Policy Brief

Legislation and Lockdowns: The Need for a Public Health Emergency Law in India

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ABSTRACT

India, the largest democracy in the world with the longest constitution amongst all present-day nations, faces a glaring insufficiency in its legal framework. While nations around the world were guided through the COVID-19 pandemic by designated governmental bodies backed by specific articles of legislation, India was forced to employ an alternative approach. The absence of a comprehensive public health emergency law has led to the diffusion of decision-making power and authority over a large number of governmental organizations. This policy brief presents an analysis of the existing legislation that addresses public health concerns within the country and discusses its shortcomings. It also illustrates the need for a comprehensive public health emergency law by drawing connections between India's response to the pandemic and its complicated legislative position.

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Introduction

According to Professor Lawrence O. Gostin, Director of the World Health Organization Collaborating Center on National and Global Health Law, there are three key principles that should form the basis of any effective public health legislation: (1) Duty – to ensure that governments and public health agencies are aware of their responsibilities and obligations, (2) Power – to enable governments and agencies to undertake actions necessary to achieve objectives, and (3) Restraint – which refers to legal remedies that prevent the abuse of power by a government (Gostin et al., 2016). At present, there is no comprehensive unified article of Indian legislation that addresses public health emergencies (PHEs) in adherence with these three principles. Much to the contrary, provisions in place to manage public health emergencies are distributed over a wide array of laws, under both central and state government jurisdictions. This leads to legal contradictions and a lack of clarity regarding the distribution of power and duty between governmental bodies. (Agarwal et al., 2021).

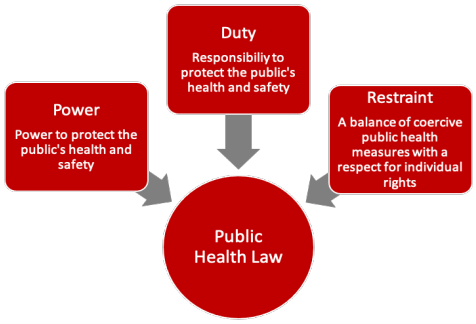

Figure 1. The Power-Duty-Restraint Framework

India's Existing Legal Architecture for PHEs

The existing legal framework for the management of PHEs in India is dominated by the Epidemic Diseases Act and the Disaster Management Act (Agarwal et al., 2021). There are a large number of insufficiencies present in both these laws that have become increasingly evident with the passage of time. The Epidemic Diseases Act (EDA) is an archaic document of legislation that has been amended on only a few occasions, most recently in 2020 (Kumar et al., 2020). The EDA was enacted during the British Raj in 1897 to manage an outbreak of bubonic plague in Bombay (now Mumbai) (Goyal, 2020). According to Gostin's duty-power-restraint framework, the EDA only provides powers to the central government without designating responsibilities or implementing checks on the actions of the government (Agarwal et al., 2021). The EDA has many other flaws, such as the absence of a categorization system for diseases according to severity; an ambiguous explanation of the government's role in restricting movement of infected individuals; no mention of regulations of drugs and vaccines; and an overall failure to address the roles and responsibilities of local governments in response to an outbreak (Gowd et al., 2021). The Disaster Management Act (DMA), 2005, while versatile, is not best suited for managing public health crises. The legislative intent of the DMA is to "provide for the effective management of disasters" and the Act has no guidelines or rules specific to public health emergencies (Gowd et al., 2021). The National Disaster Management Authority (NDMA) was established under this Act, which presently extensively manages biological disasters and health emergencies (Gowd et al., 2021). Section 6(2) of this Act empowered the government to implement the national containment measures that had been in place since March 25th, 2020. The legal justification for these lockdowns has been brought under question, as the legal definition of a 'disaster' as provided in the Act may be argued to not be inclusive of public health emergencies (Kumar et al., 2020).

Scope Of Improvement Within India's Legal Framework

The faults present within both these acts have led to documented effects on the population of India during the COVID-19 pandemic. The EDA, for example, has provided authorities with the power to conduct forceful quarantine and isolation for those exposed to SARS-CoV-2. A lack of guidelines in the Act regarding the rights of those in quarantine has led to the mistreatment of individuals exposed to SARS-CoV-2, resulting in suicides in many quarantine locations (Dsouza et al., 2020). The Disaster Management Act's flaws have also become evident during the course of the pandemic. The coordination of efforts by government bodies has been challenging due to a lack of clarity regarding power allocation. The National Disaster Management Plan (issued from the Disaster Management Act) designates the

Ministry of Health and Family Welfare as in-charge of managing biological disasters (including epidemics). However, the Disaster Management Act also designates the chairperson of the National Executive Committee of India—the Home Secretary—in charge of the administrative management of disasters. Complications arose as the Home Secretary used this power to assign the Ministry of Home Affairs as in-charge of managing the response to the pandemic—a direct contradiction to the power allocation made by the National Disaster Management Plan (Chaturvedi, 2020).

Creating A Comprehensive Public Health Emergency Law

Previous efforts were made to enact a unified law in India to address public health matters. The National Health Bill was introduced in 2009 in the lower house of parliament. The bill mandated health as a right and recommended the establishment of a National Public Health Board. This would have been particularly novel, as India does not have a designated agency to address public health emergencies (Gowd et al., 2021). In contrast, Canada has the Public Health Agency of Canada (PHAC). PHAC is primarily responsible for the "promotion of health, prevention and control of chronic diseases, prevention and control of infectious diseases, and preparation and response to public health emergencies" (Public Health Agency of Canada, 2021). The National Health Bill was ultimately not passed because many states insisted that health should remain under the state list of subjects according to the seventh schedule of the Indian Constitution (Gowd et al., 2021). Other efforts to promulgate a comprehensive national public health law include the Model Health Bill in 1955 (updated in 1987) and the Public Health (Prevention, Control and Management of Epidemics, Bio-terrorism and Disasters) Bill in 2017, but neither of these bills were passed due to state opposition (Gowd et al., 2021).

Conclusion

The events that have unfolded over the course of the COVID-19 pandemic have elucidated the need for a comprehensive public health emergency law that designates the powers of the central government to issue advisories, guidelines, and mandates in a manner that ensures their authority, while also preserving state autonomy. A clear and comprehensive public health emergency law could mitigate these issues by being specific in its process of power allocation and responsibility delegation. A lack of specificity in this department has led to the central government taking large liberties regarding the distribution of power and responsibility. This sets a dangerous legal precedent, as a power struggle between different public authorities can lead to inconsistencies in the management of epidemics and pandemics.

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