Page 3060 - 3072 **DOI:** *https://doij.org/10.10000/IJLMH.115190*

INTERNATIONAL JOURNAL OF LAW MANAGEMENT & HUMANITIES

[ISSN 2581-5369]

Volume 6 | Issue 3

2023

National Public Health Law: India's Need to Fill the Legal Lacunae of the Archaic Epidemic Diseases Act, 1897

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ABSTRACT

The world witnessed India's plight when its public healthcare system groaned under the first couple waves of COVID-19 pandemic and lifted the veil off its ingrained incompetence. Until some specific governmental regulations were released in haste, the medical arena of the nation hung by a thread. Here, even the anecdotal and archaic Epidemic Diseases Act, 1897 proved to be woefully inefficient for a country already debilitated by a pandemic. The deliberations on the same—both in the Parliament and otherwise—led to the government's announcement of enforcing a National Public Health Law.

This article primarily analyzes the flaws in the Epidemic Diseases Act and establishes why this more than a century-old blunt health law is not in consonance with the contemporary needs of the nation. Next, this article seeks to discuss potential health challenges against which India does not have the necessary legal mechanisms in place and how the draft of Public Health (Prevention, Control and Management of Epidemics, Bio-terrorism and Disasters) Act, 2017 exhibits the potential to counter them. Furthermore, this article examines the proposed structure of the new law, tests its constitutional validity, analyzes previous national health policies and laws, and discusses international covenants that focus on global cooperation via rights-based approach in Public Health Law. Lastly, in conclusion, this article attempts to find plausible suggestions and recommendations for the betterment of India's public health policy.

Keywords: *Health Law, Pandemic, Epidemic Diseases Act, COVID-19, Constitution, International Covenants.*

I. INTRODUCTION

In the September of 1896 in Mumbai, which was formerly known as Bombay, disaster struck when the Bubonic plague knocked on the city's door.[3] Soon afterwards, the disease started spreading like fire in the woods and pegged the approximate death toll to almost two thousand

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[3] R. NATHAN, I THE PLAGUE IN INDIA 108 (1896-1897).

 [ISSN 2581-5369]

victims per week for a horrifyingly long period of time. Stumbled by this intense health crisis, the British administration of Bombay province drafted the Epidemic Diseases Act[4] in a rush. Reaching the height of arbitrariness, this legislation provided extensive powers to the government administrators. These powers reduced the concept of consensual patient examination and treatment to insignificant dust.[5]

After 125 years, the Act is still alive and actively used. With amendments to lower the scale of its coercive tone,[6] it has tried to serve as the primary domestic health law but the unprecedented medical circumstances in contemporary times call for a new law to be introduced in this regard.

To serve as a catalyst for major change, the law can be valued as an important tool. Not only does it have the potential to bring a change in the society but it also possesses the power to influence and impact the other complementary tools so they can lead the path to betterment.

II. ROLE OF THE EPIDEMIC DISEASES ACT, 1897

When the recent pandemic set foot on the Indian soil, the country's crippling health laws had just one rust-laden shield left for legal protection: the Epidemic Disease Act, 1897.[7] Being one of the shortest legislations followed in our nation, the hollow act's gamut extends to merely four sections.

Although the law has proven itself in containing several outbreaks in the country like Cholera (1910), Spanish Flu (1918-20), Swine Flu (2014), and even the recent Nipah virus (2018), it has failed to handle a disease explosion as bizarre as the ongoing pandemic and has shown the real image of the outmoded law.[8] Its antiquated structure has been unequivocally inadequate in dealing with the catastrophe. Accredited to the rapidly changing needs of the healthcare structure of India, this has refuelled questions on the legitimacy and effectiveness of the Act.[9] There is a desperate need to incorporate amendments in abundance or completely repeal the Act replacing it with a suitable one. India may be "the pharmacy of the world" during the pandemic[10] but on a national level, there are many unaddressed issues in the law in place and there is a

[4] Epidemic Diseases Act, 1897, No. 3, Acts of Parliament, 1897 (India).
[5] ARNOLD DAVID, COLONIZING THE BODY : STATE MEDICINE AND EDPIDEMIC DISEASE IN NINETEENTH-CENTURY INDIA 2 (Oxford University Press 1993).
[6] Devolution Act, 1920, S.2, Schedule 1, 1920 (India).
[7] Epidemic Diseases Act, 1897, No. 3, Acts of Parliament, 1897 (India) (hereinafter "EDA").
[8] IANS, *A 123-yr-old Act to combat coronavirus in India; experts say nothing wrong*, LIVEMINT (March 14, 2020), https://www.livemint.com/news/india/a-123-yr-old-act-to-combat-coronavirus-in-india-experts-say-nothing-wrong-11584182501707.html.
[9] *The 123-year-old law that India may invoke to counter coronavirus*, ECONOMIC TIMES (March 12, 2020), https://economictimes.indiatimes.com/news/politics-and-nation/the-123-year-old-law-that-india-may-invoke-as-more-and-more-coronavirus-cases-emerge/articleshow/74593639.cms
[10] *India's ascension to become Pharmacy of the World*, INDBIZ (March 29, 2021) https://indbiz.gov.in/indias-ascension-to-become-pharmacy-of-the-world/.

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desperate need to take them into consideration.

III. PRESENT LACUNAE AND THE SUBSEQUENT NEED FOR A NEW LAW

Before anything else, the most glaring omission of not defining the terms "dangerous", "contagious" or "epidemic" in the entire Act is the primary reason for ambiguity and prejudice. This provides potential to the Government to misuse the powers that are present with an unclear tone but authorized under the act, in similarity to the colonial era.[11] Due to the lack of standard clauses, there is also no legal obligation on the unit of governance to fulfil the duties in a practicable time. Secondly, there is no explicit mention pertaining to the ethical aspects of the human rights principles in response to a state of emergency during an epidemic. For instance, the "Arogya Setu" app received heavy criticism on the point of right to privacy by the populace during the crisis.[12]

In the case of *Anavir A Aravind vs Ministry of Home Affairs and ors*,[13] the Karnataka High Court passed an interim order to restrain the Government and National Informatics Centre from sharing user data of Arogya Setu App as it was violative of Article 21 of the Constitution of India.[14] Had there been a proper procedure to implement this system under the EDA with remedial actions listed in case of privacy breach, the government would not have to bear this liability in an already exhausting situation.

Moreover, the Epidemic Diseases Act does not mention provisions requiring sequestering and sequencing of vaccines and drugs. Its spectrum extends to a lack of legal literature on preventive measures such as quarantine. Vaccinations were made mandatory for a certain age group of people unless the Supreme Court held otherwise.[15] Mass vaccination and herd immunity development seemed to be viable plans to reduce the transmission in this particular case. However, in general, if the government wishes, it can easily misuse this case as a precedent to forcefully conduct medical programmes that interfere with individual liberty and bodily autonomy.[16] Therefore, before mandating procedures are legitimized, the safety and ethical considerations should be explicitly discussed by expert professionals in the cognizance of relevant stakeholders.

In relevance to the Indian Penal Code, the violation or disobedience of Epidemic Diseases Act,

[11] Tanvi Nigam, *On the Legal Front, How Prepared Is India for the Next Public Health Emergency?*, THE WIRE (October 13, 2020), https://thewire.in/law/india-covid-19-legally-prepared-next-pandemic-epidemic.
[12] Andrew Clarance, *Aarogya Setu: Why India's Covid-19 contact tracing app is controversial*, BBC NEWS (May 15, 2020), https://www.bbc.com/news/world-asia-india-52659520.
[13] Anivar A Aravind v. Ministry of Home Affairs, GM PIL WP (C) 7483 of 2020.
[14] Constitution of India, Art 21.
[15] Jacob Puliyel v Union of India and Others [Writ Petition (Civil) Number 607 of 2021].
[16] Ibid.

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1897 finds its punishment under section 188.[17] Despite sections 269, 270 and 271 IPC which deal with malicious actions that cause the spreading of diseases[18] and violation of any quarantine mandating rule,[19] there is no mention of them in the act. Further, in Section 188 IPC the penalty is relatively very less. This kind of leniency cannot be afforded in case of serious violations of the regulations that can severely affect health, well-being, and public order. The Act relies on generic noncompliance provisions because there are not any effective enforcement measures that deliver a firm backing and meet its needs.[20]

Furthermore, the Act does not elaborate upon a procedure regarding the allocation of air ambulances. Their need was evident during the second wave of the pandemic but only the privileged could afford such an exorbitant mode of medical transportation with technical support facilities.[21] The law completely neglects the possibility of the spread of disease during ariel transportation as it was formed during the period when air travel was barely imaginable and the most common means of transport was by sea and the road.

With India's existing healthcare structure regulated separately by different establishments managing primary, secondary, and tertiary health care, primary healthcare is most crucial and is the first connection of the patients to the healthcare system. Due to lack of profitability, primary healthcare is always dealt with by the government and it makes it difficult to reach every sector of the society.[22] All the aforementioned lacunae collectively call for the immediate introduction of a legislation on the subject-matter that comprehensively lays down provisions for the issues.

IV. EXAMINING THE DRAFT PUBLIC HEALTH BILL, 2017

On the national pedestal, the draft of The Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism and Disasters) Bill, 2017 was released by the Ministry of Health & Family Welfare inviting comments from the citizens.[23] The Bill received appreciation for including elaborate definitions of terms which were absent in the archaic Epidemic Diseases Act, categorization of the diseases on the basis of agents for specialized handling of outbreaks,

[17] Indian Penal Code, 1860, S. 188.
[18] Indian Penal Code, 1860, S. 270.
[19] Indian Penal Code, 1860, S. 271.
[20] Aman Saraf, *A Critical Analysis of India's Epidemic Diseases Act, 1897*, JURIST (November 23, 2020), https://www.jurist.org/commentary/2020/11/aman-saraf-india-epidemic/.
[21] Jagriti Chandra, *Coronavirus: Demand for air ambulances soars as virus exposes crumbling healthcare*, THE HINDU (May 11, 2021), https://www.thehindu.com/news/national/coronavirus-demand-for-air-ambulances-soars-as-virus-exposes-crumbling-healthcare/article34536057.ece.
[22] Shaili Vyas et al., *Repercussions of lockdown on primary health care in India during COVID 19*, 10 JOURNAL OF FAMILY MEDICINE AND PRIMARY CARE 7 (2021).
[23] The Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism and Disasters) Bill, 2017, No. T-18014/32004/PH, Bills of Parliament, 2017 (India).

an updated list of potential threats to the contemporary medical arena and more. In addition to this, the Bill aimed to be extensive and give more teeth to the government's machinery on public health. A clause that mentioned the autonomy of states, included in its ambit the right of states to make amendments to this model structure according to the overall medical status and condition in their territory. By discussing international border regulations in times of infectious crises, the Bill provided a way for smooth internal transitions in globalization without raising doubts and conflicts in matters like trade and travel. It laid special emphasis on the government's role in shaping this modern system by strengthening and prioritizing the sectors under it by formation of a Public Health Cadre.

The bill further talks about the construction of a four-tiered health administration structure with clearly defined powers of each tier, dealing with namely: the national, state, district, and local authorities. It suggests that the Health Ministry shall chair the National Public Health Authority while the Health ministers at the state level will be heading their respective states. Moreover, the districts will be headed by the District Administrators and in the local region, medical officers and superintendents of the particular block will be in charge.

This will facilitate the regulation of violations and health hazards on a branched pattern more effectively. Further, by this method, the authorities in charge can make provisions for keeping the spread of highly contagious diseases like Polio by effectively performing vaccination drives in the local areas. In the four-tier system, even non-communicable diseases can be in control as they can be easily prevented by giving an early diagnosis facility. The formation of annual health check-up centres for people above the age of 45 can prevent many non-transmissive diseases like cardiac issues and cancer. All of this can also eventually act as a facilitator to improve India's position on the World Health Index.

This system is more approachable to people as they may approach a local medical officer on matter of accountability than the Health Ministry for their problems, which in turn will lessen the burden on higher authority and maintain effective division of work.

The system could also help in effectively managing pest attacks at local levels. If we take the example of the locust attacks in 2019-20, during the attack a large share of crops was destroyed ruining the income source of many farmers all over north and central India.[24] The only existing legislation that could be invoked was the East Punjab Agricultural Pests, Diseases, and Noxious Weeds Act, 1949[25] which does not have precise provisions to tackle the invasion, clearly

[24] Soutik Biswas, *India combats locust attack amid Covid-19 pandemic*, BBC NEWS (May 26, 2020), https://www.bbc.com/news/world-asia-india-52804981.

[25] East Punjab Agricultural Pests, Diseases, and Noxious Weeds Act, 1949, Act. 4, Acts of Punjab State Legislature,

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showcasing its incapability in handling the calamity. Even in the COVID-19 outbreak, to impose a plethora of restrictions in the "hotspot zones", clearance of permission from the State or Central authority was a mandate. Having a territorially bifurcated system will help counter all these problems, without excessive bureaucratic spirals.

However, the draft attracted heavy criticism too as it does not pioneer efforts in initiatives related to risk reduction. The language of the submission hinted at complex bureaucratic interpretations which would have led to slow progress in its implementation. Due to a lack of consultation with key stakeholders and health circuit experts, it was riddled with issues, often appearing to be misleading and ambiguous. The focus on bioterrorism seemed to be covert with the curbing strategies having a mere visionary status. The bill also failed to understand the capacity of infrastructure and equipment inventory India holds, highlighting the on-ground ignorance dragged by it.

Making things worse, it is now being labelled "as draconian as the older law, maybe even more so." The document invites this negative input due to its power to inspect premises, isolate people, test them, and treat them without any necessity of taking their consent into account, reopening the wounds of 1975's botched and forced sterilization campaign.[26] With this, it also lays tough measures of restriction and quarantine if "deemed inimical to public health."[27]

Addressing the criticisms seriously, active revision of the draft with an interface between bureaucrats and disease specialists can possibly lead to a better one that would be qualified enough for quality deliberations in the Parliament.

V. DETERMINATION OF CONSTITUTIONAL VALIDITY OF A NATIONAL HEALTH LAW

In India, anything that is legislative in nature requires to pass the scrutiny of its validity in the eyes of the nation's Constitution. By clearing the decks before the particular parliamentary initiative sees the light of day, it is ensured that no point or clause remains in contradiction to the structure of India that this "law of the land" so comprehensively discusses. If any vacuum like this is present in the draft itself or the procedure of its enactment, then the initiative is bound to be declared pyrrhic as happened in the case of the Farm Acts of 2020.[28] Therefore, to avert such circumstances that may lead to a repeal, a thorough and multi-layered checking is required

1949 (Punjab).

[26] Soutik Biswas, *India's dark history of sterilisation*, BBC NEWS (November 14, 2014), https://www.bbc.com/news/world-asia-india-30040790.

[27] The Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism and Disasters) Bill, 2017, No. T-18014/32004/PH, Bills of Parliament, 2017 (India).

[28] The Farmers' Produce Trade and Commerce (Promotion and Facilitation) Act, 2020 & The Farmers (Empowerment and Protection) 112-C/2020 Agreement on Price Assurance and Farm Services Bill, 2020.

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to be considered by the drafting authorities.

The subject of Public Health & Sanitation[29] forms a part of the State List with the responsibility towards hospitals and dispensaries also finding a place under the same jurisdiction's umbrella. As the Constitution prescribes, the duty to make law on the health aspect rests as a power given solely to the states. Due to this, the Union legislative body holds nothing more than a mere suggestive authority over them. As an apparent paradox, Union ensures the right to health for all citizens by Article 14[30], Article 15[31] and Article 21[32]. The power tussle does not end here. The Directive Principles of State Policy, as mentioned in Part IV of the Constitution of India, provide instructions regarding the Union's conduct in matters of public health.[33] Here, Article 41 focuses on the fulfilment of vital public health conditions by the State[34]. In Article 42, there is mention of maternity leave and an indication to avail proper laws on maternity health issues in both health and employment spheres[35]. There is an encouragement to establish feasible mechanisms that help ensure public health improvement on a priority basis, regulate the consumption of intoxicating substances, and work toward increasing the nutritional graph of the population in Article 47. [36]

Therefore, as there is a clear tug of war between the State and its states about the power to make laws on public health, there are four approaches by which a national policy can be formed on this subject matter by the Union.

The first approach is quite plain. It shall require the Union Legislative Assembly to create a model act outlining the major points that are of concern in relation to the Health laws prevalent in our nation. This model act is then to be taken as a sample draft by the states to form their own regional Act or bring necessary amendment to their existing one, if any. The point of difference will be evident while analyzing various crucial aspects including the presence of medical infrastructure in the region, state-wise population, the budget allocated for the state's health sphere, among other things holding social, economic, or geographical value. Accordingly, the customizations that are suitable for the concerned state can be made in the model act, and a dynamic yet quasi-uniform structure can be given to public health from a legal perspective.

Alternatively, if the legislatures of more than two states pass resolutions post providing consent

[29] Constitution of India, Seventh Schedule, List-II, Entry 7.
[30] Constitution of India, Art. 14.
[31] Constitution of India, Art. 15.
[32] Constitution of India, Art. 21.
[33] Constitution of India, Part IV.
[34] Constitution of India, Art. 41.
[35] Constitution of India, Art. 42.
[36] Constitution of India, Art. 47.

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for the Centre to make law on a State List subject, it enables the Parliament to do so under Article 252.[37] However, a law made by the Parliament from a matter of State List is only applicable to the states that submit their resolution.[38] The exercise is, thus, likely to be futile in creating a uniform impact as it is unlikely and nearly ideal fiction that all the legislatures of all states submit a similar resolution to this effect.

In the third approach, a legislation can be introduced for the entire territory of India by invoking Article 249 of the Constitution of India.[39] It would not be entirely difficult to manage and get a two-thirds majority from the Council of States, but it would be a challenge to provide adequate and soundly satisfying reasoning to the citizens for legislating on this subject matter in "national interest." Moreover, a law made on any matter enumerated in the State List is brought up through this approach, it would require a resolution that approves its continuance in force for another period of one year. Hence, it would not be able to attain a permanent status and shall survive only until the Council of States votes in favour of its continuance as a matter of national interest.[40]

The fourth way would be to circumvent the problem by labelling the initiative as an international obligation. A clever way to introduce a bill concerning public health that comes under State List can be via its rationalization as a mandate of the Public International Law. Article 253 empowers the Parliament to implement any treaty or international agreement by making any law in its regard notwithstanding any provision previously mentioned in Part XI Chapter I of the Constitution.[41] Thus, ratification of this kind would stand above and impinge upon all the 3 lists namely, State, Union and Concurrent, as the nation would be apparently compelled to honour it as a signatory of the relevant international covenant and this would also avert the wrongful infringement over a State List subject.

Following this approach leads to a rights-based one that deals with less government interference in the implementation of health laws and programmes. It advocates keeping the foundational argument that health is the fabric of life and that all other aspects of life are related to it. Without individual autonomy over the subject, involuntary legislative actions would hinder liberty and fundamental rights. By invoking Article 253, the Parliament can draft a law that is abiding by the relevant international covenant for the cause of public health improvement. [42] This can be

[37] Constitution of India, Art. 252.
[38] Constitution of India, Art. 252 cl. 1.
[39] Constitution of India, Art. 249.
[40] Constitution of India, Art. 249 cl. 2.
[41] Constitution of India, Art. 253.
[42] Constitution of India, Art. 253.

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done with a strong universal appeal subsuming such transparency and the ability to ascertain that it acts as a guardian of the rights granted by the Constitution. Article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights[43] and the Declaration of Alma-Ata 1978[44] proclaimed the right to health serving as competent international instruments in this arena.[45]

The law, thus made by the rights-inclined approach, should also aim to work toward strengthening the claims of the disadvantaged in cases where they undergo medical discrimination and fraud.

A quasi-rigid law without much intransigence and enough scope for people to exercise their rights seems to be the most suitable option that can be set as a model of inspiration for a national-level, constitutionally backed law like this. In order to broaden the scope, a mosaic perspective should be held high to take into account various types of health issues dealing with psychological and psychiatric factors. An intricate civilization like India should strive to set higher standards in the modern health paradigm, abiding by the clauses of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)[46] which talks about working towards the "highest attainable standard of health" with linkage to corresponding factors like hygiene, nutrition, and infrastructure.

VI. INTERNATIONAL COVENANTS & GLOBALIZATION IN PUBLIC HEALTH LAW

The global health tumult coupled with a plethora of diplomatic Kafkaesque wreaks havoc on a world that is already debilitated with crises. Adding fuel to the fire, ultra-nationalistic principles of nations make them shut their doors towards any cooperation. Transgovernmentalism comes forward as a viable solution to adapt in times like these in order to harmonize policies and rhyme out the cooperative measures of the ally States.[47] In today's dynamic world, it is extremely difficult to survive without multilateral relations and dialogues. No matter at what stage of development the country is, addressing from a global podium will only help fill the shambolic gaps in the system. It is a plain reality that every nation is not well-equipped with all resources. To create stability in the raw materials market, diplomatic contributions are made by nations to

[43] International Covenant on Economic, Social and Cultural Rights, 1966, 2200A (XXI), General Assembly Resolution, 1966 (New York) Art. 12.
[44] World Health Organization, *Declaration of Alma-Ata International Conference on Primary Health Care*, Alma-Ata (6-12 September, 1978).
[45] *Non-discrimination in the field of health*, REFWORLD (March 2, 1989) https://www.refworld.org/docid/3b00f0b348.html.
[46] *supra* note 41.
[47] Burris, Scott et al., *A Transdisciplinary Approach to Public Health Law: The Emerging Practice of Legal Epidemiology*, 37 ANNUAL REVIEW OF PUBLIC HEALTH 135-148 (2016).

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one another. A similar mechanism has been the need of the hour in the health arena for quite some time but due to intense laxity by organizations in forming one, it became imperative to form a not-so-comprehensive one in urgency when the Covid-19 pandemic started, bringing countries to their knees groaning.

World Health Organization (WHO), as reported on a host of occasions in this decade, has constantly neglected its competency in exercising the legal powers and responsibilities it holds.[48] The World Health Assembly utilized its authority only twice in forming the International Health Regulations and the Nomenclature Regulations before the pandemic and hardly worked with adequate administrative efficiency after the second wave of Covid-19 ended.

The Antibiotic Revolution turned out to be a boon for humanity as the miracle breakthrough resulted in the dawn of the modern phase of healthcare. As icing on the cake, the progress in the field of scientific discoveries shattered all concerns about public health's globalization. Although the WHO has shown a "historical penchant" for working on crises under its ambit within a narrow medical-technology approach. However, the Public Health Emergency of International Concern (PHEIC) declaration[49] by the organization has provided a testimony that creates a blurry vision of the potential it possesses in making this world a better place. Under this, WHO coordinates immediate response with countries hit by a disease wave.[50] In the last 9 years, all 196 countries have at least once reported their issue to the organization on International Health Regulation (IHR) indicators[51] and have received the required facilities. As a normative like this, the global health system would thrive without the need for frequent lockdowns till the time the new outbreak's agent is examined in the future.

For creating an atmosphere of medical responsibility among countries, a legally binding and well-codified Global Health Law is the need of the hour. The measures need to be detailed and inculcate all the possible factors that are closely linked with the chaos. They can range from guidelines regarding the trade of pharmaceuticals and medical equipment to food safety and medical staff to control of arms and ammunition. For a balanced action without disadvantage to any party, the voluntary submission of crucial factors like medical staff, supplies, machinery,

[48] Ho, Jing-Mao et al., *Unequal discourses: Problems of the current model of world health development*, 137 WORLD DEVELOPMENT (2021).
[49] *COVID-19 Public Health Emergency of International Concern (PHEIC) Global research and innovation forum,* WHO (February 12, 2020), https://www.who.int/publications/m/item/covid-19-public-health-emergency-of-international-concern-(pheic)-global-research-and-innovation-forum.
[50] Ibid.
[51] *International Health Regulations (2005)*, WHO (January 1, 2008), https://www.who.int/publications/i/item/9789241580410.

and vital information about the agent by the countries having an overabundance of resources can be added to the draft. This shall also help in augmenting transnational solidarity and fraternity. By providing a customization opportunity in relation to the diversity of geographical and economic factors in the nations, the concerned international organization can make the law appealing and flexible for ratification.

Even with an expanding domain, Public Health law has remained a comparatively neglected topic. Thus, the framework has to be so devised that it transcends, both in the formulation and implementation, the traditional inadequate mechanisms that remain in place across almost all States and take a step forward towards fulfilling its aim of universal access.

The efficacy of codifying a new legal instrument for medical responsibility will be realized once it catches momentum with the pace of globalization. But for that to be successful, an authoritative interpretation of the covenant would make a substantial impact. United Nations Special Rapporteur rightly explains in its 2013 report[52] how Public Health is being reduced to a "dominant market-oriented paradigm." A prominent example in this fragment of law would be the World Trade Organization's Doha Declaration on Trade and Public Health[53] which was commended for having an advanced understanding of the contemporary health model. Unfortunately, it lacked legal significance, relevance and authority to be made a universal specimen of excellence.

On crucial sub-issues, UNESCO's nonbinding covenant on Human Genome and Human Rights (1997) and International Declaration on Genetic Data (2003) have been considered exemplary drafts but their "soft" nature has led to minimal outputs. National policy and actions are made under the aegis of International Law principles if the factors are adjusted well. Once a behavioural change in the major stakeholders is stimulated, it would become possible to eventually lead to a legally-binding international health agreement.

The solution might appear plausible on a superficial level but the deep-lying limitations make the situation grotesque. Firstly, International Law dealing with public matters is unjustifiably considered to be an "inherently imperfect mechanism" to handle contemporary world civilization's concerns. There is a firm apprehension about its incompetency for global health governance due to the absence of a formal enforcement agency. Secondly, the nations have, unremittingly, shown their lack of timely fulfilment of universal commitments in the case of

[52] Anand Grover, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health on access to medicines*, (A/HRC/23/42), United Nations Digital Library (2013) https://digitallibrary.un.org/record/757829#record-files-collapse-header.
[53] World Trade Organisation, Declaration on the TRIPS Agreement and Public Health, 2001, (November 20, 2001), https://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm.

ratifications and implementations. Thirdly, the exclusion of non-State actors like Palestine from a relevant health covenant would serve as injustice and will hinder the aim of "universal access."

VII. CONCLUSION

We often wait for society to change first so a fresh law with an accurate tuning can be easily fitted into the system. However, some phenomena wreak havoc to a large-scale extent where the stagnancy in the law itself leads to violation of basic rights. Such crises build a strong case for tabling a new law without waiting for a conscious change in society.

The analysis of the issues pertaining to current health law structure of India has brought forth some suggestions that are attention-worthy. They are as follows:

- To formulate an efficiently workable national legislation concerning public health with a widely inclusive perspective, it should be a priority for the drafting members to engage in comprehensive dialogues with the primary stakeholders and workers present in this field. Without bearing in mind their suggestions, making a law covering all major aspects would be like squeezing water from a stone.
- A dedicated task force should be set up that can submit a report post-scrutinizing the criticisms and suggestions on the 2017's draft bill and work on modernizing the miscellaneous antiquated health laws. By taking into account the aforementioned potential and novel challenges, the task force can provide recommendations that are futuristic and visionary in nature.
- Compliance with the forthcoming laws with contemporary scientific developments and legal-ethical norms should also be ensured. Not only on a legislative level but in the quantitative sense as well, strategies to increase the medical infrastructure incorporating but not limited to resources, equipment, inventory, storage, staff and research information should be designed.
- Ratification of international health treaties and documents to which India is a signatory can also help the mechanism to pace up. It shall also help in highlighting India's efforts in globalization on the public health paradigm while establishing better communication and relation in both domestic and international spheres.
- The new Healthcare Bill must include provisions to fill the existing legal cavities. This subsumes modifying the penalties in the existing law and laying provisions for vaccination drives that ensure proper safety and ethicality of the procedure. Appropriate legal backing must be given to ariel and naval medical transportation considering their contribution to the

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transportation of Indian citizens stuck in other countries via Operation Samudra Setu and oxygen consignments from other nations via Operation Samudra Setu II, among others.

- On a miscellaneous level, provisions against organ trafficking, corruption, and coercive monopoly of hospital administrations should be made in linkage with the Indian Penal Code.

If the suggestions find a space in the parliamentary medical initiatives, India can truly rise as the most capable health administrator in the world and take a step forward in forgetting the horrors of the archaic and draconian Epidemic Diseases Act.

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 [ISSN 2581-5369]