NATIONAL UNIVERSITY OF ADVANCED LEGAL STUDIES

Kalamassery, Kochi - 683503, Kerala, India

DISSERTATION

SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF LAWS (LLM) DEGREE IN PUBLIC HEALTH LAW (2021-2022)

ON THE TOPIC

NEED FOR A COMPREHENSIVE LEGISLATION TO FIGHT COVID- 19 PANDEMIC - AN ANALYSIS

SUBMITTED BY:

ENLIN MARY RODRIGUES

REGISTER NO: **LM0321014**

UNDER THE GUIDANCE AND SUPERVISION OF

DR. ABHAYACHANDRAN K.

JULY 2022

THE NATIONAL UNIVERSITY OF ADVANCED LEGAL STUDIES

Kalamassery, Kochi - 683503, Kerala, India

DISSERTATION

SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF LAWS (LLM) DEGREE IN PUBLIC HEALTH LAW (2021-2022)

ON THE TOPIC

NEED FOR A COMPREHENSIVE LEGISLATION TO FIGHT COVID- 19 PANDEMIC - AN ANALYSIS

SUBMITTED BY:

ENLIN MARY RODRIGUES

REGISTER NO: **LM0321014**

UNDER THE GUIDANCE AND SUPERVISION OF

DR. ABHAYACHANDRAN K.

JULY 2022

CERTIFICATE

This is to certify that Ms. **ENLIN MARY RODRIGUS** Reg. No: LM0321014 has submitted her dissertation titled *"Need for a comprehensive legislation to fight Covid-19 pandemic - An analysis"* in partial fulfilment of the requirement for the award of Degree of Masters of Laws in Public Health Law to the National University of Advanced Legal Studies, Kochi under my guidance and supervision. It is also affirmed that the dissertation submitted by her is original, bona fide and genuine.

Date : Dr. ABHAYACHANADRAN K

Place: NUALS, Kochi Guide and Supervisor

DECLARATION

I declare that this dissertation titled *"Need for a comprehensive legislation to fight Covid-19 pandemic - An analysis"* is researched and submitted by me to the National University of Advanced Legal Studies, Kochi in partial fulfilment of the requirement for the award of Degree of Master of Laws in Public Health Law, under the guidance and supervision of **Dr. Abhayachandran K**, Assistant Professor, NUALS, Kochi. It is an original, bona fide and legitimate work pursued for an academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree of either this University or any other University.

Date:

Place: ERNAKULAM

ENLIN MARY RODRIGUS

Reg. No: LM0321014

LLM (Public Health Law)

NUALS, Kochi.

ACKNOWLEDGEMENT

This dissertation is the result of the pertinent efforts and contributions of many people around me. First, I would like to thank, **Dr. Abhayachandran K** for his insightful guidance and support. He was always approachable, respected my ideas and gave me clear, cogent and meaningful suggestions, which has aided me profusely in completing this dissertation.

I express my sincere thanks to the Vice Chancellor **Prof. (Dr.) K.C Sunny** for his constant support. I take this opportunity to thank **Prof. (Dr.) Mini S.,** the Director of the Centre for Post Graduate Legal Studies for her support and encouragement extended during the course. I would further extend my deep-felt gratitude to all the faculties of NUALS for their guidance and support.

I would also like to convey my thanks to all the Library Staff and the Technical Staff for their timely assistance to carry out the work.

Words fall short of expressing love, appreciation and gratitude to my dear family and friends for their constant encouragement.

With genuine humility, I am thankful to The Almighty for all his uncountable bounties and blessings.

ENLIN MARY RODRIGUS

ABBREVIATIONS

AIR	All India Reporter
Anr.	Another
AP	Andhra Pradesh
Art.	Article
Bom	Bombay
Cal	Calcutta
Const.	Constitution
CRIM.	Criminal
DE	Delhi
DM	Disaster management
DMA	Disaster management act, 2005
EDA	Epidemic diseases act, 1897
EMR	Electronic medical record
ILR	Indian Law Reporter
KE	Kerala
Ltd.	Limited
Mad	Madras
MANU	Manupatra
MERS	Middle East respiratory syndrome
MH	Maharashtra
MoHFW	Ministry of Health and Family Welfare
MOHW	Ministry of Health and Welfare
NDMA	National disaster management authority
NDMP	National disaster management plan
No.	Number
Ori	Orissa
Ors.	Others
PEN.	Penal
PLJR	Patna law journal review
PPE	Personal protective equipment

PROC.	Procedure
ROK	Republic of Korea
S.	Section
SARS	Severe Acute Respiratory Syndrome
SC	Supreme court
SCC	Supreme Court Cases
SCR	Supreme court records
SDMA	State disaster management authority
TL	Telangana
TN	Tamil Nadu
UK	United Kingdom
UOI	Union of India
USA	United states of America
v.	Versus
Vol.	Volume
W. P.	Writ petition
WHO	World Health Organisation

LIST OF CASES

21.	*Pradeep Gandhy v. the State of Maharashtra*	2020 SCC Online Bom 662: MANU/MH/0832/2020
22.	*Pt. Parmananda Katara v. Union of India*	1989 SCR (3) 997
23.	*Puttaswamy v. UOI*	(2017) 10 SCC 1
24.	*R. Sameer Ahmed v. State of Telangana & Ors*	MANU/TL/0367/2021
25.	*Ram Lall Mistry v. R. T. Greener*	(1904) ILR 31 Cal 829
26.	*Reepak Kansal v. Union of India.*	AIR 2021 SC 3198
27.	*Shashank Deo Sudhi v. Union of India Ors,*	W.P. No. 10816/2020
28.	*State of Madras v. VG Row*	AIR 1952 SC 196
29.	*State Of Punjab & Ors v. Ram Lubhaya Bagga*	(1998) 1 SCR 1120.
30.	*Suo Motto v. The State of Tamil Nadu*	W.P. No. 7492 of 2020: MANU/TN/2857/2020
31.	*Union of India v. Panacea Biotec Limited.*	MANU/DE/1038/2021
32.	*Vikash Chandra Guddu Baba v. The UOI & Ors*	(2008) 2 PLJR 127
33.	*Vincent Panikurlangara v. Union of India & Ors,*	AIR 1987 SC 990
34.	*Vineet Ruia v. the Principal Secretary*	AIR 2020 Cal 308
35.	*X v. Hospital Z*	AIR 1999 SC 495.

TABLE OF CONTENTS

	1.2. NEED FOR AN EXTENSIVE NATIONAL PUBLIC HEALTH LAW 1.3. THE INDIAN CONSTITUTION'S EMERGENCY HEALTH PROVISIONS.	

CHAPTER 1

INTRODUCTION

Before the pandemic, Indian society was ignorant on the importance of an efficient public health policy. Covid-19 pandemic has led to the collapse of the India's healthcare system and thousands have been rendered helpless in the absence of resources.[1] From the figures which was last updated in 25th April 2022, India's death toll has reached 5,26,074[2] and stands 3rd among the worst hit countries of Covid-19.

Main two legislations for tackling covid-19 in India are the Disaster Management act, 2005 (DMA, 2005) and Epidemics Diseases act, 1891 (EPA, 1891). The biological disaster management guidelines released by NDMA in 2008 details the role and functions of various authorities in situations of biological disasters and epidemics.[3] Along with this the Indian Constitution ensures the right to health for all without any discrimination under Article 21. Provisions related to health are mentioned in part IV of the constitution in terms of the directive principles of state policy. Both the central government and the states are empowered to make laws related to public health. Items related to public health are mentioned in all three lists of the Indian constitution. Quarantine, including all issues related to seamen's and marine hospitals and medical institutions, are mentioned in numbers 28 and 81 of the union list. The states can make legislation related to "health care, sanitation, hospitals, dispensaries, and prevention of animal diseases" under item six of the state list. The Union and states can make laws related to the health profession and the prevention of the extension from one state to another of infectious or contagious diseases or pests affecting people, animals, or plants under entries 26 and 29 of the concurrent list.

The Disaster Management Act, 2005, was invoked on March 24 to impose a lockdown to ensure consistency in the application and implementation of various measures across the country. However, even before the DM Act was invoked, several state governments

[1] Shanoor Seervai & Arnav Shah, *'India's Failure of Leadership Collapses Health System in COVID-19 Surge',* The Commonwealth fund (Apr 29, 2021)
[2] https://www.mygov.in/covid-19
[3] National Disaster Management Guidelines—Management of Biological Disasters, 2008. A publication of National Disaster Management Authority, Government of India. ISBN 978-81-906483-6-3, July 2008.

had used their powers under the Epidemic Diseases Act, 1897 to deal with the covid-19 outbreak. Although public order and public health are subjects that lie with the States as per the Indian constitution, reports indicates that the centre has used the DM act to assume complete control and creates certain friction in the current legal framework when it comes to managing a crisis such as covid-19.[4] Restrictions have also been imposed under section 144 of the code of criminal procedure by district magistrates across the country.

Along with this there are other legislations that also applicable are Indian Port Act, 1908, Livestock Importation Act, 1898, Drugs and Cosmetics Act, 1940, Indian Aircraft (Public Health) Rules, 1954 and Indian Port Health Rules, 1955. Public Health Bill, 2009 and Public Health (Prevention, Control and Management of Epidemics, Bio-fear based oppression, and Disasters) Bill 2017 were introduced in the parliament but they were not passed because many states objected to it as health is a subject under the State List.

With respect to the victim rights in India, In *Reepak Kansal v. Union of India*,[5] the supreme court directed the NDMA to recommend guidelines for ex gratia assistance of Rs 50,000 on account of loss of life to the family members of the persons who died due to Covid-19, as mandated under Section 12(iii) of DMA 2005 for the minimum standards of relief to be provided to the persons affected by disaster and other reliefs. The government also announced ₹10 lakh corpus fund for every child orphaned by covid-19.[6]

Thus, through this dissertation, researcher will be analysing the various legislations that deals with covid- 19 pandemic in India and check their capability in curbing the same by comparing it with other legislations from different countries.

RESEARCH PROBLEM

Covid-19 pandemic has led to the collapse of the India's healthcare system and thousands have been rendered helpless in the absence of resources. From the figures which was last updated in 25th April 2022, India's death toll has reached 5,26,074 and stands 3rd among

[4] Shanoor Seervai & Arnav Shah, *India's Failure of Leadership Collapses Health System in COVID-19 Surge*, THE COMMONWEALTH FUND (Apr 29, 2021)
[5] AIR 2021 SC 3198
[6] *10 lakh corpus fund for every child orphaned by covid 19*, The Hindu (May 27, 2022)

the worst hit countries of Covid-19. India witnessed its clear violation during the second wave. Newspaper reports indicate acute shortage of medical equipment in the country in which patients are forced to share their beds and oxygen cylinders.[7] Social media networks have become a public helpline platform where people are begging for information on the availability of beds, oxygen cylinders, Remdesivir, and testing facilities.[8] Moreover, cremation grounds are witnessing an unprecedented rush of dead bodies daily. People are waiting up to eight hours in line to get their family members cremated with no dignity whatsoever.[9]

The EDA,1897 which is more than a century-old piece of legislation is archaic and hence inadequate for tackling the pandemic in the present times. Even before the DMA, was invoked, several state governments had used their powers under the EDA, 1897 to deal with the Covid-19 outbreak. Although public order and public health are subjects that lie with the states as per the Indian Constitution, the centre has used the DMA to effectively bypass states and assume complete control. This indicates a certain friction in the current legal framework when it comes to managing a crisis such as Covid-19 as the centre and states do not appear to be fully in sync. States have had to take a backseat in dealing with a public health emergency that, despite having national ramifications, varies from region to region. The fragmented manner in which these legal provisions have been invoked shows a lack of clarity in how the centre and states have interpreted their roles under the constitution as it stands. The right to a health is a fundamental right granted by Article 21 of the Indian constitution. Yet, India's expenditure on public health has been dismally low. India spends only 3.01 percent of its GDP on health expenditure.[10]

HYPOTHESIS

The Legislations such as Epidemic Diseases Act, 1897 and Disaster Management Act 2005, is not competent enough and has failed in effectively curbing the covid- 19 pandemic in India. It is absolute necessary to enact a separate comprehensive legislation

[7] *Oxygen shortage kills 20 more COVID-19 patients in Delhi; customs duty on COVID-19 vaccines, medicines and medical oxygen waived for three months, and more,* The Hindu (Apr 24, 2021)
[8] Sowmya Ramasubramanian, *how social media platforms have become 'COVID-19 helplines' to combat second wave in India*, The Hindu (May 13, 2021)
[9] Zaid Nayeemi, *Delhi remembers the lethal second wave: No cremation of covid scars*, THE NEW INDIAN EXPRESS (JUNE 27, 2022)
[10] World Health Organization Global Health Expenditure database, *Retrieved* on January 30, 2022.

in India to deal with future public emergencies like covid- 19 pandemic. India is one of the worst- hitten country due to covid- 19 pandemic and one of its major reasons is not having an effective, comprehensive legal mechanism to deal with it.

METHODOLOGY

The Methodology followed is doctrinal research by the analysis of existing statutes along with case laws, articles and other publications related to the subject of study. Researcher have relied on official websites of Ministry of Health and family welfare and other authoritative government websites to collect the necessary data needed to complete this study.

RESEARCH QUESTIONS

1. Does EDA and DMA properly address India's fight to Covid- 19 pandemic?
2. How much the government successful in implementing these laws?
3. Are inadequate laws the reason for worsening India's condition due to covid-19 pandemic?
4. what are the changes to be made in the legal regime of India in strengthening India's public health care?

LITERATURE REVIEW

1. Anupam Saraph et.al (2020)[11], developed a mathematical model of the susceptible-exposed-infected-recovered population to evaluate India's responses and options to Covid-19. They simulated model with and without the existing responses of the Government of India over the first 146 days. They also explored

[11] Saraph, Anupam and Kidwai, Anab, *Evaluating India's responses and options to Covid-19* (Aug 16, 2020).

the options before India to flatten the curve of new cases per day, obtain the flattening at an early date, minimize the total cases, ensure the peaking of total cases at an early date, minimize the total deaths, stop the total deaths from advancing at an early date, flatten the active cases, and ensure the early flattening of the active cases. They find that unless strong lockdown restricting all activities that increase contact beyond 31 persons per day is continued India will not succeed in flattening the Covid-19 curve, restricting the impact and that the use of masks, immune boosting programs, or isolation of infected, and exposed persons can flatten the curve better under strong lockdown rather than under weak lockdown conditions. They also find that unless strong lockdown is exercised, if hospital under-capacity were to act as a multiplier to deaths, there could be a precipitous rise in deaths despite other interventions.

2. Rohan Marathe et.al (2020)[12] aims to analyse the Epidemic diseases act, 1897. with the sharp increase in the number of Covid-19 cases worldwide, the governments around the world, including India have put their citizens in a state of lockdown and limited movement & human social activity. It was soon realised in India that a robust lockdown was needed which was enforceable rather than voluntary and to enforce such lockdowns and to provide enabling power to criminal legislations and to punish violators, the epidemic diseases act was enforced.

3. Vrinda Bhandari et.al (2021)[13], focus on the issue of lack of legislative foundations and certain practical governance-oriented considerations related to the roll out of the Arogya Setu app. Arogya Setu app is a contact tracing app launched by the Indian government on April 2, 2020, as a tool to combat the Covid-19 crisis. Issues concerning the privacy and security concerns with the app have been discussed extensively. They began by considering the principles of evaluating executive action during a crisis and whether extraordinary times truly call for extraordinary measures. They then explore the importance of a clear and

[12] Marathe, Rohan, *Analysis of Existing Jurisprudence under the Epidemic Diseases Act* (April 17, 2020).
[13] Bhandari, Vrinda and Rahman, Faiza, *Constitutionalism During a Crisis: The Case of Arogya Setu* (May 25, 2020).

specific law and why the Disaster Management Act or Section 144, Cr.P.C. fail to provide an adequate legal foundation for the app. They then consider the importance of law and process of legislation and provide certain recommendations on addressing the procedural irregularities and governance related issues that were related to the roll out of the app.

4. Aruna Kumar Malik(2017)[14], views health and healthcare through the provision of the Alma Ata Declaration of 1978 which recommends that primary health care should include education concerning health problems, identifying, preventing and controlling the problems, promotion of food supply and proper nutrition and adequate supply of safe water and basic sanitation, maternal and child health care immunization against major infectious diseases, prevention and control of locally endemic diseases etc. It seeks to see whether the approach of Indian policy makers is in line with the above-mentioned holistic concept. It argues that India suffers from an insufficient health infrastructure.

5. Antonio Coco et.al (2020)[15], While disease outbreaks remain to a certain extent unforeseeable, international law provides a comprehensive legal framework requiring States to prevent their harmful consequences, effectively respond to ensuing health emergencies, and cooperate in achieving those aims. This contribution shows that, within this framework, many rules take the form of 'due diligence' obligations. Obligations of due diligence, albeit inherently flexible to accommodate different capabilities and circumstances, are binding on States. They impose a duty to act according to a standard of 'good governance': a State must employ its best efforts to realise certain common goals. At least five key sets of rules establishing due diligence duties are relevant to the covid-19 outbreak: a) the 'no-harm' principle; b) international disaster law; c) the International Health Regulations; d) international human rights law; and e) international humanitarian law. We preliminarily identify some of the actions required from States to prevent

[14] Aruna Kumar Malik, *Health Sector Governance and Reforms in India*, 2 Liberal Stud. 85 (2017).
[15] Coco, Antonio and Dias, *Talita, Prevent, Respond, Cooperate: States' Due Diligence Duties vis-à-vis the COVID-19 Pandemic* (May 7, 2020).

new outbreaks and respond to the pandemic, whilst assessing compliance with applicable rules. We conclude that hard lessons learned during the current pandemic should spur more decisive action to prevent and address future public health emergencies.

6. Dr. C. Sivakkolundu Chinnu (2021)[16], hints the aspects of challenges and revival measures of covid-19. The second wave of coronavirus has taken a heavy destruction and mental disturbances to India's population. Hospitals and medical facilities are struggling to keep up with the rising number of covid-19 patients. The direct impact of covid-19 pandemic on lives is almost well known to the world with gradual reporting of its various systemic effects from every country. In India, from this pandemic almost got affected being of the daily reports. Due to the population burden the low reporting of covid-19 cases as per the health infrastructure will result in the community spread of the novel virus. Covid-19 will have long term effect on various sector of the economy in India. The author tries to answer whether the pandemic goes beyond control due to mass carelessness leading to sudden rise in number of patients and resultant shortage of necessary medical facilities.

OUTLINE OF THE STUDY

Chapter 1 ~ Introduction, seeks to introduce the subject of study while outlining the preliminary requirements of research problem, Hypothesis, method adopted, research questions, literature review etc.

Chapter 2 ~ Law in India regarding communicable diseases, follows the history of legislation on communicable disease, its control and prevention. It enumerates and

[16] Chinnu, Dr. C. Sivakkolundu, *COVID-19 Second Wave: Challenges and Revival Measures* (May 22, 2021).

examines the many central and state legislations in force and their provisions. The state legislations on epidemic control and public health legislations with provisions on prevention and control of infectious diseases are both examined separately. Especially focusing on the provisions of the legislation that empowers restrictions on individual's rights and otherwise, providing for certain rights like right to health, privacy, access to medical care etc.

Chapter 3 ~ This chapter focuses on the victim's right with respect to covid- 19. India faced grave human rights violations during the covid- pandemic era. Right to health, right to dignity right to decent burial etc. have been widely violated. India witnessed its clear violation during the second wave. In the nation, where there is a severe lack of medical supplies, people are had to share beds and oxygen tanks. People are pleading for information on the availability of beds, oxygen cylinders, Remdesivir, and testing facilities on social media networks, which have evolved into a public helpline platform. Additionally, cremation cemeteries are seeing a daily influx of dead bodies that is unheard of.

Chapter 4 ~ This Chapter focuses on the lacuna's exists in current legislations used to curb covid- 19 such as disaster management act 2005, Epidemic diseases act 1897. The DM Act is being criticised in the current situation for being a top-down law. Epidemic diseases act has significant shortcomings in this period of shifting dynamics in public health emergency management, notwithstanding recent changes.

Chapter 5 ~ This chapter focuses on analysis the public health legislations in United Kingdom, United States, Singapore, South Korea, New Zealand, Australia etc.

Chapter 6 ~ Recommendations/ Suggestions, the concluding chapter seeks to summarise and enumerate the findings of the study and suggests recommendations to remedy and improve the issues observed.

CHAPTER II

LAW IN INDIA REGARDING COMMUNICABLE DISEASES

CONSTITUTION OF INDIA

Part IV of the Constitution[17] provides that it is among the primary duties of the State to raise the level of nutrition, standard of living of the people and the improvement of public health. The right to life under Article 21 and its expanded judicial interpretation has cast varied obligations on the state to ensure dignity, privacy and health of the people. This obligation is further reinforced under Article 47, it is for the State to secure health to its citizen as its primary duty[18], Right to health to be constituted within right to life.[19]

Under Article 245, the parliament can make laws for the whole or any part of the territory of India whereas the State legislatures may make laws for the whole or any part of the state. Article 246 provides that the Parliament has exclusive law-making powers regarding subjects enumerated in the union list of the Seventh Schedule and states have the corresponding exclusive legislative power with respect to the subjects in the state list. Subjects within the concurrent list can be the legislative purview of either the Parliament or State legislatures. Port quarantine, including hospitals connected therewith (entry no 28), inter-state migration and inter-state quarantine (entry no 81) etc. form part of the union list whereas public health and sanitation, hospitals and dispensaries (entry no 6), including water supply and prevention of communicable diseases are the purview of the states. The concurrent list has subjects including medical profession (entry 26), prevention of the extension from one State to another of infectious or contagious diseases or pests affecting men, animals or plants (entry 29).

[17] INDIA CONST. Art. 47.
[18] *State of Punjab & Ors v. Ram Lubhaya Bagga*, (1998) 1 SCR 1120.
[19] *Parmanand Katara v. Union of India,* AIR 1989 SC 2039.

INDIAN PENAL CODE

The substantive legislation providing for offences and punishments, the IPC[20], relates to the control of spread of communicable diseases vide sections 269,270, 271,188 etc. Section 269 makes the unlawful or negligent spreading of infection of any disease dangerous to life punishable with imprisonment for term which may extend to six months or with fine or with both. The section is framed in order to prevent people from doing acts which are likely to spread infectious diseases.[21] Unlawful or negligent act likely to spread disease dangerous to life is essential to constitute the offence.[22]

Section 270 penalises any malignant act likely to spread infection of any disease dangerous to life with imprisonment, either simple or rigorous, for a term which may extend to two years or with fine or both. The offence under Section 270 is an "aggravated form"[23] of the offence punishable under Section 269. In X v. Hospital Z,[24] the Supreme Court had held that a person suffering from HIV- AIDS knowingly marries a woman thereby transmitting the disease to her would be guilty of offences under sections 269 and 270 of IPC. Anyone knowingly disobeying any rule made and promulgated by the Government for quarantine of any vessel, or for regulating the intercourse between places where an infectious disease prevails and other places, shall be punished with imprisonment up to six months or with fine or with both.[25] The offences under Section 269 and 270 are cognizable whereas offence under Section 271 is non-cognizable but all three offences are bailable and non-compoundable.

Section 3 of the Epidemics Diseases Act, 1897 provides that any person disobeying any regulation or order made under the Act shall be deemed to have committed an offence punishable under section 188 of the Indian Penal Code. Section 188 punishes the disobedience of any order duly promulgated by a public servant with imprisonment,

[20] The Indian Penal Code, §3, Act No. 45, Acts of parliament, 1860
[21] Ratanlal Ranchhoddas & Dhirajlal Keshavlal Thakore, THE INDIAN PENAL CODE, 1145 (V.R. Manohar ed., 32 ed. 2011).
[22] *Cahoon v. Mathews*, (1897) 24 Cal 494 ; *In Re Kandaswami*, AIR 1920 Mad 420
[23] Ratanlal & Dhirajlal *supra* note 17, at 146.
[24] AIR 1999 SC 495.
[25] The Indian Penal Code, §271, Act No. 45, Acts of parliament, 1860

simple or rigorous, for a term up to six months or with fine which may extend to thousand rupees or with both if such disobedient act causes or tends to cause danger to human life, health or safety. the offence is cognizable, bailable and non- compoundable.

CODE OF CRIMINAL PROCEDURE, 1973

By an order under section 144 of the Code of Criminal Procedure[26], a district magistrate or any other Executive Magistrate in circumstances requiring immediate prevention or speedy remedy, direct any person or persons in particular or the public in general to abstain from certain acts. Such directions to be made only when it is likely to prevent or tends to prevent, obstruction, annoyance or injury to any person lawfully employed or danger to human life, health or safety or a disturbance of the public tranquillity.

EPIDEMICS DISEASES ACT, 1897

The Epidemics Diseases Act was enacted for the prevention of the spread of dangerous epidemic diseases in the country.[27] Section 2 empowers the State government to take such measures and after public notice prescribe the necessary temporary regulation to arrest the spread of dangerous epidemic disease. In particular, such measures may include inspection of persons travelling by railway or otherwise, and the segregation, in hospital, temporary accommodation or otherwise, of persons suspected by the inspecting officer of being infected with any such disease. Section 2A provides that in case of outbreak of any dangerous epidemic disease in any part of the Country the Central Government, has power to take measures and prescribe regulations for inspection of any ship or vessel leaving or arriving any port and for detention of any person sailing or intending to sail in such vessels or ships.

The Epidemic Diseases (Amendment) Ordinance was promulgated to amend the Epidemics Diseases Act. Section 2-A was amended to empower the Central government to inspect any train or buses in addition to ships and vessels and to detain any person

[26] The Code of criminal procedure, § 144, Act No. 2, Acts of parliament, 1973

[27] *M. Vijaya v. Chairman and Managing Director, Singareni Collieries Co., Ltd., Hyd. and Ors*, AIR 2001 AP 502.

travelling therein. section 2B prohibits any person from indulging in acts of violence[28] against healthcare personnel or cause any damage or loss to any property during an epidemic. Any person committing or abetting the commission of such act of violence against healthcare professionals or abets or causes damage to property is to be punished with imprisonment for a term not less than3 months but which may extend to 5 years and with fine not less than 50000 rupees, but which may extend to 2 lakh rupees.[29] Causing grievous hurt under section 320 IPC to such professional then the imprisonment may extend to a term between 6 months to 7 years and a fine not less than 1 lakh rupees, but going up to 5 lakh rupees.[30] The offences so mentioned are to be in the nature of cognizable, bailable[31] and compoundable.[32] Section 3-C of the Ordinance introduced a presumption of guilt until the contrary is proved in trial of offences provided for under the Act. Section 3-D directs the Court to presume a culpable mental state of the accused unless the defence proves otherwise. Section 3-E also provides that the accused once convicted shall also be liable to pay compensation for acts of violence or damaging property. The Ordinance was repealed and Epidemic Diseases (Amendment) Act, 2020 was enacted with similar provisions.

The Supreme court recognized the Disaster Management Act, 2005 and the Epidemic Diseases Act, 1897 amended in the year 2020 as two of legal and administrative instruments to empower and enable the State to contain and manage the covid-19 pandemic.

The EPA is a vestige of colonial times and views the individual as subject rather than citizen. The short Act gives unqualified power to the governments to arrest the spread of communicable diseases. The Amendment to the Act in covid-19 pandemic times also seeks to focus more regulatory powers to the central and state governments. The Act is silent on the ethical aspects and human rights principles, which deserve to be protected even during an epidemic outbreak.[33]

---

[28] Epidemic Diseases (Amendment) Ordinance, 2020, §1A (April 22, 2020).
[29] Id. § 3(2).
[30] Id. § 3(3).
[31] Id. § 3-A
[32] Id. § 3-B
[33] Parikshit Goyal, *The Epidemic Diseases Act, 1897 Needs An Urgent Overhaul*, 55 Econ. Pol. Wkly. (Nov. 7, 2020).

The long in force legislation fails to define or enumerate what constitutes dangerous epidemic diseases. 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.[34] The provisions of the Act consist largely of penal provisions and immunity for state action. The statute fails to provide for a particular situation of disease spread like bioterrorism which when intertwined with national security cannot be governed by individual states. The Act being the primary legislation on the subject also fails to include the changes in the global situation since its inception.

Prior to its application and amendment during the Covid-19 pandemic the central legislation was held to be redundant and recommended for repeal. The Report of the Commission on Review of Administrative laws constituted by the Department of Administrative Laws, Ministry of Personnel,

Public Grievances and Pensions in September, 1998 chaired by P.C. Jain and the Law Commission 248th Report both recommended repeal of the Act.

DISASTER MANAGEMENT ACT, 2005

The act aims at providing for the effective management of disasters and matters connected or incidental to such disasters.[35] The act aims at providing for the effective management of disasters and matters connected or incidental to such disasters. The central act has also found application during the current covid-19 pandemic in India. The definition of the term disaster in the act is "a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or manmade 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".[36] This is a very broad definition that does not limit in any way the nature of disaster

[34] Manish Tiwari, *India's fight against health emergencies: In search of a legal architecture,* Observer Rsch. Found. (March 31, 2020)
[35] *In Re: Distribution of Essential Supplies and Services During Pandemic*, AIR 2021 SC 2356.
[36] Disaster Management Act, 2005, § 2(d).

covered by the act. The Government of India citing the lack of uniformity in the measures adopted as well as in their implementation by the State governments and union territories evoked the provisions of the Act. The National Disaster Management authority has by the Order dated 24th March 2020 directed effective measures to prevent spread of covid-19 in order to mitigate the threatening disaster situation The Order envisioned enforcement of social distancing in India under the provision Section 6(2)(i) of the Act.

The Act establishes a National Disaster Management Authority with the Prime Minister as its Chairperson[37] in the national level, State Disaster Management Authorities with Chief Ministers as ex-officio chairperson[38] for each States and District Disaster Management Authorities[39] for each district within the States to be headed by the Collector or District Magistrate. The Act also envisions the formulation of National plan for disaster management for the entire country,[40] State Disaster Management Plans[41] and District Disaster Management Plans.[42] National plan provided for under Section 11 of the Act for disaster management for the entire country, it includes preventive measures, mitigation measures for various disasters, capacity building for effective response to disasters etc.

Chapter X of the Act contains penal provisions in relation to the enforcement of the Act. Any person found not complying with any direction provided under the Act or obstructs the any officer functioning under the Act is liable to be punished with an imprisonment for a term which may extend to one year or with fine or both and if such non-compliance or obstruction results in loss of life the term of imprisonment which may extend to two years.

The Act also provides for relief in its Section 12 with guidelines for minimum relief. It provides that the national authority is to recommend guidelines for minimum relief to persons affected by disasters including but limited to food, shelter, drinking water, medicine and sanitation in relief camps, special provisions for widows and orphans, ex gratia payment for loss of life, damage to houses or to livelihood due to the disaster. The National authority may also recommend loan relief or fresh loans for affected persons

[37] *Id.* § 3.
[38] *Id.* § 14.
[39] *Id.* § 25.
[40] *Id.* § 11.
[41] Id. § 23.
[42] Id. § 31.

under Section 13. It is a discretionary provision. The Supreme Court opined that *"*Human suffering and loss of livelihood that has accompanied this pandemic, NDMA may consider laying down minimum standards of relief in this regard."[43] It was clarified that this was in no way a direction of the Court. In a later case, the petitioner claimed relief of ex gratia payment for the deceased due to covid-19, under section 12 of the Act as covid-19 is a notified disease under the Act.[44] The petitioner argued that financial constraints cannot be a reason to disregard statutory obligations of the government. The Court directed the NDMA to issue guidelines under Section 12 as to minimum relief on account of loss of life due to covid-19 but refused to state a particular sum as ex-gratia leaving it to the discretion of the authority.

Section 34 measures depending upon the ground reality, action is required to be taken by the authorities and no mandamus can be issued to the District Management Authority, to take action to cover all the things mentioned in Section 34.[45]

The National plan under Section 11 of the act formulated by the NDMA includes Biological and Public Health Emergencies as a type of disaster. Biological emergencies and epidemics, pest attacks, cattle epidemics and food poisoning are included in BPHEs. Biological emergency is one caused due to natural outbreaks of epidemics or intentional use of biological agents (viruses and microorganisms) or toxins through dissemination of such agents in ways to harm human population, food crops and livestock to cause outbreaks of diseases. This may happen through natural, accidental, or deliberate dispersal of such harmful agents into food, water, air, soil or into plants, crops, or livestock. Zoonotic diseases capable of infecting humans, pest and animal diseases capable of affecting the food security of the nation and biological terrorism forms part of the plan against BPHEs. Further, the Supreme Court observed that in the present covid-19 crisis, the "National Plan, 2019 can be supplemented by the issuance of additional guidelines to tackle any aspect of disaster management including the issue of admission to hospitals and access to essential drugs and vaccines."*[46]*

[43] *In Re: Distribution of Essential Supplies and Services During Pandemic*, AIR 2021 SC 2904.
[44] *Gaurav Kumar Bansal v. Union of India and Ors*., MANU/SC/29585/2021 : 2021 6 AWC5746SC
[45] *Nasih K.K. v. Union of India and Ors.*, MANU/KE/1601/2021
[46] *In Re: Distribution of Essential Supplies and Services During Pandemic*, AIR 2021 SC 2904

NATIONAL DISASTER MANAGEMENT GUIDELINES ON MANAGEMENT OF BIOLOGICAL DISASTERS, 2008[47]

The National Guidelines prepared by the NDMA defines communicable diseases as "an infectious condition that can be transmitted from one living person or animal to another through a variety of routes, according to the nature of the disease." And epidemics as "the outbreak of a disease affecting or tending to affect a disproportionately large number of individuals within a population, community, or region at the same time.'' In Chapter 3 the Guidelines recommends the repeal and replacement of the Epidemics Act of 1897 with a new framework providing more power to the Centre government in matters of biological emergencies, bioterrorism etc.

The intent of these guidelines is to develop a holistic, coordinated, proactive and technology driven strategy for management of biological disasters through a culture of prevention, mitigation and preparedness to generate a prompt and effective response in the event of an emergency. The document contains comprehensive guidelines for preparedness activities, biosafety and biosecurity measures, capacity development, specialised health care and laboratory facilities, strengthening of the existing legislative/ regulatory framework, mental health support, response, rehabilitation and recovery, etc.) including bio terrorism deals with the prevention, preparedness, management of major epidemics & pandemics and those occurred by terrorist activities in the form of bio terrorism by the use of biological agents. Special stress is laid on prevention by strengthening Integrated Disease Surveillance Project (IDSP), immunization programmes, and preparedness by upgrading and creating Bio-safety laboratories across the country.

LIVE-STOCK IMPORTATION ACT, 1898

The Act aims at regulation of the importation of live-stock and live-stock products which are liable to be affected by infectious or contagious disorders. Section 3 empowers the Centre Government in restricting the import of live-stock liable to spread contagious or infectious diseases like anthrax, scabies or any other diseases notified by the Centre

[47] National Disaster Management Authority, National Disaster Management Guidelines- Management of Biological Disasters, (July 2008).

government. No suit, prosecution or other legal proceeding shall lie against any person for anything in good faith done or intended to be done under this Act.[48] The Law Commission 248th Report recommended repeal of the legislation after introduction of new law on the subject. The Report observed that the legislation has not kept pace with modern developments.

DRUGS AND COSMETICS ACT, 1940

The central government is empowered to regulate or restrict, manufacture, etc., of drugs in public interest, if the central government is satisfied that a drug is essential to meet the requirements of an emergency arising due to epidemic or natural calamities and that in the public interest, it is necessary or expedient so to do, then, that Government may, by notification in the Official Gazette, regulate or restrict the manufacture, sale or distribution of such drug.[49] In Union of India v. Panacea Biotec Limited[50], though it was not a relief asked for by the applicant, the Delhi high Court had directed the government to consider the emergency authorization under Section 26-B of the Russian Sputnik vaccines for the Indian population in the wake of covid-19 pandemic.

INDIAN PORTS ACT, 1908

The provisions of the Act empower the government in making rules for the prevention of danger arising to the public health by the introduction and the spread of any infectious or contagious disease from vessels arriving at, or being in, any such port.[51] The section provides for signals and anchorage for suspected ships, compulsory medical inspection of such ships and persons in such ships. The Government is also empowered to detain ships with suspected cases of infectious diseases, removal of infected persons to hospitals, disinfection of ships etc.

[48] Live Stock Importation Act,1898, § 5.
[49] Drugs And Cosmetics Act, 1940, § 26-B.
[50] MANU/DE/1038/2021
[51] Indian Ports Act, 1908, § 6(p).

Under the rule making power the Central Government has formulated the India Ports Health rules, 1955. Rule 2(14) held quarantinable diseases plague, cholera, yellow fever, smallpox, typhus and relapsing fever are held as quarantinable diseases.[52]

Rule 46 provides that the health officer has the power of not only medical examination but also to direct isolation of persons and putting on surveillance on persons disembarking the ship for a period of incubation of the infectious diseases. Rule 50 directs that a person proposing to embark on a ship departing India, refusing to undergo medical examination be prohibited for disembarking and Rule 51 provides that the health Officer shall prohibit the embarkation or re-embarkation on any ship of any person showing symptoms of any quarantinable disease.

The Ministry of Ports, Shipping and Waterways had circulated the draft Indian Ports Bill 2020 for seeking inputs from all stakeholders viz. State Governments, State Maritime Boards, major ports, General Public etc. The draft bill seeks to repeal the Indian Ports Act,1908 vide Section 95. Section 30 of the draft Bill envisions of appointment of health officers by the central government with the powers to inspection of vessels, to board vessels and medically examine medically examine all or any of the seafarer or apprentices on board the Vessel, inspect documents, log books etc. while enquiring into the health and medical condition of the persons on board the Vessel.

THE ESSENTIAL SERVICES MAINTENANCE ACT, 1968

The Act aims to provide for the maintenance of certain essential services and the normal life of the community. The Act empowers the Central Government, by orders, to prohibit strike in essential services including postal services, railway, defence services and more.[53] Any such strike shall be punishable with imprisonment for a term which may extend to six months, or with fine which may extend to two hundred rupees, or with both.[54] Section 5 penalises instigation of illegal strike with imprisonment up to a year or with a fine of 1000 rupees or both. Any person giving financial aid to illegal strikes is also liable to the same quantum of punishment.[55]

[52] India Ports Health Rules, 1955. Rule 2(14).
[53] The Essential Services Maintenance Act, 1968, § 2(a)
[54] Id. § 4.
[55] *Id.* § 6.

AIRCRAFT ACT, 1934

Section 8A provides the power to the Central Government to make rules under the Act for protecting the public health from danger arising by the introduction or spread of any infectious or contagious disease from aircraft arriving at or being at any aerodrome. Section 8B provides emergency powers for the Central Government upon outbreak or threat of outbreak of any dangerous epidemic disease to make temporary rules with respect to aircraft and persons traveling or things carried therein and aerodromes as it deems necessary in the circumstances. The Indian Aircraft (Public Health) Rules, 1954 was superseded by the Indian Aircraft (Public Health) Rules, 2015.

Rule 4 holds the Airport Health officers responsible for surveillance[56] and application of public health measures[57] at the airports, including health screening and medical examination of the travelers, if necessary; and inspection of baggage, cargo etc. during public health emergencies can require an aircraft to land in an airport not being the destination airport,[58] direct travellers to medical examination, isolation, quarantine for a period not exceeding the incubation period of the disease, require documentation as to vaccination,[59] prohibit persons suspected of suffering from infectious disease from embarking on an aircraft[60] etc.

STATE LEGISLATIONS RELATING TO COMMUNICABLE DISEASES

Health being a state list subject there are a plethora of state legislations relating to epidemic diseases and in prevention of spread of communicable diseases. The provisions are spread across particular epidemic diseases Acts or state public health legislations.

KARNATAKA EPIDEMIC DISEASES ACT,2020

The law legislated with the objective to "unify and consolidate laws relating to regulation and prevention of epidemic diseases in Karnataka." Section 3 of the Act empowers the State government to declare epidemic diseases. Section 4 provides power of the state government to take special measures and specify regulations on outbreak of an epidemic

[56] The Aircraft Act, 1934 § 2 (38)
[57] Indian Aircraft (Public Health) Rules, 2015, Rule 2(22).
[58] *Id.* Rule 6.
[59] *Id.* Rule 7.
[60] *Id.* Rule 10.

disease. It delegates the power to make temporary regulations or orders to be observed to the deputy commissioner or municipal commissioner. The regulations particularly include prohibition of gatherings, celebrations etc., restrictions on public and private transport; quarantining of persons entering the state; imposition and enforcement of social distancing; sealing of state borders etc.

Any act of contravention or obstruction of a public servant or acts of violence against public servant or any act of disobeying the regulations in force under section 4, shall be punishable with imprisonment for a term not less than 3 months which may extend to 5 years with a fine not less than Rs 50000/ under Section 5. Any damage to property attracts punishment under Section 6 including imprisonment. Upon conviction such offender shall also become liable to pay compensation the quantum of which is to be decided by the competent Courts.[61]

RAJASTHAN EPIDEMIC DISEASE ACT, 2020

The Act repeals[62] the Rajasthan Epidemic Diseases Ordinance, 2020 and the Rajasthan Epidemic Diseases (Amendment) Ordinance, 2020. Section 3 of the Act confers the power to notify epidemics diseases to the State government. Section 4 is similar to the Karnataka epidemic legislation in it being the purview of the State government to seal state borders, restrict gathering etc. The penalty for contravention of the Act provided in section 5 includes an imprisonment up to 2 years and fine not less than Rs 10,000/. Abatement of any offence under the Act also attracts the same punishment under Section 6 of the Act. Section 14 provided that the State Government may by order in the Gazette make provisions not inconsistent with the provisions of this Act as may appear to be necessary for removing any difficulty in giving effect to the provisions of the Act.

EPIDEMIC DISEASES (BOMBAY AMENDMENT) ACT, 1953

The state amendment to the Epidemic Act,1897 adds that powers under the Act be delegated to Collectors under Section 2B.

[61] Karnataka Epidemic Diseases Act, 2020, § 7.
[62] Rajasthan Epidemic Diseases Act, 2020, § 16.

EPIDEMIC DISEASES (PUNJAB AMENDMENT) ACT, 1949

The state amendment allows delegation of powers under Section 2 of the central Act to deputy commissioners to exercise within their local jurisdiction.

EPIDEMIC DISEASES ACT, 1977

The Act was legislated into force in the erstwhile State of Jammu and Kashmir. Section 2 provides to the State the powers to take special measures including inspection of travellers, segregation of infected persons etc. and penalty for contravention under Section 3 is as under the State Penal Code Section 183.

KERALA EPIDEMIC DISEASES ACT, 2021

The Act seeks to unify and consolidate the laws relating to regulation and prevention of epidemic diseases. Section 3 empowers the State Government to notify, by Official Gazette, any disease as an epidemic disease throughout the territory of the State or any specified part thereof.

Section 4 vests the government with the power to take necessary measures upon outbreak of any epidemic disease and specify temporary regulations including but not limited to

a. prohibition of any usage or act capable of spreading disease in a gathering
b. inspection of persons arriving in the State or in quarantine or isolation
c. seal state borders
d. restrict public and private transport
e. prescribe social distancing norms
f. restrict or prohibit congregation in public places and religious places
g. regulate or restrict functioning of Government and private offices
h. restrictions on functioning of shops, commercial establishments etc.
i. restrict the duration of services like banks, electricity, food supply etc.

Contravention[63] of the provisions under the Act or its abetment[64] is punishable by a term of imprisonment extending up to two years or with fine up to ten thousand rupees or both. Section 10 protects from legal proceedings or prosecution any act done in good faith under this Act.

The state epidemics legislations that have been in force for long unilaterally allow for power of state governments in the prevention and control of epidemic diseases. These legislations too fail to provide the benchmark for an epidemic disease, merely providing for the power of the state governments to declare the state to be visited or threatened with an epidemic disease. The power of regulation and prevention of spread of disease is conferred on district executives without qualifying the extent and limits of the exercise of power along with penalty for non-compliance. The state epidemics acts legislated during the pandemic times are providing for tailor-made regulations for control of covid-19. These statutes providing for social distancing, restrictions of gathering etc. relevant in the present times may fall redundant in the control of another communicable disease threat whose mode of spread, infectivity, treatment and control may differ from that of covid-19.

MODEL PUBLIC HEALTH ACT

The model public health act to be adopted by the Centre and States was first recommended by the Report of the Health Survey and Development Committee, published in 1946. The Government of India appointed a Model Public Health Committee which produced a draft of the Act in 1955. The Model Public Health Draft was revised in 1987. The object of the model Act is to make provision for health services in the States and Union Territories. Section 5 of the Model act envisioned the setting up of the Board of Health in the States and Union Territories with the Minister of health as its President overlooking functions related to health services and health campaigns.

The local authorities are made responsible for preventing the occurrence of any communicable diseases and dealing with it in the event of an outbreak according to section 13. The responsibility of the local authorities to provide services like

[63] Kerala Epidemic Diseases Act, 2020, § 5
[64] *Id*. § 6.

immunization centres, public health laboratory services, isolation hospitals and facilities, ambulance services were made conditional upon the availability of financial resources.

To control and prevent spread of diseases the following measures are provided

1. Removal of persons: According to section 120, health officer may remove any person suffering from a communicable disease, while without proper lodging or accommodation, or lodged in a place with more than one family or is without medical supervision or when his presence is a danger to the neighbourhood, to any hospital or place for treatment. no one so removed shall leave such a facility without the permission of the health officer. any obstruction to such removal or taking away of the removed person is liable for punishment of imprisonment for a term of 3 months or fine or both.
2. Prohibition of exposure of other persons to infectious diseases in public places under section 121 and prohibition of use of public conveyance by infected persons under section 136.
3. Prohibition on infected persons engaging in certain trades relating to food for human consumption under Section 123.
4. Every medical practitioner, manager of any factory or public building, keeper of lodging houses, heads of family, owner and occupier of houses etc to report or give information in cases of notified infectious diseases to health officer.
5. Health officers and other officials have powers of inspection and to take such measures to prevent spread of the disease.
6. Restrict persons from entering a house or otherwise contact a person suffering from cholera, plague or other dangerous disease and direct isolation for violators.
7. Magistrates are empowered to close down places where food is manufactured in case of occurrence of notified diseases in the premises in the interest of the public.
8. Restrictions on infected clothing and articles.
9. Prohibition of use of public libraries or use of books from libraries.
10. Magistrate to prohibit assemblage of over 50 people in private or public when such assemblages are likely to spread diseases.
11. upon declaration in the official Gazette, of any place to be visited by or threatened with outbreak disease the collector will be empowered to evacuate houses in

infected areas, make vaccination and preventive inoculation compulsory, compulsory medical examination of persons arriving from outside, disinfection, destruction of infected articles etc. the power includes the direction to restrict movement of infected persons, power to close markets etc. any breach of such regulation under Section 140 is punishable with imprisonment of term of 3 months or with fine or both.

There is a lack of uniformity in adoption of public health laws by States. Legislation like the Tamil Nadu Public health Act, 1939 have been in force before the Constitution, whereas there are States and Union Territories with no public health legislations.

State public health legislations include:

TAMIL NADU PUBLIC HEALTH ACT, 1939

An outbreak of infectious diseases[65] empowers the health officer with the local authorities to appoint additional medical staff, provide medicines, equipment etc. as needed.[66] The duty to set up isolation wards and hospitals to treat affected persons is upon the respective local authorities in the areas of outbreaks[67]. Section 56 binds the medical practitioner to inform on any case of tuberculosis and enteric fever specifically. The health officer can affect the removal of any infected person, without lodging or medical care or living in such situation as to be dangerous to any person living with them, to a hospital or such place infectious persons are lodged.[68] Such removed person is prohibited from leaving such place without leave of the health officer[69] and any person obstructing such removal or takes away such removed person in liable for imprisonment which may extend to three months, or with fine, or with both.[70] Persons suffering from infectious diseases is prohibited from knowingly exposing other persons in public places like markets, theatre, factory, shops[71] etc., or use public conveyance[72] and such persons, likely to spread diseases, are also prohibited from carrying on trade related to food for

[65] Tamil Nadu Public Health Act, 1939, § 52.
[66] *Id.* § 53.
[67] *Id.* § 54.
[68] *Id.* § 58(1)
[69] *Id.* § 58(3)
[70] *Id.* § 58(4).
[71] *Id.* § 59.
[72] *Id.* § 69.

human consumption or such other trades requiring special permits from the health officer.[73] The power of the health officer relating to infectious diseases among animals is limited to recommendations to the local authority to adopt.[74] The health officer with the sanction of the district collector, may enter upon, occupy and use any premises for the purposes related to control and prevention of any notified diseases. The owner or occupier is entitled to a 36 hour notice and compensation for damages and reasonable rent.[75] The health officer and such person so deputed also has power to inspect and take such preventive measures as required for control of the notified infectious diseases[76] including destruction of any hut or shed[77], closing down of lodging houses.[78] Magistrates in local areas are empowered under section 75 to prohibit gatherings and assembly of more than fifty persons.

MADHYA PRADESH PUBLIC HEALTH ACT, 1949

The Act seeks the constitution of a Public Health Board[79] to advise the government on matters of public health including measures against epidemics.[80] The Government shall have power to inspect, control and superintend the operations of local authorities under the Act and define the powers to be exercised by the Director of Health.[81] This power of the Director of Health and staff to advise and recommend necessary measures to local authority.[82] The local authority is to appoint a Health inspector to carry out the duties under the Act, upon the direction of the State Government.[83]

Section 50 enumerates specific diseases as infectious diseases; the definition is inclusive of such diseases the state government may by notification declare to be an infectious disease in the state or any part thereof. Section 51 provides those certain diseases and such others as the state government may notify as Notified infectious disease.

---

[73] *Id.* § 72.
[74] *Id.* § 61.
[75] *Id.* § 63.
[76] *Id.* § 65.
[77] *Id.* § 66.
[78] *Id.* § 67.
[79] Madhya Pradesh Public Health Act, 1949, § 4.
[80] *Id.* § 5.
[81] *Id.* § 6.
[82] *Id.* § 7
[83] *Id.* § 9.

The provision for additional medical staff, medicines and equipment in case of emergencies[84], provision for hospitals, isolation wards,[85] ambulances[86] etc., are the responsibility of the local authorities. The Act also directs mandatory intimation of information on those affected by notified infectious diseases[87] and removal of such infected persons to hospitals.[88] The penalty for obstructing such removal or leaving from such facility without permission of the health officer entails an imprisonment which may extend to three months or with fine, or with both.[89] Apart from compulsory removal such persons suffering from infectious diseases is prohibited from exposure of other persons in public places,[90] restrictions are placed on using public conveyance and taking part in certain trade related to food for human consumption[91] etc.

No person shall, while suffering from, on in circumstances in which he is likely to spread, any infectious disease bath, wash, wash clothes in or near or lake water from any public well, tank, pond, pool, spring, stream, or water-course or other sources of public water-supply; or wilfully touch any article of food, drink, medicine or drug exposed for sale by others.

The health officer has the power to occupy any house or building without the consent of the owner or occupier, for any purpose connected with the prevention or control of infection and such owner is entitled to 36-hour notice and adequate compensation.[92] Such officers shall also have the powers of taking preventive measures against spread of disease including entry and inspection of any house, factory, workplace etc[93]., destruction of huts or sheds,[94] closure of lodging houses.[95] Under Section 71 the Government has the power to confer special powers on health officers in local areas visited or threatened with infectious diseases. Such special powers include the power to order the evacuation of infected house and houses adjoining them or in their neighbourhood, or generally of all

[84] Id. § 52
[85] Id. § 53.
[86] Id. § 54.
[87] Id. § 55.
[88] Id. § 57.
[89] Id. § 57(3)
[90] Id. § 58.
[91] Id. § 59.
[92] Id. § 61.
[93] Id. § 62.
[94] Id. § 63.
[95] Id. § 64.

houses in any infected locality, power to make vaccination and preventive inoculations compulsory, power to direct persons arriving from outside, or those residing adjacent to infected persons to undergo medical examination, power to close down markets or assign special areas for market, power to prohibit fairs, festivals etc. It is in the discretion of the local authority to give compensation to any person who has sustained substantial loss by the destruction of any property due to exercise of such powers but no claim for compensation shall lie for any loss or damage caused by any exercise of the said powers.

Under Section 70, any Magistrate not being a Magistrate of the third class, having local jurisdiction shall have power to prohibit assemblages consisting of any number of persons exceeding fifty, in public or private which is likely to become a means of spreading the disease or of rendering it more virulent.

The one provision ensuring treatment of affected persons is included in the section 77 of the Act which binds the local authority to provide free diagnosis and treatment of persons suffering from or suspected to be suffering from leprosy and take steps to prevent the spread of the disease. The provisions of the Act that required Medical Certificates to certify that a person is free from leprosy, restrictions on diseased persons to accept employment as teachers, personal attendants etc., or attend schools, colleges or public libraries and their detention in segregated accommodations were repealed. Such a beneficial provision is restricted to only leprosy alone and not to other communicable diseases.

ASSAM PUBLIC HEALTH ACT, 2010

The legislation aims to provide for the protection and fulfilment of rights in relation to health and well-being, health equity and justice. Communicable diseases are defined as any "*illnesses caused by microorganisms and transmissible from an infected person or animal to another person or animal.*"[96] Public health emergency means any unusual or unexpected occurrence or imminent threat of illness which affects or is likely to affect a large population which needs immediate public health intervention to prevent death or disability to a large number of people.[97] Apart from the duties of ensuring access to health

[96] Assam public health act, 2010, § 2(c).
[97] Id. § 2(r).

services,[98] sanitation, basic housing, adequate food and nutrition,[99] the specific duty to take effective measures to prevent, treat and control epidemic and endemic diseases falls on the government and the department of Health and Family Welfare.[100] Section 4 empowers the Government in the health department to take appropriate legal steps through amendment or review of the public health law or through rules and orders under the Act to fix responsibility and accountability to concerned departments and agencies in case of repeated outbreaks or recurrence of communicable, viral and waterborne diseases found to be due to failure to improve sanitation and safe drinking water facilities.

Chapter III of the Act provides for collective and individual rights in relation to health. Section 5 provides that every person shall have the right to appropriate healthcare and essential drugs,[101] right to effective measures for prevention, treatment and control of epidemic and endemic diseases and the right to effective mechanisms in public health emergencies. Outside the management of communicable diseases, a user has the rights to information about healthcare, their health status,[102] right to access to medical records,[103] right to autonomy and exercise of prior and fully informed consent[104] and the right to confidentiality[105] of his health status and medical information. The section 20 of the Act provides for immunity for the Government or any of its personnel acting under the Act from liability due to death or injury to any individual or property while complying with the provisions of the Act. No action for damages shall lie against actions done by its servants in good faith purported to be done under the Act. No provision exists for penalty or criminal liability for contravention of the Act.

The Assam Act moves away from the existing public health legislations. It binds the government and departments with responsibility for control of communicable disease spread. The Act also enumerates the rights of the diseased and affected persons making it a first of its kind rights- based legislation on the subject. The Act eschews the coercive penal provisions against non-compliance.

---

[98] Id. § 3(1)(b).
[99]Id. § 3(2).
[100]Id. § 3(3)(b).
[101]Id. § 5(a).
[102]Id. § 6.
[103]Id. § 7.
[104] Id. § 8.
[105] Id. § 9

THE GOA, DAMAN AND DIU PUBLIC HEALTH ACT, 1985

The Act aims to make provision for advancing public health in the union territory of Goa, Daman and Diu. Chapter VII of the Act exclusively deals with prevention, notification and treatment of diseases. The diseases under the infectious disease includes acute influenza, anthrax, chicken pox and any other diseases notified by the Government.[106]

The local authority in such localities is obliged to provide isolation wards, hospitals etc. for reception treatment of patients with infectious diseases.[107] According to section 50 of the Act it is the duty of the Director of health services of the Government to provide and maintain suitable conveyances, with sufficient attendants and other requisites, for free carriage of persons suffering from any infectious diseases and to make available proper places and apparatus and establishment, for the disinfection of conveyances, clothing, bedding or other articles which have been exposed to infection to be used by the public for free or for a fixed fee.

Every registered medical practitioner who becomes cognizant or suspects the existence of any case of the infectious diseases is duty bound to inform the specified authority which could be the local authority or the health inspector or sanitary inspector.[108] Similar provision of removal of persons,[109] prohibition of exposure,[110] engaging in trade,[111] like the model act is also enforced. The health officer is empowered, with the sanction of the Collector enter upon, occupy and use, or depute any person to enter upon, occupy and use, without having recourse to the provisions of the Land Acquisition Act, 1894, any building or place for any purpose related to the prevention or control of infection from a notified disease.[112] The person who may be occupying such a building or place is entitled to a 36 hour notice to be given by the health officer and also, entitled to receive compensation for any damage or expenses incurred and to a reasonable rent for the period of occupation. Health officers or other authorized persons are empowered to conduct

[106] Goa Public Health Act, 1987, § 57.
[107] Id § 48
[108] Id. § 51.
[109] Id. § 53.
[110] Id. § 54.
[111] Id. § 55.
[112] Id. § 58.

inspection of any place with reported cases of notified disease or where there is a suspicion of such diseases and take appropriate preventive measures. Such authority is not bound to give notice of such inspection except in case of dwelling houses.[113] Preventive measures may include destruction of house or shed which the health officer may direct if he reasonably feels it necessary to prevent the spread of any notified disease after giving previous notice to the owner and occupier of his intention to destroy such premises.[114] The owner or any person suffering loss due to such destruction is entitled to receive such compensation as the local authority may decide but he is barred from otherwise claiming compensation for loss or damage under section 61(3).

PUBLIC HEALTH LAW IN KERALA

There exists in force two public health legislations for the territory in Kerala- the Travancore- Cochin Public Health Act, 1955 and the Madras Public Health Act, 1939.

The Travancore- Cochin Public Health Act has similar regulatory measures as the Model Public health Act, in section 50 to 72. The Madras Public Health Act legislated for the erstwhile Malabar region of Kerala have provisions for the establishment of a public health Board, otherwise confers similar power on local authorities to prevent spread of infectious diseases like removal of persons, restriction on movement, restrictions on assembly etc. The Kerala Public Health Ordinance, 2021 sought to unify the existing laws to enhance the public health administration in the State and repealed and ceased the operation of the Travancore- Cochin public health Act and Madras public health act.

Section 2(b) of the Ordinance defines communicable diseases as *"*a clinically manifest disease of man or animal resulting from an infection*"* and clause (g) defines epidemics "the sudden and rapid increase in the number of cases of a disease or other condition of public health importance in a population." The Ordinance establishes the State Public Health Authority, District Public Health Authority and Local Public Health Authority responsible for implementation of the provisions of the Ordinance.[115]

[113] Id. § 60.
[114] Id. § 61(1).
[115] The Kerala Public Health Ordinance, 2021, § 3 (Feb. 23, 2021).

THE UTTAR PRADESH PUBLIC HEALTH AND EPIDEMIC DISEASES CONTROL ACT, 2020

The power to declare[116] epidemics and regulations[117] to control and prevent vests with the State Government. Section 5 of the Act established the State Epidemic Control Authority and District Epidemic Authorities to implement the provisions of the Act. The government and authorities will have power to order lockdown under Section 7.

The Act specifically has more restrictive measures relative to the above-mentioned legislations. Some of the restrictive measures that the Government and Epidemic Authorities are empowered exercise under the Act include:

a. declaration of reward for tracing an afflicted person or a person likely to be afflicted due to contact with an afflicted person, who is evading detection.
b. requires to trace and bring an afflicted person to the treatment centre.[118]
c. issues a proclamation in respect of an afflicted person to airport authorities or other State
d. Governments to take appropriate steps in respect of such person
e. taking such a person traced to a treatment facility. Section 10 clarifies that such action not to amount to arrest under Criminal Procedure Code
f. authorized persons to enter any place to search and trace any person in compliance of a requisition.[119]
g. order that expenditure incurred by the Government or loss or damage caused by the deliberate or negligent conduct or behaviour of any individual or an organisation be recovered from such individual or organisation under Section 13
h. section 14 prohibits voluntary help or material assistance to be given to afflicted persons independently by individuals, the same must be done through agency of the State
i. section 15 punishes concealment or evasion of detection with imprisonment for a term not be less than one year but may extend to three years and with fine which shall not be less than fifty thousand rupees but which may extend to one lakh rupees

[116] Uttar Pradesh Public Health and Epidemic Diseases Control Act, 2020, §3.
[117] Id. § 4.
[118] Id. § 9.
[119] Id. § 11.

j. Section 16 punished travel by public conveyance of afflicted persons with imprisonment for a term which shall not be less than one year but may extend to three years and with fine which shall not be less than fifty thousand rupees but which may extend to two lakh rupees

k. Section 17 punished violation of quarantine with rigorous imprisonment for a term 'which shall not be less than one year but may extend to three years and shall also be liable to be punished with fine which shall not be less than ten thousand rupees tut which may extend to one lakh rupees.

l. Section 18 punishes persons running away from epidemic disease treatment with rigorous imprisonment for a term which shall not be less than one year but may extend to three years and shall also be liable to be punished with fine which shall not be less than ten thousand rupees but which may extend to one lakh rupees.

m. section 19 punishes obscene or vulgar or act or indecent act or gesture shall be punished with imprisonment for a term which shall not be less than one year but may extend to three years and shall also be liable to be punished with fine which shall not be less than fifty thousand rupees but which may extend to one lakh rupees

n. section 20 punishes incitement of violation of provisions under the act shall be punished with rigorous imprisonment for a term which shall not be less than two years but may extend to five years and shall also be liable to be punished with fine which shall not be less than fifty thousand rupees but which may extend to two lakh rupees

o. section 21 penalises malicious propaganda with rigorous imprisonment for a term which shall not be less than six months but may extend to three years and shall also be liable to be punished with fine which shall not be less than ten thousand rupees but which may extend to one lakh rupees

p. attack and obstruction of officers authorized under that Act is punished under Section 22 with imprisonment for a term which shall not be less than three months, but which may extend to five years and with a fine, which shall not be less than fifty thousand rupees but which may extend to two lakh rupees.

q. section 23 punishes malignant conduct with intention or knowledge that it may spread contagion or disease to others with rigorous imprisonment for a term which shall not be less than one year but may extend to three years and shall also be liable to be punished with fine

The Act disproportionately penalises non-compliance and does not contain elaboration on what can possibly constitute malignant conduct or malicious propaganda. Upon such a situation, the provisions of the Act are liable to abuse. In effect the Act enforces requisitioning and compulsory treatment of afflicted persons and enforces restrictions with penal sanction essentially making falling sick a potential criminal activity.

THE PUBLIC HEALTH (PREVENTION, CONTROL AND MANAGEMENT OF EPIDEMICS, BIO-TERRORISM AND DISASTERS) BILL, 2017

In 2017, the Ministry of Health and Family Welfare made the draft Bill[120] public for comments and feedback from interested parties and stakeholders. In a number of circumstances, the draft Bill would grant state and municipal governments the power to react effectively to public health emergencies like epidemics and bioterrorism.

The Bill, which was created by the National centre for Disease Control and the Directorate General of Health Services, has given states and local governments the authority to take the necessary actions, such as placing people in quarantine, decontaminating areas, isolating infectious agents and performing surprise inspections in the event of a public health emergency.[121]

The Bill focuses primarily on the authorities of the central and state governments during an epidemic, but it makes no mention of those government's obligations to prevent and control the epidemic or of individual's rights in the event of a serious disease outbreak.

The provocation and caution that permit the State to reduce or restrict persons' rights to liberty, privacy, property, and movement would be expressly explained in a modern and comprehensive public health legislation. As a result, government decision-making would become predictable and transparent.

FOUR-TIER HEALTH ADMINISTRATION STRUCTURE

[120] The public health (Prevention, control and management of epidemics, bio-terrorism and disasters) bill, 2017 (India)

[121] The public health (Prevention, control and management of epidemics, bio-terrorism and disasters) bill, 2017, §3 (India)

A four-tiered system of health administration is envisioned in the draft bill, with national, state, district, and local public health authorities, each with distinct roles and duties for handling public health emergencies. The extensive powers that the Bill grants to the state, district, and local authorities have drawn criticism.

The national public health authority would be led by the Union Health Ministry, but state health ministers would serve as its chair. Local units would be commanded by Block Medical Officers or Medical Superintendents, while the next tier would be managed by District Collectors. These authorities would have the power to conduct preventive measures against emerging infectious diseases and non-communicable diseases.

POWERS OF THE STATE AND LOCAL AUTHORITIES, AND THEIR IMPLICATIONS

The extensive powers that the Bill grants to the state, district, and local authorities have drawn criticism. The proposed Bill outlines a number of actions taken principally by the Centre and States to stop the spread of covid-19 and stipulates that the Authorities shall have the authority to take such actions once again if necessary.

The Bill also gives state and union territory governments the authority to undertake any medical examinations, including laboratory tests, and to administer vaccinations or other treatments for any diseases to those who have been exposed to them or who are ill or are suspected of being ill with them. The relevance of the concerned person's agreement for carrying out such medical or laboratory examinations, as well as for administering vaccinations or treatments, is not addressed by the clause.

The Bill includes definitions for the terms "epidemic," "isolation," "quarantine," and "social distance," as well as definitions for "public health emergency of international significance," "ground crossing," "disinfection," "de-ratting," and "decontamination".[122]

SCOPE OF THE BILL

In the Public Health Bill of 2017, concepts including "bioterrorism," "public health emergency," "social separation," and "quarantine" were defined. The definition provision of the Bill alone demonstrates the necessity of current laws on the subject.

[122] The public health (Prevention, control and management of epidemics, bio-terrorism and disasters) bill, 2017, §2 (India)

The phrase "clinical establishment" is defined in Section 2(d), and it is given a wide-ranging definition. For the purposes of the Bill, every medical facility, regardless of its makeup, ownership, size, or specialty, was included in the definition of a clinical establishment. The broad definition of "clinical establishment" also extends to small doctor-only clinics and other types of research and diagnostic labs. Clinical establishments owned, managed, and directed by the Armed Forces are the only exception in this regard. Section 3 of the proposed legislation explains how useful this term is.

The state governments, union territories, district, and local administrations are granted a plethora of authorities under Section 3. These tools have the power to impose social exclusion, isolation, and other preventative health measures on any individual or group of individuals. They have the authority to impose restrictions on specific behaviours, outlaw or control the use of dangerous substances like drugs, administer medical examinations, and carry out a variety of decontamination procedures.

These authorities had the authority to issue orders to all clinical institutes under Section 3. Any state government, union territory administration, district, or local authority may use these powers if they believe that a public health emergency is occurring or about to occur.

PENAL PROVISIONS

The Public Health Bill of 2017 provisions would have been beneficial at the time. Any individual who is authorised by this act or the rules promulgated under it is included in the definition of a public servant as stated in Section 21 of the Indian Penal Code by Section 7 of the draft Bill. If this clause had been in effect, it would have served as a deterrent to the nefarious members of society who have turned to violence against medical professionals.

The Public Health Bill of 2017 punishment provisions take a variety of potential scenarios into account. For the first negligent violation, the defaulter may be fined up to Rs. 10,000, and for subsequent violations, up to Rs. 25,000. A fine of up to Rs. 1 lakh and up to two years in prison may be imposed for wilful violations. The amount of the fine specified in the Bill reflects the state of the economy today, and the degree of deterrent provided by incarceration is reasonable.

Any attempt to restrain the actions of any person who has been granted authorization under the Act may be sanctioned under Section 188 of the Indian Penal Code, which is a just punishment. On the other hand, according to Section 188 of the IPC, the only legal recourse for disobeying the Epidemic Diseases Act's regulations is a fine of 200 rupees or imprisonment for a maximum term of one month, or both. A person can also face up to six months in prison, a fine of up to Rs. 1000, or both if their actions endanger human life, health, or safety or create or contribute to riots or altercations.

According to Section 188 of the IPC, the offender must also be aware that he is required to execute any instructions issued by a public official who has the authority to do so. The Public Health Bill of 2017 does not make this restriction regarding knowledge of the offender a requirement. Such a condition wouldn't have existed, and the lockdown would have been better managed as a result.

SCHEDULES IN THE BILL

The fourteen sections of the Bill are supplemented by two schedules. The first schedule contains illnesses that are prone to epidemics. The potential bioterrorists are listed on the second schedule. The new Coronavirus (also known as SARS-COV-2) is a mutation of the SARS virus, which is included in the first schedule.

As a result, this Bill would have been applicable without the need for changes to this schedule had it become law. The Public Health Bill, 2017 or comparable legislation must be reintroduced in light of the points made above and the severity of the current chaotic situation.

ISSUES WITH THE BILL

The difficulties in implementing the Public Health Bill can be summed up as follows:

- It would be challenging to successfully implement the proposed Public Health Bill without a committed public health cadre.
- Due to the ease of access to the Internet, many erroneous claims and warnings have the potential to go viral, spreading worry and terror among the populace. To stop such actions, adding sanctions should be taken into consideration. During an

outbreak, providing compensation to those impacted by government orders may be considered.

- All of the government's powers at each level are explicitly stated, but potential rights violations during public health emergencies have not been considered, and their redress methods have not been defined. Although this Act permits appeal, the potential for an appeal in the context of Sections 9 and 10 is severely constrained.

A public health law must maintain a balance between the government's powers and the rights guaranteed by the constitution. It is a difficult challenge to control the covid 19 pandemic with a colonial act that contains more than a century-old provisions. The four sections' applicability in modern times is constrained. A law that incorporates all pertinent health-related laws and surveillance initiatives, considers all potential threats to the public's health, and strengthens the response to any public health emergency is urgently needed.

To create such a comprehensive law, the Public Health Bill 2017 is a positive step. While it accurately describes the capabilities of the federal government, state government, and municipal authorities, it falls short when it comes to the appeals processes for those who have been wronged. It should take into account other concerns, such as false news spread via social media or recompense for anyone harmed by any government orders during a public health emergency. Comprehensive legislation is an urgent need that will support other emergency public health actions.

Any national pandemic law must be built on the principle of equal access to healthcare services. On this aspect, the EDA and the proposed Bill both fall short. It is necessary to establish civil society's obligations in such a crisis as well as the obligations of healthcare personnel and other employees, as well as their rights and the safety standards to which they are entitled.

The Bill needs extensive input and debate with key stakeholders and health experts in its current form. To address the effects of the Bill after its implementation, more extensive engagement is needed. Another important step in resolving the problems with the Bill would be to consult state public health laws and take lessons from international public health management systems.

Any national pandemic law must be built on the principle of equal access to healthcare services. On this front, both the current Epidemic Diseases Act and the new Bill fall short.

The covid-19 programme has given the union government the chance to enact comprehensive central legislation that satisfies both legislative and political intent. The foundation of an effective public health system must be a new public health law. The Bill needs to address the legislative shortcomings in person protection, coordination, communication, and surveillance during a public health emergency.

The Indian law that is now in effect on covid-19 has many flaws. Other nations, including the UK, Australia, New Zealand, and Spain, have the necessary legislative structure to handle the pandemic and have been successful in containing its impacts. India's large population makes managing any disease a significant administrative challenge. But when there is a legislation with a clear path of action, the administrative management can be somewhat strengthened.

The Bill sought to repeal the Epidemic Diseases Act and fully address any future health crisis that India might have. The Bill was never introduced in Parliament due to initial reservations about the increased emphasis on bioterrorism and a lack of governmental enthusiasm for the issue.

CHAPTER - 3

VICTIM'S RIGHT

Indian government's imposition of a complete nationwide lockdown during the Covid-19 outbreak reportedly violated the citizen's fundamental rights to life and personal liberty, which are specifically stated in Article 21 of the Indian Constitution. Part IV of the Constitution makes reference to provisions relating to health in terms of the Directive Principles of State Policy. The obligation of the State to ensure citizens' rights to appropriate means of subsistence is mentioned in Article 39(a)[123]. According to Article 39(e)[124], The State must watch out for the "health and strength of employees, men and women, and the delicate age of children". According to Article 41[125], the State must "offer public assistance in circumstances of unemployment, old age, disease, and disablement". The phrase "protect the health of the new born and mother by maternity benefit" appears in Article 42[126]. "Raising the level of nutrition and the standard of living of people and boosting public health" is the focus of Article 47[127]. In *Akhil Bharatiya Soshit Karmachari Sangh v. Union of India*[128], the Supreme Court has noted that "The Fundamental Rights are intended to foster the ideal of a political democracy and to prevent the establishment of authoritarian rule but they are of no value unless they can be enforced by resort to courts. So, they are made justifiable. However, it is also evident that notwithstanding their great importance, the Directive Principles cannot in the very nature of things be enforced in a Court of Law, but it does not mean that Directive Principles are less important than Fundamental Rights or that they are not binding on the various organs of the State."

India is made up of 8 Union Territories and 28 States. The working powers and obligations of the government bodies of the central government and the states and

[123] INDIA CONST. art. 39(a)
[124] INDIA CONST. art 39(e)
[125] INDIA CONST. art. 41
[126] INDIA CONST. art. 42
[127] INDIA CONST. art. 47
[128] AIR 1981 SC 298.

territories are segregated by the constitution. The seventh schedule of Article 246[129] of the Indian Constitution deals with the division of powers between the Union and the States. The Union List, State List and the Concurrent List are the three lists found in the Seventh Schedule. The 97 things included in the Union List are subject to legislative action by the Parliament, whilst the 62 items on the State List are the purview of state legislatures. On the other hand, there are 52 items on the Concurrent list that cover topics under the competence of both the Parliament and state legislatures. But in the event of a disagreement, the Constitution grants supremacy to Parliament on Concurrent list issues. The ability to enact laws governing public health rests with both the central government and the states. All three of the Indian Constitution's lists include items pertaining to public health. Numbers 28 and 81 of the Union List refer to quarantine and all matters pertaining to seamen's and marine hospitals and medical facilities. Under item six of the State List, the states have the authority to enact laws pertaining to "health care, sanitation, hospitals, dispensaries, and control of animal diseases." Under items 26 and 29 of the Concurrent List, the Union and states may pass legislation pertaining to the health profession and the prevention of the spread of infectious or contagious illnesses or pests that affect people, animals, or plants from one state to another. The 15th Finance Commission's High-Level Group (HLG), which was established for the health industry, suggested moving health subjects to the Concurrent List. It also suggested that the "Right to Health" be mentioned as a fundamental right.

RIGHT TO HEALTH UNDER ARTICLE 21

In Indian society, the right to health is a topic of vital importance. The medical community is accountable for defending, upholding, and enforcing the right to health, but so are other public officials including judges and administrators. Without exception, everyone has a right to health under the Indian Constitution.

[129] INDIA CONST. art. 246

The Right to Health is not explicitly mentioned in the Indian Constitution as is the Right to Education, but through several rulings:

In the case of *Vincent Panikurlangara v. Union of India & Ors*[130], the Supreme Court rendered an extremely significant decision in 1987 that was of great public interest. It was held that this is an obligation on the State in view of the fundamental directives of State policy enshrined in Part IV of the Constitution. The Supreme Court gave a direction to the Central Government to examine the objections raised in the petition against the drugs or refer them to the consultative Committee for examination and take a decision within six months. In this case, it was decided that in a welfare state, it is the duty of the State to ensure the creation and maintenance of conditions conducive to good health. Thus, it is acknowledged that humans have the right to enjoy life as a peaceful experience that is vastly superior than animal existence. Therefore, personal autonomy free from appropriation and intervention is a constitutional reality. Part of the right to survive is the ability to do so in peace, including the ability to eat, sleep, and rest in a healthy manner. Section 133(1)(b)[131] acknowledges this principle, which is congruent with the natural laws of existence and is reflected via law and culture. The clause allows for regulation or outright prohibition of *"the practice of any trade or occupation, or storing of any products or merchandise, detrimental to the health or physical comfort of the community."*

In the case of *CESC Ltd. v. Subash Chandra Bose*[132], the Supreme Court relied on international agreements to reach the conclusion that the right to health is a basic right. It went on to say that health is not just the absence of disease:

> *"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 labor, to keep him physically fit and mentally alert for leading a successful economic, social and cultural*

[130] AIR 1987 SC 990
[131] The code of Criminal Procedure, 1973, § 133 (1)(b), No. 2, Acts of Parliament, 1973 (India)
[132] AIR 1992 SC 573

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 the light of Articles 22 to 25 of the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights and in the light of socio-economic justice assured in our Constitution, right to health is a fundamental human right to workmen. The maintenance of health is a most imperative constitutional goal whose realization requires interaction by many social and economic factors."

The Supreme Court in the case of *Consumer Education and Research Centre vs. Union of India*[133] first time explicitly held in 1997 that "the right to health is an inherent fact of a meaningful right to life." The risks to occupational health of workers in the asbestos sector were the subject of this case. By interpreting Article 21[134] in light of the pertinent directive principles protected by Articles 39(e)[135], 41[136], and 43[137], the Supreme Court determined that the right to health and medical care is a fundamental right and enhances the dignity of the workman's existence. In a number of subsequent cases, the Court held that the State must ensure the creation of the conditions necessary for good health, including provisions for basic curative and preventive health services and the assurance of healthy living and working conditions, in addition to providing emergency medical services. This recognition established a framework for addressing health concerns within the area of public interest litigation.

In a very significant decision regarding the social right to health, the Supreme Court particularly addressed the problem of resource availability and rejected the claim that social rights are unenforceable due to resource scarcity.

The Court addressed the issue of the sufficiency and accessibility of emergency medical treatment in the well-known case of *Paschim Banga Khet Mazdoor Samity & Ors v. State*

[133] 1995 SCC (3) 42.
[134] INDIA CONST. art. 21
[135] INDIA CONST. art. 39(e)
[136] INDIA CONST. art. 41
[137] INDIA CONST. art. 43

of West Bengal & Anr[138], which was the subject of the discussion. In this instance, Hakim Sheikh, a Paschim Banga Khet Mazdoor Samity member, was injured seriously after falling off a train. For the treatment of his wounds, he was taken to a number of State hospitals, including both general hospitals and specialized clinics. Due to a shortage of beds and trauma and neurological services, seven state hospitals were unable to treat his injuries urgently. Finally, he was sent to a private medical facility where he received care. The petitioner filed this appeal with the Supreme Court and requested compensation after feeling wronged by the callous and insensitive approach taken by the government hospitals in Calcutta when delivering emergency treatment. The Court was asked to decide whether a deprivation of the fundamental right to life under Article 21[139] occurred in the absence of adequate medical facilities for emergency care.

According to the ruling, Article 21[140] of the Constitution requires the State to do all possible to protect human life. The Court determined that a welfare State's principal responsibility is to make sure that appropriate and accessible medical facilities are available to give treatment. Compensation was granted to the petitioner as a result of the infringement of his right to life. The Supreme Court acknowledged the necessity for funding to offer these facilities in this case, but Justice SC Agarwal stated:

> *'... But at the same time, it cannot be ignored that it is the constitutional obligation of the State to provide adequate medical services to the people. The Court recognized that substantial expenditure was needed to ensure that medical facilities were adequate. However, it held that a state could not avoid this constitutional obligation on account of financial constraints. Whatever is necessary for this purpose has to be done. In the context of the constitutional obligation to provide free legal aid to a poor accused this Court has held that the State cannot avoid its constitutional obligation in that regard on account of financial constraints. The said observations would apply with equal, if not greater, force in the matter*

[138] 1996 SCC (4) 37.
[139] INDIA CONST. art. 21
[140] INDIA CONST. art. 21

of discharge of constitutional obligation of the State to provide medical aid to preserve human life.'

The court ordered the state to make sure that primary health care facilities are set up to deliver emergency stabilization care for catastrophic injuries and emergencies. Additionally, the Court mandated that the state establish a central communications network among state hospitals so that patients could be transported right away to the facilities with room for them, as well as increase the number of specialist and regional clinics available to treat serious injuries across the nation. The need of provide preventive health services to the Indian population has been addressed by the courts, who have also considered the issue of emergency medical care as a component of the right to health. A healthy body is also the cornerstone of all human activity, according to the courts, thus precautions should be made to maintain that health.

The petitioner in *Mahendra Pratap Singh v. Orissa State*[141], was a former sarpanch of the Pachhikote Gram Panchayat. He asked the court to issue the right writ, ordering the opposing parties to take action to properly operate the Primary Health Center at Pachhikote inside Korei block in the district of Jaipur by providing all amenities and services. According to the ruling, the Gram Panchayat was willing to donate their building to house the health centre. If the structure was still available, it may be used to running the PHC while the new structure was being built.

The right to live with human dignity, guaranteed by Article 21, is drawn from the directive principles of state policy, and as a result, includes protection for one's health. This was stated by the Supreme Court's ruling in *Bandhua Mukti Morcha v. Union of India*.[142] This was the first instance in which the court determined that the pursuit of a right life requires humane working conditions. It stipulates that employee must have access to medical care, clean drinking water, and sanitary facilities so they can live in dignity.

The case of *Pt. Parmananda Katara v. Union of India*[143] addressed the problem of providing emergency medical care to an accident victim in a medico- legal setting.

[141] AIR 1997 Ori 37.
[142] AIR 1984 SC 802
[143] 1989 SCR (3) 997

According to a ruling, all doctors—private or public—have a duty to provide emergency medical care to the injured in order to save their lives without waiting for the police to follow the rules of the Criminal Procedure Code. The paramount duty placed on medical professionals cannot be avoided or delayed through law or state action. Since the commitment is total, absolute, and paramount, any laws or other procedures that would prevent it from being fulfilled must be abandoned since they cannot be upheld. This is a crucial decision made by the court, saved the lives of many accident victims because doctors often delay providing prompt care because they are not qualified to handle medicolegal issues. According to *Francis Corallie Mullin v. Delhi*,[144] the 'right to live with human dignity and all that goes with it, namely, the bare requirement of life' is included in the definition of "right to life" under Article 21.

The dead are also entitled to dignity. In the covid pandemic, actions such as mass funerals, improper burial, etc. violated people's dignity.

RIGHT TO A DECENT BURIAL

The covid-19 pandemic has caused paranoia to spread throughout the entire world. Dead bodies are being dumped and thrown out with the trash. Even the covid-19 patients relatives avoid the bodies of such patients when they pass away for fear of contracting the disease. Instead of ashes, countless dead bodies are being dumped in the river ganga.[145]

The number of incidents where the right to burial has been flagrantly violated has increased since the onset of the covid-19 pandemic. Dead bodies were improperly handled and disposed of by authorities. Even the living avoids claiming bodies or administering last rites. The covid-19-infected body disposal rules released by the WHO[146] and the government of India[147] have either been wilfully disregarded or not fully

[144] 1981 SCR (2) 516

[145] Zaid Nayeemi, *Delhi remembers the lethal second wave: No cremation of covid scars*, THE NEW INDIAN EXPRESS (JUNE 27, 2022, 07:55 AM)

[146] Infection prevention and control for the safe management of a dead body in the context of COVID-19: interim guidance, WORLD HEALTH ORGANISATION (SEPT 4, 2020)

[147] *Covid-19: Guidelines on Dead Body Management*, Directorate General of Health Services (EMR Division), Ministry of Health & Family Welfare, GOVERNMENT OF INDIA (Mar 15, 2020)

adhered to. It should be highlighted that no scientific investigation has shown that the novel coronavirus spreads through corpses or dead bodies; as a result, the corporation and other relevant authorities have been given the authority to designate cemeteries and burial grounds.

The World Health Organization issued interim guidance on 'Infection prevention and control for the safe management of a dead body in the context of covid-19' on September 4, 2020.[148] It is intended for those who care for those who have passed away from suspected or confirmed coronavirus disease in 2019. Managers of morgues and healthcare facilities, as well as clerics and public health officials, are potential customers. Additionally, this document offers recommendations for the management of the dead in low, middle, and high-income settings in the framework of covid-19.

Some of its primary factors include:

- The safety and well-being of those who tend to dead bodies is critical. People should make sure they have access to the proper PPE, cleaning and disinfection materials, hand hygiene supplies, and facilities before handling a dead body.
- The family of the deceased, as well as their cultural and religious customs, should be honoured and safeguarded at all times.
- All actions should be taken to uphold the dignity of the deceased, including refraining from hastily disposing of a covid-19 victim's body.
- Authorities should handle each deceased body individually, striking a balance between the family's rights, the necessity to look into the cause of death, and the dangers of infection exposure.

The regulations provide instructions on how to properly prepare and pack a body for transit from a patient room in a medical facility to an autopsy unit, morgue, cremation, or burial location. Infection prevention and control (IPC) standard precautions, including hand hygiene before and after interaction with the body, the patient environment, and the use of the appropriate PPE (eye protection, such as a face shield or goggles, as well as medical mask, gown, and gloves), depending on the level of interaction with the body, should be followed by all personnel who interact with the body (healthcare or mortuary

[148] Infection prevention and control for the safe management of a dead body in the context of COVID-19: interim guidance, WORLD HEALTH ORGANISATION (SEPT 4, 2020)

staff, or the team preparing the body for burial or cremation). The trained medical professionals should make sure that any bodily fluid leakage from orifices is confined and that there is little movement or manipulation of the body.

There are also guidelines for cremation or burial. According to regional customs and family requests, covid-19 victims may be buried or cremated. The appropriate handling and disposal of the remains may be governed by national and municipal rules. According to local norms, the body may be viewed by family and friends after it has been readied for burial. After the viewing, they should wash their hands and avoid touching or kissing the body. Family and friends should also abide by local regulations governing the maximum number of guests allowed at a viewing or funeral as well as any mask laws in the area. Wearing gloves is recommended for those who are responsible for putting the body in the grave, on the funeral pyre, etc. Once the burial is finished, remove the gloves and wash your hands with soap and water. A body in a coffin or body bag can be handled in accordance with regional standards and customs. Use surgical or waterproof rubber gloves to lay the body in the grave or funeral pyre if it will be buried or burned without a casket or body bag. Afterward, wash your hands. Keep the number of people involved in the burial or cremation to a minimum.

Guidelines titled *"Covid-19: Guidelines on Dead Body Management"* were also released by the Ministry of Health & Family Welfare Directorate General of Health Services (EMR Division) of the Government of India on March 15, 2020.[149] This recommendation lists the Standard Precautions that medical personnel should adhere to when managing covid-dead persons, Training in infection control and prevention procedures, removing the body from a quarantined area or room, cleaning and disinfecting the environment, handling a dead body in a morgue, autopsies on covid-19 dead bodies, etc. The burial Ground staff should be made aware that covid 19 does not pose an additional risk with regard to burial and cremation. The staff must follow industry standards for using gloves, masks, and hand washing. It may be possible for the staff to allow viewing of the deceased corpse by unzipping the face end of the body bag (while maintaining customary safeguards) so that the relatives can view the body for the final time. Religious procedures that don't include touching the body, including reading from religious texts or dousing

[149] *Covid-19: Guidelines on Dead Body Management*, Directorate General of Health Services (EMR Division), Ministry of Health & Family Welfare, GOVERNMENT OF INDIA (Mar 15, 2020)

the body with holy water, are permitted. Giving dead body a bath, a hug etc. is not permitted.

The right to a dignified funeral is included in the right to life. In various decisions, various courts have expanded and revised the purview of Article 21 of the Indian constitution by establishing the inseparability of the right to life and the right to a dignified cremation. They have also repeatedly acknowledged the need to treat a dead body (a human corpse) fairly and with dignity after death. Article 21 guarantees a person's rights not just while they are alive but also when they pass away. The scope of Article 21 of the Indian Constitution has been altered and expanded by several High Courts. Additionally, by putting the right to cremation with proper respect and dignity within the right to life, it has been acknowledged that it is necessary to treat the deceased with respect and dignity even after they have passed away.

P. Rathinam v. The Union of India[150] is one of the first decisions where the reach of Article 21[151] was broadened to include a person's dignity. The Supreme Court emphasized that the right to life involves a meaningful existence with human dignity, not just an animal life. A person who has passed away is also entitled to dignity. In this case, a petition was submitted to the court challenging the constitutionality of Section 309[152] of the IPC, which states that anyone who attempts suicide or takes any action that contributes to the commission of such an offence is subject to a sentence of simple imprisonment for a term that may not exceed one year, a fine, or both. Moreover, because it violates Articles 14 and 21 of the Indian Constitution, Section 309 of the IPC is invalid. The fundamental question that has been addressed by the Supreme Court on numerous occasions is whether or not the right to life protected by Article 21 of the Indian Constitution also encompasses the right to not be subjected to forced labour and, as a result, the right to death. The idea is that if Article 21 included the right to die, then attempting suicide would be considered a violation of a fundamental right. According to Article 21 and several Supreme Court rulings, any law that restricts a fundamental right is unconstitutional.

[150] 1994 SCC (3) 394
[151] INDIA CONST. art. 21
[152] The Indian Penal Code, 1860, § 309, No. 45, Acts of Parliament, 1860 (India)

The definition of "right to life" was enlarged in the decision of *Kharak Singh v. State of Uttar Pradesh*[153] to encompass "right to life with human dignity" as well as "animal existence." He believed that it was against this right to have the authority to break into someone's home in the middle of the night to verify their existence. Since the right to life could only be regulated by "law," and the executive regulations of the Uttar Pradesh Police did not fit the concept of "law," this clearly breached Article 21. The Supreme Court of India ruled that the relevant laws, which permitted police to visit "habitual criminals" or people who were likely to become habitual criminals at their homes, were unconstitutional. The petitioner argued that the shadowing of repeat offenders violated his right to privacy, but the court rejected this argument on the grounds that the Indian Constitution does not recognize this right as a basic one. In the historic *Puttaswamy v. UOI*[154] judgement from August 2017, a nine-judge panel of the Supreme Court found unanimously that the right to privacy was a basic right under the Indian Constitution, thus overturning the latter part of the judgement.

Later, it was argued that the right to live with dignity extends even after death in the case of *Common Cause (registered society) v. Union of India.*[155] By offering a suitable dying procedure, the deceased should be treated with the same dignity. Common Cause, a registered group, filed this petition in an effort to have Article 21 of the Constitution interpreted to include both the right to live and die with dignity. It also requested instructions for the State to create suitable policies that would let people with declining health or terminal illnesses to execute living wills or advance medical directives.

The Court determined that the right to a dignified death falls under Article 21 after carefully examining domestic and international precedence, notably the ruling in *K.S. Puttaswamy & Anr. v. Union of India & Ors*.[156] Additionally, the Court approved the use of advance medical directives, saying that through this mechanism, a person's autonomy may be protected to ensure that they died with dignity. The Court went into great length about the evolution of the right to privacy, pointing out that it is necessary for maintaining human dignity without which freedom cannot be realized. The right to privacy was also

[153] 1964 SCR (1) 332
[154] (2017) 10 SCC 1
[155] AIR 2018 SC 1665
[156] (2017) 10 SCC 1

seen as being essential to maintaining one's physical integrity, freedom of choice, and autonomy.

A fundamental right is the right to a good burial, and burials must follow religious regulations. In *Ashray Adhikar Abhiyan v. Union of India*,[157] the Supreme Court of India reaffirmed it. In accordance with the proper religious practices and rules, the dignity of the deceased should be upheld. The Supreme Court ruled that a homeless person who passed away on the street had a right to a respectable funeral that adhered to his or her religion. The Bench therefore stated that "Traditions and cultural features are integral to the last rites of a person's dead corpse. The right to a proper funeral can also be found in Article 25 of the Indian Constitution, which guarantees religious freedom subject to public order, morality, and health as well as the other essential rights under Part III of the Constitution.

The court determined in *Vikash Chandra Guddu Baba v. The UOI & Ors*[158] that it is the state's and the hospital's responsibility to dispose of unclaimed or any Jane Doe in complete compliance with the legislation of the land. If the deceased's religion can be determined, then the final rites must be carried out in accordance with that faith's customs.

In *Pradeep Gandhy v. the State of Maharashtra*[159], a suit was brought in the Bombay High Court contesting a BMC circular designating burial area for the disposal of covid-19 patient bodies. However, the petition was denied by the HC. "Right to a decent burial, commensurate with the dignity of the individual, is recognized as a component of the Right to life protected by Article 21 of the Constitution," the Bench declared. There is no explanation as to why a person who passes away during this crisis due to a suspected or confirmed covid-19 infection would not be entitled to the facilities to which he or she would have otherwise been entitled.

In *Vineet Ruia v. the Principal Secretary*[160], Calcutta High Court has ruled that both living individuals and deceased bodies are covered by Article 21 of the Constitution. The court

[157] (2002) 2 SCC 27
[158] (2008) 2 PLJR 127
[159] 2020 SCC OnLine Bom 662: MANU/MH/0832/2020
[160] AIR 2020 Cal 308

additionally determined that engaging in such behavior with regard to tradition and culture is also a Fundamental Right protected by Article 25.

Additionally, the Telangana High Court in *R. Sameer Ahmed v. State of Telangana & Ors*[161], observed that "Even in death, human bodies are not being treated with the dignity they deserve" and ordered the state government to inform the court as to whether the deceased are being cremated or buried in a dignified manner.

In the case of *Suo Motto v. The State of Tamil Nadu*,[162] the court held that the right to a proper funeral falls within the purview and range of Article 21 of the Indian Constitution. Given the particulars of this case, it further stated that anyone interfering with the process of a respectful burial will be held accountable under Section 297 of the Indian Penal Code, which deals with trespassing on graves. the constitutionally guaranteed fundamental rights to life and freedom. the Madras High Court cautioned the locals against objecting regarding the disposal of the bodies of a covid-19 victim while observing that the Fundamental Right to Life guaranteed by the Constitution includes the Right to Decent Burial or Cremation.

THE RIGHT TO COMPENSATION

The issue in *Reepak Kansal v. Union of India*[163] was whether covid-19 qualified as a disaster under the terms of the Disaster Management Act, 2005, and whether Indian citizens, whose right to life is guaranteed by Article 21 of the Indian Constitution, are entitled to financial and other reliefs under Section 12 of the same Act. In this case, the Apex Court was contemplating how to interpret the Disaster Management Act in a PIL seeking monetary compensation and other reliefs under Section 12 of the said Act, which establishes standards for ex- gratia assistance among other basic standards of relief. The court noted that the word "Shall" was used twice in the aforementioned passage and that there was much debate surrounding its use. The provision's phrasing is quite straightforward and clear. The court further pointed out that, in accordance with the established legal principle outlined by this Court in a string of cases, statutory enactments

[161] MANU/TL/0367/2021
[162] W.P. No. 7492 of 2020: MANU/TN/2857/2020
[163] AIR 2021 SC 3198

must typically be interpreted in accordance with their plain meaning when the wording of the provision is clear and unambiguous. The law's advantageous provision must be literally interpreted in order to accomplish the statutory goal rather than defeat it.

As required by Section 12(iii) of the DMA 2005[164] for the minimum standards of relief to be provided to the persons affected by disaster and other reliefs, the Court further instructed the National Management Authority to recommend guidelines for ex gratia assistance on account of loss of life to the family members of the persons who died as a result of Covid-19.

The National Disaster Management Authority (NDMA) announced that anyone wishing to file a claim for compensation for a family member's death brought on by Covid-19 must do so by May 23rd, 2022.[165] All Covid-19 deaths that occurred before March 20th, 2022 are entitled to apply for compensation. According to the statement, they have to be processed and paid out within 30 days of the claim's receipt. Claims must be filed within 90 days of the death for deaths that take place beyond the deadline.

The Grievance Redressal Committee will assess such claims on a case-by-case basis, the notice stated. In cases of exceptional difficulty when any claimant could not submit an application within the allotted time, the claimant might approach the committee and make the claim through it. The notice further said that if the Grievance Redressal Committee determined that a particular claimant's failure to submit a claim within the allotted time was due to circumstances beyond their control, their case might be reviewed on the merits.

The notification issued a warning against filing false claims, stating that "In a bid to minimize the risk of fake claims, a random scrutiny of the 5% of the claim applications shall be made at the first instance. If it is found that anybody has made a fake claim, the same shall be considered under Section 52 of the Disaster Management Act, 2005[166] and liable to be punished accordingly."

[164] The Disaster Management act, 2005, § 12(iii), No. 52, Acts of Parliament, 2005 (India).
[165] *NDMA notifies guidelines for Covid-19 death compensation*, THE INDIAN EXPRESS (April 28, 2022)
[166] The Disaster Management act, 2005, §52, No. 52, Acts of Parliament, 2005 (India).

CHAPTER 4

LACUNAS IN THE CURRENT LEGAL REGIME

DISASTER MANAGEMENT ACT, 2005

Covid-19 is the disaster which brought the Disaster Management Act to the front stage in all the discussions including discussions focusing on efficacy of the Disaster Management Act itself. It is the first pan India disaster being handled after the enactment of the Disaster Management Act in 2005. Covid-19 has resulted into unprecedented steps which are also being termed draconian by a few.

Although the Act is more comprehensive in its approach than the Epidemic Diseases Act, 1897, it still has a number of flaws that the legislature has to fix.

It is important to highlight that the NDMA has only operated in accordance with Section 6(2)(i)[167] of the Act and has not established particular disaster management strategies in accordance with Section 6(2)(a) of the Act.[168]

Some states, such as Gujarat, have their own unique laws, such as the Gujarat State Disaster Management Act, 2003, which was established before the Act and, in many ways, is more thorough and extensive than the Act, which is at the national level.

In the current covid-19 scenario, the Act ignores critical elements like the categorization of disasters, the proclamation of disaster-prone areas, or containment zones. The Act makes no mention of how local authorities' involvement and duties might be simplified. Plans at the district level are where the Act ends. There are no substantive rules for local authorities, although they do have a bigger responsibility in controlling any issue on a micro level. The state legislation outlines the specific responsibilities of local administrations.

Again, despite the fact that it was passed later than the aforementioned state law, the Act contains no provisions designating any particular region as a disaster-prone or

[167] The Disaster Management act, 2005, § 6(2)(i), No. 52, Acts of Parliament, 2005 (India).
[168] The Disaster Management act, 2005, § 6(2)(a), No. 52, Acts of Parliament, 2005 (India).

containment area. As a result, proactive measures for these regions are only taken as necessary, and there are no established standards to determine which region requires more support.

A progressive disaster, like the present epidemic where covid-19 has gradually affected the country, is not included in the definition of disaster. Laws in the country of South Africa, where disasters strike both suddenly and gradually, can serve as models. As a result, the Act is more of a generic character and not specifically tailored for pandemic scenarios.

Even though the Act calls for the creation of several entities at all levels, there is overlap in the duties and no organised system of intergovernmental coordination. This might cause confusion and has been a problem in the current situation. An obvious example of a lack of cooperation and coordination is the legal dispute between the state governments of Kerala and Karnataka regarding the opening of borders.

The NDMA's constitution, which stipulates that of the ten members, one shall be the Prime Minister and the others shall be appointed solely by the Prime Minister, presents one of the Act's main problems. Because of the political power struggle in our nation, it is possible for one person to have undue influence. This is true since the Prime Minister alone is responsible for doing all necessary acts for disaster management. This Act won't be actually relevant in the future if any Prime Minister fails to take initiative. Therefore, a strategy that is more focused on experts is needed. For these members, there is no set eligibility or qualification.

One of the innovative, forward-thinking, and supportive sections of Gujarat's state law relates to the responsibility of the community, private industry, and other agencies. This law acknowledges that all stakeholders—not just the government—share equal responsibility for society and ought to participate in disaster response. Public and commercial organisations are both required to take part in drills aimed at boosting capacity and providing help after a disaster without distinction. Currently, the government has used specific rights to engage the private sector, many of which are voluntary. As a result, the state law is more progressive, and the Act needs to be changed to reflect this. Many nations laws, including those of Japan, New Zealand, and South Africa, make mention to this type of community involvement.

It is crucial that healthcare workers be regarded as officers under the Act for prompt action given the unprecedented impact of Covid-19 and the appalling harassment of healthcare professionals like doctors, nurses, and support staff. The authorities may act against violators without waiting for a FIR to be filed and can take suo moto cognizance.

The Disaster Management Act of 2005 defines a 'Disaster' as 'a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or man-made causes',[169] which includes hurricane, landslide, cyclone, and tsunami given that the Act was passed in response to the Indian Ocean tsunami of 2004 and primarily focuses on preparation, response, and relief measures to deal with the calamity. A sickness may be a disaster, but it's a biological hazard rather than a long-lasting, physically or geographically localised threat.

The National Disaster Management Guidelines, 2008[170] created by the NDMA define a biological disaster but do not specify whether or not the other elements are put into practise. For instance, the recommendations that it be guaranteed that vulnerable populations have a minimal level of living are not followed.

The Act gives the authority[171] the responsibility to issue guidelines that specify a minimum standard of assistance to those impacted by the disaster, including minimum standards to be supplied in the relief camps in terms of shelter, food, drinking water, medical coverage, and sanitary conditions. Ex gratia help should be given in the event of a death and for the restoration of means of subsistence, and special arrangements should be made for both widows and orphans. The authorities can also suggest relief in repayment of loans to those persons who are affected by the disaster.[172] However, the Government did not carry out these provisions. The Supreme Court took Suo moto cognizance of the migrant issue and issued an interim order[173] noting that the migrant workers should not be required to pay for bus or train fare and that the originating state should provide them with free meals. But it's unclear how much of the injunction has actually been put into practise.

---

[169] The Disaster Management act, 2005, § 2(d), No. 52, Acts of Parliament, 2005 (India).

[170] National Disaster Management Guidelines—Management of Biological Disasters, 2008. A publication of National Disaster Management Authority, Government of India. ISBN 978-81-906483-6-3, July 2008, New Delhi.

[171] The Disaster Management act, 2005, §12 & 19, No. 52, Acts of Parliament, 2005 (India).

[172] The Disaster Management act, 2005, §13, No. 52, Acts of Parliament, 2005 (India).

[173] *In Re: Problems and miseries of Migrant Workers,* W.P. (C) No. 11394/2020.

Furthermore, the Act gives the Prime Minister a wide range of authority, opening the door for political meddling in the decision-making process. The Act's ability to address the pandemic threat was either not initially intended for it to do so or is now seriously questioned.

THE EPIDEMIC DISEASES ACT, 1897

This 125-year-old law was used, along with measures from the Disaster Management Act, to stop the coronavirus epidemic as it spread across the nation. The act allows government officials to admit, isolate, and quarantine people in specific circumstances. The majority of Indian states, including Delhi, Uttar Pradesh, Maharashtra, and Bihar, have notified regulations under the act. Invoking the legislation, numerous governments implemented steps to address the problem, including the closing of schools, malls, gyms, and institutional and residential quarantines.

The statute still has significant shortcomings in this period of shifting dynamics in public health emergency management, notwithstanding recent changes. The spread of communicable illnesses has altered over time. We face ongoing challenges from novel viral illnesses that are more aggressive and potent in appearance. There is more pressure on natural resources, increased migration, increased global connectivity, closed urban spaces, and increased international travel. The act is out of step with the modern epidemic disease prevention and control's evolving requirements.

A "dangerous epidemic disease" is not defined in the act. The standards that must be met in order to label an illness as "dangerous" or "epidemic" are not clearly defined.[174] It makes no mention of aspects like the scope of the issue, the severity of the illness, the distribution of the affected population across age groups, a potential global expansion, or the lack of a recognised treatment. Additionally, the statute makes no mention of the need for quarantine procedures or the distribution of medications or immunizations. When the act was created, there were no such things as constitutional principles, fundamental rights, or basic human rights. When implementing emergency measures in the midst of an

[174] Parikshit Goyal, *The Epidemic Diseases Act, 1897 Needs An Urgent Overhaul*, Economic and Political weekly Vol. 55, Issue No. 45, 07 Nov, 2020

epidemic, there are no underlying human rights principles that must be upheld.[175] The act concentrates on the government's authority during an outbreak, but it makes no mention of the government's responsibilities for managing or preventing an epidemic or the rights that citizens may have in the event of one.

Under the existing epidemic disease response framework, there are worries about disease surveillance and the possibility of a privacy breach. Each district is equipped with a surveillance unit and a fast reaction team as part of the Integrated Disease Surveillance Programme to handle disease outbreaks. A large network of healthcare providers and government officials has been established to support surveillance activities and response procedures. Information technology (IT)-based data dissemination has also been implemented to support this network. The section in the statute that allows for the devolution of power to "any" individual makes little sense when there is already a mechanism in place for disease surveillance.

The right to privacy was deemed to be an integral aspect of the right to life under Article 21 of the Constitution in a landmark decision by the supreme court, *Justice K S Puttaswamy (Retd) and Anr v. Union of India and Ors.*[176] The Court established a few criteria for restricting governmental discretion without violating the right to privacy, including procedural safeguards against excessive interference that could be required to achieve a justifiable goal. It should be noted that the Epidemic Diseases Act does not offer any procedural safeguards against any abuse of state authority involving invasion of privacy. There is concern that the law will be abused to target particular people and conduct mass quarantines and profiling. Public employees who work for it are given general legal protection. The act, as measured against the standards of privacy rights, is utterly inadequate since it fails to meet the requirements of reasonable limitations on invasions of privacy.

The act has been subjected to judicial scrutiny on numerous occasions by different courts. In *Ram Lall Mistry v. R. T. Greener*[177], the Calcutta High court assessed the applicability of section 4 of the legislation. The question before the court at the time was whether the Calcutta Corporation chairman was immune from liability resulting from the demolition

[175] Tewari, Manish, *India's Fight against Health Emergencies: In Search of a Legal Architecture,"* Observer Research Foundation, (31 Mar, 2020)
[176] (2017) 10 SCC 1.
[177] (1904) ILR 31 Cal 829

of a structure carried out in accordance with the plague rule to stop the spread of the plague. The court explained that this liability was imposed by Rule 14 of the plague regulation, and as a result, the building owner must get compensation. However, Section 4 of the Act does not provide protection for such non-payment of compensation (1904).

A fine under Section 188 of the IPC is imposed for disobeying directions made in accordance with the act. Mens rea, or an intention to injure, is irrelevant under this rule, nonetheless. It is sufficient if the individual is aware of the order they are disobeying. In *J Choudhury v. The State,*[178] the Orissa High Court found a medical professional accountable for violating the act's requirements by refusing to receive cholera immunisation. The Court noted that the doctor's purpose was unimportant because his disobedience was already illegal under the legislation. The Epidemic Diseases Act was included as one of the laws that several committees recommended be repealed but that the government did not take any action to do so in the 248th Report by the Law Commission of India, 2014.

It is clear that the act lacks a scientific strategy to combat epidemics like covid-19 and is solely regulatory in character. Additionally, it makes no mention of the ethical considerations and basic human rights standards, which must be upheld even when an epidemic is in progress. To the greatest extent feasible, individual liberty, autonomy, and privacy should be maintained.[179]

A fundamental right is the right to privacy, which also includes the right to one's own freedom, liberty, and dignity. The right is nevertheless subject to legitimate limitations, such as those that serve the public good. The Puttaswamy ruling[180] established the following criteria for restricting state discretion without violating the basic right to privacy:

1. The action must be sanctioned by law
2. The proposed action must be required to achieve a justifiable goal.
3. The degree of the interference must correspond to the degree to which it is necessary.

[178] AIR 1963 Ori 216
[179] Rakesh, P S., *The Epidemic Diseases Act of 1897: Public Health Relevance in the Current Scenario*, Indian Journal of Medical Ethics, Vol 1, No 3, (NS) (2016).
[180] (2017) 10 SCC 1.

4. Procedural safeguards must be in place to prevent the misuse of such interference.

The Epidemic Diseases Act, 1897 passes the criteria for a reasonable objective because one of its purposes is to stop the spread of a harmful epidemic disease. In a parent legislation, it is hard to specify precise proportionate rules for a novel infectious disease. As a result, the legislation grants the states a limited amount of legislative authority

The parent law, however, does not offer procedural safeguards against the abuse of the State's authority to intrude on people's privacy. For instance, there is no definition or guidance in the legislation about what constitutes a dangerous epidemic disease.

The citizens are thus at risk of both state inaction and excessive compulsion. In the past, residents were compelled to file court petitions to order the State to act or to defend themselves against the State's overreaching actions.

The State may abuse the law to target particular people and conduct mass quarantines and profiling. Public employees who work under it are nonetheless granted legal immunity. As a result, the law ignores any procedural safeguards against the abuse of its authority in favour of the public interest. The Epidemic Diseases Act fails to meet the criteria for imposing justifiable limitations on people's basic right to privacy as a result.

CHAPTER 5

COMPARATIVE ANALYSIS

UNITED KINGDOM

With regard to covid-19, the United Kingdom has passed the Coronavirus Act, 2020 and the Health Protection Coronavirus Regulations, 2020, two significant and well-known regulations.

The Health Protection (Coronavirus) Regulations 2020, which were created under section 45R of the Public Health (Control of Disease) Act 1984, were the government's initial response to the pandemic. The Coronavirus Act, 2020 was later passed, and these regulations were subsequently repealed. However, same rules are also applied to places that the government has designated as impacted zones. The regulations put limitations on motion, gatherings, and events, as well as criminal penalties for disobeying the instructions. However, a justifiable justification is an exception to this requirement. These restrictions could only be carried out by authorised individuals, law enforcement, and municipal authorities.

The Coronavirus Act, 2020 has mandated powers and duties to address the pandemic. The Act will expire in two years after a six-month parliamentary review. The Act contains 102 sections and 29 Schedules.

The Act's main provisions include emergency new registration of health professionals, emergency temporary registration of social workers, compensation programme to make up for volunteer's loss of income and expenses, interim amendments to current mental health laws that deal with patient detention and treatment, indemnity coverage in case of clinical negligence of health care workers, increase the number of Judicial officers, forbid and restrain events and gathering, direct temporary shutdown of educational institutions, suspension of pension schemes, recovery of Statutory sick pay, financial assistance to coronavirus related activity, postponement of election till 6th May 2021.

The United Kingdom's Parliament passed the Coronavirus Act 2020, which gives the government emergency handling authority for the Covid-19 pandemic. The act gives the government the discretionary power to restrict or ban public gatherings, detain people who may be carrying Covid-19, and intervene in or relax rules in a variety of sectors to stop the spread of the disease, lessen the burden on public health services, and help healthcare professionals and those who are negatively impacted economically. The National Health Service, social care, schools, police, Border Force, local councils, funerals, and courts are among the institutions covered by the legislation. The legislation was brought to Parliament on March 19, 2020, and passed the House of Commons without a vote on 23 March, and the House of Lords on 25 March. The act subsequently received royal assent on 25 March 2020.[181]

The two-year duration of the act may be shortened or lengthened by six months at the minister's discretion. Some of the provisions of the act were repealed early, on July 17, 2021, while others were extended for an additional six months after the two-year deadline.

The two-year-limited provisions of the Coronavirus Act give the government the power to limit or forbid public gatherings, regulate or suspend public transportation, order shops and restaurants to close, temporarily detain people suspected of having the covid-19 virus, halt operations at ports and airports, temporarily close educational institutions and childcare facilities, and enrol medical students and retired healthcare professionals in the health insurance programme.

The statute also includes provisions for actions against the pandemic's financial effects. The government will reimburse employers for the cost of statutory sick pay for workers affected by covid-19, and supermarkets will be required to report supply chain disruptions to the government. It includes the authority to stop the eviction of tenants, prevent emergency volunteers from losing their jobs, and provide special insurance coverage for healthcare staff taking on additional responsibilities.[182]

---

[181] *Coronavirus Act 2020 receives Royal Assent*, Cambridge Network. (27 Sept 2020) www.cambridgenetwork.co.uk.

[182] Davies, Gareth, "*UK coronavirus lockdown plans: What the Government advice means for you*". The Daily Telegraph. (20 March 2020).

The act gives the UK and relevant devolved administrations the authority to push back any future elections, local referendums, or recall petitions until May 6th, 2021, officially delaying the local elections that were initially set for May 2020. The normal election cycle will be maintained by having local council members, elected mayors, and police and crime commissioners serve three-year terms rather than the typical four after their elections in 2021.[183]

Many of the act's provisions can be suspended by national authorities and section 97 of the act mandates that the Secretary of State publish a report on the status of the non-devolved provisions every two months. The Department of Health & Social Care published a table outlining the status of each provision, including those that were not yet in effect, on May 7, 2020. This was followed on May 29, 2020, by the first two-monthly report, which provided an overview of how much each provision had been used for those that were already in effect.[184] Subsequent reports were published every two months after that.

Schedule 21, which deals with possibly contagious individuals, received a lot of attention in the current scenario. The term "potentially infectious" is used in the act to describe anyone who is coronavirus-infected or contaminated and poses a risk of spreading the virus to others, as well as anyone who has lived in a contaminated area within the previous 14 days or travelled to a location outside the UK where there is a high risk of virus transmission. The act also specifies enforcement procedures, such as that a person must relocate immediately to the designated location where they can be checked and assessed if a public health official, police officer, or immigration officer has reasonable reasons to suspect that they are possibly infectious. If the person doesn't follow those instructions, he can be taken to the designated location.

However, given the spread of the virus in the UK and the definition of "possibly infectious," nearly everyone will fall into this category because there is no way to know if a person is contaminated without performing a test. The measure was also criticised for suspending the Care Act, 2014 and easing regulations for social care services and supports, which would negatively affect elderly and disabled persons. The fundamental

[183] Johnston, Nei, *"Coronavirus Bill: Elections*", House of Commons Library. pp. 3–5. (Mar 19, 2020)
[184] *"Two monthly report on the status of the non-devolved provisions of the Coronavirus Act 2020*" , GOV.UK. Department of Health & Social Care. (May 29 2020)

human rights of the people are violated by certain rules, such as the detention of individuals on the basis of mental health.

UNITED STATES OF AMERICA

Four significant pieces of covid-19 legislation were passed in the United States of America throughout various stages (Phase 1, 2, 3, 3.5). All four of these pieces of legislation contain measures for addressing the difficulties brought on by the epidemic, and each one specifies how long those provisions are in effect.

Phase I saw the implementation of 'The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020'. According to this act, funding would be available for a number of years. This Act authorises 8.3 billion dollars in emergency financing for several government agencies to deal with the problems caused by the coronavirus pandemic. The fund is divided among domestic organisations for the development of therapeutics, vaccines, diagnostics, and other health-related technologies. It is also used to replenish the Infectious Diseases Rapid Response Reserve Fund and to support small businesses affected negatively by the coronavirus through the Small Business Administration's (SBA) disaster loan programme. Funds are allotted for aiding international health systems that are battling the coronavirus outbreak, as well as for assisting with humanitarian relief, economic development, and security initiatives.

The funding provided by the measure is broken down into the following categories:

- Over $3 billion will be spent on "vaccine research and development, as well as medicines and diagnostics"
- $950 million "in public health funds to support state and local agencies in preventative, preparedness, and response initiatives"
- For "medical supplies, health-care readiness, Community Health Centers, and medical surge capacity," around $1 billion is needed.
- A $1.25 billion multinational Covid-19 defence budget.[185]

[185] Breuninger, Kevin *"Senate passes $8.3 billion emergency coronavirus package, sending bill to Trump's desk"*. CNBC. (5 March 2020).

Organized by department, the following agencies and departments of the US Department of Health and Human Services get emergency additional funds from the bill:

- Food and Drug Administration
- Centres for Disease Control and Prevention
- National Institutes of Health
- Public Health and Social Services Emergency Fund.[186]

The Families First Coronavirus Response Act[187] was passed during Phase II. This law mandates free testing for everyone, paid time off for workers, protection for public health professionals, and the provision of significant advantages to kids and families. The Act is divided into several sections, and each section was created by a separate committee.

Division A of the Act provides funding to ensure that the four primary nutritional aid programmes have the necessary supplies. It also offers support to local food banks to fulfil the growing need. Additionally, it states that low-income seniors who are housebound, disabled, or have multiple chronic illnesses should receive nutritional assistance, as should low-income pregnant women or mothers who live with children, kids who receive free or reduced-price meals if schools are not closed due to the outbreak, and residents of other US territories. Division B of the Act specifies a number of exemptions, including those for school meals, meal pattern requirements for child and adult care facilities.

The provisions for Emergency Unemployment Insurance and Benefits are included in Division E of the Act. The law gives states a billion dollars to raise unemployment insurance benefits under specified circumstances. Until December 31, 2020, states may also offer interest-free loans to assist in covering jobless compensation. Additionally, if a state's unemployment rate is ten percent higher than the previous year or higher, it offers extended benefits to those states. Additionally, technical support for establishing work-sharing programmes should be given to the states.

The Act's Division F focuses on paid sick leave. Every company must offer seven days of paid sick time and an additional 14 days in the event of a public health emergency, such as the coronavirus. It also includes days when the child's workplace or school is

[186] *Coronavirus Preparedness and Response Supplemental Appropriations Act*, 2020". Congress.gov. (5 March 2020)
[187] Families First Coronavirus Response Act, 2020

closed or when a member of the family is under quarantine or isolation. Businesses with 50 or less employees are eligible for reimbursement for the expense of paid sick time.

The Act's health-related provisions are included in Division G. It has provisions for the state to waive the cost of the Medicare programme and for the National Disaster Medical System to reimburse uninsured people for the cost of covid-19 diagnostic testing. For diagnostics and services connected to covid-19, the health insurance provider should offer coverage. Even more money has been set aside for the Indian Health Service. The Act's Division H covers financial provisions.

Under Phase 3, The Coronavirus Aid, Relief and Economic Security (CARES) act was passed. It is the largest relief measure passed by the United States to date and comes with a package worth 2.2 trillion dollars. The scope of unemployment benefits under this Act has been expanded to cover laid-off workers, gig workers, and independent contractors. It states that different households, airlines, hospitals, healthcare systems, air cargo carriers, and airline contractors will all receive remuneration. The municipal and state governments would also receive funding. The Pay- check Protection Program is one of the Act's most important features. A specific sum is designated to help small enterprises by covering their payroll and overhead costs. The main goal of this component is to keep employees employed and paid during the coronavirus epidemic.

The following provisions are contained in the Act.[188]

- contributes $130 billion to the medical and healthcare industries. Include companies who make medical equipment as well.
- Reauthorizes and funds public health initiatives.
- enables the Food and Drug Administration to approve changes to the rules governing over-the-counter medicines without giving the public enough notice or an opportunity to comment.
- demands an investigation, a report, and suggestions for improving the safety of the medical supply chain in the US.
- adds to the Strategic National Stockpile personal protective equipment, medical gadgets, diagnostic tests, and medical supplies that deliver medications, vaccinations, and other biological goods.

[188] *Coronavirus Aid, Relief, and Economic Security Act*. govtrack. Civic Impulse, LLC. (Mar 27, 2020)

- legal immunity from any claims for loss caused by respiratory protective devices under federal and state law to makers, distributors, and administrators.
- demands that in times of critical drug shortages, the Department of Health and Human Services priority the assessment of drug applications.
- mandates that Medicare, health insurance providers, group health plans, and covid-19 testing and vaccination be covered.[189]
- grants to community health care facilities for the prevention, identification, and treatment of COVID-19 are authorised and appropriated for $1.32 billion.
- funding totaling $145 million over five years to advance telehealth.
- creates a medical professional Ready Reserve Corps in the event of a national or public health emergency.
- restricts state and federal liability for injury to patients resulting from the diagnosis, prevention, or treatment of COVID-19 in unpaid healthcare volunteers.
- permits the release of medical records of de-identified patients with substance use disorders.
- enables the use of funding for nutrition support for older people for a person who is unable to access meals owing to social isolation. During the COVID-19 health emergency, the customary dietary guidelines rules are waived.
- requires the Department of Health and Human Services to conduct a national education campaign to inform the public of the necessity, benefits, and importance of blood donation.
- accelerates the creation and approval of new veterinary medications for illnesses that could have detrimental effects on human health.
- increases the amount that Medicare pays to healthcare providers between May 1 and December 31 of 2020.

NEW ZEALAND

[189] Goodrich, Kate, *How the CARES Act Supports America's Healthcare System in the Fight Against COVID-19* (March 30, 2020).

One of the few nations to have completely eradicated the virus within its borders is New Zealand. The covid-19 alert system in New Zealand has four levels, with various types of restrictions for each level. It has drafted two new legislations and three existing legislations were made active.

In order to address the crisis, the Health Minister, Director-General, and Medical Officers of Health were given extensive authority under the health Act, 1956. The Epidemic Preparedness Act of 2006 was put into effect by the government because it believed that the coronavirus crisis would obstruct and disrupt crucial business and government operations. Under this act, the government issued the necessary notices to address the problems caused by the outbreak. The New Zealand government's response to the covid-19 epidemic is governed under the covid-19 Public Health Response Act.[190] It replaces the country's state of emergency declarations, applies all alert levels under the covid-19 Alert Level Framework, and gives police and other "enforcement officers" the authority to impose a variety of lockdown restrictions, such as closing down buildings or roads, prohibiting travel and public gatherings, and requiring people to isolate themselves at home or in their social circles.[191]

The Health Act 1956's sections 70 and 92L constitute the foundation for the "section 11" orders that the Minister of Health may issue under the Act. If enforcement officials such as the Director General of Health, medical officers, police officers, and anyone else authorised by the Director General have "reasonable grounds" to believe that a person is disobeying any requirement of a section 11 order, they may enter any land, building, craft, vehicle, place, or thing without a warrant. Officers in charge of enforcing the law have the authority to close down enterprises that are operating against section 11 orders. Criminal penalties, such as fines and jail terms of no more than six months, are also provided for by Sections 26 and 26 for those found in violation of "section 11" orders.

[190] *COVID-19 Response (Vaccinations) Legislation Act 2021*. Public Act No. No 51, New Zealand Parliament. of 25 November 2021.
[191] *COVID-19 Public Health Response Act 2020: Bills Digest 2628*. New Zealand Parliament. (July 17 2020)

The Act also has a two-year sunset clause and will automatically be repealed unless it is continuously renewed by the New Zealand House of Representatives every 90 days. The Bill received royal assent on May 13.[192]

Amendments

- The covid-19 Public Health Response Act 2020 underwent several amendments after the government passed the covid-19 Response (Vaccinations) Legislation Act 2021 on November 23, 2021.[193]
- Empowering the Director-General of Health to specify covid-19 vaccination exemption criteria and covid-19 vaccine dosages.
- Establishing stay-at-home orders, allowing access to certain locations, limiting the type of work that infected employees can perform, and regulating covid-19 vaccine certificates.
- requiring vaccination records from PCBUs and forbidding affected individuals from working until they have received their shots.
- allowing designated covid-19 enforcement personnel to issue orders requiring people to provide proof of compliance.
- enables the keeping and sharing of personal data as long as it's used to verify that a person has received a covid-19 immunisation certificate, is in compliance with a health order, the covid-19 Public Health Response Act, or the Health Act of 1956.

The New Zealand government was criticised by its citizens for acting in an illegal and chaotic manner despite all of these laws. Without additional review, the covid-19 Public Health Response Act, 2020 was quickly passed. The act gives enforcement officers a great deal of authority by allowing them to enter any property without a warrant if they have reason to believe that a person disobeyed a section 11 order.

[192] Wade, Amelia,"*Covid-19 coronavirus: Controversial bill passed to enforce alert level 2 powers*". The New Zealand Herald. (14 May 2020).

[193] "*Mandate legislation pushed through Parliament amid fierce opposition"*. Radio New Zealand. (Nov 24, 2021)

The Australian government has invoked a plethora of new and pre-existing laws, decrees, rules, ministerial directives, and executive orders. Regarding Insolvency & Bankruptcy, Employment, Competition and Consumer Law, Leasing, Small Business, Restrictions on Events and Movement, Environmental Planning, Electronic Transactions, Corporate Governance, Government Assistance, Foreign Investment, and Data Protection, the Government has made new laws and amended existing ones. In Australia, each jurisdiction has the authority to enact and carry out its own laws, rules, and directives.

As a financial response to the coronavirus crisis, the Australian government has passed a number of laws. The Government passed the Stimulus Package Acts in its first and second phases of its economic reaction to the pandemic. This Act consists of several acts that address business, credit flow, employment, document requirements, and witness requirements. The act's main provisions include procedures for providing social security and income support payments to individuals and households, extending the deadline for responding to bankruptcy notices, temporarily assisting struggling businesses, and allocating funds to severely affected regions and industries. The Job-keeper Payment Scheme was launched by the government as a component of the third economic response. The programme enables qualified employers who are adversely impacted by the crisis to obtain government assistance so they may keep paying their employees.

A number of modifications, including, were passed to benefit seniors and address their financial issues. According to the Biosecurity Act of 2015, the Governor General of Australia declared a biosecurity emergency. Activities and measures to stop the spread of disease in Australia are outlined in the Biosecurity Act, 2015.

The covid-19 Emergency Response Act, 2020[194] is one of Australia's more notable recent pieces of legislation. This Act has the power to change a number of existing acts and laws in order to issue temporary instructions to combat the epidemic. Some of the most significant changes allow the director general to take the necessary precautions to stop the spread of viruses, extend provisional orders of domestic violence for a period of six

[194] COVID-19 Emergency Response Act, 2020 (May 3, 2022)

months, and allow employers to give employees less than sixty days' notice before taking long service leave.

The policy objectives of the Bill are to:

- allows for the full or partial use of teleconferencing or videoconferencing technologies for Legislative Assembly meetings while the covid-19 emergency is in effect; and
- makes it clear that members of parliament can use technology to participate in committee meetings;
- provide an authority to create emergency regulations for the residential tenancy and lodging industries to handle the covid-19 emergency's effects;
- requirements for physical presence, usage of papers, and attendance at events or meetings
- statutory deadlines; and
- court and tribunal proceedings.

The covid-19 Emergency Response Legislation Amendment Act, 2020 eventually received approval. In order to allow the government to adjust to new measures implemented to deal with the disaster, this act was passed to give immediate effect to both Commonwealth agreements and operational responses. The Public Health Act, 1997 was eventually amended by the Public Health (Emergencies) Amendment Act 2020. The amendment's main features are the ability of the minister to revoke the further extension of the public health emergency as well as the Chief Health Officer's authority to seize control of assets like personal protective equipment, medications, hotels, and stadiums for Clinique, quarantine, or stadium purposes.

SINGAPORE

The covid-19 (Temporary Measures) Act, 2020[195] is arguably the law with the strongest commercial leanings. The Act grants a temporary reprieve from coercive measures and forbids the beginning or continuation of legal or arbitral proceedings for failure to fulfil

[195] COVID-19 (Temporary Measures) Act, 2020, No. 14 of 2020

contractual obligations due to Covid-19. This is contingent on the contracting party serving a notification for relief in accordance with the Act's requirements and an assessor's determination in the event of a challenge.

Additionally, upon the filing of a copy of the notification for relief, all ongoing legal, arbitral, or other legal proceedings must be stayed. While shielding one contracting party, the Act increases the term of limitation for initiating action in connection to the contract.

The Act specifies that a performance bond or similar may not be used earlier than seven days before to the date of expiry following the issuance of notification for relief, taking into account potential disputes that may arise for construction and supply contracts.

The Act also allows for the extension of the performance bond upon the beneficiary's request. Any non-refundable deposit for contracts involving the travel and tourism sector, which is among the most severely impacted industries globally, must be returned, unless an assessor determines otherwise. If you don't comply, you risk getting caught and paying a fine.

Relevantly, the period of default owed to the covid-19 is to be disregarded for the purposes of calculating liquidated damages payable under contracts. As a temporary measure for financially challenged individuals, organisations and other businesses, the pecuniary limit and time lines under the bankruptcy, company, insolvency and other laws stand raised greatly.

The Act also offers a property tax exemption, which must be passed on to the tenant. By virtue of the covid-19 (Temporary Measures) (Control Order) Regulations, 2020[196], everyone in Singapore is required to remain at their place of residence in order to control and prevent the spread of covid-19, with the exception of those performing essential services. A person may not meet another person for any social purpose, make use of sports or recreation facilities, etc. Alternative meeting arrangements have also been recommended. According to the terms outlined there, live video or a live television link may be utilised for the conduct of court proceedings for purposes including recoding witness testimony, the appearance of the accused, etc.

[196] COVID-19 (Temporary Measures) (Control Order) Regulations, 2020, Act 14 of 2020 (Singapore)

The ROK has a number of contingency strategies in place for public health catastrophes brought on by infectious diseases brought in from abroad, such as severe acute respiratory syndrome (SARS) and influenza A (H1N1). Based on these lessons learned, the government enacted the Infectious Disease Control and Prevention Act (revised by incorporating the Communicable Diseases Protection Act and Parasite Diseases Prevention Act of December 29, 2009; Enforcing Decrees of Infectious Case Control and Prevention as a subordinate statute), and the Ministry of Health and Welfare (MOHW) creates and updates thorough and syndromic infectious disease surveillance systems. During this time, local governments developed and implemented enforcement measures for the management of infectious diseases in their individual communities. By outlining fundamental aims and guidelines for the prevention and control of infectious illnesses, this law and the master plans' main objectives were to establish systematic quarantine actions throughout national and local governments and to strengthen the bonds between them.

The main elements were as follows:

- declaration and report.
- surveillance and epidemiological investigation.
- vaccination.
- blocking the transmission of infection, and
- prevention.[197]

A standard guidebook for risk management was also produced by the ROK government and can be utilised to deal with an outbreak of an infectious disease. The actions recommended in this manual are to be taken by a pan-governmental crisis management system and by specific government institutions to prevent harm to the public's health during an infectious disease crisis. According to the severity and rate of transmission, a crisis alert system with four levels is used to handle outbreaks. The system specifies what actions the federal, state, and municipal governments should take. The main reaction

[197] Ministry of Health and Welfare & Korea Disease Control and Prevention Agency. The plan for prevention and control of infectious diseases (Jun 8, 2021).

principles at levels 1-3 include a robust first response and intensified surveillance, while levels 2-4 envisage the formation of a pan-government cooperation framework.[198]

The readiness for pandemic catastrophes, effective reactions and stopping of future transmission, as well as rapid, accurate, and timely responses, are the main goals of the crisis management response system.

The government of the ROK established a legal mechanism that aims to "prevent outbreaks and epidemics of infectious diseases that are harmful to public health and stipulate measures necessary for their prevention and management" after the global pandemics of SARS in 2003 and influenza A (H1N1) in 2009.[199] The government reorganised the rules and regulations pertaining to infectious diseases under the Infectious Disease Control and Prevention Act and established an infectious disease control committee based on the 2005 announcement of the International Health Regulations.[200]

However, the infectious disease response system was ineffective during the MERS outbreak of 2015, and as a result, 186 confirmed cases and 38 fatalities were reported in the ROK.[201]During that time, inability to contain super-spreaders, poor hospital infection control, inadequate central government crisis communication, and the dissemination of false information not only stoked public mistrust and concern but significantly increased the number of sick persons.[202]The Infectious Disease Control and Prevention Act was updated in June 2015 to guarantee information transfer was transparent, quick, and that materials and human resources were used effectively. This act made it possible for open information sharing and centralised control management, which aided in the early stages of the covid-19 outbreak's successful reaction.[203]The government has attempted to further enhance the national quarantine management system in response to the ongoing issue by

---

[198] *Korea Disease Control and Prevention Agency. Policy information:* response to infectious disease crisis. (Mar 19, 2021)

[199] Chun B. *Public policy and laws on infectious disease control in Korea: past, present and prospective.* Infect Chemother 2011; 43:474–484.

[200] Korea Disease Control and Prevention Agency. Guideline for infectious disease management in Korea (Jun 9 2021)

[201] Choi J, Kim KH, Cho YM, Kim SH. *Current epidemiological situation of Middle East respiratory syndrome coronavirus clusters and implications for public health response in South Korea*. J Korean Med Assoc 2015; 58:487–497.

[202] Kim KH, Tandi TE, Choi JW, Moon JM, Kim MS. *Middle East respiratory syndrome coronavirus (MERS-CoV) outbreak in South Korea, 2015: epidemiology, characteristics and public health implications*. J Hosp Infect 2017; 95:207–213

[203] Borowiec S. *How South Korea's coronavirus outbreak got so quickly out of control* (Mar 19, 2021).

amending the law to take into account the views of specialists in the field. The Infectious Disease Control and Prevention Act, the Quarantine Act, and the Medical Service Act were all amended as their first legislative action in February 2020.

The Infectious Disease Control and Prevention Act was passed in August, which was the second phase.[204]The bill was updated in September 2020 to account for increases in both patient volume and travel over the winter holidays. The Infectious Disease Control and Prevention Act's articles on "Duties of State and Local Governments, Medical Personnel, and Citizens, as well as Citizens' Rights," "Designation of Facilities for Quarantining Contacts," "Stockpiling Medicines and Equipment," and "Request for Provision and Verification of Information" enable efficient and effective management of infectious diseases.

Through its articles on "Protection Measures for Persons Vulnerable," "Compensation for Losses," "Subsidization to Medical Persons and Founders of Medical Institutions," and "Livelihood Assistance for Patients with Infectious Diseases," it is also used as a legal justification for helping those who are suffering because of COVID-19.

[204] Ministry of Health and Welfare. Infectious Disease Control and Prevention Act passed at the parliament on 4th of August

CHAPTER 6

CONCLUSION

The Indian response to pandemic is governed by multiple statutes, fragmented between the central and state levels. The Epidemic Diseases Act, the primary legislation, provides the powers of the central government in relation to control of pandemic. The Disaster Management Act has been employed to deal with the Covid-19 pandemic based on which the disease has been declared a disaster adds another dimension of government action. The state legislations in force in the respective territories empowers the state government and its functionaries to deal with communicable diseases. The legislation provides for restrictive measures to be placed on those affected or exposed to communicable diseases to prevent the danger to themselves and the public at large. The restrictive measures statutorily provided in the examined statutes include inspection of vehicles, mandatory removal of exposed persons to health facilities, compulsory treatment, restrictions on travel and movement, sealing of state borders. The compliance is ensured by providing varying amounts of penalties including imprisonment and fines. The quantum of punishment for non-compliance varies with the statute.

The research study has observed that victim's rights has been violated throughout the country during the pandemic. Right to health is described as an inherent fact of a meaningful right to life.[205]Along with that, the right to live with human dignity and all that goes with it, namely, the bare requirement of life is included in the definition of "right to life" under Article 21.[206] The dead are also entitled to dignity. In the covid pandemic, actions such as mass funerals, improper burial, etc. violated people's dignity. The world health organisation and India's ministry of health and family welfare has published guidelines on dead body management during covid- 19 pandemic titled *"Infection prevention and control for the safe management of a dead body in the context of covid-19"* and *"Covid-19: Guidelines on Dead Body Management"* respectively. But these guidelines haven't been adhered to during the pandemic. Along with that, there are

[205] *Consumer Education and Research Centre vs. Union of India,* 1995 SCC (3) 42.
[206] *Francis Corallie Mullin v. Delhi,* 1981 SCR (2) 516

several rulings of both supreme court and high court highlighting the right to decent burial.[207] Right to compensation to pandemic victims has been upheld by the apex court.

Researcher has found lacunas that exists in EPA and DMA, the major two legislations used to fight the pandemic. Absence of provision for declaration of 'disaster prone zones', neglect on the progressive behaviour of disasters, overlapping of functions as the act calls for the establishment of multiple national level bodies, no substantive provisions for guiding the functioning of local self-government bodies, delayed response, in appropriate implementation of the plans and the policies, procedural lags etc are some of the lacunas exists in the Disaster management act, 2005. The Epidemic diseases act, 1897 is a 125-year-old legislation and has significant shortcomings in this period of shifting dynamics in public health emergency management. A "dangerous epidemic disease" is not defined in the act. The standards that must be met in order to label an illness as "dangerous" or "epidemic" are not clearly defined.[208] It makes no mention of aspects like the scope of the issue, the severity of the illness, the distribution of the affected population across age groups, a potential global expansion, or the lack of a recognised treatment. Additionally, the statute makes no mention of the need for quarantine procedures or the distribution of medications or immunizations. When the act was created, there were no such things as constitutional principles, fundamental rights, or basic human rights. When implementing emergency measures in the midst of an epidemic, there are no underlying human rights principles that must be upheld.[209] The act concentrates on the government's authority during an outbreak, but it makes no mention of the government's responsibilities for managing or preventing an epidemic or the rights that citizens may have in the event of one.

The researcher also did a comparative analysis of legislations used to fight covid- 19 in United states, United Kingdom, Singapore, South Korea, Australia and New Zealand. All these countries, unlike India, has enacted separate legislations to combat the covid- 19 which include comprehensive provisions to properly address the pandemic.

---

[207] *Ashray Adhikar Abhiyan v. Union of India*, (2002) 2 SCC 27

[208] Parikshit Goyal, *The Epidemic Diseases Act, 1897 Needs An Urgent Overhaul*, Economic and Political weekly Vol. 55, Issue No. 45, 07 Nov, 2020

[209] Tewari, Manish, "*India's Fight against Health Emergencies: In Search of a Legal Architecture,"* Observer Research Foundation(31 March, 2020)

The first research question was whether the Epidemic diseases act, 1897 and Disaster management act, 2005 properly address India's fight to covid- 19 pandemic. The answer to this question has been answered by the researcher in the fourth chapter while analysing the lacunas exists in these two legislations. The shortcomings exist in the acts makes it incapable to aid our country in her fight to pandemic. The government was not successful in implementing these acts. The government's response to the covid-19 epidemic has brought to light significant inconsistencies in the framework for legal and policy disaster management. The structure for the delegation of biological disaster management obligations appears to be incoherent, and the duties assigned to various authorities do not line up with the provisions listed in the Allocation of business rules, the DM Act, or the framework thereto. Inadequate laws are not the only reason for worsening India's condition due to covid-19 pandemic. While Epidemic diseases act, 1897 has been criticised as an inadequate law, the disaster management act on the other hand is a law that is not followed by government in its entirety.[210]

The Existing laws are not entirely adequate in curbing the pandemic. Unlike countries such as New Zealand, Sweden, and Taiwan, India has not enacted any specific legislation to tackle the covid-19 pandemic. Instead, the executive in India created a complex web of orders under the Disaster Management Act, 2005 (DMA), the Epidemic Diseases Act, 1897 (EDA), and the Code of Criminal Procedure, 1974. All actions undertaken by the government to control the outbreak are based on these three legislations. But none of these provides any safeguards to prevent arbitrary conduct or misuse of powers on part of the executive. Neither the EDA nor the DMA provide any guidance on how discretion must be exercised by the executive. Many orders passed under the EDA and the DMA, to control the spread of the virus, were disproportionate. The DMA and the EDA also haven't provided any procedural safeguards for the executive discretion.

To address the issues brought on by the virus, a fresh, modern, and robust epidemic law needs to be drafted. A new law should be drafted that establishes a nodal authority that is made up of representatives from the centre and the state for the purposes of organising and carrying out the necessary actions, such as isolation, quarantine, surveillance, testing, etc. The Act should grant the States sufficient autonomy and authority to plan and carry out actions at the district, block, and gram panchayat levels. The Act should also specify

[210] Sandeep Phukan, *Disaster Management Act is a good law: Sibal,* THE HINDU (Jun 03, 2020)

how money will be distributed across other societal sectors, including local governments, farmers, the healthcare industry, businesses, and vulnerable populations. In the event of a disobedience of a directive or order from the authorities, the Act should include both civil and criminal penalties. The legislation should also address the issues of migratory workers, food accessibility, eligibility to statutory minimum relief, and providing a means of subsistence for workers earning a daily wage.

A coronavirus outbreak, for example, calls for special procedures and actions. Only by transparency and accountability can the government earn the public's trust. India has an excessive number of laws and acts. Having laws but not executing them is useless. If a new law is created to address the pandemic's effects, it must be successfully adopted and carried out in order to accomplish the intended goal.

The covid-19 pandemic has raised concerns about a number of factors in India, including the standard of medical care, how institutions and governments have responded, and problems with law and order. These issues should be addressed with the assistance of the constitutional and legislative framework. The Indian government successfully implemented the lockdown and reduced the number of cases, although some MPs and legal professionals questioned the lockdown's constitutional constitutionality and the government's response. The EDA and the DMA have been implemented by the Central Government, however given the dynamic character of the disease, these are insufficient to adequately address the health emergency. In order to close the gap and enhance the constitutional and legal framework for handling any potential future health emergencies, many possibilities have been examined in this study. These crises will provide abundant opportunity to close the gap in the legal system and enable our next generations to be better equipped for any kind of health disaster.

The Hypothesis of this study was the Legislations such as epidemic diseases act, 1897 and disaster management act 2005, is not competent enough and has failed in effectively curbing the covid- 19 pandemic in India. It is absolute necessary to enact a separate comprehensive legislation in India to deal with future public emergencies like covid- 19 pandemic. India is one of the worst- hitten country due to covid- 19 pandemic and one of its major reasons is not having an effective, comprehensive legal mechanism to deal with it. Testing the same, the researcher finds that the hypothesis is correct.

The Disaster Management Act of 2005 defines a 'Disaster' as 'a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or man-made causes',[211] which includes hurricane, landslide, cyclone, and tsunami given that the Act was passed in response to the Indian Ocean tsunami of 2004 and primarily focuses on preparation, response, and relief measures to deal with the calamity. A sickness may be a disaster, but it's a biological hazard rather than a long-lasting, physically or geographically localised threat.

The National Disaster Management Guidelines, 2008[212] created by the National Disaster Management Authority define a biological disaster but do not specify whether or not the other elements are put into practise. For instance, the recommendations that it be guaranteed that vulnerable populations have a minimal level of living are not followed.

The Government did not carry out many of the provisions in the act such as minimum standards. Furthermore, the Act gives the Prime Minister a wide range of authority, opening the door for political meddling in the decision-making process.

The Epidemic Diseases Act, 1897[213] contains four sections and do not clarify what a 'epidemic disease' is. The 2008 National Disaster Management Guidelines recommend that the Epidemic Diseases Act needs to be repealed and replaced with a new law that takes current and future public health requirements into account. But these guidelines were not taken into consideration and the fragile act was implemented in some areas.

The Epidemic Diseases Act, 1897 is the sole law in India that has previously served as a framework to control the spread of a variety of illnesses, such as cholera and malaria. The law establishes rules to regulate residents and gives the Union and state governments the authority to take extraordinary measures to contain and stop the spread of disease.

The provocation and caution that permit the State to reduce or restrict person's rights to liberty, privacy, property, and movement would be expressly explained in a modern and comprehensive public health legislation. For a variety of reasons, the Epidemic Diseases Act, 1897 is ineffective and lacks authority. An outbreak is not defined under the Act.

[211] The Disaster Management act, 2005, § 2(d), No. 52, Acts of Parliament, 2005 (India).
[212] National Disaster Management Guidelines—Management of Biological Disasters, 2008. A publication of National Disaster Management Authority, Government of India. ISBN 978-81-906483-6-3, July 2008, New Delhi.
[213] The Epidemic Diseases act, 1897, No.3, Acts of Parliament, 1897 (India)

The Act makes no mention of the guidelines, processes, or tests that must be used to determine whether a given illness qualifies as an epidemic in the nation.[214]

The EDA also does not include any procedures for the sequestering and sequencing of pharmaceuticals, immunizations, quarantine requirements, or other necessary precautions. The fundamental human rights principles that must be upheld when emergency measures are put in place during an outbreak are not clearly defined.

SUGGESTIONS

After our assessment of numerous acts and constitutional provisions, three recommendations arise from this analysis to strengthen India's constitutional and legal frameworks for dealing with covid-19 and similar future circumstances.

1. The Colonial Era EDA needs to be thoroughly reviewed.
2. It is necessary to pass comprehensive public health legislation that addresses all facets of health and guarantees everyone's right to health.
3. Lastly, there is a need to explore various options to include health emergency provisions in the Indian Constitution.

~ EPIDEMIC DISEASES ACT, 1897 AMENDMENTS ~

The EDA is flawed for the reasons listed below.

1. The statute omits defining and classifying the various types of diseases and their severity levels.
2. The statute just specifies the state's responsibility to limit the movement of the individual; it makes no mention of the confinement procedure or the designation of zones based on severity levels.
3. The function of Panchayats and other local administrations is not addressed in the act.

[214] *Shashank Deo Sudhi v. Union of India Ors*, W.P. No. 10816/2020

4. The act omits any reference to restrictions on medications and immunizations in times of epidemic.
5. There is no mention of air travel in the legislation, which places an emphasis on preventing the transmission of disease via ship. There is an urgent need for the implementation of stronger screening measures that need to be implemented at the airport and by airlines given modern realities, in which air travel vastly outweighs travel by ship.

The following changes must be made in order to strengthen the law:

a. For the EDA to be fully functional to address any future health emergency, changes relating to detecting, testing, isolating, tracing contacts, controlling, coordinating, and containing any epidemic are required.
b. Changes in the description and classification of various diseases as well as the demarcation of areas according to severity levels are required.
c. For better collaboration with diverse state and local administrations, it is imperative to clarify the Union's function explicitly.
d. It is important to investigate and include in the act the creation of quarantine facilities at airports or close to them.
e. It is important to identify the quarantine areas that will best help to contain the pandemic from a geographical and scientific standpoint. These ought to be situated in rural areas with little population inflows and outflows.

~NEED FOR AN EXTENSIVE NATIONAL PUBLIC HEALTH LAW~

The adoption of a comprehensive national public health law is the second recommendation. The Model Health Bill from 1955, revised in 1987, the National Health Bill from 2009, and the Public Health (Prevention, Control, and Management of Epidemics, Bioterrorism, and Disasters) Bill from 2017 all attempted to create public health laws, but none of them were successful.

Since states are responsible for regulating health, there was opposition in each of these situations. States with their own public health legislation include Madhya Pradesh and Tamil Nadu, as was previously mentioned. To strengthen India's public health law, many laws at the subnational level and in other nations must be reviewed. The National Health Security Act of 2007 in Australia creates the "structures and processes for preventing and

reacting to national health emergencies" in the nation.[215] The Public Health (Control of Disease) Act was passed in England in 1984, and it uses a system of surveillance and intervention to safeguard the general public's health.[216] Singapore, which is nearer to India, introduced the Infectious Diseases Act (IDA) in 1976 and tightened it in the wake of the 2003 worldwide SARS pandemic.[217] Singapore has acted swiftly as well and approved the covid-19 (Temporary Measures) Act 2020. (CTMA). The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 was just enacted in the USA to provide funding for the development of vaccines, treatments, and diagnostics.[218]

A comprehensive national public health law must aim to strengthen India's public health law while taking into account social, political, economic, cultural, and environmental concerns. It must also incorporate practical measures in various nation's legislative responses to a health emergency. The Union's involvement in examining and addressing the concerns of the states is essential in fostering an atmosphere for a comprehensive public health law.

To ensure that citizens have access to health care, the comprehensive public health law should include the following clauses:

1. Without causing any conflicts, the functions of the central, state, and local governments—panchayats and municipalities—should be clearly defined.
2. An institutional structure shall be established that may create a network among governments, research organisations, and healthcare providers.
3. The law shall specify the various procedures and systems for diagnosing, treating, and controlling epidemics through prompt and effective interventions at the central, state, and local levels.

[215] Buchanan, K., *Australia: Legal responses to health emergencies*. Library of Congress. (May 19, 2020)
[216] Griffith, R., *Using public health law to contain the spread of COVID-19*. British Journal of Nursing, 29(5), 326– 327.
[217] Neo, J., & Darius, L., *Singapore's legislative approach to the COVID-19 public health 'emergency'. Verfassungsblog on Matters constitutional.* (May 19, 2020)
[218] Oum, S., Wexler, A., & Kates, J., *The U.S. response to coronavirus: Summary of the coronavirus preparedness and response supplemental appropriations act, 2020*. Global Health Policy (May 24, 2020)

4. There should be financial and temporary relief for municipal and state governments during medical emergencies.

5. Health care and sanitation professionals should receive extra protection while keeping in mind the social dynamics of society.

6. The Coronavirus Act, 2020 of UK's main provisions include emergency new registration of health professionals, emergency temporary registration of social workers, compensation programme to make up for volunteer's loss of income and expenses, interim amendments to current mental health laws that deal with patient detention and treatment, indemnity coverage in case of clinical negligence of health care workers, increase the number of Judicial officers, forbid and restrain events and gathering, direct temporary shutdown of educational institutions, suspension of pension schemes, recovery of Statutory sick pay, financial assistance to coronavirus related activity. These provisions may be included in the new act.

7. According to 'The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020', of united states, funding would be available for a number of years. The fund is divided among domestic organisations for the development of therapeutics, vaccines, diagnostics, and other health-related technologies.

8. In South Korea, a pan-governmental crisis management system and individual government institutions are to take the steps suggested in this manual in order to prevent harm to the public's health during an infectious disease crisis. The four levels (Level 1 to Level 4), depending on the scope and rate of transmission. The system gives specific instructions regarding what central and local governments should do. At levels 1-3, a strong initial response and enhanced surveillance are the primary response principles, while levels 2-4 see the establishment of a pan-government cooperation system.

As was previously said, the Indian Constitution contains no provisions for medical emergencies. In order to limit and control the epidemic, France just passed the Emergency Response to the covid19 Epidemic Act in a hasty manner on March 23, 2020. According to the new Act. L3131-12 CSP, of the French Constitution, states, "the State of health emergency can be declared in the event of a health disaster endangering, by its nature and gravity, the health of the population".[219] By amending the New Influenza Special Measures Act on April 7, 2020, Japan also activated a health emergency clause. The President of India has the authority to declare a national emergency under Article 352 of the Indian Constitution *'whenever the security of India or any part thereof is threatened, whether by war, external aggression, or armed rebellion.'* A health emergency does not, however, justify declaring a national emergency or limiting public movement. The possibility of including a health emergency clause in the Indian Constitution can be considered by India. Given how emergency measures affect people fundamental rights, there needs to be extensive discussion both inside and outside of the Parliament. Even though right to health is protected under article 21 of the Indian constitution due to various rulings, it is not expressly provided in the constitution. Thus, right to health, like right to education has to be declared expressly in constitution as a fundamental right so as to attract the attention it deserves and to make people aware of their right. Right to Health should be specifically included in the Indian Constitution along with provisions for bolstering the healthcare system. Some sections of society believe that the lockdown is unlawful, and the central government's overbearing role in enforcing the lockdown has drawn criticism.[220] The Supreme Court has received Public Interest Petitions (PILs) that seek to impose a financial emergency in accordance with Article 360 of the Indian Constitution.[221] The fundamental rights guaranteed by Article 19 (1)(d) to free movement throughout the territory of India and 19 (1)(e) to stay and settle in any portion of that territory will be affected by clarity regarding the lockdown that inhibits mobility of people. The disproportionate involvement played by the Central Government in enforcing lockdown by designating the health emergency as a matter for federal units is another factor that is opposed to the lockdown order. The concerted actions of the union, state,

[219] Platon, S., *From one state of emergency to another – Emergency powers in France, Verfassungsblog on Matters constitutional*. (May 25, 2020)
[220] Owaisi, A., *Unconstitutional nationwide lockdown*. Telangana Today. (May 20, 2020)
[221] Kannan, B., *Coronavirus and The Constitution,* Live Law. (May 25, 2020)

and local governments are essential in controlling this pandemic since covid-19 is extremely contagious, virulent, and has no geographic limits. Imposing lockdown will undoubtedly have an impact on managing the pandemic given the different population and viewpoints. What one should understand is that, in a pandemic crisis, the right to life and individual freedom are more crucial than freedom of speech.

Undoubtedly, India's large population makes it difficult to manage any crises, particularly a pandemic like covid-19. However, there are three alternative strategies to improve management overall.

First, a national-scale biological crisis needs close administrative and political coordination, with the Centre in charge and the State governments, Disaster Management Authorities, and other stakeholders following. National and state political and administrative organisations should cooperate and consult more in line with the genuine spirit of the DM Act and the federal system. Issues that directly affect millions of people in the nation, such as migrant labourer movement, food availability, securing livelihoods for daily wage earners, relief camps, and eligibility to statutory minimum relief, require special attention. In addition, it was indicated in the 2013 ‘Report of the Task Force to Review DM Act’ that the current organisation of the various authorities under the DM Act is not suitable for carrying out the activities it has been charged with carrying out.

The district administration and local self-government institutions continue to be the greatest option for the effective implementation of the national and state choices made under the DM Act. A coordinated effort is needed to guarantee that these entities have the administrative, political, and financial authority mandated by Sections 30 and 41 of the DM Act.

Finally, constitutional courts must function in these circumstances. Numerous regions of the nation have reported incidents of prejudice, excessive police force, malnutrition, lack of medical assistance, etc. Relevantly, the DM Act lacks a grievance redressal system and limits the authority of courts. All of the constitutional courts in the nation are required to suo motu register PILs, closely monitor the implementation of the DM Act, ensure rule of law, and protect human rights as guaranteed by the Constitution of India.

BIBLIOGRAPHY

STATUTES REFERRED

1. Constitution of India, 1950
2. Indian penal code, 1860
3. Code of criminal procedure, 1973
4. Epidemics diseases act, 1897
5. Disaster management act, 2005
6. Live-stock importation act, 1898
7. Drugs and cosmetics act, 1940
8. Indian ports act, 1908
9. The essential services maintenance act, 1968
10. Aircraft act, 1934
11. Karnataka epidemic diseases act,2020
12. Rajasthan epidemic disease act, 2020
13. Epidemic diseases (bombay amendment) act, 1953
14. Epidemic diseases (punjab amendment) act, 1949
15. Epidemic diseases act, 1977
16. Kerala epidemic diseases act, 2021
17. State public health acts
18. Tamil nadu public health act, 1939
19. Madhya pradesh public health act, 1949
20. Assam public health act, 2010
21. The goa, daman and diu public health act, 1985
22. The Uttar pradesh public health and epidemic diseases control act, 2020
23. COVID-19 Response (Vaccinations) Legislation Act 2021.

BILL

1. The public health (prevention, control and management of epidemics, bio-terrorism and disasters) bill, 2017

ARTICLES

1. Parikshit Goyal, *The Epidemic Diseases Act, 1897 Needs an Urgent Overhaul*, Economic and Political weekly Vol. 55, Issue No. 45 (07 Nov, 2020)
2. Rakesh, P S., *The Epidemic Diseases Act of 1897: Public Health Relevance in the Current Scenario, Indian Journal of Medical Ethics*, Vol 1, No 3, (NS) (2016).
3. Choi J, Kim KH, Cho YM, Kim SH. *Current epidemiological situation of Middle East respiratory syndrome coronavirus clusters and implications for public health response in South Korea.* J Korean Med Assoc 2015; 58:487–497.
4. Kim KH, Tandi TE, Choi JW, Moon JM, Kim MS. *Middle East respiratory syndrome coronavirus (MERS-CoV) outbreak in South Korea, 2015: epidemiology, characteristics and public health implications.* J Hosp Infect 2017; 95:207–213.
5. Aruna Kumar Malik, *Health Sector Governance and Reforms in India*, 2 Liberal Stud. 85 (2017).

ONLINE DATABASE

1. Shanoor Seervai & Arnav Shah, *India's Failure of Leadership Collapses Health System in COVID-19 Surge*, THE COMMONWEALTH FUND (Apr 29, 2021)
2. *Oxygen shortage kills 20 more COVID-19 patients in Delhi; customs duty on COVID-19 vaccines, medicines and medical oxygen waived for three months, and more,* THE HINDU (Apr 24, 2021)
3. Sowmya Ramasubramanian, *how social media platforms have become 'COVID-19 helplines' to combat second wave in India*, THE HINDU (May 13, 2021)
4. Zaid Nayeemi, *Delhi remembers the lethal second wave: No cremation of covid scars*, THE NEW INDIAN EXPRESS (Jun 27, 2022)
5. Saraph, Anupam and Kidwai, Anab, *Evaluating India's responses and options to Covid-19* (Aug 16, 2020).
6. Marathe, Rohan, *Analysis of Existing Jurisprudence under the Epidemic Diseases Act (*Apr 17, 2020).

7. Bhandari, Vrinda and Rahman, Faiza, *Constitutionalism During a Crisis: The Case of Arogya Setu* (May 25, 2020).
8. Coco, Antonio and Dias, Talita, *Prevent, Respond, Cooperate: States' Due Diligence Duties vis-à-vis the covid-19 Pandemic* (May 7, 2020).
9. Chinnu, Dr. C. Sivakkolundu, *COVID-19 Second Wave: Challenges and Revival Measures* (May 22, 2021).
10. Buchanan, K. *Australia: Legal responses to health emergencies*. LIBRARY OF CONGRESS. (May 19, 2020)
11. Griffith, R. *Using public health law to contain the spread of COVID-19*. BRITISH JOURNAL OF NURSING, 29(5), 326– 327 (2020).
12. Neo, J., & Darius, L. *Singapore's legislative approach to the COVID-19 public health 'emergency'. Verfassungsblog on Matters constitutional.* (May 19, 2020)
13. Oum, S., Wexler, A., & Kates, J., *The U.S. response to coronavirus: Summary of the coronavirus preparedness and response supplemental appropriations act, 2020*. GLOBAL HEALTH POLICY. (March 11, 2020).
14. Platon, S., *From one state of emergency to another – Emergency powers in France, Verfassungsblog on Matters constitutional*. (April 9, 2020).
15. Owaisi, A, *Unconstitutional nationwide lockdown.* TELANGANA TODAY. (May 20, 2020)
16. Kannan, B., *Coronavirus and The Constitution*, LIVE LAW. (May 25, 2020)
17. Manish Tiwari*, India's fight against health emergencies: In search of a legal architecture*, OBSERVER RSCH. FOUND. (March 31, 2020)
18. Zaid Nayeemi, Delhi remembers the lethal second wave: No cremation of covid scars, THE NEW INDIAN EXPRESS (Jun 27, 2022)
19. *NDMA notifies guidelines for Covid-19 death compensation*, THE INDIAN EXPRESS (April 28, 2022)
20. Davies, Gareth, "*UK coronavirus lockdown plans: What the Government advice means for you"*. THE DAILY TELEGRAPH. (20 March 2020).
21. Johnston, Nei, "*Coronavirus Bill: Elections",* HOUSE OF COMMONS LIBRARY. pp. 3–5. (Mar 19, 2020)
22. *"Two monthly report on the status of the non-devolved provisions of the Coronavirus Act 2020*", GOV.UK. Department of Health & Social Care. (May 29 2020)

23. Breuninger, Kevin, *Senate passes $8.3 billion emergency coronavirus package, sending bill to Trump's desk.* CNBC. (5 March 2020).
24. *Coronavirus Aid, Relief, and Economic Security Act".* govtrack. Civic Impulse, LLC. (Mar 27, 2020)
25. Goodrich, Kate, *How the CARES Act Supports America's Healthcare System in the Fight Against COVID-19* (March 30, 2020).
26. Wade, Amelia, *Covid-19 coronavirus: Controversial bill passed to enforce alert level 2 powers*. THE NEW ZEALAND HERALD. (14 May 2020).
27. *Mandate legislation pushed through Parliament amid fierce opposition.* RADIO NEW ZEALAND. (Nov 24, 2021)
28. Chun B. *Public policy and laws on infectious disease control in Korea: past, present and prospective*. INFECT CHEMOTHER 2011; 43:474–484.
29. Borowiec S. *How South Korea's coronavirus outbreak got so quickly out of control* (2021 March 19).
30. *10 lakh corpus funds for every child orphaned by covid 19,* THE HINDU (May 27, 2022)

GUIDELINES

2. *National Disaster Management Guidelines—Management of Biological Disasters, 2008. A publication of National Disaster Management Authority*, Government of India. ISBN 978-81-906483-6-3, July 2008.
3. *Infection prevention and control for the safe management of a dead body in the context of COVID-19: interim guidance*, WORLD HEALTH ORGANISATION (SEPT 4, 2020)
4. *Covid-19: Guidelines on Dead Body Management, Directorate General of Health Services (EMR Division),* Ministry of Health & Family Welfare, GOVERNMENT OF INDIA (Mar 15, 2020)