as tuberculosis, polio and HIV/AIDS and directed state governments to comply with their instructions in enforcing the schemes, thereby determining the last mile usage of the funds devolved.\textsuperscript{38}

Therefore, the Centre has assumed a more active role in determining public health policies despite a lack of defined constitutional obligation. Although it is exclusively given the responsibility of public health, it is not adequately provided with the fiscal power or the institutional support to effectively make or implement policies.\textsuperscript{39}

It may, therefore, be time to re-think the distribution of constitutional power with respect to public health and adopt an approach whereby the states and the Centre can work cooperatively.

**Constituent Assembly on public health**

The intention behind the Constituent Assembly placing public health under the State List is evident from the Constituent Assembly debates, with members in favour primarily desiring decentralisation. However, during the debates, various members raised concerns of placing it exclusively under the State List citing reasons such as the limited finances of states and the difficulty for the Centre to coordinate national health programmes.\textsuperscript{40}

\textsuperscript{34} https://www.livemint.com/news/india/india-s-economy-needs-big-dose-of-health-spending-11586365603651.html
\textsuperscript{35} https://fincomindia.nic.in/writereaddata/html_en_files/fincom15/StudyReports/High Level group of Health Sector.pdf
\textsuperscript{38} https://www.health.state.mn.us/communities/practice/resources/chsadmin/mnsystem-responsibility.html
\textsuperscript{39} https://www.health.state.mn.us/communities/practice/resources/chsadmin/mnsystem-responsibility.html
\textsuperscript{40} Public Health and Federalism: https://www.constitutionofindia.net/blogs/public_health_and_federalism
Contributions of Frank Anthony and HV Kamath, who sought to move public health from the State List to the Concurrent List, are noteworthy in this regard.41

Anthony, a nominated Anglo-Indian member felt that in three particular matters, police administration, education and health, a recognised degree of Central control was crucial along with that of the states.42 Kamath, known for his vocal opposition against granting the army extraordinary powers under the Armed Forces Special Powers Act, stated that ‘health schemes that are launched by provincial Governments, while commendable as regards their good intentions- fail to achieve the desired consummation, because of the lack of direction and coordination from the Centre’.43

He also reminded the Constituent Assembly of how the health minister during India’s first budget session had pleaded for more powers for the Centre to coordinate and initiate various health schemes in the provinces so that national health standards can be raised effectively.44

This discussion in the Constituent Assembly is especially relevant during the time of the COVID-19 pandemic.45 The Central government’s ability to use its fiscal power to usurp constitutional powers of the states, even if it is well-intentioned, is likely to cause a breakdown in the Centre-State relationship. It is not a distant impossibility to see state governments in the future cite the lack of a constitutional basis to refuse to implement Central public health schemes, to retain autonomy in public health governance. On a subject as crucial as public health, it is imperative for states and the Centre to cooperate and have specific responsibilities earmarked.46

Towards cooperative federalism
A high-level committee on health constituted to advise the 15th Finance Commission strongly suggested a shift of public health from the State List to the Concurrent List to balance the power play between the Centre and the states in such a manner that the states commit to the Central government’s goals and also preserve their autonomy to design the implementation of public health policies within their respective borders.47

Currently, various health-related subjects such as food adulteration, drugs and poisons, population control, family planning and...
medical profession reside in the Concurrent List, allowing the Centre to determine national standards and governance frameworks while ensuring that states oversee implementation of the policies regarding these subjects.\textsuperscript{48}

The Supreme Court in the case of Security Association of India vs. Union of India in 2014, 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.\textsuperscript{49}

To enable a welfare-oriented governance framework in line with cooperative federalism, legislative subjects, especially welfare subjects, require both national and state vision.

One such experiment of balancing national and regional goals was undertaken in the 42nd Amendment to the Constitution which enabled a shift of ‘education’ from the State List to the Concurrent List. While former prime minister Indira Gandhi’s objective behind this amendment may be questionable, some scholars note that the shift of education to the Concurrent List has improved the state of education by recognising a defined role for the Central government and mandating it to cooperatively work with states.\textsuperscript{50}

This approach is not uncommon, with other commonwealth countries such as Australia and Canada, allowing for shared responsibility between Centre and state governments on public health. Specifically, in the case of Schneider vs. the Queen,\textsuperscript{51} the Supreme Court of Canada in 1982 held that health as a subject should not be subject to specific constitutional assignments but should be addressed by both federal and provincial legislatures according to the nature and scope of the health problem.

COVID-19 has shown us how the current constitutional framework impedes cooperative federalism on the subject of public health.\textsuperscript{52} Shifting public health from the State List to the Concurrent List would not be antithetical to the concept of decentralisation as it would provide states with a better bargaining power for finances for public health from the Centre, and would empower them to hold the Centre responsible for improper disbursement of resources.

It would also enable states to design localised public health responses while complying with national goals. Though the process of reshaping the constitutional structure for public health is fraught with political and social challenges, the COVID-19 outbreak has made us realise that it is time we begin discussing it.\textsuperscript{53}

\textsuperscript{48} https://science.thewire.in/health/public-health-neglect-india-coronavirus-government-responsibility/

\textsuperscript{49} http://www.supreme courtcases.com/index2.php?option=com_content&itemid=1&do_pdf=1&id=20265


\textsuperscript{52} https://www.asianpaints.com/healthshield?cid=DI_N18_DM_B&utm_source=news18&utm_medium=fixed&utm_campaign=RHS&utm_content=banner

\textsuperscript{53} https://www.asianpaints.com/healthshield?cid=DI_N18_DM_B&utm_source=news18&utm_medium=fixed&utm_campaign=RHS&utm_content=banner
Despite public health being a state subject, the central government is the key actor in designing health policies and programmes. This has largely been due to greater spending ability and availability of better technical resources. For instance, to advise the Ministry of Health and Family Welfare, the government is assisted by the National Centre for Disease Control, National Health System Resources Centre and the Indian Council for Medical Research (ICMR).54

Unfortunately, the state governments have been unable to invest in such agencies and benefit from their advice, leaving them to rely on the Centre’s aid and advice not only for nationwide pandemics, but local public health matters as well.55

A centralised public health research institution’s functioning has consequences on the last mile delivery system of a country’s health services. A World Bank report titled ‘India’s Public Health System: How Well Does it Function at the National Level’ observed that “implementation of the research findings of central agencies had become a challenge due to the lack of technical capacity at sub-national levels”.56

This indicated that the benefits of health research are not effectively reaching those responsible for planning and implementation. States require specific and localised technical advice to design public health regulations for its residents. Better technical capacity will allow municipalities and lower governments bodies to efficiently manage factors impacting public health, such as sanitation and water supply.57 Currently, states only have a Directorate of Health Services, which in most states has become a coordination forum for health-related recruitment and lacks the technical capacity to provide required scientific advice.58 The lack of frameworks for ability of state governments to seek expert advice is evident from the multiple states compelled to set up Covid-19 technical task forces composed of expert doctors who act as advisers. To strengthen the capacities of states in the long run, ad-hoc task forces may not be an appropriate way forward.59

CONCLUSION:

“The health of people is the foundation upon which all their happiness and all their powers as a state depend.”
- Benjamin Disraeli, Former Prime Minister of the United Kingdom

In this changing world, with unique challenges that threaten the health and well-being of the population it is imperative that the Government and community collectively rise to the occasion and face these challenges.

56 https://openknowledge.worldbank.org/bitstream/handle/10986/14215/WPS3447.pdf?sequence=1&isAllowed=y
57 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3114612/
59 https://theprint.in/opinion/health-a-state-subject-but-covid-proved-how-dependant-indias-states-are-on-centre/442602/
simultaneously, inclusively and sustainably.\(^6^0\)

Discussing the shift of ‘public health’ from state list to concurrent list, it would also enable states to design localised public health responses while complying with national goals. Though the process of re-shaping the constitutional structure for public health is fraught with political and social challenges, the COVID-19 outbreak has made us realise that it is time we begin discussing it.\(^6^1\)

It is true that a lot has been achieved in the past. The milestones in the history of public health that had a effort on millions of lives – launch of expanded program of immunization in 1974, Primary health care enunciated at Alma Ata in 1978, eradication of small pox in 1979, launch of polio eradication in 1988, FCTC ratification in 2004 and COTPA Act of 2005, to name a few.

It has been a glorious past but the future of a healthy India lies in mainstreaming the public health agenda in the framework of sustainable development.\(^6^2\)

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\(^6^0\) http://www.jfcmonline.com on Wednesday, September 28, 2016
\(^6^1\) https://www.asianpaints.com/healthshield.html?cid=DL_N18_DM_B&utm_source=news18&utm_medium=m=fixed&utm_campaign=RHS&utm_content=banne
\(^6^2\) http://www.jfcmonline.com on Wednesday, September 28, 2016