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"Exploring the Complex Role of Law in Public Health Emergencies: Assessing Legal Frameworks and Governance for Preparedness and Response"

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Abstract

In public health, the role of the law is not always self-evident. Nonetheless, public health administration and governance are vital in preparing for and responding to public health emergencies ("PHE"). As a sovereign entity, the state has the authority and responsibility to enact legislation and promote social welfare, which gives the government a role in PHE preparedness and response. Strong legal frameworks may be required to support the government's role as a "safety net" for individuals, communities, and nations. This article examines the influence and role of the law as it applies to PHE and considers where legal frameworks for public health emergencies are deficient, inequitable, and ineffective.

Introduction

The novel coronavirus (COVID-19) compelled the Indian government to fine-tune its public health strategy in accordance with applicable national laws and policies. COVID-19's incidence and prevalence compelled the government to implement the Epidemic Diseases Act, 1897, on March 11, 2020, through social isolation and a voluntary public curfew.[1]

The public health laws are passing through a process churning in the COVID-19 pandemic in India. The efficacy of quarantine law under 160 years old Indian Penal Code, 1860, and 123 years old Epidemic Diseases Act, 1897 proved temporary euphoria. Thus, there is no point to wonder that Indians have been subjected to the most stringent restrictions in the history of human civilization; yet, with all the best strategies being employed by governments around the world, the situation at

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[1] "A 123-yr-old Act to combat coronavirus in India; experts say nothing wrong"
Available at https://www.livemint.com/news/india/a-123-yr-old-actto-combat-coronavirus-in-india-experts-say-nothingwrong-11584182501707.html

national as well as international levels can be looked upon differently.[2] But how did the pandemic spread itself? How does the law allow for speedy response in time and in space? It was believed that SARS originated from Wuhan but it took weeks before WHO acknowledged the first cases. At this stage, it becomes clear that the public health system has evolved over the past few decades. However, some questions about the legal dimension of public health remain unanswered. Does a disease that started as an epidemic spread worldwide? Is COVID-19 one of the many diseases which start out as outbreaks but later become spread globally?

The initial case was reported after 11 April in Wuhan.[3] Since then, the country's authorities have been forced to strengthen global coordination and cooperate with other countries on fighting COVID-19. However, there are certain areas where the laws do not allow time-sensitive investigations. This paper will discuss these topics. Specifically, it examines the issue of jurisdiction over a crime committed abroad in times of emergency.

Legal regulation to combat Public Health Emergency in India

There is no single, consolidated PHE preparedness and response code in India. PHE-related legal provisions are scattered across a variety of central and state laws, including epidemic and infectious disease laws, disaster management laws, public health legislation, and criminal laws. The absence of a shared PHE legal regime adds to the difficulty of making India's response to emerging PHEs consistent, effective, and fair. In this article, we assess what the law is today and what it should be in order to fully protect PHE workers and doctors, patients and compensate them for the risks they take when responding to a PHE.[4]

[2] Rajesh Sharma and Rajeev Khandekar. "Covid-19 Pandemic and Domestic Law and Policy in India." The Journal of Infectious Diseases & Prevention Nursing 1.2 (2020): 5-10. Web. 9 June 2020.

[3] Rajesh Sharma and Rajeev Khandekar. "Covid-19 Pandemic and Domestic Law and Policy in India." The Journal of Infectious Diseases & Prevention Nursing 1.2 (2020): 5-10. Web. 9 June 2020.

[4] "What should a Public Health Emergency Law for India Look Like?", A White Paper, March 2021, Vidhi Center for Legal Policy.

The legal framework governing PHEs is dominated by two major pieces of legislation: the Epidemic Diseases Act and the Disaster Management Act.[5] When the duty-power-restraint framework is applied:

(a) the Epidemic Diseases Act confers only powers, with no obligations or restrictions on government (these themes were largely replicated in state regulations issued under the Act during the Covid-19 pandemic); and

(b) the Disaster Management Act confers government powers and duties to manage disasters, but it is not a PHE-focused law, and thus does not provide for PHE preparedness and response measures.

(c) In addition, PHE workers and doctors have other laws protecting their person and property – the Indian Penal Code (IPC), the Code of Criminal Procedure (CrPC), and the Indian Medical Council Act.

Right to Health as a Constitutional Right

India's Constitution does not explicitly guarantee a fundamental right to health. As 'social' rights, the rights to health and healthcare are addressed in Part IV of the Constitution's Directive Principles of State Policy ("Directive Principles"). According to Article 37, these are non-justiciable but are intended to guide government policy and legislation. The Directive Principles have informed various laws in independent India, such as labor welfare and land reform laws, and the courts have repeatedly turned to them for guidance in interpreting the Constitution's provisions and the State's corresponding obligations. The courts have specifically stated that Article 21 of the Constitution (which guarantees the fundamental rights to life and personal liberty) in conjunction with the Directive Principles guarantees every person the fundamental right to health and healthcare as an intrinsic component of the right to life.[6]

[5] Nomani, M.Z.M., Rahman, F., and Alhalboosi, A.K.K. (2019). Consumer Protection Act, 2019 and its implication for the medical profession and health care services in India. Journal of Indian academy of forensic medicine, 41(4): 282-285

[6]State of Kerala and Anr v N M Thomas and Ors AIR 1976 SC 490

- promote the well-being of the country and its people by making sure there is a fair social, economic, and political system (Article 38);
- ensure that workers have fair and humane working conditions, as well as maternity leave (Article 42);
- improve the nutritional status of the population and the standard of living, and improve public health (Article 47).

As a result, the right to health is envisioned by the Constitution as encompassing the right to its underlying determinants as well as other rights. This is consistent with the widely held international viewpoint[7], and it is reflected in the decisions of Indian courts[8].

With the power to legislate on "Public health and sanitation; hospitals and dispensaries" (Item 6 of the 'State List'), Article 246 of the Constitution empowers the states to give legislative effect to the rights and principles discussed above. Aside from this power, the courts have recognized the State's obligation as a welfare state to implement the Directive Principles' social justice ideals.

Thus, the Indian state's constitutional mandate is to promote and protect public health as well as individual health rights. In a PHE, where the public's health and safety are most at risk, this responsibility inevitably extends and expands. The Constitution has given the state the necessary legislative and executive powers to fulfill this responsibility. While Article 21 of the Indian Constitution recognizes the right to health as a component of the right to life, this has not automatically translated into the right to receive medical treatment at any healthcare establishment of one's choice.[9]

India needs specific PHE Legislation

[7] Article 25(1), Universal Declaration of Human Rights:
Article 25: (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.; (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.
[8] Francis Coralie Mullin v Administrator, Union Territory of Delhi and Ors, AIR 1981 SC 746.
[9] Indian Courts have, however, recognized the right to access emergency medical care. See, Paschim Banga Khet Mazdoor Samity v State of West Bengal AIR 1996 SC 426.

Despite the fact that Article 21 of India's constitution recognizes the right to health as a component of the right to life, this has not automatically translated into the right to receive free medical treatment at any facility of one's choosing.[10]

In India, public health falls primarily within the legislative scope of the states. The center and states are both empowered to enact legislation to prevent the spread of infectious or communicable diseases between states. There are several concurrent state and central laws dealing with the prevention and control of infectious disease outbreaks.

The existing Indian PHE legal framework needs to be re-evaluated to address its flaws and incorporate modern PHE legislation elements appropriate to the Indian context. Among the issues to consider are:

1. the focus of PHE legislation – international obligations or domestic administrative responsibilities;
2. the administrative infrastructure's ability to handle PHE preparedness and response activities, responsibilities, and coordination mechanisms;
3. the necessity of state-specific legislation, as well as the principles governing the division of responsibilities among the various levels of government;
4. Pattern of distribution of power and authority: the demarcation of authority in primary and secondary legislation, and the legal status of PHE relation in relation with the law.
5. the framework, roles, and scope of authority monitoring and transparency mechanism;

Implementation of existing Legal Framework during Covid-19

The issue of health care rights is one of many concerns that are being raised in connection with the ongoing pandemic. The National Democratic Alliance (NDA), the ruling party in the State, believes in “a humanistic approach” towards addressing such issues, including women’s health rights. It aims to provide maternity leave to mothers till 30 years. Since 2016, it has worked on making hospitals more affordable and better equipped. However, it could not provide universal coverage without ensuring the basic right to health care. For example, when they tried to

[10] ibid

implement universal coverage, it was resisted out of fear. Even now it remains a controversial issue. There are some laws such as the Pradhan Mantri Jan Arogya Yojana (PMJAY) and PMLAY which would reduce the cost of health care but cannot provide it to all sections of the population due to several reasons. People who do not have a proper understanding of what their constitutional rights are cannot be taken care off because most people lack legal knowledge about them. Even the courts are not aware of the Constitutional nature of rights of individuals. The court has often refused to hear petitions challenging constitutional provisions, but it cannot stop governments from making those decisions. If the Constitution provides a certain way to provide services, then it should not be the only way. This is why it becomes important for us at Vocal Media to highlight pertinent topics related to this issue, especially during Covid-19 and even earlier in other incidences, to sensitize our readers about the rights of others. At present, there are around 18 states and union territories with active anti-Covid laws. Despite their efforts, the number of infections in the country continues to rise. According to Indian Council for Medical Research, on 19 January, the death toll from the coronavirus pandemic passed the 24-crore mark, which was the highest ever recorded in April. On 25 April 2020, there were a total of 6,46,964 cases in India. By 31 December, there will be 9.5 million cases. Out of a total population of 1.3 billion, about 474 million people have died. According to the latest figures provided by the Ministry of Home Affairs, 50 million cases are estimated to be reported and 3 million deaths reported so far. So far, more than 12,000 doctors and nurses have lost their lives due to the coronavirus pandemic. In some parts of the country, such as Uttar Pradesh, the death rate from infection has surpassed 10%. This shows how deadly the Coronavirus disease has become in the world. Of course, the death rate among women is higher than for men. Also, more women than men are dying of the virus. However, according to a study conducted by WHO, between March 1 and June 29, 2020, the overall mortality rate among females was 28.7 times higher than that of males. According to data available online, there are over 500 000 deaths in India, owing to the spread of the coronavirus in this country. And if there is no end in sight, perhaps it may take another two or three months to reach its peak in terms of a death rate. A high percentage of infected people end up in the intensive care unit (ICU) and in the ICU itself. The figure from the World Health Organization says that more than 42% of confirmed COVID-19 cases worldwide have been treated in ICUs. So, while many people die, the proportion of infected people who need hospitalization and treatment remains far. The US has the worst

mortality rate among countries in Europe. More people die in their 60s. This is similar to the U.S.A. and Canada where more than 40% of deaths occur in their middle age (between ages 50 and 59). But, here too, researchers say the reason for rising death rates lies in early life factors (such as smoking, obesity, etc.). More than 50% of deaths occur within 10 days of diagnosis. Another factor is that the virus has an incubation period of seven to 14 days, which means that the risk of severe illness increases more than after the initial infection. In addition, younger people with co-morbidities such as diabetes and heart problems are also at greater risk. According to a recent report, the mortality rate among children below 18 years old has been approximately double in six countries: 1 in 13 cases in Belgium, 2 in 15 cases in Spain, 3 in 21 cases in France, and 8 in 22 cases in Germany. These numbers show that there is a need to put in place measures to ensure access to health care for all, irrespective of social background, age, gender, region, etc.

An existing legal framework of regulations, directives, guidelines, and advisories, provided the foundation for the PHE response to the Covid-19 pandemic. Central and state governments issued directives under the various PHE laws to implement lockdowns and restrict movements. The central and state governments also worked together to implement these directives, issuing guidelines and advisories on various aspects of the pandemic response and enforcing them where necessary.

Epidemic Diseases Act, 1897& 1937

The EDA is the main piece of legislation that aims to prevent and contain outbreaks of 'dangerous epidemic diseases.' The EDA empowers state governments to prevent and control the spread of "dangerous epidemic diseases" by inspecting passengers and isolating infected individuals in hospitals or temporary housing, as defined in Section 2 of the Act. The EDA has been used to combat epidemics in various parts of the country on occasion, and states have occasionally adopted the provisions through regulations or amendments addressing specific outbreaks. Additionally, several states passed ordinances in response to the need for more detailed provisions than those contained in the EDA during the Covid-19 pandemic. However, the Act as a whole remains skeletal legislation, with only extremely broad emergency powers granted to state and federal authorities. Due to the pandemic, the majority of States and Union Territories enacted regulations under the EDA (the 'Covid-19 Regulations'). These regulations fill in the details of the parent act

and also carry out central directives issued under the Disaster Management Act, 2005 that are not covered by the parent act. On the following point, the act falls short during PHEs.

- There is no specific legal obligation on the part of the government to take public health emergencies preparedness or emergency response plans.
- Nondiscrimination and protection of vulnerable populations are not explicitly mandated.
- In the event of a Public Health Emergency, there is no obligation under the Act to inform the public.
- The government's discretion is not constrained by any rules or regulations. For the most part, district authorities have the authority to enact "any other measure" not listed in the regulations.

The Disaster Management Act, 2005

When the Covid-19 pandemic broke out, the central government turned to the Disaster Management Act of 2005 ("DMA") for additional help. It was enacted after the 2004 tsunami, and it provides a comprehensive framework for the federal, state, district, and local governments of all sizes to plan for and respond to disasters.

Unlike the EDA, which imposes no explicit duties on the government, the DMA requires specific functions of the various authorities established under it. These activities include developing disaster management policies and plans, coordinating their enforcement and implementation, and taking additional measures to prevent or mitigate disasters. Additionally, the Act vests specific authorities, particularly at the state level, with the authority to impose certain restrictions and exercise control over other authorities.

Directives issued during Covid-19 outbreak:

It was through the various directives and advisories issued by the center and states that the pandemic response measures were put into action as new scientific insights, epidemiological observations from around the world, and administrative learnings from the impact of various government measures were being developed on a day-to-day basis. As a result of these directives, PHE management has been given greater legal and administrative protection in the United States. When it comes to containment measures, the current combination of legal provisions and executive orders may appear to cover the essentials, but the lack of consistency in the implementation of

various measures across states and public violations are two things that have been noted in the news reports and government notifications.

Conclusion

The government has not fulfilled its constitutional commitment to create public health and disaster preparedness laws in epidemic-pandemic COVID-19-like scenarios, according to a critical analysis of Indian public health legislation. It hid behind the colonial Epidemic Diseases Act of 1897, or, at best, followed the path of the Disaster Management Act of 2005. The International Health Regulations, 2005, which ushered in a slew of legal reforms to address biological, chemical, and radio-nuclear threats at the entry, control, and mitigation levels, is likewise an instance of neglect and apathy. The National Health Bill of 2009 and the Health Services Personnel and Clinical Establishments (Prohibition of Violence and Property Damage) Bill of 2019 are both currently pending. As a crisis, COVID-19 provided an opportunity to address long-standing reforms of public health regulations, but it was a huge miss. The Epidemic Diseases (Amendment) Ordinance, 2020, is considered as more of a criminal statute than a civilian approach to health care and equity, as it is based on 123-year-old colonial legislation.