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Legislative Response to Epidemics and Pandemics in India: Need for a Contemporary Comprehensive Law

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Introduction

Epidemics of communicable diseases and influenza pandemics are known to impose a heavy economic burden on individuals, families, communities, and the nation at large including crises of health resources and political destabilization (Kakkar et al., 2010). In 1918-19 when the influenza pandemic struck the world, an estimated 25 million persons died globally and about 17-18 million died alone in the Indian sub-continent (Nandraj, 2020). The coronavirus (Covid-19) pandemic, identified in late 2019 in the Wuhan City, Hubei Province of China revealed that every country is vulnerable to disease pandemics. World Health Organisation officially declared the Covid-19 outbreak, a public health emergency of international concern in January 2020 and a pandemic by March 2020. The Covid-19 pandemic highlighted the lack of preparedness both at the global and national levels. As of today (11 October 2021), more than 219 million cases of Covid-19 and over 4.5 million deaths have been reported globally (Ritchie et al., 2020).

A disease is considered an *outbreak* when its cases are more than what would normally be expected. The number of cases that would be considered as an outbreak varies according to what causes the disease and the size and type of previous exposure to the infecting agent (Meningitis Research Foundation, 2020). An increase, often sudden, in the number of cases of a disease, or an illness or health-related event above what is normally expected in a population in that area is referred to as an e*pidemic,* as defined by the Centers for Disease Control and Prevention. The presence of an epidemic varies according to the infecting agent, size and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence (Centers for Disease Control and Prevention, 2012). A *pandemic* refers to an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people. The key difference between an epidemic and a pandemic is the degree to which it has spread in the population group and not the severity of the disease (Kelly, 2011; Columbia Mailman School of Public Health, 2021).

In India, of the total disease burden measured as DALYs[1], 33% was attributed to infectious and associated diseases in 2016, varying from 14% to 43% across Indian states (Indian Council of Medical Research et al., 2017). Such a high burden of infectious diseases predisposes the country to outbreaks

[1] Disability-Adjusted Life Year (DALY): To measure the overall burden of disease, it is a time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability. https://www.who.int/data/gho/indicator-metadata-registry/imr-details/158

of emerging and re-emerging infectious diseases. In the last three decades, India has witnessed several outbreaks of infectious diseases. For instance, the cholera epidemic in 1992, the outbreak of plague in Surat in 1994, the large scale spread of chikungunya, dengue fever, avian influenza (H5N1) and H1N1 influenza, and the outbreak of Ebola and Zika virus (Rakesh, 2016). The latest in the series is the Covid-19 pandemic, first case of which was recorded on 30 January 2020 from Kerala. The spread has now increased to 33,953,475 cases and 450,589 deaths, as of 11 October 2021 in India (Ritchie et al., 2020).

A legal framework plays a key role during public health emergencies as it prescribes the role of governments, their power, and duties as well as responsibilities of citizens to manage the disease spread and promote the population's health. The WHO's Influenza Pandemic Preparedness and Response plan when published in 2005 saw a positive response from several countries and many of them updated their public health legislation (Kakkar et al., 2010). The Covid-19 pandemic prompted countries to look back at their legislative measures for their appropriateness and effectiveness to control a pandemic like situation. Countries used different legal means, ranging from public health laws, pandemic-specific laws, disaster management and civil emergency laws, to laws enacted specifically in response to the Covid-19 pandemic. However, countries such as India, Jamaica, Hong Kong continued to use colonial-era quarantine laws (Mehta et al., 2021). The existing legal framework and functions of regulatory authorities in India, in times of disease outbreaks, epidemics and pandemics have drawn critical attention of the policymakers, researchers and experts.

This paper puts together the literature on the existing legislations that have been invoked to contain the spread of the Covid19 pandemic in India, the draft bills relating to disease outbreaks, epidemics and pandemics and the gaps in the current legislative framework.

Legislation to manage epidemics and pandemics in India

Legal provisions to prevent the spread of epidemics and pandemics in India are spread across different central statutes regulated by different regulatory authorities under the supervision of various ministries. The Epidemics Act 1897, Disaster Management Act 2005, Indian Penal Code, and other relevant central legislations are used for the management of epidemics and pandemics in India.

The Epidemic Diseases Act 1897

The Epidemic Diseases Act 1897 was enacted to contain the bubonic plague that broke out at that time in the then Bombay Presidency for the prevention of the spread of dangerous epidemic diseases. The Epidemic Diseases Act (EDA) has four sections: the first section explains the title and scope of the

Act; the second section gives powers to the governments to take special measures and formulate regulations that are to be observed by people to contain the spread of the disease; penalties for violating the regulations, in accordance with Section 188 of the Indian Penal Code have been described in Section three of the Act; and legal protection for implementing officers acting under the Act has been explained in Section four.

In the past, the Epidemic Diseases Act 1897 has been invoked to control the spread of communicable diseases, to segregate H1N1-affected persons and get them treated at recognised hospitals, to direct private hospitals to set up isolation treatment facilities and to notify cases of dengue and H1N1 (Rakesh PS, 2016). Most recently the GoI invoked the Act to control the COVID-19 pandemic.

The Epidemic Diseases Act 1897 is limited in scope in several aspects. Known for its brevity, the Act leaves several pertinent issues unaddressed and ambiguous. Over the years, the Act has been described as archaic, blunt, coercive, colonial, policing, restrictive legal instrument. Since the Act does not define what constitutes 'dangerous epidemic diseases', there is no clarity on the criteria based on which a disease/event may be declared as 'dangerous' or 'epidemic'. The EDA 1897 is not in line with today's scientific understanding of disease outbreak prevention and response strategies. The Act focuses on isolation and quarantine measures as a disease outbreak prevention strategy but does not say anything about other scientific methods of disease outbreak prevention and control, such as vaccination, surveillance and organised public health response (Goyal, 2020; Gowd, 2021).

The Act prescribes the Central and State government's powers but does not specify their duties in controlling and preventing an epidemic. The EDA 1897 also fails to provide clarity in delineating the roles and responsibilities of various other administrative agencies and departments in combating an epidemic and pandemic. It is purely regulatory in nature prescribing the powers of the government and penalty for citizens for violating the law with no public health focus (Rakesh PS, 2016).

One of the key challenges recognised in the Covid-19 pandemic was the lack of legal provisions to protect human rights during the containment of disease outbreaks and epidemics. EDA 1897 does not establish a regulatory authority or appellate mechanism to address grievances about its implementation and does not specify which administrative authority will supersede in case of any dispute. It does not mention anything about the citizens' rights or any provision for them to seek legal recourse in case of abuse of power by the state in the implementation of the Act. The absolute power granted to the state undermines the individual autonomy, liberty, and privacy of the people (Goyal, 2020).

The EDA amendment notified in 2021 increases the power of the Central government to inspect other modes of travel such as buses, trains, goods vehicles, aircraft in addition to ships/vessels under section 2A of the EDA 1897. It also addresses the issues related to the safety of healthcare personnel. However, some of the states such as Karnataka, Maharashtra, Rajasthan, Tamil Nadu, and West Bengal have their own laws to protect health care personnel with penal provisions other than the Epidemic Diseases (Amendment) Act 2020. It is unclear how both the Central and the State Acts would be implemented simultaneously in these states, for example, whether the fines would be collected in the State or the Central exchequer (Boddupalli & Francis, 2020).

The Epidemic Diseases Act 1897 is a century-old blunt Act that needs substantial overhaul to counter the rising burden of infectious diseases, both new and old. Issues like the definition of epidemic disease, territorial boundaries, ethics and human rights principles, empowerment of officials, punishment, etc., need more deliberation and warrant a relook.

Disaster Management Act 2005

The Disaster Management Act 2005 has been enacted for the effective management of disasters in the country. The Act provides for the formation of disaster management authorities and plans for disaster management at district, state, and national levels. It lays down in detail the roles and responsibilities of the various government departments and the authorities during disasters arising from natural or man-made causes, or by accident or negligence which could result in substantial loss of life or human suffering, measures that are to be taken at different administrative levels, and how to coordinate and implement them. The Act permits immediate procurement of materials and use of other resources for the purpose of rescue and relief without following the due process of tendering etc.

One of the key issues with respect to the DMA 2005 is whether an epidemic or pandemic can be considered a "disaster" under the Act. As per Section 2 (d) of the DMA *disaster is "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."* Health emergency created by Covid19 pandemic could be considered as an event of "grave occurrence" for managing it under the Act.

Biological Disaster Management Guidelines 2008 prepared under the DMA 2005 elaborate upon the measures to deal with several types of disasters. The updated National Disaster Management Plan

(2019) formulated under the DMA 2005 includes Biological and Public Health Emergencies (BPHE) as a sub-category of disasters and suggests that due to an increase in travel within and across national boundaries *"the likelihood of fast global spread of epidemics has increased dramatically making localised outbreaks into national epidemics and global pandemics*". But while the guidelines lay down elaborate measures to deal with disease outbreaks, epidemics, and pandemics, the subsequent plans and policies focus mostly on the preparation of risk resilience. Also, the technicalities and challenges associated with managing a public health emergency are not covered by the DMA 2005. For instance, the issues of pricing of health care services, human rights violations at health facilities are not addressed under the DMA 2005 (Chaturvedi, 2020).

The Disaster Management Act also fails to acknowledge that the nature and lifecycle of a pandemic are different from other disasters and, thus, it needs to be responded in a different manner. For instance, the Covid-19 pandemic is unpredictable and long-standing in comparison to disasters. The Central and State governments enforced a nationwide and local lockdown restricting public movement to contain the spread of the Covid-19 (National Disaster Management Authority, 2020). But the lockdown strategy neglected the economic impact and deficiency of essential supplies leading to survival crisis, especially for the daily wage earners and migrant workers. (Chaturvedi, 2020).

The provisions mentioned in the guidelines, policy, and plans of the DMA 2005 are not coherent with each other, including in the delegation of responsibilities to various ministries.

Other Central Legislations

Other Central legislations that could be used to provide relevant legal support during an epidemic and pandemic situation are Drugs and Cosmetics Acts 1940 and Drugs and Cosmetics Rules 1945; Aircraft Act 1934 and Aircraft (Public Health) Rules 1954; Indian Ports Act 1908 and Indian Port Health Rules 1955; and Indian Penal Code 1860 (Kakkar, 2010; Gowd, 2021; Mehta, 2021). The legal support for enforcing certain public health measures in an epidemic or pandemic situation could be drawn from these central statutes by the states.

Drugs and Cosmetics Act 1940 and Drugs and Cosmetics Rules 1945: The Act provides for ensuring the availability and distribution of vaccines and drugs during an outbreak of dangerous and infectious diseases. Section 33A of the Drugs and Cosmetics Rules 1945 (DCR 1945) permits the import of small quantities of a new drug, which may be otherwise prohibited under Section 10 of the Act, for treatment of patients suffering from life-threatening diseases. Clause 1 (3) of Schedule Y of the DCR 1945 provides an exemption to toxicological and clinical data requirements as deemed appropriate by

the Licensing Authority for drugs to cure life-threatening diseases or diseases of special relevance to the Indian health scenario.

Aircraft Act 1934 and Aircraft (Public Health) Rules 1954: Section 8A of the Aircraft Act 1934 prescribes that the Central government can make rules for the prevention of danger arising to public health by the introduction or spread of any infectious or contagious disease through an aircraft entering the country. The Aircraft (Public Health) Rules deal with the inspection and isolation of 'infected' passengers of an aircraft entering India. Section 12 provides that if any aircraft, which has started from or alighted in an airport situated in a yellow fever infected area, attempts to enter India without having been disinfected may be refused entry.

The 'Quarantinable diseases' listed under the Aircraft (Public Health) Rules 1954 are yellow fever, plague, cholera, smallpox, typhus, and relapsing fever. 'Isolation' when applied to a person or group of persons means the separation of that person or group of persons from other persons, except the health staff on duty, in such a manner as to prevent the spread of infection, as defined under the Rules.

Indian Ports Act 1908 and Indian Port Health Rules 1955: As per Section 6 of the Indian Ports Act, the Central government can make rules to prevent danger arising due to the introduction of an infectious disease through vessels entering the country. Indian Port Health Rules 1955 provide for medical inspection, detention of vessels, detention and/or removal of onboard persons suspected of having infectious diseases, and cleansing, ventilation, and disinfection of such vessels.

Indian Penal Code 1860: Provisions related to infectious diseases and public health:

- Section 269: If any person suffering from a dangerous disease spreads the infection unintentionally, punishment may be imprisonment up to six months, or fine, or both.
- Section 270: If any person conducts a "malignant act likely to spread infection of disease dangerous to life", the punishment may be imprisonment up to two years, or fine, or both.
- Section 271: Anyone disobeying any rule of quarantine by the government, the punishment may be imprisonment up to six months, or fine, or both.

Public Health Bill

Since independence, there have been multiple attempts by the Central Government to strengthen the legal framework for providing a comprehensive national public health law and for better management of disease outbreaks/epidemics. Though there have been attempts to establish a public health law since 1955, none have been passed yet. First in 1955, and then in 1987 (Model Public Health Bill by

the Central Bureau of Health Intelligence, 1987), the Central Government developed Model Public Health Acts, but these were not adopted by the states. A National Public Health Bill was drafted by the National Institute of Communicable Diseases (now, National Centre for Disease Control) in 2002-03 but was not approved (Patro et al., 2013) (Rakesh, 2016).

The draft National Health Bill 2009 provided for "protection and fulfilment of rights in relation to health and wellbeing, health equity and justice, including those related to all the underlying determinants of health as well as health care; achieving the goal of health for all; and for matters connected therewith or incidental thereto" (MoHFW, 2009). It offered a legal framework to ensure essential public health services and adequate response to public health emergencies through effective collaboration between the Centre and the states. The Bill adopted a rights-based approach and upheld the right to treatment and care. The Bill provided for the formation of public health boards at the national and state levels for smooth implementation and effective coordination. It also had provisions for community-based monitoring and grievance redressal mechanisms to ensure transparency. However, the Bill was also not passed (Rakesh PS, 2016).

The draft Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism and Disasters) Bill 2017, which was to repeal the Epidemics Diseases Act, 1897 is the latest effort by the Government of India. Clear definitions of disinfection, derating, isolation, quarantine, public health emergency of national concern, etc., were mentioned in the Bill. It advised public health measures like social distancing, quarantine, isolation, diagnosis, and guidelines for treatment, rather than segregation and detention of people as is mentioned in the EDA 1897. The Bill also laid the concept of 'Public health service" which includes health promotion, immunization, prevention, treatment of diseases, environmental sanitation, upkeep of facilities for any such services which are relevant in case of a pandemic like Covid-19. It gave the list of diseases that may be categorised as epidemic-prone diseases, listed the potential bioterrorism agents and was cognizant of public health emergencies of international concern, as the ongoing Covid-19. Bill also provided for appeal before the state, district and local authorities (Verma, 2017; Bahurupi, 2020).

Though the draft Public Health Bill 2017 was a marked improvement over the Epidemic Diseases Act 1897, the Bill combined varied events like epidemics, bio-terrorism and disasters which are very different from each other in terms of their nature and magnitude and therefore need different preventive and management strategies. The Bill mentioned the powers of the government at each level but the violation of human rights during public health emergencies was not addressed and redressal mechanisms were not clearly defined, like what is missing in the DMA 2005 and EDA 1897. Maintaining a balance between the rights provided by the Constitution and the power of the

government, an essential element of public health law, was missing from the Bill. Nevertheless, the Bill was not tabled in the Parliament.

State Public Health Legislation

States and UTs that have public health legislation include Andhra Pradesh, Assam, Goa, Madhya Pradesh, Tamil Nadu, Telangana, and Puducherry (UT). Andhra Pradesh (Andhra Area Public Health Act) and Tamil Nadu (Madras Public Health Act) enforced the law in 1939 and have amended it from time to time. Provisions within both the Acts recommend necessary steps to be taken for prevention, notification, and treatment of a disease, which the government may declare to be infectious either throughout the state or in a local area. Telangana Infectious Diseases Act 1950 (earlier Andhra Pradesh (Telangana Area) Infectious Diseases Act 1950); Madhya Pradesh Public Health Act formulated in 1949; Goa Public Health (Amendment) Act 2019 (earlier Goa, Daman and Diu Public Health Act 1985); and Puducherry (Public) Health Act 1973 are framed on the lines of the Madras Public Health Act 1939. The Assam Public Health Act 2010 defines some of the terms which are not specified in other state legislations mentioned above, such as 'epidemic', 'endemic' and 'public health emergency of international concern'.

In the backdrop of the Covid-19 pandemic, various states have introduced legislation to reinforce health infrastructure in the state as well as to ensure that healthcare is more accessible to its citizens, especially in times of disease outbreak or a public health emergency. Some states notified state-specific legislation to manage the pandemic and some others notified regulations under the Epidemic Diseases Act 1897 for the purpose. For instance, Rajasthan Epidemic Diseases Act was passed in 2020 and the state of Kerala passed Kerala Public Health Ordinance in 2021 unifying the Travancore Cochin Public Health Act 1955 and the Madras Public Health Act 1939 relating to public health in Kerala. Delhi, Uttar Pradesh, Maharashtra and Bihar, notified regulations under the EDA 1897 authorising the government officials to admit, isolate and quarantine people in certain situations (Goyal, 2020). In the past, states have adopted the Central Epidemic Diseases Act with some amendments to respond to specific situations. For example, the Epidemic Diseases (Bihar Amendment) Act 1960 gave the state government the power to make requests for vehicles during epidemics. The Epidemic Diseases (Punjab Amendment) Act 1944 conferred powers on specific officials to execute various provisions of the Act in the state of Punjab. Haryana and Chandigarh passed similar amendments, while Himachal Pradesh included provisions for vaccination through the Epidemic Diseases (Himachal Pradesh Amendment) Act 1984 (Rakesh, 2021).

The Supreme Court directed all the states to formulate their public health legislation while hearing public interest litigation (PIL) to cap the prices for Covid-19 treatment in private hospitals (Supreme Court of India, 2020). The states of Karnataka, Punjab, Sikkim, Odisha, Manipur, Jharkhand, Meghalaya, Maharashtra and the UT of Dadra and Nagar Haveli and Daman and Diu are believed to be formulating a Public Health Bill. Whereas West Bengal, Chandigarh, Jammu and Kashmir, Uttarakhand, Mizoram, Nagaland, Haryana and Andaman and the Nicobar Islands have no plan to draft such a law (Sinha, 2020).

Need for a contemporary comprehensive law to manage epidemics and pandemics

The response of the governments to the Covid-19 pandemic, at both the Centre and in states, has highlighted various shortcomings in the Indian legislation. Aspects such as disease surveillance, testing and treatment protocols were marred with controversy and ambiguity throughout the crisis, with inconsistent implementation of the orders across states. Containment and contact tracing efforts often fell short and there were frequent violations of quarantine rules by the public. The delay in initiating testing for Covid-19, initial exclusion of the private sector from providing testing services, issues of quality and pricing, and inconsistent and premature advisories regarding treatment protocols put patients and healthcare providers at risk. The ambiguity regarding the statutory authority, functioning, and respective roles of the government bodies cannot be overstated (Mehta et al., 2021). The confusion started with the procurement of personal protective equipment and ventilators and continued with the procurement and distribution of the Covid-19 vaccine.

Several instances of human rights violation were noted during the pandemic where patients were denied health services and discriminated against because of the nature of the disease, their caste and financial status. The pandemic has yet again highlighted the need to focus on the issues of patient rights and the importance of legislation to protect their rights in times of emergency.

Public health emergencies often involve a fast-spreading contagion, widespread illness, and death. It has been widely established that the Epidemic Diseases Act 1897 is obsolete and inadequate to address the present-day epidemics and pandemics. The DMA 2005 is supporting legislation that cannot by itself address the challenges posed by public health emergencies. The newer and more potent infectious diseases warrant more contemporary, comprehensive legislation that balances between the rights and responsibilities of both the government and the people. However, as discussed above several attempts by the Government of India to bring in new legislation have not yielded results.

A report by Vidhi Centre for Legal Policy recommends a framework for drafting a comprehensive public health emergency law. The framework recommends using the values of social control, integration of

human rights, good governance, accountability, transparency, inclusiveness etc. under the three principles of duty, power and restraint for examining a public health law. The modern public health emergency law must consider the scope of legislation at the centre, the need for state-specific legislation, demarcation of responsibilities between the different tiers of government, the capacity of the administrative infrastructure, structure and functions of monitoring, accountability mechanisms, rights and duties of citizens under the legislation (Mehta et al., 2021).

It is suggested that before we frame another draft of a public health bill, it is important to examine and understand how the public and private health sectors handled the challenges posed by the current pandemic including the actions of administrators, government officials, healthcare professionals, scientific and research institutions.

Conclusion

Situations like the current Covid-19 crisis call for a concerted effort by both Central and state governments. However, the conundrum over the distribution of roles, responsibilities and powers between the Centre and state government to fight the pandemic, persists. The existing laws are outdated and limited in scope to define the role of governments in managing pandemic like situations. Therefore, a central law with defined protocols for transparent division of roles and powers, protection of the rights of providers and patients with transparent grievance redressal mechanism is much needed.

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