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Analyzing India's Central Public Health Emergency Laws and Its Impact on India's Economy: A Comprehensive Study

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Abstract *:* Public health emergencies present complex challenges that require coordinated legal responses and medical interventions to mitigate their impact. This research article explores the dynamic interplay between legal frameworks and medical strategies in addressing such emergencies. By analyzing existing legislation, it investigates the effectiveness of legal tools in facilitating timely and effective medical interventions during crises. The primary legislation that somewhere address the public health emergency in India namely the Epidemic Disease Act, 1897 along with some other acts. This research article conducts a comprehensive study of India's central public health emergency laws, the impact pandemic like Covid-19 had on the Indian economy, examining their scope, efficacy, and applicability in addressing various health crises. Through an analysis of legislation, case studies, and policy documents, the study evaluates the strengths and weaknesses of existing laws in facilitating timely and effective responses to emergencies. Furthermore, it explores the role of these laws in coordinating medical interventions, ensuring resource allocation, and safeguarding public health during emergencies. By shedding light on the legal landscape of public health in India, this study aims to inform policymakers, health professionals, and stakeholders about areas for improvement and optimization in the country's preparedness and response mechanisms.

Keywords: Public health emergency, Epidemic Diseases Act, Medical intervention, Resource allocation. Economic Impact.

Introduction

The history of central public health emergency laws in India can be traced back to the colonial era, with the Epidemic Diseases Act of 1897 being the primary legislation. This Act was enacted to tackle the bubonic plague in Bombay State and has only four sections, making it a relatively simple but extraordinary law necessary for dealing with epidemics. However, the EDA might be insufficient to deal with modern public health emergencies, such as the COVID-19 pandemic, due to its age and limited scope.

In British India[1] in the late 19th and early 20th centuries, public health emerged, and polling gave way to microscopic medical research, which laid a substantial foundation for the development of new healthcare systems. The emergence of infectious diseases and the development of tropical medicine were encouraged by colonial administration. The ecology of infectious diseases, the majority of which continue to exist in underdeveloped and third-world nations today, can be linked to the history of illness and precaution in the colonial setting. Since 1600, when the first ship carrying doctors from the British East India Company arrived, Western medications have been utilized in India.[2]

In recent years, there have been attempts to draft more comprehensive public health legislation. For example, the Union Ministry of Health & Family Welfare drafted the Public Health (Prevention, Control and Management of epidemics, bio-terrorism, and disasters) Bill in 2017[3], which aimed to address gaps in the EDA and empower local government bodies. However, this bill has not been tabled in Parliament, and the old Epidemic Diseases Act, 1897 remains in force. The Indian Constitution empowers the President of India to declare three kinds of emergencies: national, state, and financial. However, health emergencies are not explicitly mentioned in the emergency provisions of the Indian Constitution. The role of the government at all three levels (Union, State, and local) is crucial in providing healthcare to all citizens during health emergencies. The COVID-19 pandemic has highlighted the shortcomings of the existing Indian

[1] Mushtaq, M. U. (2008). Public Health in British India: A Brief Account of the History of Medical Services and Disease Prevention in Colonial India. Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine, 34(1), 6-14. https://doi.org/10.4103/0970-0218.45369
[2] Ibid
[3] Inviting Comments on Draft Public Health Bill, 2017.pdf (mohfw.gov.in)

legal framework for public health emergencies. The response to the pandemic has included containment measures, quarantine and isolation efforts, testing strategies, and the involvement of authorities. However, these efforts have been marked by inconsistent implementation, capacity constraints, lack of protective equipment, confusion and misinformation, frequent violations by the public, and legal challenges to digital monitoring efforts for privacy concerns.

i. Public Health – A Corollary Of Right To Life Under Constitution Of India

The right to health isn't specifically guaranteed by the constitution of India, which means that it is not protected by Indian law. However, the Constitution contains numerous references to public health and the role of the state to provide healthcare for people. The Right is based on part IV of the Indian Constitution, which outlines the fundamental foundations of governmental policy for example - Art. 39 (E) directing the State to protect employees' health, yet Art. 42 mandates equal pay for equal effort, whereas Art. 47 requires that the State promote better health by boosting citizen's nutritional & dietary standards. Art. 243G, Municipalities as well as Panchayats have powers in addition to the States (read with 11th Schedule, Entry 23). According to the interpretation of various landmark judgments, Article 21, which provides the right to life, also ensures the right to health and healthcare. In September 2019, the 15th Finance Commission also recommended establishing healthcare a fundamental right and transferring it from the State to the Concurrent list. In the context of Indian cooperative federalism, "public health and sanitation; hospitals and dispensaries" is listed in the VII Schedule, state authorities are required by the constitution to develop, administer, and enforce public health regulations. States in India had unequal public health systems, based on an NITI Aayog 2019 evaluation; this difference was primarily due to a lack of technical expertise and financial constraints. It is true that state monetary dependence on the national govt which continues to be a major problem, but adding health care to the Concurrent List will result in more paperwork, institutional constraints, and bureaucracy. Even if the federal executive's political ideology would continue to influence the policy decisions of states, this centralization would strip states of their constitutional rights. An all-encompassing plan would also fail to provide each state in India the individualized attention they need. Cooperative federalism is a vital part of the Indian Constitution, but it must not be impeded by central-state collaboration on a critical issue like health.

ii. Discussion on the two-central legislation's on PHE in India:

Two central laws that are particularly important in this regard are the Disaster Management Act, 2005, and the Epidemic Diseases Act, 1897.

1. The Epidemic Diseases Act, 1897:

The Epidemic Diseases Act of 1897[4] is a colonial-era law enacted to control the spread of dangerous epidemic diseases. It was promulgated to empower the government to take special measures to prevent the outbreak of epidemic diseases and their spread. Some of the key provisions of the then enactment are- The Act grants special powers to the government to deal with the outbreak of epidemic diseases. This includes the power to inspect individuals, segregate patients, quarantine areas, regulate public gatherings, and implement other necessary measures to control the spread of diseases. It prescribes penalties for violating the orders issued under its provisions, ensuring compliance with public health regulations. The Act is applicable to all states and union territories in India and provides a uniform legal framework for managing epidemic diseases across the country.

The Acts application to Public Health Emergencies: The Act is invoked during public health emergencies such as outbreaks of communicable diseases like cholera, tuberculosis, or more recently, COVID-19. It empowers the government to enforce containment measures, quarantine protocols, and other public health regulations necessary to mitigate the spread of the disease.

2. The Disaster Management Act, 2005.

Act (DMA) of 2005 was enacted in response to the realization of the need for a comprehensive legal framework to manage disasters effectively. The Act came into force on December 26, 2005, replacing the earlier Disaster Management Act of 2005[5]. It provides for the effective management of disasters, including natural or man-made calamities, and public health emergencies fall under its purview.

[4] 1625462448.pdf (mohfw.gov.in)
[5] DM_act2005.pdf (ndma.gov.in)

The DMA establishes various authorities at the national, state, and district levels to oversee disaster management. These include the National Disaster Management Authority (NDMA)[6] at the central level, State Disaster Management Authorities (SDMAs)[7] at the state level, and District Disaster Management Authorities (DDMAs) at the district level. The Act delineates the roles and responsibilities of these authorities in disaster management, including prevention, mitigation, preparedness, response, relief, rehabilitation, and recovery. The Act empowers the central and state governments to take necessary measures for disaster management. This includes the issuance of guidelines, directives, and orders to address public health emergencies effectively. The Act also emphasizes the importance of coordination between various agencies, departments, and stakeholders involved in disaster management. The act mandates the formulation of national policies, plans, and guidelines for disaster management, including those specific to public health emergencies.

During public health emergencies such as pandemics, the DMA provides a legal framework for the government to implement measures such as lock downs, quarantine, travel restrictions, resource mobilization for healthcare facilities, and coordination of relief efforts.

iii. Analysis of the Existing Legislation:

According to Patro et al. (2013), the EDA is the sole act that offers legal interventions in the event of a national or sub-national epidemic. The act's title and the scope of its execution are provided in the first section. The second section discusses the federal and state governments' authority to impose laws and take exceptional action in the event of a hazardous disease outbreak. The state government may, in accordance with section 2 of the act, require anybody to issue notices or restrictions that the public is expected to abide by during the outbreak. The Central Government is authorised by Section 2A to take preventative measures, establish guidelines for the inspection of ships and other boats, and control anyone who plans to sail. Penalties are part of the third section while the fourth section deals with the protection of those acting in accordance with the act. According to section 188 of the Indian Penal Code 45 of 1860, disobedience to the directives of public servants under the act is punishable by up to 1000 rupees in fines and/or six months in jail. Since there had been instances of attacks on healthcare professionals, the Modi Cabinet used its authority under Article 123 to draft an ordinance amending the EDA on April 22, 2020. Section 3 of the EDA was modified by the ordinance. Anyone who damages or destroys property faces 'imprisonment for a term of 3 months to 5 years and with a fine of Rs. 50,000/- to Rs. 200,000/-' as punishment.[8]

Health care personnel who commit acts of aggression or physical attacks may face imprisonment for a maximum of six months to seven years, as well as a fine ranging from Rs. 100,000 to Rs. 500,000. Furthermore, 'the perpetrator shall additionally be obligated to furnish the victim with compensation and twice the fair market value of the damaged property.'[9]

iv. Shortcomings of the existing legislation:

The pandemic exposed challenges in enforcement, coordination, and oversight within the legislative framework, emphasizing the need for a more comprehensive approach to public health emergencies. The lack of a unified national strategy, coordination mechanisms, and governance arrangements hindered a whole-of-nation approach to managing the crisis. The legal system's limitations in facilitating consultation processes, ensuring evidence-based measures, and protecting privacy rights were also evident during the pandemic.

Since the ED Act was created approximately 127 years ago, it has significant limitations in this day and age when public health emergency management goals are shifting. Over time, other elements have also altered that contribute to the emergence and spread of communicable illnesses. Increasing rates of international travel, a greater reliance on air travel than on sea travel, increased migration within states for economic reasons, the shift from agrarian to industrial societies, increased urbanisation, a sharp increase in population density in some areas, increased intensity of contact with animals and birds, man-made ecological changes, shifting climatic conditions, mass food production technologies, breakdowns in public health protocols, and bio-safety lapses are some of the factors that require immediate attention.

[6] Chapter II of Disaster Management Act, 2005
[7] Chapter III of Disaster Management Act, 2005
[8] The Epidemic Diseases (Amendment) Ordinance, 2020 (prsindia.org)
[9] The Epidemic Diseases (Amendment) Ordinance, 2020 (prsindia.org)

Given the evolving situation, changes to the Epidemic Diseases Act are necessary. For instance, it speaks too much about travelling by ship and says nothing about 'air travel,' which was unusual back then. Over time, there have also been changes to the epidemiological principles related to the prevention and control of epidemic diseases. The Epidemic Diseases Act solely represents the legal and scientific norms that were in place at the time it was drafted, not the current scientific understanding of outbreak prevention and response.

For instance, the Act over emphasizes isolation or quarantine policies while remaining mute about other evidence-based strategies for controlling and preventing outbreaks, such as vaccination, surveillance, and coordinated public health responses. The nation's political landscape has evolved, as have the dynamics between center-states. Therefore, in light of the current circumstances, the Act of 1897 is insufficient to address the prevention and control of infectious diseases.

The term 'dangerous' for an epidemic is not well defined; it cannot be determined by the scope of the issue, the severity of the problem, the age distribution of the affected population, or the likelihood of an international spread. In order to prevent abuse of the Act and to ensure openness, it is imperative that we understand who determines what constitutes a 'dangerously epidemic disease' and the factors that guide this determination.

The Epidemic Diseases Act doesn't specifically address public health rather, it is mainly regulatory in nature. It makes no mention of the government's responsibilities for stopping and managing epidemics. The Act highlights the authority of the government but says nothing about citizen rights. It contains no provisions that take the interests of the people into account. People-centeredness means considering the requirements, preferences, values, social contexts, and lifestyles of others while collaborating to create solutions that meet those needs.

The Act says nothing about the moral considerations or human rights precepts that apply when responding to an epidemic. To the greatest extent feasible, individual liberty, autonomy, and privacy should be respected even when laws are being enforced. It would have been beneficial if the Act had made explicit the circumstances under which the government may restrict an individual's liberty, privacy, autonomy, and property rights such as shutting down a hotel would guarantee that authorities make unbiased choices and also aid in lowering misconceptions within the community.

The Act is more akin to a guidance document than it is to explicit executive orders. It makes no mention of any scientific measures that must be implemented by the government in order to restrict or stop the spread of illness.

The effectiveness of the implementation and the ambiguity of the provisions present were made clear that there exists:

1. ***Lack of clarity and specificity:*** The laws lack specificity in addressing pandemics and public health emergencies on the scale of COVID-19. The Epidemic Diseases Act, being more than a century old, may not have provisions tailored to modern-day challenges. There's a need for updated legislation that explicitly addresses the complexities and challenges of managing pandemics, including provisions for testing, contact tracing, vaccine distribution, and international cooperation.

2. ***Fragmented Implementation and coordination:*** Despite the establishment of national, state, and district-level authorities under the DMA, coordination between different levels of government and agencies has been fragmented at times. Lack of coordination between health, law enforcement, and other relevant departments has led to gaps in the implementation of containment measures and resource allocation.

3. *Absence of a Concrete Central Policy:* The pandemic laid bare the structural failures of the country's healthcare system and the absence of a concrete central policy to provide a road map for the country's future and the health of its citizens.[10]

4. ***Lack of Implementation of the Epidemic Diseases Act, 1897*****:** The Epidemic Diseases Act, 1897, has been criticized for its insufficiency in handling the situation created by the pandemic and for ignoring the right to health of citizens. The sudden lockdown of the nation took the unorganized sector by surprise, leaving thousands of migrant workers and domestic workers to the mercy of their employers.[11]

v. Impact on India's Economy:

Laws pertaining to public health emergencies are essential for protecting the public during emergencies like pandemics. The Epidemic Diseases Act, 1897, the Disaster Management Act, 2005, and many parts of the Indian Penal Code (IPC) are the main legislation that govern public health emergencies in India. These restrictions have had a significant

[10] https://www.downtoearth.org.in/blog/health/a-look-at-india-s-flawed-public-health-policies-through-covid-19-s-prism-79876

[11] Kamthan, M. (2023). The Need for Health Emergency Law in India. In: Singh, A. (eds) International Handbook of Disaster Research. Springer, Singapore. https://doi.org/10.1007/978-981-19-8388-7_11

economic impact in addition to being crucial in controlling the COVID-19 outbreak. The Indian economy was severely impacted by the implementation of these regulations, especially the national shutdown. For the first time in more than 40 years, India's GDP shrank by 7.3% during the 2020–21 fiscal year. The economy shrank by 23.9% in the first quarter of the fiscal year, when the effects were most noticeable. Due to the lockdown, which stopped all economic activity, trade, manufacturing, and services all experienced severe declines.[12]

Many jobs were lost as a result of the abrupt shutdown, especially in the informal sector, which employs a sizable portion of the labour force in India. From 7.6% in March 2020 to around 24% in April 2020, the jobless rate increased dramatically.[13] Due to the loss of millions of migrant workers jobs, there was a significant reverse migration to rural areas. These workers and their families were under tremendous financial duress, which emphasizes the need for stronger social safety nets.

In addition to causing significant misery, the COVID-19 pandemic in India also disrupted society and the economy. An estimated 0.45 million people perished from COVID-19 infections up until October 2021, which affected 34.3 million individuals. A public assessment of the condition of the health system was one of the pandemic's defining characteristics. Was India's healthcare system equipped to handle a widespread pandemic? What financial consequences resulted from the lockdown put in place to contain the pandemic? And where does India's public healthcare system stand now?

(a) Was India's healthcare system equipped to handle a widespread pandemic?

The inability to treat COVID-19 pandemic affected individuals will be significantly hampered by a shortage of skilled physicians, nurses, and support personnel. It takes time to overcome years of neglect.

The question that needs to be addressed is how to combat the COVID-19 pandemic. Which possibilities do we have for policy? Several short- and long-term tactics have already been implemented.

The more expensive private sector, which serves both rural and urban areas and provides an estimated 75% of health services, dominates India's healthcare system. In contrast to most other nations, India spends a far less percentage of its GDP on public healthcare. Concerns regarding healthcare quality, affordability, and equity have led to legitimate criticism of the private sector's hegemony in India, given its significantly lower level of regulation. Compared to the majority of other developing nations, patients in the private sector spend a far larger percentage of their income out of pocket. A 2010 study estimates that the cost of out-of-pocket healthcare in India caused 63.22 million people to fall below the poverty level in 2004.[14] The primary reason for the spread of a disease such as COVID-19 is that a large number of people will not be able to pay private treatment or testing, and public (and some private) hospitals will probably not be as equipped to get the equipment they need in a timely manner.

Along with a clear urban-rural gap, there are also major socioeconomic discrepancies in terms of equitable access to high-quality healthcare, including caste, class, and gender. Compared to underfunded public health facilities in rural regions, where over 60% of India's population resides, cities and urban areas, which boast a more developed private healthcare system, are better equipped to handle demands for extensive testing and treatment.[15]

When considering more general reports from India's medical sector regarding the lack of access to essential medical equipment and facilities for both those receiving and delivering treatment, these disparities are exacerbated in response to COVID-19. To yet, it is not evident how the central government of India intends to address the problems caused by a more unequal and commercialized healthcare system. In addition, a large number of states are about to reach a financially precarious situation where they will be unable to increase spending on improving public health capabilities absent intervention from the federal government.

To fight against the COVID-19 pandemic, India still needs to ensure community-based testing, tracing and treating patients at a large scale, all of which require a radical overhaul in the existing asymmetric model of healthcare delivery across the states.

(b) What financial consequences resulted from the lockdown put in place to contain the pandemic?

[12] https://www.hindustantimes.com/business-news/expert-views-india-s-economy-shrinks-record-23-9-in-first-quarter/story-GA2FU4kQ3P8hlahs1iW3SP.html

[13] https://www.bbc.com/news/world-asia-india-52559324

[14] Berman, P., Ahuja, R. & Bhandari, L. The impoverishing effect of healthcare payments in India: new methodology and findings. Econ. Polit. Wkly. 45, 65–71 (2010).

[15] Banerjee, S. Determinants of rural-urban differential in healthcare utilization among the elderly population in India. *BMC Public Health* **21**, 939 (2021). https://doi.org/10.1186/s12889-021-10773-1

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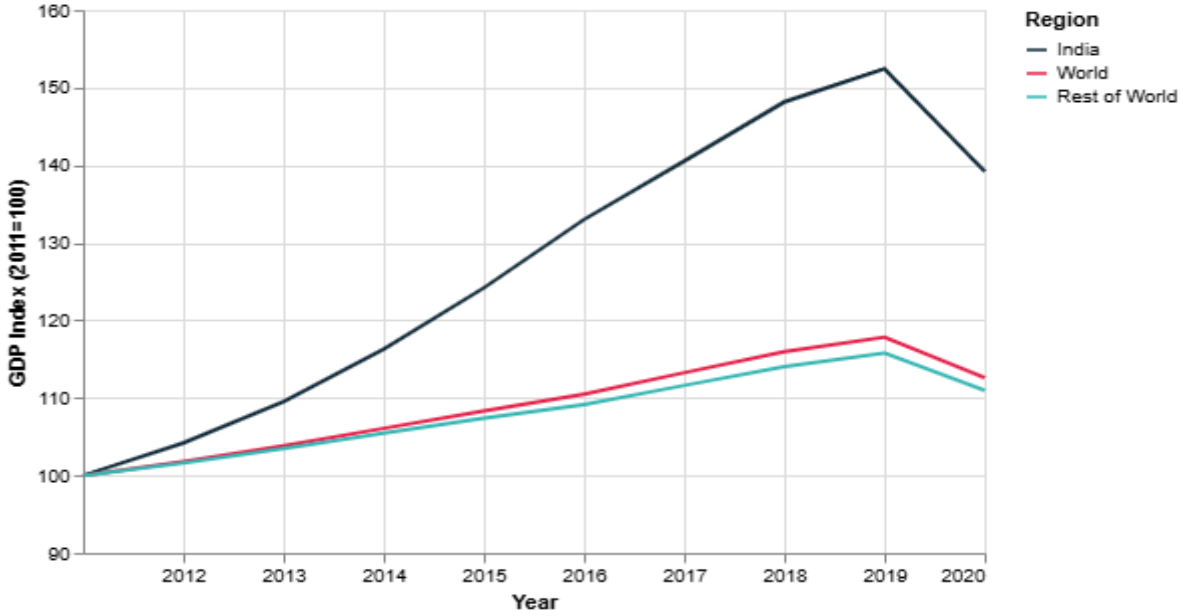
The financial consequences of the lockdown imposed to contain the COVID-19 pandemic in India were profound and multifaceted. The abrupt halt in economic activities led to a significant contraction in GDP, with the economy shrinking by 23.9% in the first quarter of FY2020-21 and by 7.3% for the entire fiscal year.[16] Unemployment rates soared, reaching 24% in April 2020, disproportionately affecting informal workers and leading to mass reverse migration. Various sectors, including manufacturing, services, and MSMEs, faced severe disruptions and liquidity crises, with many businesses shutting down temporarily or permanently. Supply chain disruptions caused shortages of essential goods and inflationary pressures, notably in food prices. Despite government relief measures, such as the Pradhan Mantri Garib Kalyan Yojana and the Atmanirbhar Bharat package, the economic strain highlighted significant vulnerabilities and the need for robust financial resilience and strategic policy responses to mitigate future crises.

Several assistance packages were launched by the Indian government in an attempt to lessen the economic impact. The vulnerable population received direct cash transfers, free food grains, and other benefits through the ₹1.7 lakh crore Pradhan Mantri Garib Kalyan Yojana (PMGKY). The goal of the ₹20 lakh crore Atmanirbhar Bharat package was to boost the economy by implementing a number of incentives, financial support programs, and reforms. Furthermore, the government allocated ₹15,000 crore for medical supplies, infrastructure, and immunisation programs, a major boost in healthcare spending.

c.) Where does India's public healthcare system stand now?

India's public healthcare system, post-pandemic, stands at a pivotal point marked by significant improvements and ongoing challenges. Increased budget allocations and investments have enhanced healthcare infrastructure and facilitated one of the world's largest COVID-19 vaccination drives. Initiatives like the National Digital Health Mission aim to modernize healthcare delivery. However, the system still grapples with disparities in healthcare access between urban and rural areas, a shortage of healthcare professionals, and a high burden of non-communicable diseases. While schemes like Ayushman Bharat and Health and Wellness Centers are steps toward reducing out-of-pocket expenses and improving primary healthcare, sustained efforts are needed to ensure comprehensive, equitable, and quality healthcare across the nation.

Figure: Economic contraction in India and the world during Covid-19



Source: World Economic Outlook, International Monetary Fund, April 2021.

Note: The gross domestic product (GDP) per capita, constant prices is measured at purchase power parity; 2017 international dollars. the GDP per capita of each series is normalised to 100 in 2011. We use population-weighted average as the aggregation method.

[16] https://www.imf.org/-/media/Files/Publications/WEO/2020/October/English/ch2.ashx

Way forward.

In order to stop the entry, spread, and occurrence of infectious illnesses in India, stronger legal frameworks are required. With respect to addressing the emergence and resurgence of communicable diseases in the nation, the over a century-old Epidemic Diseases Act 1897 is severely limited, particularly in light of the evolving public health landscape. Numerous states have created their own public health laws over time, and some have modified the provisions of their Acts pertaining to epidemic diseases. These Acts content and quality, may differ most only deal with 'policing' measures meant to contain epidemics, they don't address coordinated, scientific approaches to stop and contain outbreaks. For the purpose of controlling epidemics in India, a comprehensive, actionable, and pertinent legal provision is required. This provision should be formulated with a rights-based, people-focused, and public health-oriented approach. One such piece of proposed legislation is the draft National Health Bill 2009; however, it is still in the long gestation stage and its future is uncertain.

As India grapples with future health crises, policymakers must revisit and strengthen existing legal frameworks, ensuring their adaptability to evolving challenges. Simultaneously, investments in healthcare infrastructure, social safety nets, and targeted policy interventions are essential to mitigate the adverse effects on vulnerable populations. By integrating legal, economic, and healthcare considerations, India can better navigate public health emergencies while safeguarding both the well-being of its citizens and the nation's economy.

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