

# India's Fight Against Health Emergencies: In Search of a Legal Architecture

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**ABSTRACT** The ongoing pandemic of COVID-19 (caused by the novel coronavirus or SARS-CoV-2) has exposed glaring gaps in India's domestic laws. Absent a rationally structured legislation to fall back on, the Union government in March advised states to invoke the Epidemic Diseases Act of 1897 to tackle the pandemic in their jurisdictions. The 123-year-old colonial law, however, does not even define what a disease is, let alone an epidemic or a pandemic. Indeed, a Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism and Disasters) Bill had been drafted in 2017, intended to replace the old Epidemic Diseases Act of 1897. The Bill has yet to be tabled in Parliament. This brief calls for the creation of a sound legal architecture to deal more effectively with outbreaks of infectious diseases, especially pandemics of the scale of COVID-19.

## THE EPIDEMIC DISEASES ACT, 1897: LIMITATIONS

The colonial-era Epidemic Diseases Act (EDA) of 1897 is India's solitary law that has been historically used as a framework for containing the spread of various diseases including cholera and malaria.<sup>1</sup> On its own, however, the EDA—comprising four sections in one page—might be insufficient to deal with the ongoing pandemic of COVID-19, an infectious disease caused by the novel coronavirus or SARS-CoV-2. At the time of writing, there are 575,444 confirmed cases of COVID-19 in 201 countries; 26,654 people have died.<sup>2</sup> In India, there are 1,037 cases and 26 deaths.<sup>3</sup>

Democratic countries such as Australia, Canada, England, and the United States (US) have in place more comprehensive and updated legislations to deal with public health emergencies such as the ongoing pandemic.<sup>4</sup> These countries continuously adapt their existing laws to contemporary needs, enabling them to customise their responses to evolving emergencies. In contrast, the Indian government appears to have a limited arsenal comprising the colonial-era Epidemic Diseases Act, the battered Section 144 of the Indian Penal Code which prohibits public gatherings, and the Disaster Management Act of 2005.

The EDA came into effect on 4 February 1897, amidst the outbreak of the bubonic plague in Bombay (now Mumbai). The law proved inadequate, and the plague soon spread to Bangalore (now Bengaluru) and other parts of India.

The law authorises the Central and state governments to take “exceptional measures and prescribe regulations” to be observed by the citizens to contain the spread of a disease. Over the years, no standard or Model Rules and Regulations have been prescribed as a corollary to the law. The law merely outlines a set of rudimentary elements, including travel restrictions, examination and quarantine of persons suspected of being infected in hospitals or temporary accommodations, and statutory health inspections of any ship or vessel leaving or arriving at any port of call. The law specifies consequences that will be faced by those violating the remit of the Act, with penalties being *pari passu* with Section 188 of the Indian Penal Code, which is the law that deals with acts of disobedience to a government order.

The EDA is deficient for three key reasons. First, the law fails to define “dangerous”, “infectious”, or “contagious diseases”, let alone an “epidemic”. There is no elaboration in the Act on the extant rules and procedures for arriving at a benchmark to determine that a particular disease needs to be declared as an epidemic. The law is silent on the steps to categorise an epidemic as “dangerous” based on variables like the scale of the disease, the distribution of the affected population across age groups, the possible international spread, the severity of the malady, or the absence of a known cure.

The second limitation is that the EDA contains no provisions on the sequestering and the sequencing required for dissemination of drugs/vaccines, and the quarantine measures and other preventive steps that

need to be taken. Third, there is no underlying delineation of the fundamental principles of human rights that need to be observed during the implementation of emergency measures in an epidemic. The Act emphasises only the *powers* of the central and state governments during the epidemic, but it does not describe the government's *duties* in preventing and controlling the epidemic, nor does it explicitly state the *rights* of the citizens during the event of a significant disease outbreak.

It does not help that the country's existing healthcare apparatus is highly regimented, with separate institutions in-charge of primary, secondary, and tertiary health care. Such a siloed approach is a serious impediment to the country's efforts at tackling any epidemic such as the current COVID-19. The imperative is for the formulation of a seamless approach.

By way of example, in India's medical template, the Integrated Disease Surveillance Programme (IDSP) units are in-charge of early detection. The medical officer stationed in the primary health centre, community health workers and field workers, function in close coordination with the District Chief Medical Officer and the designated district level teams for the prevention and containment of disease outbreaks. When a system already exists, especially with regard to disease reconnaissance, the provision in the 1897 EDA for devolution of power to "any" person makes little sense; in an exigency, the biggest challenge would be to break hierarchies and establish seamless coordination. Except for providing for anodyne supervisory directions for different levels of the government

machinery, the 1897 Act does not mention any scientific steps that are required to prevent or contain the spread of an epidemic.

The punishment prescribed in terms of Section 3 of the Act that is *pari passu* with Section 188 of the Indian Penal Code<sup>5</sup> also needs to be revisited. This Section provides for a fine of INR 200 and imprisonment of one month for violating an order of a public servant.

India has a number of laws that can be applied during a public health emergency. There is, for instance, the Indian Ports Act, as well as the Livestock Importation Act, the Aircraft Rules and Drugs and Cosmetic Act, which all contain provisions that can be used during a situation such as COVID-19. The requirement is for these provisions to be harmonised into a single overarching legislation.

## **THE IMPERATIVE OF A HOLISTIC LAW**

Ideally, contemporary legislation should clearly provide both the trigger and the caveats in empowering the state to curtail or restrict certain rights of the citizens like to liberty, privacy, movement, and property. This would then lead to predictable and transparent decision-making. India's EDA fails in this regard; similarly, it fails to address the human aspect of healthcare. Indeed, the Union Ministry of Health & Family Welfare had drafted a Public Health (Prevention, Control and Management of epidemics, bio-terrorism, and disasters) Bill in 2017 to fill these gaps. Jointly prepared by the National Centre for Disease Control (NCDC) and

the Directorate General of Health Services (DGHS), it also tried to address—albeit in a limited manner—the need to empower local government bodies given the peculiarities of each emergency situation. It was expected that with the implementation of this law, the old Epidemic Diseases Act, 1897 would be repealed. However, for reasons that remain unclear, the Bill has not been tabled in Parliament.

The key pillar of a national epidemic law must be equal access to healthcare services. The EDA fails on this count, too. The obligations of healthcare professionals and other workers, juxtaposed with their rights and the safety standards that they would be entitled to, also need to be delineated, along with the responsibilities of civil society during such a crisis. After all, India is familiar with incidents such as Air India crew returning from rescue missions of Indian citizens stranded in other countries, being ostracised<sup>6</sup> by neighbourhood associations rather than being feted.

In the past, there have been attempts to draft statutes predicated on community health such as the Model Public Health Act of 1955 updated in 1987. The Union government, however, has been unable to convince states to adopt the law since health is a State subject.<sup>7</sup> Many Indian states have had their own epidemic disease acts since the colonial era, like the Madras Public Health act of 1939 and the Malabar Public Health Act of 1939. More recently, states like Karnataka and Gujarat have drafted their own public health legislations.

The National Health Bill 2009<sup>8</sup> was similarly targeted at providing an overarching legal framework for the provision of essential public health services by recognising health as a fundamental right of the people. It also provided for a response mechanism for public health emergencies by outlining a collaborative federal framework. However, none of these initiatives ever fructified as states considered it as an encroachment on their domains.

When push comes to shove, India, with its bare-bones legislative structure, would find it hard to find an enabling legal framework that will allow an efficient lockdown of entire cities, the quarantining of people, the temporary closure of business, and the distribution of medicines. There is anecdotal evidence of travellers who, upon returning from abroad, have been reported as unwell by their neighbours and consequently picked up by the police.

In a recent discussion on the COVID-19 pandemic in the Lok Sabha, some members raised the legal “anomaly” with regard to the pandemic, urging the government to rectify the situation and bring about emergency legislation while Parliament is in session. The suggestion has not been heeded.

With little or no legal backing for the government's actions, it has had to resort to the much-maligned Section 144 of the Indian Penal Code, curfews, and other draconian measures to limit the spread of the disease. One must bear in mind that other countries of the Commonwealth, that have analogous

legal provisions in criminal law such as Section 144, are not compelled to invoke them to control the spread of an infectious diseases due to well-structured and sensitive contemporary legislation on public health situations.

## LEARNING FROM GLOBAL BEST PRACTICES

Certain lessons can be drawn from contemporary laws that exist in advanced democratic countries such as Australia, Canada, Britain, and the US.

### **Canada**

In Canada, emergency measures and emergency management requirements at the federal level are governed by the Emergency Act of 1988 and the Emergency Management Act 2007.<sup>9</sup> Most provinces also have their own Health Acts that clearly delineate measures that are to be implemented in case of a health emergency. However, there is a comparatively higher bar for the federal government to take the lead in the situation of a health emergency. Therefore, most health crises in Canada are handled at the provincial level, in close coordination with the Central government.

The Public Health Agency of Canada Act of 2006 led to the creation of the Public Health Agency of Canada (PHAC) which is responsible for the promotion of health, prevention and control of chronic diseases, prevention and control of infectious diseases, and preparation and response to public health emergencies. The Public Emergency Act

gives the power to the Federal government to regulate movement of people, the requisition and disposition of property, the regulation of distribution of essential goods, the establishment of emergency hospitals, and the imposition of fines. Moreover, the Quarantine Act of 2005<sup>10</sup> “authorizes the Minister of Health to establish quarantine stations and quarantine facilities anywhere in Canada, and to designate various officers, including quarantine officers, environmental health officers, and screening officers.” Indeed, the provincial governments have greater powers to quarantine and impose penalties.

### **Australia**

In Australia, the National Health Security Act, 2007 lays down processes and structures to preempt, prevent and, in an eventuality, deal with national health emergencies. Designated entities provide coordination and oversight at the national level, with the provinces applying their own laws, jurisdictional responses, and coordination processes. The National Security Health Arrangement 2008 supports the National Health Security Act, 2007 and the National Health Security Regulations, 2008. Both of these give effect to the WHO's International Health Regulations (2005). These regulations required Australia to “develop multi-level capacities in the health sector to effectively manage public health threats and to develop, strengthen and maintain the capacity to detect, report and respond to public health events.”<sup>11</sup>

The National Health Security



Arrangement is primarily concerned with strengthening Australia's public health surveillance and reporting system. It spells out the responsibilities of entities at the national and state levels of government with regard to surveillance and reporting of communicable diseases and responding to significant public health events. The National Health Emergency Response Arrangements, also called the Nat-Health Arrangements, "articulate the strategic arrangements and mechanisms for the coordination of the Australian health sector in response to emergencies of national consequence."<sup>12</sup> The document further provides structure for information flows during a health emergency, while also providing a governance structure for coordination, command and control.

Apart from having sophisticated legislation, Australia has also set up coordination entities such as the Australian Health Protection Committee, National Health Emergency Management Subcommittee, Communicable Diseases Network Australia, Public Health Laboratory Network, and Australian Medical Assistance Teams. They respond to, and coordinate efforts during disease outbreaks. Furthermore, the Federal Quarantine Law clearly defines what a quarantine is and lays out for what purposes people can be quarantined along with punishments for those who fail to comply. The keystone of this administrative superstructure is transparency. The Department of Health, through the National Notifiable Diseases Surveillance System, provides information on notifiable diseases that is updated three times a week and is

online and publicly available. Summary data going back to 1991 is available online, along with data disaggregated by region and disease.

### **England**

The Public Health (Control of Disease) Act of 1984<sup>13</sup> was brought into force with the aim of creating specific functions for different authorities in response to a national health emergency. This Act provides for a clear hierarchical chain in which the primary, secondary and tertiary responders need to operate when dealing with a health challenge. Responsibilities from the local level up till the national level are clearly defined in the Act. Not only does England have laws in place to deal with an outbreak of the magnitude of COVID-19, but it is updating these laws to adapt to current challenges.

A Coronavirus Bill was introduced on 23 March in the House of Commons; it is currently being debated in the House of Lords. The provisions include empowering the police to enforce isolation for those who are symptomatic, and to shut down ports. The Bill provides for a host of capacity-building measures for the National Health Service (NHS) such as return of retired staff, reduced paperwork for discharge of patients, and extra employment safeguards for volunteers to allow them to suspend their jobs for up to four weeks.

### **The US**

While the guiding US legislation is dated (The Public Health Services Act 1944), it is

comprehensive enough to facilitate necessary action and creates an administrative framework through which any public health emergency can be channeled. It even foresees the need for supplemental personnel by creating a reserve corps. The law was last amended in December 2019.<sup>14</sup> President Donald Trump has also invoked the Defense Production Act 1950 to battle the pandemic.

## THE WAY FORWARD

The COVID-19 public health emergency provides the Union government a rare opportunity to update the country's laws; otherwise, this legislative and policy gap could soon prove to be India's Achilles' heel.

An Approach Paper on a new Public Health Act proposed by a Task Force<sup>15</sup> put together by the government in 2012 had suggested that laws needed to be an integral part of a robust public health system. The paper contended that deficiencies in the public health system's legal preparedness found generally in relation to planning, coordination and communication, surveillance, management of property and protection of persons during a public health emergency, needed to be addressed by the proposed new public health Act.

Even the law that has been invoked to deal with COVID-19 and order a curfew underpinned by a 21-day lockdown – the Disaster Management Act of 2005—<sup>16</sup> was never designed to cater to health emergencies. This is evident from the definition of “Disaster” in Section 2-(d) of the said Act: “(d) “disaster” means a catastrophe, mishap, calamity or grave occurrence in any area,

arising from natural or man-made causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and destruction of, property, or damage to, or degradation of, environment, and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area.” This definition does not allude to a medical emergency, except perhaps by a loose interpretation. Similarly, the two sections of the said Act under which notifications have been issued, namely Section 6 (2) I and Section 10 (2) I, are both supplemental sections to the substantive provisions of this Act.

Further, Sections 6 (1) & (2) read as follows:

6. Powers and functions of National Authority.—(1) Subject to the provisions of this Act, the National Authority shall have the responsibility for laying down the policies, plans and guidelines for disaster management for ensuring timely and effective response to disaster.

(2) Without prejudice to generality of the provisions contained in sub-section (1)


and subsection i reads as (i) take such other measures for the prevention of disaster, or the mitigation, or preparedness and capacity building for dealing with the threatening disaster situation or disaster as it may consider necessary.

Similarly, Section 10 (2) I states:

(i) evaluate the preparedness at all

governmental levels for the purpose of responding to any threatening disaster situation or disaster and give directions, where necessary, for enhancing such preparedness;

This analysis of the lacunae in the existing 1897 law, and the illustration of global best examples, make it clear that India is short of a legal architecture to effectively fight a

pandemic like COVID-19. Without an updated and comprehensive law on health emergencies, the state governments are resorting to the use of Section 144 of the Indian Penal Code and other draconian laws. Once the COVID-19 crisis abates, the country's lawmakers should use this opportunity to repeal the colonial law and pave the way for a new one that can better address health emergencies that India might face in the future. 

#### **ABOUT THE AUTHOR**

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## ENDNOTES

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