GOVERNMENT OF INDIA

LAW COMMISSION OF INDIA

A COMPREHENSIVE REVIEW OF THE EPIDEMIC DISEASES ACT, 1897

Report No. 286

February, 2024

The 22nd Law Commission was constituted by Gazette Notification for a period of three years vide Order No. F No. 45021/1/2018-Admn-III(LA) dated 21st February, 2020 issued by the Government of India, Ministry of Law and Justice, Department of Legal Affairs, New Delhi. The term of the 22nd Law Commission was extended vide Order No. FA No. 60011/225/2022-Admn.III(LA) dated 22nd February, 2023.

The Law Commission consists of a Chairperson, three full-time Members, Member Secretary, two *Ex-officio* Members and two Part-time Members.

Chairperson

Hon'ble Justice Ritu Raj Awasthi

Full-time Members

Hon'ble Justice K.T. Sankaran

Prof. (Dr.) Anand Paliwal

Prof. D.P. Verma

Member Secretary

Dr. Reeta Vashishta

***Ex-officio* Member**

Dr. Rajiv Mani, Secretary, Legislative Department and Secretary, Department of Legal Affairs (Additional Charge)

Part-time Members

Shri M. Karunanithi

Prof. (Dr.) Raka Arya

Law Officers

Smt. Varsha Chandra, Joint Secretary & Law Officer

Shri Atul Kumar Gupta, Deputy Law Officer

Legal Consultants

Shri Rishi Mishra
Shri Gaurav Yadav
Shri Shubhang Chaturvedi
Ms. Priya Rathi
Ms. Ruchika Yadav
Ms. Deepika Chaudhary
Ms. Diksha Kalson
Shri Govind Gupta
Shri Kumar Abhishek
Ms. Shanivi Singh
Ms. Ritu Thomas
Ms. Shivangi Shukla
Dr. Taruna Solanki
Ms. Swikriti Mahajan
Shri Anubhav Dubey
Shri Animesh Pareek

The Law Commission is located at:
2nd and 4th Floor, 'B' Wing
Lok Nayak Bhawan, Khan Market
New Delhi-110 003.

The text of this Report is available on the Website at:

www.lawcommissionofindia.nic.in

Justice Ritu Raj Awasthi
(Former Chief Justice of High Court of Karnataka)
Chairperson
22nd Law Commission of India

न्यायमूर्ति ऋतु राज अवस्थी
(सेवानिवृत मुख्य न्यायधीश, कर्नाटक उच्च न्यायलय)
अध्यक्ष
भारत के 22वें विधि आयोग

D.O. No. 6(3) 339/2023-LC(LS) **Date:** 7th February, 2024

Hon'ble Sri Arjun Ram Meghwalji
Namaskar!

I am pleased to forward you **Report No. 286** of the Law Commission of India on **"A Comprehensive Review of the Epidemic Diseases Act, 1897".**

The COVID-19 pandemic unleashed an unprecedented challenge for the Indian health infrastructure. In the course of dealing with this crisis, certain limitations in the legal framework relating to health were realised. While the Government was quick to respond to the emerging situation, it was felt that a more comprehensive law could have enabled a better response to the crisis.

The immediate response to COVID-19 such as the imposition of lockdown was invoked under the Disaster Management Act, 2005. Further, in light of the immediate challenges, especially those faced by the healthcare workers, the Parliament amended the Epidemic Diseases Act, 1897 in 2020. However, these amendments fell short as critical gaps and omissions remained in the Act.

In this highly globalized and interconnected world, future outbreaks of epidemics are a real possibility. Further, given that the right to health is a fundamental right implicit in Article 21 of the Constitution and the State is duty-bound to ensure the same to the citizens, it becomes imperative to revisit and strengthen the law in order to effectively tackle any such future health emergency.

The 22nd Law Commission holds the view that the existing legislation exhibits significant deficiencies in addressing the containment and management of future epidemics in the country as new infectious diseases or novel strains of existing pathogens may emerge. Therefore, the absence of a comprehensive law specifically addressing severe epidemics, which have

कार्यालय पता : कमरा नं. 405, चतुर्थ तल, 'बी' विंग, लोक नायक भवन, खान मार्किट, नई दिल्ली–110003
Office Address : Room No. 405, 4th Floor, 'B' Wing, Lok Nayak Bhawan, Khan Market, New Delhi-110003
आवासीय पता : बंगला नं. 8, तीस जनवरी मार्ग, नई दिल्ली–110011
Residence : Bungalow No. 8, Tees January Marg, New Delhi-110011
email : rituraj.awasthi@gov.in Tel. : 011-24654951 (D), 24340202, 24340203

Justice Ritu Raj Awasthi
(Former Chief Justice of High Court of Karnataka)
Chairperson
22nd Law Commission of India

न्यायमूर्ति ऋतु राज अवस्थी
(सेवानिवृत मुख्य न्यायधीश, कर्नाटक उच्च न्यायलय)
अध्यक्ष
भारत के 22वें विधि आयोग

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

detrimental effects on the overall health and well-being of the population, necessitates immediate attention.

In light of the foregoing, the Law Commission *suo motu* undertook extensive examination of the existing legal framework on this subject. In the course of this analysis as well as in-depth deliberations, the Commission identified key shortcomings in the law. The Commission has recommended that either the existing law needs to be suitably amended to address existing gaps or a new comprehensive legislation be enacted on the subject. Accordingly, this Report is being submitted for your kind perusal.

With warmest regards,

Yours sincerely,

7.2.2024.

(Justice Ritu Raj Awasthi)

Shri Arjun Ram Meghwal
Hon'ble Minister of State (Independent Charge)
Ministry of Law & Justice
Government of India
Shastri Bhawan
New Delhi -110001.

कार्यालय पता : कमरा नं. 405, चतुर्थ तल, 'बी' विंग, लोक नायक भवन, खान मार्किट, नई दिल्ली–110003
Office Address : Room No. 405, 4th Floor, 'B' Wing, Lok Nayak Bhawan, Khan Market, New Delhi-110003
आवासीय पता : बंगला नं. 8, तीस जनवरी मार्ग, नई दिल्ली–110011
Residence : Bungalow No. 8, Tees January Marg, New Delhi-110011
email : rituraj.awasthi@gov.in Tel. : 011-24654951 (D), 24340202, 24340203

ACKNOWLEDGEMENT

The Commission wishes to extend its deepest gratitude to all those who have generously contributed to finalising this Report on "A Comprehensive Review of the Epidemic Diseases Act, 1897".

We would like to thank the Ministry of Health & Family Welfare for contributing to the Commission's understanding on the issue. In particular, we appreciate the efforts of Shri Subrata Hazra, Deputy Secretary and Shri Pradeep Khasnobis, DDG, DM Cell of the Ministry who took out their valuable time to furnish their comments and submissions on the subject at hand. We further extend our gratitude to Prof. Aditya Prasad Dash who shared his domain expertise and gave excellent insights on the subject.

The Commission also acknowledges the assiduous efforts of Mr. Rishi Mishra, Ms. Priya Rathi, Ms. Ruchika Yadav, Ms. Deepika Chaudhary, Mr. Govind Gupta, Ms. Ritu Thomas, Dr. Taruna Solanki, Mr. Anubhav Dubey, and Mr. Animesh Pareek, who worked as Legal Consultants. We applaud their valuable contribution towards the comprehensive research and drafting of this Report. We place on record our heartfelt admiration for the diligent and painstaking labour they have put in to materialise this Report.

TABLE OF CONTENTS

ABBREVIATIONS

&	and
AIR	All India Reporter
AHMAC	Australian Health Minister's Advisory Council
AHMPPI	The Australian Health Management Plan for Pandemic Influenza
AHPPC	Australian Health Protection Principal Committee
AIPH University	Asian Institute of Public Health University
art.	Article
AUSMATs	Australian Medical Assistance Teams
BNS	Bharatiya Nyaya Sanhita
CDINS	Communicable Disease Incident of National Significance
CDPLAN	The Emergency Response Plan for Communicable Disease Incidents of National Significance
CESCR	Committee on Economic, Social and Cultural Rights
COVID-19	Coronavirus disease of 2019
CSIR	The Council of Scientific & Industrial Research
CTMA	COVID-19 (Temporary Measures) Act, 2020
DCGI	Drug Controller General of India
D.Sc.	Doctor of Science
EDA	Epidemic Diseases Act
EHOC	Emergency Health Operations Centers
ICMR	Indian Council of Medical Research
ICSECR	International Covenant on Social, Economic and Cultural Rights
IDSP	Integrated Disease Surveillance Programme
IHR	International Health Regulations
IPC	Indian Penal Code
IT	Information Technology
MCO	Movement Control Order
MERS	Middle East Respiratory Syndrome
MHA	Ministry of Home Affairs
MoH&FW	Ministry of Health and Family Welfare
NABL	National Accreditation Board for Testing Calibration Laboratories

NatHealth Arrangements	National Health Emergency Response Arrangements
NDMA	National Disaster Management Authority
NDMP	National Disaster Management Plan
NHS Act	National Health Security Act 2007
NPPA	National Pharmaceutical Pricing Authority
NSC	National Security Council
NZHC	High Court of New Zealand
Ors.	Others
Ph.D.	Doctor of Philosophy
PPE	Personal Protective Equipment
PPP	Public-Private Partnerships
RRT	Rapid Response Teams
SARS	Severe Acute Respiratory Syndrome
SC	Supreme Court
SOP	Standard Operating Procedure
UK	United Kingdom
v.	Versus
WHO	World Health Organization

1. INTRODUCTION

1.1. The COVID-19 pandemic brought the entire world to a stand-still. It unleashed a challenge of an unprecedented magnitude on how to best manage the emerging crisis. Even the most trusted systems and resilient economies were overawed by the crisis that was unfolding before them. While measures were taken under the current legal framework, the same proved to be insufficient in some regards. This experience has brought to light the limitations of the existing international and national systems to respond to such emergencies. There is unquestionable need to develop adaptable systems at both national and international level in order to meaningfully respond and contain such pandemics in the future. Such resilient systems and capacity building are indispensable given that a new pandemic may hit the world at any time. As the World Health Organisation Chief Dr. Tedros Adhanom Ghebreyesus said in his address at the 76th World Health Assembly, "*When the next pandemic comes knocking – and it will – we must be ready to answer decisively, collectively, and equitably.*"

1.2. Countries being the constituent units in the global order, any meaningful and collaborative response requires national-level planning, operational preparedness, capacity building and coordination. Thus, it is imperative upon nations to reform their national laws and policy in order to best contain and respond to such infectious diseases if and when they emerge.

1.3. In the Indian context, going by the recent experience of managing the COVID-19 pandemic, it has been felt that the existing legal framework to deal with such health exigencies falls short. It is clear that significant changes are required to make the law holistic in its approach and functioning. A consolidated approach in coordination and planning is essential to prepare for an appropriate response to any epidemic. Law has to be an intrinsic part of the healthcare system and any insufficiency in the legal sphere to manage and control a public health emergency like an epidemic, needs to be addressed urgently. The COVID-19 pandemic has left an opportunity to re-examine and revise India's response to such epidemics in the future.

1.4. The terms of reference of the 22nd Law Commission *inter-alia* enjoin upon the Commission to make recommendations for the removal of anomalies, ambiguities and inequities in the law. In pursuance of the same, the 22nd Law Commission, *suo moto* engaged in a comprehensive review of the existing laws in India pertaining to epidemic diseases. The Commission undertook an in-depth perusal of the Epidemic Diseases Act, 1897,[1] International Health Regulations,[2] model Acts and draft bills,[3] and deliberated on various aspects of epidemic diseases. The Commission is of the opinion that there are some critical areas that require immediate attention. These aspects can be addressed through amendments in the existing Epidemic Diseases Act, 1897 such as by including certain important terms that are presently absent from the scheme of the Act and by incorporating

[1] Epidemic Diseases Act, 1897 (Act No. 3 of 1897).
[2] International Health Regulations, 2005.
[3] The Model Public Health Act, 1987; The National Health Bill, 2009; The Public Health (Prevention, Control and Management of epidemics, bio-terrorism and disasters) Bill, 2017.

effective planning measures, or by enacting a comprehensive legislation afresh.

1.5. During the course of this review, the Law Commission held a consultation with the Ministry of Health & Family Welfare (MoH&FW), wherein it was brought to the notice of the Commission that a Bill on Epidemic Diseases has been drafted in the year 2023 by the Ministry. The MoH&FW not only made the said draft Bill available to the Commission but also sought the Commission's suggestions on the same. The Law Commission after perusing the said Bill found some areas of improvement. In light of the same, the Commission is proposing various suggestions that may be taken into consideration while enacting an Epidemic Diseases Act afresh or while amending the existing Act.

A. Background

1.6. Legal frameworks serve as an extraordinary tool to promote individual well-being, social justice, economic development and overall stability of the nation.[4] Protection of the health of the people from epidemic diseases through a proper legal framework is of paramount importance because a healthy society is a key component of human development. India has witnessed the outbreak of many infectious diseases in the past.[5] Epidemiological studies on the

[4] Rule of Law and Development, *available at:* https://www.un.org/ruleoflaw/rule-of-law-and-development/ (last visited on January 26, 2024).

[5] V. R. Mahammadh, "Plague Mortality and Control Policies in Colonial South India, 1900–47" 40 *South Asia Research* 323-343 (2020), *available at:* https://journals.sagepub.com/doi/full/10.1177/0262728020944293 (last visited on January 26, 2024); Muhammad Umair Mushtaq, "Public Health in British India: A Brief Account of the History of Medical Services and Disease Prevention in Colonial India" 34 Indian Journal of Community Medicine 6–14

colonial period depict that between 1896 and 1921, millions of people fell prey to epidemic diseases.[6] This period marked by the successive spread of various diseases proved to be an alarming year for the Colonial Government which had to adopt measures for prevention of spread, disinfection of places as well as improvement of sanitary conditions.

1.7. The British Government enacted Epidemic Diseases Act, 1897 for the first time in response to the outbreak of bubonic plague in Bombay with the aim to ameliorate prevention of the spread of dangerous epidemic diseases. This law granted special powers to the Government to take measures to control the spread of epidemic diseases. The Act empowered the Government to take anti-plague measures. During this period, infected people were forced to segregate themselves and to evacuate the place in order to get that place disinfected.[7] Many historical evidences also reveal that while dealing with the outbreak of plague, infected places were demolished and this practice persisted till the end of the 19th century.[8]

1.8. Subsequently, even after independence, colonial-era legislation on epidemic diseases has continued to be in force and has been invoked to contain the spread of different infectious diseases such as Spanish

---

(2009), *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2763662/ (last visited on January 26, 2024).

[6] Suhail-ul-Rehman Lone, "What Epidemics from the Colonial Era Can Teach Us About Society's Response" *The Wire*, April 8, 2020, *available at:* https://thewire.in/history/colonial-era-epidemics-india (last visited January 27, 2024).

[7] Muhammad Umair Mushtaq, "Public Health in British India: A Brief Account of the History of Medical Services and Disease Prevention in Colonial India" 34 Indian Journal of Community Medicine 6–14 (2009), *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2763662/ (last visited on January 26, 2024).

[8] Prashant Kidambi, "'An infection of locality': plague, pythogenesis and the poor in Bombay, c. 1896-1905" 31 *Urban History* 249 (2004), *available at*: https://www.jstor.org/stable/44614117.

flu, cholera, swine flu, dengue, malaria, smallpox, Nipah, SARS etc. Over the years, this Act has been significant in shaping the legal response of the Government to various epidemics and infectious diseases. However, the 20th Law Commission of India in its 248th Report titled 'Obsolete Laws: Warranting Immediate Repeal', identified the Epidemic Diseases Act,1897 as one of the existing statutes that warrants further study with a view to assess its suitability for repeal.[9]

1.9. In the past, multiple incidents of disease outbreaks have escalated into an alarming situation and have prompted the Government to respond with proactive measures on prevention, control and management of diseases. A list of epidemics that have occurred in India have been provided below:

LIST OF MAJOR EPIDEMICS IN INDIA[10]

Year	Epidemic
1910-1911	Cholera
1918-1920	Spanish flu (Pandemic)
1974	Smallpox
1994	Plague
2002-2004	Severe Acute Respiratory Syndrome (Pandemic)
2006	Chikungunya

[9] Law Commission of India, "248th Report on Obsolete Laws: Warranting Immediate Repeal (Interim Report)" (September, 2014), *available at*: https://cdnbbsr.s3waas.gov.in/s3ca0daec69b5adc880fb464895726dbdf/uploads/2022/08/2022081643-1.pdf (last visited January 27, 2024).

[10] Abhisek Mishra, Bijaya Nanda Naik, et.al., "Covid-19: Catalyst for a Comprehensive Law to Combat Potential Pandemics in India" 7 *Indian Journal of Medical Ethics* 231 (2022), *available at*: https://doi.org/10.20529/IJME.2022.039 (last visited January 27, 2024).

2009	Swine flu
2018	Nipah
2020	COVID-19

1.10. Recently in 2020, in wake of the COVID-19 pandemic which wreaked havoc throughout the nation, the Epidemic Diseases Act, 1897 was invoked along with the Disaster Management Act, 2005, to control and contain the spread of the COVID-19 pandemic. To combat against COVID-19, the strategy of nationwide lockdown was adopted through regulated guidelines enforced under the Disaster Management Act, 2005 and Epidemic Diseases Act,1897. Another emerging aspect of this epidemic was the threat to their own health and physical safety that was being faced by the healthcare personnel. The healthcare personnel on account of their close proximity with the patients who had COVID-19, faced higher risk of contracting the virus themselves. Further, there were many reported incidents of hostilities against healthcare workers. In order to address these, amendments were introduced to the Epidemic Diseases Act, 1897 in the year 2020 by promulgation of the Epidemic Diseases (Amendment) Ordinance (later converted to Act) which included punitive actions for the offences against healthcare personnel within the ambit of the Act. Despite these amendments, the Epidemic Diseases Act, 1897 continues to have limitations and ambiguities.

1.11. A definitive and adaptive law on epidemic diseases plays a crucial role in safeguarding public health and provides the legal basis for public health interventions that prioritize the safety and well-being of the

community. The importance of a law with clear rules and regulations cannot be understated in a fight to prevent, manage and control epidemics such as COVID-19 and its new variants. Timely and coordinated responses are crucial to contain the spread of diseases and mitigate their impact on the population. Any policy paralysis cannot be afforded at such a critical point and can be avoided by the existence of a proper legal framework that provides a clear basis for government intervention. Since, measures to contain an epidemic may involve limitations on individual freedoms, such as restriction on movement etc., having clarity as to which authority may implement the same will bring in more legal certainty. Such clarity in law also helps in communicating the importance of individual as well as collective responsibility during the outbreak of an epidemic. The law dealing with public health exigencies must include provisions that are in consonance with public health needs, ethical considerations and ensuring that interventions are proportionate as well as respectful of individual rights.

1.12. Law is not static but dynamic. It continues to adapt and evolve so as to be relevant and effective in the face of social, economic, political and technological changes. Laws addressing public health and safety are no exception and must also evolve to respond to a changing environment. In a highly globalized and interconnected world, a pandemic such as COVID-19 may not be a one-off occurrence. Even if not on a global scale, infectious diseases may spread domestically at a faster pace on account of various factors such as increased mobility, trade etc. Therefore, it is of utmost importance that we revisit and update our laws on epidemics in tune with the present

realities. Further, continuous review of epidemic law ensures that such legal frameworks are well equipped to address the complexities of epidemic diseases and to protect public health effectively. The dynamic nature of epidemics, coupled with advancements in science, technology and global interconnectedness, necessitates that health laws should be adaptable and approaching to upcoming health emergencies. Aspects pertaining to appropriate resource allocation, funds, healthcare infrastructure and emergency response measures need to be focused on and specifically addressed. Nature of every epidemic may differ depending upon the underlying disease or virus. An understanding as to how the new disease is emerging and how the pathogens are mutating can assist in adopting the proper legal measures to effectively manage such outbreaks.

1.13. "Public health services in general and environment health services in particular, constitute a pure public good, and form a basic part of a country's developmental infrastructure.[11]The ultimate measure of effective public health service delivery is that nothing happens- no major disease outbreaks occur. Its hallmark is, planning to avert any serious potential threat".[12] Lessons learnt from previous epidemics and pandemic faced in the recent past reveal some areas for improvement in the legislative framework to respond against such emergent situations, which have been elaborately discussed in this Report.

---

[11] Monica Das Gupta, B R Desikachari, *et.al.*, "How Might India's Public Health Systems Be Strengthened? Lessons from Tamil Nadu" 45 *Economic and Political Weekly* 46-60 (2010), *available at*: http://www.jstor.org/stable/25664195 (last visited on January 30, 2024).

[12] *Id.*

2. EXISTING CONSTITUTIONAL AND LEGAL FRAMEWORK RELATED TO EPIDEMICS

2.1. In this globalized world marked by changing dynamics, the pattern of spread of diseases and its very nature has changed over the years. Diseases like COVID-19 pose a constant threat to the health care system and its management strategies. Due to the increase in international travel, migration from rural to urban spaces, global connectivity and ecological imbalances, the natural resources have also been left over-burdened. In the past, India has been successful in eradicating, eliminating or significantly reducing many diseases such as smallpox, polio and HIV. These successes are a direct result of effective measures taken by the health care system. However, responding to COVID-19 posed a significant challenge for the Country on account of the highly virulent nature of the disease as well as the sheer scale of its impact that was previously unseen.

2.2. Public health services are conceptually distinct from medical services.[13] The key focus of public health services is reducing a population's exposure to disease through various measures such as enforcing food safety and other health regulations; controlling vectors, keeping an eye on the water system and waste disposal; and providing health education to enhance individual health behaviours and increase public demand for improved public health outcomes.[14] While these services are largely invisible to the public, yet these are

[13] Monica Das Gupta, "Public Health in India: Dangerous Neglect" 40 *Economic and Political Weekly* 5159-5165 (2005).
[14] *Id.*

indispensable as any failure in public health system has grave consequences for the public in terms of illness, debility and death as well as significant economic costs.[15] Considering such ill effects, our founding fathers have provided enough safeguards in our Constitution to effectively deal with the health emergencies and protect the health of the people.

A. Constitutional Mandate Related to Health

2.3. The Seventh Schedule of the Constitution clearly enumerates the separate and joint legislative powers of the Centre and State legislature by dividing various subject matters in three separate lists *viz.* the Union List, the State List and the Concurrent List. Thus, there is a clear demarcation between various subject matters within the Constitution itself and power of the respective governments to legislate.[16]

2.4. 'Public Health and Sanitation' is mentioned under Entry 6 of the State list as provided in the Seventh Schedule. This empowers the State to legislate on the issues and concerns regarding public health and sanitation; hospitals and dispensaries in the State.[17]

2.5. Further, it is important to note that certain dimensions of "health" such as those related to economic and social planning, mental health, drugs, food safety, labour safety and welfare, prevention and control of

---

[15] *Id.*
[16] The Constitution of India, sch. VII.
[17] *Id*, Entry 6 of List II of Schedule VII.

communicable diseases or vectors affecting humans, medical profession, are covered within the purview of the Concurrent List in the Seventh Schedule. Thus, both the Centre and States share the authority to legislate on these subject matters as per Article 246.[18]

2.6. According to Entry 29 of the Concurrent List, Parliament and the State Legislative Assemblies are empowered to legislate for the purpose of 'prevention of the extension from one State to another of infectious or contagious diseases or pests affecting men, animals or plants.'[19]

2.7. The Constitution obligates the State to guarantee the right to health to all, without any discrimination. Similarly, the Directive Principles of State Policy, contained in part IV of the Constitution, mandate that the State shall endeavour to provide certain viable public health conditions, and promote the welfare of the nation and its people by securing a socially, economically and politically just social order.[20] Article 42 enjoins the State to provide for just and humane conditions of work and for maternity relief. Further, Article 47 places a duty on the State to raise the standard of living and to improve public health.

2.8. Article 21 of the Constitution guarantees the right to life and personal liberty. The judiciary has interpreted this right to include the right to live with human dignity. Right to health and its underlying determinants are intrinsically linked with the right to life and hence holistically conceived by the Constitution. The evidence can be found

[18] *Id*, List III of Schedule VII.
[19] *Id*, Entry 29 of List III of Schedule VII.
[20] *Id*, art. 38.

in various decisions of the Supreme Court. For instance, in *Francis Coralie Mullin* v. *Administrator, UT of Delhi.*,[21] the Supreme Court held that the right to life includes the right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter.

2.9. In *Bandhua Mukti Morcha* v. *Union of India & Ors.*,[22] the Hon'ble Supreme Court, on the anvil of Articles 39(e), 39(f), 41 and 42 which form part of the Directive Principles of State Policy, held protection of health of workers to be included within the ambit of Article 21.

2.10. In *Vincent Panikurlangara* v. *Union of India*,[23] the apex Court highlighted that "*maintenance and improvement of public health have to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends on the building of the society which Constitution makers envisaged.*"

2.11. In *C.E.S.C. Ltd.* v. *Subhash Chandra Bose*,[24] the Hon'ble Supreme Court relied on international instruments and held that "*The term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensures 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 labour, to keep him physically fit and*

---

[21] AIR 1981 SC 746.
[22] AIR 1984 SC 802.
[23] AIR 1987 SC 990.
[24] AIR 1992 SC 573 : (1992) 1 SCC 441.

mentally alert for leading a successful, economic, social and cultural life...."[25]

2.12. In *Consumer Education and Research Centre* v. *Union of India,*[26] a wider interpretation to Article 21 of the Constitution was given by the Supreme Court. It was held that right to health of workers is an integral facet of a meaningful right to life. The Court further clarified that the right to health and medical care is a fundamental right under Article 21 read with Articles 39(e), 41 and 43 of the Constitution.

2.13. In *State of Punjab* v. *Ram Lubhaya Bagga,*[27] the Supreme Court observed that "*When we speak about a right, it correlates to a duty upon another, individual, employer, government or authority. In other words, the right of one is an obligation of another. Hence the right of a citizen to live under Article 21 casts obligation on the State. This obligation is further reinforced under Article 47, it is for the State to secure health to its citizen as its primary duty. No doubt the Government is rendering this obligation by opening government hospitals and health centres, but in order to make it meaningful, it has to be within the reach of its people, as far as possible, to reduce the queue of waiting lists, and it has to provide all facilities for which an employee looks for at another hospital. Its upkeep, maintenance and cleanliness has to be beyond aspersion. To employ the best of talents and tone up its administration to give effective contribution. Also bring in awareness in welfare of hospital staff for their dedicated*

---

[25] *Id.*
[26] AIR 1995 SC 922 : (1995) 3 SCC 42.
[27] AIR 1998 SC 1703 : (1998) 4 SCC 117.

service, give them periodical, medico-ethical and service-oriented training, not only at the entry point but also during the whole tenure of their service. Since it is one of the most sacrosanct and valuable rights of a citizen and equally sacrosanct sacred obligation of the State, every citizen of this welfare State looks towards the State for it to perform its this obligation with top priority including by way of allocation of sufficient funds. This in turn will not only secure the right of its citizen to the best of their satisfaction but in turn will benefit the State in achieving its social, political and economical goal....."

2.14. In *Ashwani Kumar* v. *Union of India*,[28] the Supreme Court, while expansively reading the right to life under Article 21, held that right to life encompasses several rights including the right to health which is basic and fundamental. It was further held that the State is obligated to ensure that this fundamental right is protected, enforced and made available to all citizens.

2.15. Several other decisions have also reiterated that right to health is implicit in Article 21 and have underscored the significance of this fundamental right as well as shed light on its various facets.[29]

2.16. Thus, the health of people is entrenched within the constitutional mandate, emphasizing its utmost significance. Further, Article 253

---

[28] (2019) 2 SCC 636.

[29] *Balram Prasad* v. *Kunal Saha*, (2014) 1 SCC 384 : (2014) 1 SCC (Civ) 327; *State of Punjab* v. *Mohinder Singh Chawla*, (1997) 2 SCC 83 : 1997 SCC (L&S) 294; *Devika Biswas* v. *Union of India*, (2016) 10 SCC 726; *Arjun Gopal* v. *Union of India*, (2017) 16 SCC 280; *Union of India* v. *Moolchand Kharaiti Ram Trust*, (2018) 8 SCC 321; *Arjun Gopal* v. *Union of India*, (2019) 13 SCC 523 : (2019) 4 SCC (Cri) 598 : (2020) 1 SCC (Civ) 409; *Occupational Health & Safety Assn.* v. *Union of India*, (2014) 3 SCC 547; *T.N. Medical Officers Assn.* v. *Union of India*, (2021) 6 SCC 568.

empowers the Parliament to enact laws in order to fulfil India's international obligations.

2.17. International treaties and agreements often influence domestic legal framework to facilitate cooperation. Along with national, collaborative efforts with international organizations and adherence to international health guidelines also helps in promoting and updating legal framework related to health. India is signatory to WHO's International Health Regulation.

2.15. The World Health Assembly adopted International Health Regulations (IHR) in 1969 which were revised in the later years. [30] Subsequently, IHR (2005) was adopted on 23rd May 2005 by the fifty-eighth World Health Assembly and it came into force on 15th June 2007. The IHR (2005) provides an overarching legal framework clearly defining rights and obligations of States in handling public health emergencies that have the potential to cross borders in order to ensure an adequate response.

2.16. The application of the IHR (2005) is not limited to specific diseases. This is to ensure that the regulations will maintain their relevance and applicability for a long time even in the face of continued evolution of diseases and of the factors determining their emergence and transmission.[31] The provisions in the IHR (2005) update and revise many of the "*technical and other regulatory functions, including*

---

[30] International Health Regulations, 2005, *available at:* https://www.who.int/publications/i/item/9789241580410.
[31] *Id.*

certificates applicable to international travel and transport and requirements for international ports, airports and ground crossings."[32]

B. Existing Legal Framework Related to Epidemic Diseases

2.17. The existing legal framework to deal with health exigencies such as epidemic diseases flow out of the Epidemic Diseases Act, 1897 which was enacted during the colonial era. Subsequently, the law has been amended to meet the evolving needs. Furthermore, various other legislative frameworks have also been proposed over the years so as to effectively respond to such crises. The relevant Act, proposals and amendments have been briefly outlined in the following paragraphs.

i. The Epidemic Diseases Act, 1897

2.18. The Epidemic Diseases Act (EDA) is the main legislation on the subject matter. The primary objective of EDA is preventing and controlling the outbreaks of epidemic diseases. The Act was passed urgently on 4th February, 1897, by the Governor General of India in order to empower the provincial authorities to control and contain bubonic plague of 1896. The EDA granted extensive powers to State Governments to regulate, prevent and control the dangerous epidemic diseases.

2.19. Originally, EDA consisted of four sections and was thus considered as one of the shortest laws in India. Thereafter, one more section was

[32] *Id.*

inserted by an amendment to the Act. The provisions contained in the EDA have been discussed in the following paragraphs.

2.20. Section 1 describes the title and extent of EDA. Section 2 provides power to the State Government to take special measures and to prescribe regulations as to dangerous epidemic disease. Section 2A empowers the Central Government to take measure and to prescribe regulations for the inspection of any ship or vessel leaving or arriving at any port in the territories or any person intending to sail therein or arriving thereby to which this Act extends.

2.21. Further, Section 3 provides punishment under Indian Penal Code, 1860 for disobeying any regulation or order made under EDA. Section 4 provides protection to persons acting in good faith under EDA from any other legal proceeding.

2.22. The object of the law signifies the purpose it is made for. In the absence of a properly defined object, a law cannot serve the ultimate purpose. This holds true especially of the EDA. Thus, the Epidemic Diseases Act, 1897 is a mere skeletal legislation conferring powers to Central and State Governments.

2.23. In addition to the EDA, different States and Union territories have also enacted their own public health laws and regulations. The provisions of these legislations have the potential to address region-specific challenges or emerging health crises.

ii. Other Relevant Legislative Proposals Related to Epidemic Diseases

2.24. **Model Public Health Act, 1987:** In order to bring a comprehensive legislation on public health including epidemics in its purview, many efforts have been made by the Government previously. One such step was the Model Public Health Act, 1987, which was drafted first in the year 1955 and updated later in the year 1987. While it is one of the comprehensive legislative proposals on public health, yet some of its provisions are outmoded as it is more than three decades old. The powers conferred to health officers under this Act were very general in nature to take appropriate measures to mitigate and to prevent a disease.

2.25. **National Health Bill, 2009:** Another step in the right direction was the National Health Bill, 2009 wherein a clear distinction between the obligations of Centre and State with regard to health was described. It also ideated the individual and collective right in the time of health emergency. However, it was not passed due to certain limitations. One of the major inadequacies was that the Bill did not list specific powers related to health emergencies.

2.26. **Public Health (Prevention, Control, and Management of Epidemics, Bio-Terrorism and Disasters) Bill, 2017:** To fill the gap in Epidemic Diseases Act, 1897 and to replace it with one comprehensive law, before the occurrence of COVID-19, a draft of Public Health (Prevention, Control, and Management of epidemics, bio-terrorism and disasters) Bill, 2017 was prepared by National

Centre for Disease Control and Directorate General of Health Services for the Ministry of Health & Family Welfare. Public comments were also invited on the draft Bill but it could not be tabled before Parliament. The draft Bill tried to define epidemic, bioterrorism and health emergencies. It envisaged the terms like social distancing, quarantine, clinical establishment, isolation and provided a schedule enumerating various categories of epidemic diseases. Further, it also empowered the local governments during situations like an epidemic.

iii. The Epidemic Diseases (Amendment) Act, 2020

2.27. In the light of COVID-19, a few amendments were introduced in the existing Epidemic Diseases Act, 1897 in the year 2020 vide the Epidemic Diseases (Amendment) Act, 2020.[33] A brief scheme of Epidemic Diseases Act, 1897 post the 2020 amendments has been enumerated below:

Epidemic Diseases Act, 1897 (As amended in 2020)

Provision	Description
Section 1	Short title and extent
Section 1A	Definition
Section 2	Power to take special measures and prescribe regulation as to dangerous epidemic disease
Section 2A	Powers of Central Government
Section 2B	Prohibition of violence against healthcare service personnel and damage to property

[33] The Epidemic Diseases (Amendment) Act, 2020 (Act 34 of 2020).

Section 3	Penalty
Section 3A	Cognizance, investigation and trial of offenses
Section 3B	Composition of certain offenses
Section 3C	Presumption as to certain offenses
Section 3D	Presumption of culpable mental State
Section 3E	Compensation for Acts of violence
Section 4	Protection to persons Acting under Act

2.28. The amended Epidemic Diseases Act, 1897 focused more on the protection of healthcare workers in the light of violence and other hostilities faced by healthcare workers during COVID-19. Although the amended Act gave a significant and required relief to the healthcare workers at a crucial time, however it misses out many points of consideration such as the criteria to declare a disease as epidemic, definitions of necessary terms, duties of citizens etc. to deal with such exigent situations.

2.29. It was not the first time that the Government took steps to bring forth suitable legislation to deal with epidemic diseases. As explained above, there have been efforts by the previous governments to make a comprehensive law on epidemics. In this regard, many private member bills were also drafted highlighting the urgent need of a new epidemic diseases law covering the considerable aspects such as health emergencies, definition of epidemic, surveillance systems, procurement of vaccines etc. However, none of these Bills could see the daylight in Parliament. Therefore, it is the need of the hour to have a single, consolidated legislation which is dedicated to the prevention,

control and management of epidemic diseases. Presently, legal mechanisms under the domestic arena are absent with a flexible, clear and unambiguous planning machinery to tackle health exigencies like epidemics. 'Public health' is a generic term whereas outbreak of epidemic/pandemic requires extra ordinary legal and health measures. Hence, the law related to epidemic diseases must be strengthened to address such emergent life-threatening situations.

3. LIMITATIONS OF THE EPIDEMIC DISEASES ACT, 1897

3.1. Given the shifting social patterns and growing population, the management, control and prevention of epidemic diseases cannot be restricted to a century old law. The law as it was originally enacted was not devised to meet the complex and manifold contingencies that are prevalent in contemporary society. The original Epidemic Diseases Act was enacted to implement anti-plague measures during the late 19th Century. Having been drafted by the British, the Act of 1897 had a great potential for abuse by the colonial authorities. The vast powers given by the Act during the colonial rule were misused and it did not succeed to address the actual intent of the enactment of Epidemic Diseases Act.[34] Over the years, the variants of communicable diseases have changed and mutated to bring forth new challenges for the healthcare system. With the increased globalization and connectivity, outbreaks of contagious and dangerous diseases can rapidly convert into epidemics and further into pandemics, thereby affecting several countries across the globe.

3.2. To strengthen the provisions of Epidemic Diseases Act 1897, a comprehensive legislation to enwrap all the modern-day challenges is the need of the hour. Although, during COVID-19, the Government introduced amendments in the Epidemic Diseases Act, 1897, however, the amendment only addressed the aspect of protection for healthcare workers. The amendment made in the year 2020, was only

[34] P.S. Rakesh, "The Epidemic Diseases Act of 1897: Public Health Relevance in the Current Scenario" 1 *Indian Journal of Medical Ethics* 156 (2016), *available at:* https://ijme.in/articles/the-epidemic-diseases-act-of-1897-public-health-relevance-in-the-current-scenario/ (list visited on January 27, 2024).

for a limited purpose and it did not deal with the other relevant issues, which remain unaddressed. Therefore, it is necessary to identify the major areas of concern that must be considered to make India's health emergency response robust in its operation and futuristic in its approach.

3.3. The Epidemic Diseases Act, 1897 (prior to the 2020 amendment) contained no definitions and merely stipulated regulatory powers of the Central and State Government. Even after the amendment in 2020, only 'act of violence', 'healthcare service personnel' and 'property' were specifically defined.

3.4. The Epidemic Diseases Act,1897, does not define an 'epidemic' disease or an 'infectious' disease. The existing Act does not differentiate between an 'outbreak', 'epidemic' and 'pandemic' due to which, there is no line of clarity on the criteria for declaring an epidemic and invoking the said Act. The Act is also silent on several other important definitions, which are necessary to understand the emergent health hazard and the measures to be taken thereby. Not defining terms specifically leaves ambiguity and thus the possibility of lack of planning and preparedness to effectively manage the epidemic.

3.5. The Epidemic Diseases Act does not appropriately decentralize and demarcate the power between the Centre, State and local authorities to regulate the epidemic situation. Currently, the Act confers very wide powers on Central and State authorities. Due to the absence of a proper enforcement mechanism as per the nature and gravity of the

epidemic disease, implementation of prevention and controlling measures get hampered, leading to uncoordinated response to combat epidemic diseases. Lack of uniformity in the implementation of various measures also lead to misconception and misinformation. The Act is silent with respect to superseding powers and thus there is no guidance as to whose power will supersede in case of disagreement or conflict between State(s) and the Centre. Such unbridled and incongruous powers may create ambiguity and conflicts during execution and management of epidemics. The Act does not define roles and responsibilities of various levels of the government in a succinct manner and does not provide statutory force to local governments.

3.6. The Epidemic Diseases Act does not specifically stipulate the procedure and guidelines that will be followed pertaining to isolation and quarantine. The Act is silent on identification of quarantine and isolation facilities. No proper criteria are mentioned in the Act which must be fulfilled before requisitioning a clinical establishment and converting it as an isolation or quarantine centre.

3.7. There are no specific guidelines mentioned in the Act for effective disease surveillance. India has developed an Integrated Disease Surveillance Programme (IDSP), whereby several surveillance units have been created across various States, which are managed by Rapid Response Teams (RRTs). The Programme also has a wide network of other data professionals and health experts who have the responsibility to conduct surveillance activities and manage the outbreak of epidemics. Since, IDSP is already effective throughout

the Country, therefore, the Epidemic Diseases Act should clearly give the power of disease surveillance under the system of IDSP. Moreover, there is a lack of explicit legal framework for data sharing. Sharing and collection of such data considering the principle of proportionality in designing such a framework can ensure better disease surveillance.

3.8. The disease surveillance system must be inter-connected with the functioning of diagnostic laboratories for early detection and effective tracking mechanism. The Act is silent on joint working of all the laboratories including independently established diagnostic labs and hospital aided laboratories.

3.9. Additionally, the Act lacks a synchronized framework between public and private diagnostic laboratories and fails to address the primary question as to who can conduct and regulate the diagnosis. During COVID-19, the Central Government by invoking the Disaster Management Act, 2005 appointed ICMR as the apex body for determining strategy for COVID-19 testing, which brought all the private laboratories within the purview of ICMR to conduct COVID-19 tests as well as to check commercial testing kits.[35] It is to be underscored that the delegation of power to ICMR by invoking Disaster Management Act lacks clarity on the ground that Drugs & Cosmetics Act, 1940 provides the power of approving diagnostic kits to Drug Controller General of India (DCGI). Moreover, ICMR levied

[35] Order F. No. Z.28015/23/2020-EMR, dated 21st March, 2020 of Ministry of Health and Family Welfare, Government of India, *available at*: https://www.mohfw.gov.in/pdf/NotificationoflCMguidelinesforCOVID19testinginprivatelaboratoriesiIndia.pdf (last visited on January 30, 2024).

many restrictions on private laboratories to conduct testing.[36] Gaps in regulatory framework leads to underutilization of the resource pool of the Indian healthcare system. Thus, there is a need for a proper mechanism for effective cooperation between public and private health care institutions during an epidemic. Since the private healthcare sector contributes significantly to deliver essential healthcare services, it is necessary to streamline private healthcare services for better utilization of available resources.

3.10. The Epidemic Diseases Act, 1897 needs to specify through a guided framework the regulation and the distribution channel of essential medicines, drugs and vaccines, price control of vaccines, medicinal drugs and other primary healthcare facilities. Currently, there is no specification in the Act which ensures the availability of essential vaccines and drugs during epidemic situations. The Act must focus on the Government's duties in controlling or regulating the production, distribution, transportation and storage of necessary vaccines, medicines and other medical equipment.

3.11. The Act makes no mention of specific regulations for the safe disposal of infectious medical waste and human corpses. Such infectious medical waste and human corpses may act as catalysts in spreading further infection and hence safe disposal of the same is required to be addressed under the Act. Although there are allied Acts and Bio-medical Waste Guidelines, the Epidemic Diseases Act should

[36] Guidelines for 'Strategy of Covid-19 testing in India', dated 17th March 2020, by Indian Council of Medical Research, *available at*: https://www.icmr.gov.in/pdf/covid/strategy/Strategy_COVID19_testing_India.pdf (last visited on January 30, 2024).

nonetheless clearly give power to specific authorities for disposal of such medical waste and corpses in accordance with the guidelines, to be specified in the Act.

3.12. The Act is also silent on authentic information dissemination systems regarding epidemic diseases which become imperative to control further spread and to notify current status of disease. Any epidemic can be efficiently managed only with the cooperation of the Government and citizens. The primary responsibility of making the citizens aware about the epidemic situation, its consequences and ways to protect, is upon the government. A cue can be taken from the lessons learnt by South Korea, which in the wake of battling Middle East Respiratory Syndrome (MERS) updated its legal and policy framework with respect to disclosure, publication or restriction of information providing the basis for disclosing private information and cooperation between Central and local authority. 'Right to know' is guaranteed to the citizens of South Korea as per the Infectious Disease Prevention and Control Act of South Korea.[37] Thus, it is important that the legislation dealing with epidemics provides effective mechanisms or clear guidelines to properly disseminate information.

3.13. The Epidemic Diseases Act, 1897 provides for punishment under Section 188 of the Indian Penal Code, 1860 for disobeying any regulation or order made under this Act. This punishment was given a statutory force keeping in mind the nature of British rule, whereby citizens were punished for disobeying the Crown's orders. The

[37] Infectious Disease Prevention and Control Act, 2009 (Act No. 9847 of 2009); Quarantine Act, 2009 (Act No. 9846 of 2009).

provision of punishment against the person violating the provisions of the Act is outdated. In the present scenario, a fine of up to Rs. 1,000 or an imprisonment of up to six months may not prove to have sufficient deterrent effect.

4. LAWS ON EPIDEMIC DISEASES IN OTHER JURISDICTIONS

4.1 It is essential to acknowledge that health legislations, or similar laws in different countries, will differ depending on the unique circumstances of each nation, the specific public health challenges they face, and the evolving understanding of infectious diseases within that particular country. The global landscape is undergoing transformation due to the COVID-19 pandemic, impacting not just public health but also introducing significant changes in social, economic, and legal/constitutional aspects.

4.2 India is bound by its commitment as a signatory to numerous international human rights conventions and its active involvement in the World Health Organization. Notably, it has also pledged adherence to the WHO's International Health Regulations. Additionally, in the realm of infectious diseases, India is obligated to comply with the IHR and other guidelines promulgated by the WHO.[38]

4.3 The IHR of 2005 serves as regulatory standards that define the roles and responsibilities of member states of the WHO in managing public health emergencies of international concern.[39] The IHR 2005 aims to: "prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate

[38] World Health Organization, *Basic documents: forty-ninth edition* 28 (2020), *available at*: https://apps.who.int/gb/bd/pdf_files/BD_49th-en.pdf (last visited on January 30, 2024).
[39] Brigit Toebes, "International health law: An emerging field of public international law" 55 *Indian Journal of International Law* 299-328 (2015).

with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[40] Changes to IHR or Guidelines, which may be issued by WHO, could prompt countries to update their domestic legislation to align with international best practices. While implementing the IHR 2005, State parties are required to uphold the full respect for the dignity, human rights, and fundamental freedoms of individuals.[41]

4.4 In addition to the IHR 2005, India has also committed as a signatory to the International Covenant on Social, Economic and Cultural Rights ('ICSECR'). General Comment No. 14 on the ICSECR emphasizes the essential obligations of signatory States in ensuring the realization of the 'Right to Health' under the ICSECR. This includes the obligation to:

> *"(f) adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups."*[42]

4.5 This indicates that a rights-based legal framework capable of directing the State in fulfilling its public health responsibilities, including

---

[40] Foreword, International Health Regulations, 2005.
[41] International Health Regulations, 2005, art. 3(1).
[42] Committee on Economic, Social and Cultural Rights, "CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)" Doc E/C.12/2000/4 (August 11, 2000).

addressing epidemic diseases, constitutes an integral aspect of the State's international legal obligations regarding the right to health which encompasses entitlements to medical care and protection from illness.[43] Accordingly, it is the responsibility of the Indian State to fulfil the people's right "to the enjoyment of the highest attainable standard of physical and mental health."[44] This involves activities such as the 'prevention, treatment, and control of epidemic, endemic, occupational, and other diseases.'[45] Additionally, there is a duty to 'develop, strengthen, and maintain' capabilities for 'detecting, assessing, notifying, and reporting' disease occurrences, along with the capacity to 'respond promptly and effectively to public health risks and public health emergencies of international concern.'[46] Indeed, these international commitments are connected to constitutional obligations, and Article 253 of the Indian Constitution, granting Parliament the authority to legislate in line with international obligations, serves as the foundation for the enactment of a law addressing Public Health Emergencies to fulfil these commitments.

4.6 The authority necessary to confront significant threats to the countries does not necessarily have to involve declaring a state of emergency. Many countries have implemented laws to address different diseases, either within their health Acts or by enacting specific legislation aligned with their constitutional and legal principles. In fact, as highlighted by Ferejohn and Pasquino,[47] many countries adopt the

[43] *Vincent Panikurlangara* v. *Union of India and Ors.* AIR 1987 SC 990.
[44] International Covenant on Economic, Social and Cultural Rights., art. 12(1).
[45] International Covenant on Economic, Social and Cultural Rights., art. 12(2)(c).
[46] International Health Regulations, 2005, arts. 5, 13.
[47] John Ferejohn and Pasquale Pasquino, "The Law of the Exception: A Typology of Emergency Powers" 2 *Oxford University Press and New York University School of Law* 216-219 (2004).

legislative model, where emergencies are addressed through regular legislation that delegates "special and temporary powers to the executive." Further, in managing COVID-19, some nations even adopted a legislative model as this approach facilitates thorough legislative oversight of the executive's use of powers and establishes a predefined conclusion to that delegation. The United Kingdom, Malaysia, and Singapore followed this legislative model in response to COVID-19.[48]

4.7 For the purpose of this analysis, a few countries were selected based on the presence of pre-existing laws related to public health, infectious disease control, and disaster management. The study encompasses instances where existing legislation, including disaster management laws, was implemented in response to the COVID-19 pandemic. Additionally, the study considers situations where new legislations were specifically introduced to address the challenges posed by the COVID -19 pandemic, along with any amendments made to existing public health laws in order to combat COVID -19 effectively.

4.8 The table below shows how countries have used different sets of rules during the COVID-19 pandemic:

Countries	**Existing Legislations**	**Laws invoked or newly enacted to deal with COVID-19 pandemic**

[48] Li-ann Thio, "Singapore and Pandemic Regulation" (November 14, 2020), *available at*: SSRN: https://ssrn.com/abstract=3766066 (last visited on January 19, 2024).

UK	a. Public Health (Control of Disease) Act, 1984 b. The Civil Contingencies Act, 2004.[49]	a. Coronavirus Act, 2020 b. Health Protection (Coronavirus) Regulations 2020 (revoked by the Coronavirus Act 2020 which largely made equivalent provision)
Singapore	a. The Immigration Act, 1959	a. COVID-19 (Temporary Measures) Act b. The Infectious Diseases (COVID-19 – Stay Orders) Regulation 2020
Malaysia	a. The Prevention and Control of Infectious Diseases Act, 1988 b. The Police Act, 1967	A series of Movement Control Order (MCO) were implemented utilizing the Prevention and Control of Infectious Diseases Act 1988 and the National Security Council (NSC) assumed the role of the coordinating body for the Cabinet and the executive branch's response to the COVID-19 situation.

[49] Joint Committee on Human Rights, UK Parliament "The Government's response to COVID-19: human rights implications" September 21, 2020, *available at*: https://publications.parliament.uk/pa/jt5801/jtselect/jtrights/265/26505.htm#_idTextAnchor005 (last visited on January 22, 2024).

Australia	a. Therapeutic Goods Act, 1989 b. The National Health Security Act, 2007 c. The Biosecurity Act, 2015	There exists a CDPLAN which has been developed under the auspices of the National Health Emergency Response Arrangements (NatHealth Arrangements 2009 and where no disease-specific plan exists, it is considered to be the primary response plan.
New Zealand	a. Civil Defence Emergency Management Act, 2002 b. Health Act, 1956 c. Epidemic Preparedness Act, 2006	a. COVID-19 Public Health Response Act 2020, b. Social Security (COVID-19 Income Relief Payment to be Income) Amendment Act 2020, c. Remuneration Authority (COVID-19 Measures) Amendment Act 2020, d. Overseas Investment (Urgent Measures) Amendment Act 2020, e. Imprest Supply (Third for 2019/20) Act 2020 (now repealed), f. COVID-19 Response (Taxation and Social

		Assistance Urgent Measures) Act 2020, g. COVID-19 Response (Taxation and Other Regulatory Urgent Measures) Act 2020.
Brazil	a. Law No. 6259 of 1975 (National Immunization Policy) b. Law 8080 of 1990 (Organic Health Law)	a. Federal Law No. 13,979 of 2020
South Africa	a. National Health Act, 2003	a. Disaster Management Act, 2002

A. United Kingdom

4.9 The Government of the United Kingdom released its Coronavirus action plan on March 3, 2020, outlining reasonable, appropriate, and evidence-based actions to combat the COVID-19 pandemic.[50] The

[50] Coronavirus: action plan: A guide to what you can expect across the UK, *available at*: https://www.gov.uk/government/publications/coronavirus-action-plan/coronavirus-action-plan-a-guide-to-what-you-can-expect-across-the-uk (last visited on January 22, 2024).

strategy also anticipated that legislative modifications might be required to provide public bodies throughout the United Kingdom with the resources and authority required to effectively respond to this disaster. As an initial measure in addressing the pandemic early on, the UK government responded to the pandemic early by introducing the Coronavirus Act, 2020, which on March 25, 2020 received Royal Assent and became law.[51] Corresponding regulations were also introduced under the Public Health (Control of Disease) Act, 1984.[52] Together, these two legislations have been indispensable in minimizing the transmission risk in communities, safeguarding the functionality of the NHS, and ultimately, saving lives. Public Health (Control of Disease) Act, 1984 is an Act to consolidate certain enactments relating to the control of disease and to the establishment and functions of port health authorities, including enactments relating to burial and cremation and to the regulation of common lodging–houses and canal boats, etc.[53]

4.10 Laws vary across different regions of the UK, and the COVID-19 legislations have been formulated to address their application in England, Wales, Scotland, and Northern Ireland. The majority of COVID-19 related laws are considered secondary legislations, created within the authority granted by primary legislation. For example,[54] the

[51] The Coronavirus Act, 2020, 2020 c. 7.
[52] Joint Committee on Human Rights, UK Parliament, "The Government's response to COVID-19: human rights implications" (September 21, 2020), *available at*: https://publications.parliament.uk/pa/jt5801/jtselect/jtrights/265/26505.htm#_idTextAnchor005 (last visited on January 22, 2024).
[53] Public Health (Control of Disease) Act 1984, c. 22.
[54] Coronavirus Legislation, *available at*: https://www.legislation.gov.uk/coronavirus (last visited on January 2, 2024).

two primary legislative elements encompassing emergency powers concerning Coronavirus and health protection in England are:

- Coronavirus Act, 2020
- Public Health (Control of Disease) Act, 1984

4.11. Similarly, the two primary legislative components containing emergency powers related to Coronavirus and health protection in Wales are:

- Coronavirus Act, 2020
- Public Health (Control of Disease) Act, 1984

4.12. Additionally, the four primary legislative components containing emergency powers relating to Coronavirus and health protection in Scotland are:

- Coronavirus Act, 2020
- Coronavirus (Scotland) Act, 2020: This legislation is designed to address the emergency created by the COVID-19 pandemic and works in tandem with and adds to the provisions of the Coronavirus Act 2020, which was enacted by the UK Parliament on March 25, 2020, and received consent from the Scottish Parliament on March 24, 2020.
- Coronavirus (Scotland) (No.2) Act, 2020: This legislation complements and enhances the provisions of the Coronavirus Act 2020, approved by the UK Parliament, and the Coronavirus (Scotland) Act 2020, ratified by the Scottish Parliament on April 1, 2020.

- Public Health etc. (Scotland) Act, 2008: This is an Act of the Scottish Parliament to restate and amend the law on public health; to make provision about mortuaries and the disposal of bodies; to enable the Scottish Ministers to implement their obligations under the International Health Regulations; to make provision relating to the use, sale or hire of sunbeds; to amend the law on statutory nuisances; and for connected purposes.

4.13. Likewise, the two primary legislative components encompassing emergency powers concerning Coronavirus and health protection in Northern Ireland are:

- Coronavirus Act, 2020
- Public Health Act (Northern Ireland), 1967: This legislation is designed to streamline and modify the statutes concerning the notification and prevention of specific infectious diseases, while also making amendments to certain laws pertaining to public health.

4.14. The Coronavirus Act provides England, Scotland, Wales, and Northern Ireland with the authority to effectively address the evolving COVID-19 pandemic, serving as a crucial facilitator of the government's strategy in combating the crisis.[55] The decision to set a two-year duration for this legislation aims to maintain its capabilities for a reasonable period without extending beyond necessity.[56]

[55] Department of Health, UK, "Coronavirus Act analysis", *available at*: https://www.health-ni.gov.uk/coronavirus-act-analysis (last visited on January 2, 2024).
[56] House of Commons Library, UK Parliament, "Coronavirus Bill: What is the sunset clause provision?" (March 20, 2020), *available at*: https://commonslibrary.parliament.uk/coronavirus-bill-what-is-the-sunset-clause-provision/ (last visited on January 11, 2024).

B. Singapore

4.15. The initial response of Singapore was based upon two statutes that were already existing. The first one was the Immigration Act, 1959, which was used to impose travel restrictions and the other one was the Infectious Diseases Act, 1976. Singapore already had a strong legislative framework as the law was already amended and expanded in 2003 after the SARS outbreak. The amendment in 2003 gave the power to investigate, prevent and contain outbreak of infectious disease to the Ministry of Health. Another set of amendments, passed in April 2003, expanded the scope of quarantine measures. Previously limited to hospitals and other 'suitable' locations, the amendments now included the option for 'home quarantine.' This allowed health authorities to isolate and monitor individuals with infectious diseases within their homes.[57]

4.16. The Government of Singapore realized the need of a further realistic model of legislation and passed the much-needed COVID-19 (Temporary Measures) Act, 2020 i.e., CTMA on an urgent basis.[58] The CTMA introduced temporary measures to offer relief to individuals and businesses facing financial distress. It also addresses various private and public law aspects of the crisis by amending statutes like the Bankruptcy Act and the Companies Act. In terms of public law, the CTMA empowered the Minister of Health to issue control orders if there is a substantial threat to public health due to the

---

[57] Jaclyn L. Neo and Darius Lee, "Singapore's Legislative Approach to the Covid-19 Public Health 'Emergency'" *VerfBlog* (April 18, 2020), *available at,* https://verfassungsblog.de/singapores-legislative-approach-to-the-covid-19-public-health-emergency/ (last visited on January 6, 2024).

[58] 94, *Parliamentary Debates*, on April 7, 2020, *available at*: https://sprs.parl.gov.sg/search/#/sprs3topic?reportid=bill-intro-384 (last visited on January 16, 2024).

spread of COVID-19 in the community. These orders could involve restrictions on movement, closure of premises, limitations on business activities, and the prohibition or restriction of events or gatherings. Additionally, the CTMA allowed the court proceedings to be conducted using remote conferencing technology, adapting the legal system to the challenges posed by the pandemic. The CTMA granted the executive, particularly the Minister for Health, powers to enact the control orders. These orders may include restrictions on leaving specific places, regulating movement and contact between individuals, closing premises, controlling business activities, and managing events or gatherings.[59]

4.17. During the outbreak of COVID-19, the Government of Singapore promulgated two regulations under the Infectious Diseases Act, 1976. The executive rule-making power played an important role while dealing with the COVID-19 situation as the regulations were introduced through subsidiary legislation. The Control Order Regulations established restrictions which included:[60]

- Restriction of movement outside the country,
- Prohibition on gatherings of persons except living in same household,
- Criminalization of certain acts which violated social distancing.

4.18. Another regulation, the Infectious Diseases (COVID-19–Stay Orders) Regulation 2020, was introduced which laid guidelines for social

[59] Covid-19 (Temporary Measures) Act 2020, s. 34(1).
[60] Jaclyn Neo and Shirin Chua, "Singapore: Legal Response to Covid-19" *The Oxford Compendium of National Legal Responses to Covid-19* (May 2022), available at: https://oxcon.ouplaw.com/display/10.1093/law-occ19/law-occ19-e30 (last visited on January 27, 2024).

distancing. It prohibited organizing certain events and also prohibited gatherings of more than 10 persons. A strict fine of $10,000 or imprisonment of up to 6 months were prescribed for the violation of the same.[61]

4.19. Another subsidiary legislation[62] was introduced by the Ministry of Health which laid specific rules and regulations for the protection of migrant workers. It is also noteworthy that Singapore has a huge population of migrant workers. About 300,000 migrant workers live in dormitories, usually from China and other South Asian countries. [63]

4.20. There were more than 28 regulations that were passed under the CTMA to cover a broad range of issues which arose due to the COVID-19 outbreak. The Executive through its power had also established Multi-Ministry Taskforce to coordinate Singapore's response to the pandemic.[64]

C. Malaysia

4.21. To enhance the Ministry of Health efforts in keeping the spread and mortality due to COVID-19, under control, a Movement Control

---

[61] Covid-19 (Temporary Measures) Act 2020, ss. 34(7), 35(11); 94, *Parliamentary Debates*, on April 7, 2020 *available at*: https://sprs.parl.gov.sg/search/#/sprs3topic?reportid=bill-intro-384 (last visited on January 16, 2024).

[62] (Temporary Measures) (Foreign Employee Dormitories – Control Order) Regulations 2020 ('Foreign Employee Dormitories Regulations').

[63] Rebecca Wai, "Singapore's Response to COVID-19, An explosion of cases despite being a 'Gold Standard'" in Scott L. Greer, Elizabeth J. King et.al. (eds.), *Coronavirus Politics: The Comparative Politics and Policy of COVID-19* 163 (University of Michigan Press, 2021), *available at*: https://www.jstor.org/stable/10.3998/mpub.11927713.11 (last visited on January 30, 2024).

[64] Timothy Goh, "Singapore sets up task force to deal with Wuhan virus, MOH advises against travel to Chinese city", *The Straits Times*, January 23, 2020.

Order (MCO) was implemented on March 18, 2020 under the Prevention and Control of Infectious Diseases Act, 1988 and the Police Act, 1967 to control the spread of the virus.[65]

4.22. In Malaysia's efforts to address the challenges posed by COVID-19, two primary mechanisms, one legislative and the other executive, were identified. The legislative aspect involves the utilization of the Prevention and Control of Infectious Diseases Act, 1988 by the Federal Government. This legislation has been invoked to declare a series of Movement Control Orders (MCOs) nationwide. Under the Act, the Minister for Health is empowered to designate any area within Malaysia as an 'infected local area' and prescribe, through executive-issued subsidiary legislation, the necessary measures to control or prevent the spread of infectious diseases. The Act also grants extensive authority to authorized officers, allowing them to instruct individuals to undergo isolation, observation, treatment, or surveillance, and to implement 'any other measures deemed necessary by the authorized officer to control the disease.'[66]

4.23. The executive component involves the National Security Council (NSC), which has assumed the role of the coordinating body for the Cabinet and the executive branch's response to the COVID-19 situation. The Senior Minister (Defence and Security Cluster) had

---

[65] Yin Shao Loong and Wan Amirah Wan Usamah, *The Malaysian Economy and Covid-19: Policies and Responses from January 2020 – April 2021*, UNCTAD/BRI PROJECT/RP30, June 2022, *available at*: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://unctad.org/system/files/official-document/BRI-Project_RP30_en.pdf (last visited on January 29, 2024).

[66] Wilson Tay Tze Vern, "Law-making and accountability in responding to COVID-19: The case of Malaysia", *Melbourne Forum on Constitution-Building, available at*: https://law.unimelb.edu.au/__data/assets/pdf_file/0008/3473765/MF20-Web2-Malaysia-WTay-FINAL.pdf (last visited on January 2, 2024).

become the de facto spokesperson for the NSC, regularly conveying the Federal Government's agenda, strategy, and directives through daily interactions with the mass media. Simultaneously, the Director-General of the Ministry of Health conducted daily briefings to address operational matters, such as the daily count of infections, the locations of new infection clusters, the condition of healthcare facilities, and updated best practices that the public was expected to follow.[67]

4.24. In general, the legislative and executive mechanisms appeared to operate effectively as Malaysia managed the crisis without the need to declare a state of emergency or turn to security legislation such as the National Security Council Act, 2016.[68]

D. Australia

4.25. As a signatory, Australia has a range of obligations, including reporting and maintaining certain core capacities at designated points of entry. The Australian Government Department of Health is responsible for planning for the management of national health emergencies. Part of this responsibility is planning how the health sector will respond to and manage communicable disease outbreaks, epidemics or pandemics that threaten to impact human health and

[67] Ain Umaira Md Shah, Syafiqah Nur Azrie Safri, *et.al.*, "Covid-19 Outbreak in Malaysia: Actions Taken by the Malaysian Government" 97 *International Journal of Infectious Diseases* 108-116 (2020), *available at*: https://doi.org/10.1016/j.ijid.2020.05.093 (last visited on January 29, 2024).

[68] Azmil Tayab and Por Heong Hong, "Malaysia: Improvised Pandemic Policies and Democratic Regression", in Victor V. Ramraj (ed.), *Covid-19 in Asia: Law and Policy Contexts* 321–334 (Oxford Academic, January 21, 2021), *available at*: https://doi.org/10.1093/oso/9780197553831.003.0022 (last visited on January 29, 2024).

result in increased demand for health service delivery and healthcare workers.

4.26. The Emergency Response Plan for Communicable Disease Incidents of National Significance (CDPLAN) was developed by the Communicable Diseases Network Australia, a standing committee of the Australian Health Protection Principal Committee. CDPLAN was endorsed by the Australian Health Protection Principal Committee on 11th August, 2016.[69] CDPLAN has been developed under the auspices of the National Health Emergency Response Arrangements (NatHealth Arrangements 2009).[70]

4.27. Where disease-specific plans exist, such as the Australian Health Management Plan for Pandemic Influenza (AHMPPI)[71] and the National Polio Emergency Response Plan,[72] these are the primary plans used in response to specific incidents.

---

[69] Australian Health Protection Principal Committee, Department of Health, Australian Government, "Emergency Response Plan for Communicable Disease Incidents of National Significance", September 2016, *available at*: https://www.health.gov.au/sites/default/files/documents/2022/07/emergency-response-plan-for-communicable-diseases-of-national-significance-cd-plan.pdf (last visited on January 16, 2024).

[70] Australian Health Protection Committee, Department of Health and Ageing, Australian Government, "National Health Emergency Response Arrangements", November 2011, *available at*: https://www.health.gov.au/sites/default/files/documents/2020/05/national-health-emergency-response-arrangements.pdf (last visited on January 16, 2024).

[71] Department of Health and Aged Care, Australian Government, "Australian Health Management Plan for Pandemic Influenza (AHMPPI)", *available at*: https://www.health.gov.au/resources/publications/australian-health-management-plan-for-pandemic-influenza-ahmppi?language=en (last visited on January 16, 2024).

[72] Office of Health Protection, Department of Health, Australian Government, "Poliovirus Infection Outbreak Response Plan for Australia" January 23, 2019, *available at*: https://www.health.gov.au/sites/default/files/documents/2022/05/poliovirus-infection-outbreak-response-plan-for-australia.pdf (last visited on January 16, 2024).

4.28. Where no disease-specific plan exists, CDPLAN[73] is considered the primary response plan. The objective of this plan is to:

- Describe the context within which the Australian Government Department of Health and state and territory government health departments will function during any national communicable disease related emergency.
- Clarify roles and responsibilities of the Commonwealth and state and territory health authorities including inter-jurisdictional committees and decision-making bodies.
- Describe the mechanisms through which a communicable disease incident of national significance (CDINS) is declared, how this plan will be escalated and stood down.
- Describe preparedness and response measures that may be taken by the public health and healthcare system in anticipation of, or during a CDINS.

4.29. Key areas of legislation in the health and emergency sectors include:

- **The Biosecurity Act, 2015:**[74] This Act authorizes activities used to prevent the introduction and spread of target diseases into Australia. People reasonably suspected to have, or have been exposed to these diseases can be ordered to comply with a range of control activities including observation, examination, segregation and isolation. The Governor-General has the power to

[73] Australian Health Protection Principal Committee, Department of Health, Australian Government, "Emergency Response Plan for Communicable Disease Incidents of National Significance", September 2016, *available at*: https://www.health.gov.au/sites/default/files/documents/2022/07/emergency-response-plan-for-communicable-diseases-of-national-significance-cd-plan.pdf (last visited on January 16, 2024).
[74] Biosecurity Act, 2015 (Act No. 61, 2015).

authorize a broad range of actions to respond to an epidemic (within the scope of the Act).

- **The National Health Security Act, 2007:**[75] This Act authorizes the exchange of public health surveillance information (including personal information) between the Commonwealth, states and territories and the World Health Organization (WHO). The National Health Security Agreement supporting the NHS Act formalizes decision-making and coordinated response arrangements that have been refined in recent years to prepare for health emergencies.
- **Therapeutic Goods Act, 1989:**[76] This Act establishes a framework for ensuring the timely availability of therapeutic goods (i.e., medicines, medical devices and biological products) that are of acceptable quality, safety and efficacy/performance. There are provisions within the legislation that operate at an individual patient level and at a program level (such as the maintenance of a National Medical Stockpile) to allow for the importation and supply of products that have not been approved for use in Australia. These products may be required to deal with an actual threat to individual and public health caused by an emergency that has occurred or to prepare to deal with a potential threat to health that may be caused by a possible future emergency.
- **Disaster and Emergency Acts:** Each Australian jurisdiction has a disaster or emergency Act. These Acts outline broad emergency arrangements, conveying of special powers, arrangements for

[75] The National Health Security Act, 2007 (Act No. 174, 2007).
[76] Therapeutic Goods Act, 1989 (Act No. 21, 1990).

declaring a state of emergency and roles and responsibilities of lead and support agencies.[77]

- **Privacy Act, 1988:**[78] This Act enables information exchange between Commonwealth Government agencies, State and Territory Government agencies, private sector organizations, non-government organizations and others (including community health centres and local government) in an emergency or disaster for a permitted purpose.
- **Other legislations:** Agencies in other sectors will also have relevant legislation, such as the Migration Act 1958[79], the Air Navigation Act 1920[80] and the Social Security Act 1991[81].

E. New Zealand

4.30. As a member of the World Health Organization (WHO), New Zealand is bound by the International Health Regulations 2005 (IHR), without reservation, and has agreed to fully implement the regulations.[82]

4.31. According to various measures, New Zealand's handling of the COVID-19 situation, initially focused on elimination and later shifted

---

[77] Department of the Prime Minister and Cabinet, Australian Government, "Australian Government Crisis Management Framework", November 2022, *available at*: https://www.pmc.gov.au/sites/default/files/resource/download/australian-government-crisis-management-framework.pdf (last visited on January 17, 2024).
[78] Privacy Act, 1988 (Act No. 119, 1988).
[79] Migration Act, 1958 (Act No. 62, 1958).
[80] Air Navigation Act, 1920 (Act No. 50, 1920).
[81] Social Security Act, 1991 (Act No. 46, 1991).
[82] Ministry of Health, 'International Health Regulations 2005'; Ministry of Health, 'Background to the International Health Regulations' (updated December 2007); *Borrowdale* v. *Director-General of Health* (2020) NZHC 2090 (High Court of New Zealand) p. 37-42.

to mitigation, stands out as one of the most effective globally.[83] On March 25, 2020, a national state of emergency was proclaimed in accordance with the provisions of the Civil Defence Emergency Management Act, 2002.[84] In late March 2020, an epidemic notice declaring the occurrence of a COVID-19 outbreak was additionally issued under the Epidemic Preparedness Act, 2006.[85] In May 2020, the COVID-19 Public Health Response Act, 2020 was enacted to grant targeted emergency health powers for addressing the COVID-19 pandemic. This new framework was crafted to supersede the specific powers outlined in the Health Act, 1956 aimed at combating infectious diseases, although the latter powers were still retained.[86] The key avenues for the implementation of public health measures through executive rule-making have been the authority to issue health orders under the Health Act, 1956 and COVID-19 orders under the COVID-19 Public Health Response Act, 2020, respectively.[87]Although New Zealand benefits from factors like geographic isolation, a stable political environment, a robust Central Government, a history of dealing with crises, disasters, and a small

[83] Michael Baker and Nick Wilson, "New Zealand's Covid Strategy Was One of the World's Most Successful – What Can We Learn from It?" *The Guardian* (April 5, 2022), *available at*: https://www.theguardian.com/world/commentisfree/2022/apr/05/new-zealands-covid-strategy-was-one-of-the-worlds-most-successful-what-can-it-learn-from-it (last visited on January 22, 2024).

[84] Declaration of State of National Emergency by Minister of Civil Defence (March 25, 2020); Minister of Civil Defence, Declaration by Minister Extending State of National Emergency (March 31, 2020); Minister of Civil Defence, Declaration by Minister Extending State of National Emergency (May 5, 2020); Department of the Prime Minister and Cabinet, 'State of National Emergency and National Transition Period for Covid-19' (July 31, 2020).

[85] Epidemic Preparedness (Covid-19) Notice 2020 (March 24, 2020).

[86] J McLean, "Risk and Rule of Law" 16 *Policy Quarterly* 11 (2020).

[87] Dean Knight, "New Zealand: Legal Response to Covid-19" *The Oxford Compendium of National Legal Responses to Covid-19* (April 2021).

population, there are valuable lessons from its COVID-19 response that could be applied in different contexts.[88]

4.32. Health related relevant legislations in New Zealand are:

- **Health Act, 1956:** This Act contains a specific infectious diseases regime.[89] Amongst other things, the Act gives medical officers of health special directive powers in order to prevent the outbreak or spread of an infectious disease. These powers are activated when a state of emergency has been declared, an epidemic notice issued or when otherwise authority by the Minister of Health.[90] These special powers are traceable back to the turn of last century, then used to combat outbreaks of the plague, polio, and tuberculosis.[91]
- **Civil Defence Emergency Management Act, 2002:** The Civil Defence Emergency Management Act, 2002 is the primary 'all hazards' emergency regime. It allows for the declaration of states of national or local emergency, if an emergency has occurred or may occur.[92]
- **Epidemic Preparedness Act, 2006:** The Epidemic Preparedness Act, 2006 is a specific emergency legislation addressing epidemics, supplementing general civil defence legislation. An epidemic notice notifying an outbreak of COVID-19 was also

[88] Thomas Jamieson, "'Go Hard, Go Early': Preliminary Lessons from New Zealand's Response to Covid-19" 50 *American Review of Public Administration* 1 (2020), *available at*: https://journals.sagepub.com/doi/10.1177/0275074020941721 (last visited on January 16, 2024).
[89] Health Act 1956, part 3.
[90] Health Act 1956, s. 70.
[91] *Borrowdale* v. *Director-General of Health* (2020) NZHC 2090 (High Court of New Zealand), p. 52.
[92] Civil Defence Emergency Management Act, 2002, s. 4.

issued in late-March 2020 under the Epidemic Preparedness Act, 2006.[93]

- **COVID-19 Public Health Response Act, 2020:** This Act was passed in May 2020 to provide specific emergency health powers to combat COVID-19.[94] The new regime was designed to supersede the special powers to combat infectious diseases under the Health Act, 1956, although the latter powers remained available. The principal mechanism under the Act is the issue of COVID-19 orders, requiring people to comply with public health restrictions and measures. While the Health Act, 1956 regime had been practically effective, the COVID-19 Public Health Response Act, 2020 is more bespoke, containing a wider range of powers and is built on a more modern and robust deliberative framework. The new Act also avoids the doubts that had been raised about the legal underpinnings of some of the health orders made under the Health Act, 1956.[95] The COVID-19 Public Health Response Act 2020 is now the main legislative framework for imposing public health measures and numerous COVID-19 orders have been issued.[96]
- **Other legislations:** Other legislations were also passed to assist with the response. Six budget-related statutes provided some

---

[93] Gazette of New Zealand, 2020-go1368, "Epidemic Preparedness (Covid-19) Notice 2020" March 24, 2020, *available at*: Epidemic Preparedness (COVID-19) Notice 2020 - 2020-go1368 - New Zealand Gazette (last visited on January 22, 2024).

[94] C Geiringer, "The Covid-19 Public Health Response Act 2020" *New Zealand Law Journal* 159 (2020); J McLean, "Risk and Rule of Law" 16 *Policy Quarterly* 11 (2020); DR Knight, "Stamping Out Covid-19 in New Zealand" *Public Law* 241 (2021).

[95] New Zealand Parliament Debates on May 12th, 2020 *available at*: https://www.parliament.nz/en/pb/hansard-debates/rhr/combined/HansDeb_20200512_20200512_34 (last visited on January 22, 2024).

[96] COVID-19 Public Health Response Act 2020, *available at*: https://www.legislation.govt.nz/act/public/2020/0012/latest/LMS344134.html (last visited on January 19, 2024).

economic and social assistance;[97] a number of other bills provided further support or implemented temporary pandemic-related governance and administrative arrangements.[98]

F. Brazil

4.33. In response to COVID-19, the Brazilian federal government implemented various measures, first of which was the declaration of a state of Public Health Emergency of National Importance on January 10, 2020.[99] The Ministry of Health of Brazil activated the Emergency Health Operations Centres ('EHOC'), coordinated by the Health Surveillance Secretariat, to respond to COVID-19 emergency by coordinating action within the Unified Health System. The EHOCs were also required to advise States and the federal government and other health services with respect to contingency plans and response measures. [100]

4.34. After the identification of the first Coronavirus case in Brazil, the National Contingency Plan was published by the Ministry of Health on January 28, 2020 along with surveillance guidelines and

[97] Social Security (Covid-19 Income Relief Payment to be Income) Amendment Act 2020; Remuneration Authority (Covid-19 Measures) Amendment Act 2020; Overseas Investment (Urgent Measures) Amendment Act 2020; Imprest Supply (Third for 2019/20) Act 2020; Covid-19 Response (Taxation and Social Assistance Urgent Measures) Act 2020; Covid-19 Response (Taxation and Other Regulatory Urgent Measures) Act 2020.

[98] Parliamentary Counsel Office, 'Covid-19 Legislation', *available at*: https://www.pco.govt.nz/covid-19-legislation/ (last visited on January 19, 2024).

[99] Ordinance no. 188 of February 3, 2020, Brazil, *available at*: https://perma.cc/ZU3A-3UX5 (last visited on January 19, 2024).

[100] Julio Croda, "COVID-19 in Brazil: Advantages of a Socialized Unified Health System and Preparation to contain cases", The Journal of the Brazilian Society of Tropical Medicine (2020), *available at*: https://www.scielo.br/j/rsbmt/a/bwLKCs6ZfGhyFn3mp4RDhdQ/# (last visited on January 19, 2024).

recommendations for social distancing, hygiene practices, and the use of personal protective equipment.

4.35. COVID-19 was declared a public health emergency by Brazil on February 3, 2020 and the Ministry of Health approved the Federal Law No. 13,979 of 2020 (the Quarantine Law) to provide for measures to be determined by the States to respond to public health emergency arising from COVID-19, including isolation, quarantine, medical examinations and tests, medical treatments, use of personal protective masks, exhumation, cremation, corpse handling, restrictions on entry and exit from the country, interstate and intercity transportation.[101] Under this law, the people affected by the measures were assured of the right to be permanently informed about their health status and assistance to their family, right to receive free treatment, full respect for dignity, human rights and fundamental freedoms of people as recommended in Article 3 of International Health Regulations.[102]

4.36. The Supreme Court of Brazil also played an active role to prevent the spread of COVID-19 and ordered the Health Ministry to 'fully establish the daily dissemination of epidemiological data on the

---

[101] Law no. 13,979, of February 6, 2020, Brazil, *available at*: http://www.planalto.gov.br/ccivil_03/_ato2019-2022/2020/lei/L13979.htm (last visited on January 19, 2024).

[102] International Health Regulations, 2005, art. 3:

"1. The implementation of this Regulation will be carried out with full respect for the dignity, human rights and fundamental freedoms of people.

2. The implementation of this Regulation will comply with the Charter of the United Nations and the Constitution of the World Health Organization.

3. The implementation of this Regulation will comply with the goal of its universal application, for the protection of all peoples of the world against the international spread of diseases.

4. States have, according to the Charter of the United Nations and the principles of international law, the sovereign right to legislate and implement legislation in order to fulfill their own health policies. When exercising this right, they must observe the purpose of this Regulation."

COVID-19 pandemic, on the Ministry's website.' Orders were also passed to protect the indigenous population of Brazil from COVID-19 pandemic.[103]

4.37. The Ministry of Health further announced recommendations to prevent the spread of COVID-19 vide Decree no. 356 of 2020. It regulated the law of isolation and quarantine, whereby isolation could only be ordered on the recommendation of doctors and epidemiological surveillance agents or competent bodies. It further provided that quarantine can be recommended only after a formal administrative act by the Secretary of Health of State, Municipality or Minister of State for Health, till the time health emergency is in operation.[104]

G. South Africa

4.38. South Africa is a party to the International Health Regulations, 2005. However, it did not have a general legislation to provide emergency provisions in response to COVID-19 crisis. Basic framework provided by the Disaster Management Act, 2002[105] was utilized to deal with COVID-19. This Act provides the primary legislative framework for disaster management policy (including epidemics)

---

[103] "What should a public health emergency law for India look like? A White Paper" Vidhi Centre for Legal Policy (March 2021) at p. 24, *available at*: https://vidhilegalpolicy.in/wp-content/uploads/2021/03/What-Should-a-Public-Health-Emergency-Law-for-India-Look-Like.pdf (last visited on January 19, 2024).

[104] "Follow-up of the evolution of COVID-19 measures" COVID-19 Observatory in Latin America and the Caribbean, United Nations Economic Commission for Latin America, *available at*: https://statistics.cepal.org/forms/covid-countrysheet/index.html?country=BRA (last visited on January 19, 2024).

[105] Act No. 57 of 2002, South Africa, *available at*: https://www.gov.za/sites/default/files/gcis_document/201409/a57-020.pdf (last visited on January 19, 2024).

including its prevention, reduction, mitigation, emergency provisions and rapid response. Under this Act, the Minister of Cooperative Governance and Traditional Affairs has the authority to declare a state of disaster which in the Act is defined 'disaster' as "a progressive or sudden, widespread or localized, natural or human-caused occurrence which causes or threatens to cause death, injury or disease; or damage to property, infrastructure, or the environment; or disruption of the life of a community" [106], and thus could be applied to the situation of COVID-19.

4.39. The provisions under the Disaster Management Act were supplemented by the Regulations pertaining to Surveillance and Control of Notifiable Medical Conditions which are notified under the National Health Act, 2003[107] and govern measures relating to control of infectious diseases.

4.40. Disaster Management Act provides for declaration of state of disaster at different levels, including national, provincial or municipal. National state of disaster must be declared when more than one province is involved or when the disaster cannot be managed by a single province in an effective manner. On declaration of this state, the provincial and municipal disaster management authorities are required to cooperate and aid the National Authority.

---

[106] *Id.*, s. 1.

[107] National Health Act, 2003, Act No. 61 of 2003, South Africa, *available at*: https://www.gov.za/documents/acts/national-health-act-61-2003-23-jul-2004 (last visited on January 19, 2024).

4.41. In March 2020, South Africa declared a national state of disaster in response to the COVID-19 pandemic. This declaration provided the government with additional powers to take urgent and necessary measures to address the crisis.[108]

4.42. Section 27 of the Disaster Management Act, 2002 empowers the executive to prescribe regulations and issue directions with respect to steps to prevent acceleration of disaster, releasing resources and personnel of national government and regulation of movement of persons and goods in disaster-struck areas. These powers may be exercised only if they are necessary to protect the public, providing relief to the public, protecting property and dealing with the effects of disaster.

4.43. The government issued various regulations under the Disaster Management Act to implement specific measures to curb the spread of COVID-19. These regulations covered aspects such as social distancing, restrictions on gatherings, mandatory mask-wearing, and the closure of non-essential businesses.

4.44. Section 15 and 22 of the Disaster Management Act empowers the National Disaster Management Centre to exercise consultative and advisory powers and to publish guidelines and recommendations for the national government.

---

[108] Petronell Kruger, Khulekani Moyo, Paul Mudau, Marius Pieterse, Amanda Spies "Republic of South Africa: Legal Response to Covid-19" Oxford Constitutional Law, *available at*: https://oxcon.ouplaw.com/display/10.1093/law-occ19/law-occ19-e6#:~:text=56.,measures%20to%20address%20the%20pandemic. (March 2023) (last visited on January 19, 2024).

4.45. In 2005, National Disaster Management Framework was prescribed, which provides 'a coherent, transparent and inclusive policy on disaster management appropriate for the Republic as a whole.'[109] Further, in 2010, Disaster Management Volunteer Regulations were published which provide for setting up of units of volunteers to engage in disaster management.[110]

4.46. Under the Disaster Management Regulations, the responsibility for enforcement of regulations relating to lockdown has been put upon the enforcement officers including peace officers. Their duties include prevention of unauthorized gatherings, making arrests and detention of persons who refuse to disperse from unauthorized gatherings, medical examinations, treatment, isolation etc.

4.47. To combat COVID-19, South Africa used a 'risk-adjusted alert system', whereby public health measures were graded according to the level of spread of COVID-19 and preparedness of the health system. A system of lockdown levels was implemented with varying degrees of restrictions, which were adjusted based on the severity of the pandemic. Each lockdown level had specific regulations governing travel, business operations, and social activities.

---

[109] General Notice no. 654 of 2005, South Africa, *available at*: https://www.gov.za/sites/default/files/gcis_document/201409/275340.pdf (last visited on January 19, 2024).

[110] General Notice Regulations no. 1215 of 2010, South Africa, *available at*: https://www.ndmc.gov.za/Regulations/Disaster%20Management%20Volunteer%20Regulations%20(E-Book).pdf (last visited on January 19, 2024).

H. Concluding Remarks

4.48. By their very nature, pandemics pose a collective threat, as the actions of individuals impact others. "The Asian Development Bank (2020) observed that in the developing nations of Asia and the Pacific, the poor and the vulnerable in cities are the most adversely affected by the pandemic. Although various diseases and epidemics have influenced the development of cities over the centuries, this pandemic has had an unprecedented impact on cities across the globe. The pandemic has exposed the vulnerability of Governments, health care systems and prevailing political ideologies. COVID-19 pandemic is the most severe disruption experienced worldwide since structural adjustment and liberalization of economies in the 1990s."[111]

4.49. Drawing upon the best practices in emergency management research, several initial lessons can be gleaned from each country's response to the crisis, which may be applicable for other settings. For example, in Australia, CDPLAN has been developed under the auspices of the National Health Emergency Response Arrangements (NatHealth Arrangements 2009) and where no disease-specific plan exists, CDPLAN[112] is considered the primary response plan. Similarly, South Africa does not have a general legislation to provide emergency provisions in response to COVID-19 crisis and the basic framework

[111] Souvanic Roy and Tathagata Chatterji, "The Pandemic and Reimagining the Urban Through the Lens of Progressive State Responses" 49 *Social Scientist* 45-56 (2021), *available at*, https://www.jstor.org/stable/27027156 (last visited on January 16, 2024).

[112] Australian Health Protection Principal Committee, Department of Health, Australian Government, "Emergency Response Plan for Communicable Disease Incidents of National Significance", September 2016, *available at*: https://www.health.gov.au/sites/default/files/documents/2022/07/emergency-response-plan-for-communicable-diseases-of-national-significance-cd-plan.pdf (last visited on January 16, 2024).

provided by the Disaster Management Act, 2002[113] was utilized to deal with COVID-19. In general, the legislative and executive mechanisms appeared to operate effectively as Malaysia managed the crisis without the need to declare a state of emergency or turn to security legislation such as the National Security Council Act, 2016.

4.50. Considering the distinct circumstances of each nation, the specific public health challenges they encounter, and the evolving comprehension of infectious diseases within their borders, it can be asserted that there is no one-size-fits-all approach or single legislation that can be universally adopted to address such contingencies. Consequently, consultations were held by the Law Commission to understand the best practices and recommendations are provided in Chapter 6.

[113] Act no. 57 of 2002, South Africa, *available at*: https://www.gov.za/sites/default/files/gcis_document/201409/a57-020.pdf (last visited on January 19, 2024).

5. CONSULTATIONS HELD BY THE COMMISSSION

5.1. The Commission sought input from the Ministry of Health and Family Welfare ('MoH&FW') and Padma Shri Professor A. P. Dash, Ph.D. and D.Sc., serving Member of the CSIR Society, to explore enhancements in the current health legislations aimed at addressing future health emergencies. This initiative was prompted by the identification of shortcomings in India's domestic health legislation, particularly the deficiencies exposed in the Epidemic Diseases Act, 1897 during the COVID-19 pandemic. Throughout this collaborative consultation, numerous issues concerning the current legislation were brought to attention and have been described herein below.

A. Consultation with the Ministry of Health and Family Welfare (MoH&FW)

5.2. Concerning the requirement for a stronger response to future epidemics, it was deliberated whether a new Epidemic Diseases Act or an amendment to existing Epidemic Diseases Act, 1897 would suffice. It was also contemplated whether there was a need to consolidate the provisions of the Epidemic Diseases Act with the Disaster Management Act, 2005. The Ministry of Health and Family Welfare (MoH&FW) acknowledged the necessity for an amendment and conveyed to the Commission that a proposal to enhance the public health response to epidemics is already under consideration. Further, the need for introducing penal provisions to prevent obstacles that could impede the services of healthcare professionals during epidemics was emphasized. However, it's noteworthy that MoH&FW

did not advocate for merging the Epidemic Diseases Act with the Disaster Management Act.

5.3. Regarding the possibility of enacting a new Epidemic Diseases Act and its characteristics, the Ministry expressed its aim to put forth a comprehensive legislation designed to assist both the Central and State Governments to effectively respond to an epidemic. The primary objective is to effectively control and alleviate the impact of such epidemics. The MoH&FW further apprised the Commission that the Ministry was already in the process of preparing a 'Draft Epidemic Diseases Bill, 2023' and asked the Commission to provide its suggestions on the same.

5.4. The prospect of biological warfare may appear distant to many. Nevertheless, the potential of bioterrorism remains a cause of increasing concern. In this vein, upon being asked by the Commission on the possibility of including bioterrorism under the Epidemic Diseases Act, MoH&FW conveyed that this responsibility lies with the Ministry of Home Affairs (MHA) as per the Cabinet Secretariat Crisis Management Plan. However, if such an event were to transpire as an epidemic, it is imperative for both the Ministry of Health and Family Welfare and State Health Departments to engage in control and containment activities to alleviate the impact of such occurrences. This obligation is further elaborated in the National Disaster Management Authority's National Disaster Management Plan, 2019 at the National, State, and District levels.

5.5. Regarding the definition of the term 'epidemic' and whether it should encompass endemic infectious diseases as well, MoH&FW conveyed to the Commission that the definition of 'Epidemic Disease' has already been incorporated into the Draft Epidemic Diseases Bill, 2023. The Ministry was of the opinion that 'endemic infectious diseases' does not require inclusion in the Epidemic Diseases Act, as the term refers to the persistent and sustained presence of a disease in the community along anticipated patterns.

5.6. On the question of whether the authority to prevent, control, and manage epidemic diseases, should be decentralized among the Central, State, and local authorities, considering the fact that public health and sanitation are specified in the State List, while infectious or contagious diseases like epidemics are listed in the Concurrent List of the Seventh Schedule of the Constitution, the Ministry indicated that the authority to prevent, control, and manage epidemic diseases is already decentralized, extending down to the district level as outlined in the National Disaster Management Authority's National Disaster Management Plan (NDMA's NDMP).

5.7. In light of the above, it was also discussed whether there be a distinction between National and State Epidemics and if so, should different authorities be responsible for managing National and State epidemics. While MoH&FW emphasised that delineating an epidemic in a specific region of concern is necessary, considering the magnitude of the disease, it did not agree with the proposal to establish distinct National and State regulatory authorities equipped with robust and

clearly defined mechanisms to effectively address respective epidemics.

5.8. With respect to ensuring the effectiveness of the new Act, the question arose as to whether it should delineate the roles and responsibilities of different authorities, citizens' duties, surveillance mechanisms, and other relief measures or should the Act solely outline the organizational structure for managing epidemics and empower various authorities and Governments to formulate rules, regulations, and take actions as required. The Ministry of Health and Family Welfare holds the perspective that the existing legislation i.e., the Epidemic Diseases Act, 1897 (as amended in 2020) has been appropriately enacted, incorporating provisions for formulating regulations and prescribing measures as needed. It is pertinent to highlight that both public health and law and order are State subjects, with powers related to the enforcement of measures and regulations falling under the jurisdiction of the State Government. However, in light of the fact that epidemics are a subject included in the Concurrent List of the Seventh schedule, the law dealing with the same is enacted and amended by the Central Government.

5.9. Regarding the incorporation of a well-defined mechanism in the Epidemic Diseases Act, 1897, for the proper disposal of medical waste and human corpses to prevent the potential spread of infection among the living population, the Ministry informed the Commission that the Central Pollution Control Board's compliance with the Biomedical Waste Management Rules, 2016, and the National Disaster Management Authority's guidelines on managing the deceased in the

aftermath of disasters already addresses this concern. Furthermore, according to the guidelines of the National Disaster Management Authority (NDMA), there are no public health threats associated with deceased bodies. The guidelines specify that the management of the deceased is not primarily the responsibility of the health sector.

5.10. The Ministry of Health and Family Welfare also brought to the Commission's attention that the monitoring of pricing and distribution of essential medical care facilities and drugs (including vaccines) during epidemics is already being undertaken by various agencies such as the National Pharmaceutical Pricing Authority (NPPA).

5.11. Another aspect that was considered was whether a robust Disease Surveillance & Tracking Mechanism requires statutory support through the new Act and its potential impact on the right to privacy; need for a proportional standard for restricting individual rights, including the right to privacy and right to livelihood; and whether these individual rights should be explicitly dealt with under the Epidemic Diseases Act. The Ministry of Health and Family Welfare was of the opinion that an epidemic constitutes an emergency situation. In this context, except for the right to life, other fundamental rights may be considered temporarily suspended during the epidemic. Such stringent measures can be relaxed once the relevant regulatory bodies determine that the epidemic situation is under control.

B. Consultation with Professor A.P. Dash

5.12. Professor Aditya Prasad Dash was conferred with the Padma Shri award in 2022 for his distinguished service in the field of science and engineering as a "Distinguished Biologist specializing in vector-borne tropical diseases like dengue, malaria, kala-azar and chikungunya." Professor A. P. Dash has been the Advisor to the World Health Organisation (WHO) and is presently a member of the CSIR Society. In light of his expertise on the subject matter, the Commission thought it fit to have a consultation with Professor A.P. Dash.

5.13. According to Professor Dash, the foremost task of any Act dealing with epidemics is to clearly distinguish between the stages of 'outbreak', 'epidemic', and 'pandemic'. Clear definitions of these terms as per the country's requirements are essential, as each of these phases demands varying levels of attention from different authorities. This is only possible if we are able to demarcate such different stages succinctly.

5.14. A disease should be promptly declared as an epidemic/pandemic so as to cause early alert and to pace up the preparedness plan of the health care system. Professor Dash stressed on the importance of notifying the stage of disease to the public and other relevant authorities at the primitive stage only. There should not be any delay in declaring a disease as Pandemic so as to alert countries and give them sufficient time to prepare. He elaborated on this aspect through the glaring example of COVID-19, whereby the disease was not

declared as a pandemic during early stages of its detection. Due to non-declaration, the countries across the globe were not able to prepare in advance and were able to respond only after severe damage was done in the country.

5.15. Professor A.P. Dash stressed on proper decentralization of power, whereby Union Government acts as a 'Guiding Force', having the power to issue guidelines as per the nature and gravity of the epidemic disease and the State Government acts as an 'Implementing Force', having the power to take preventive and controlling measures and to implement such actions efficaciously on ground. Thus, he conveyed the need of having a 'Standard Operating Procedure', distinguishing the powers between different levels of the government as per the stage of the infectious disease. Moreover, he also emphasized on the need for people's participation in management of an epidemic along with the government's efforts.

5.16. On the aspect of Bio-terrorism, Professor Dash holds the perspective that in any comprehensive legislation dealing with epidemic diseases, there should be a dedicated chapter incorporating bioterrorism, given the potential harms that may be caused due to bio-warfare. In his opinion, the ill effects of bio-terrorism affect the general health of people at large and thus, to protect the health of the people, consequences from such an act must be protected under the Act.

5.17. Professor Dash also focused on efficient disease surveillance programmes giving early warning signals. According to him, during such public health emergencies caused by highly contagious diseases,

detection and contact tracing is the key to contain the spread and hence appropriate technical support should be given to monitor and strengthen disease surveillance systems. The Government's efforts should be more focused on research and development to create a responsive and prepared study to tackle epidemics/pandemics. He also stressed on the need for enhanced promotion of Public-Private Partnerships (PPPs), in the wake of limited public resources and advanced private medical facilities. During a crisis situation, coordinated efforts are required to effectively manage and control epidemics.

6. CONCLUSION & RECOMMENDATIONS: SUGGESTIVE FRAMEWORK FOR EPIDEMIC DISEASES ACT

6.1. The existing legal framework enacted for the protection against epidemics and infectious diseases throughout the country are dispersive. Considering the areas for improvement and lacunas of the current Epidemic Diseases Act, 1897, as discussed in the foregoing chapters and in the light of the need to better manage any future epidemics, it is important to revise and review the existing Act to cover the current as well as future requirements for dealing with the deadly epidemic diseases that adversely impact the health of the people at large. There is an ardent need for comprehensive legislation to deal with epidemics that provide for a coordinated response in the unforeseen event of an epidemic. Considering the modern scientific advancements, the new or the amended Act should not only give the Government mere stipulated powers rather it should shape appropriate response mechanisms in preventing and controlling epidemic diseases. In the considered opinion of the Law Commission of India, following areas must be considered while amending the existing Epidemic Diseases Act, 1897 or enacting a new comprehensive legislation for the same:

A. New Definitions

6.2. In order to make a holistic legal framework relating to epidemic diseases, certain terminologies have to be defined in a comprehensive manner to develop an understanding about the situation and management procedure. The amended Act or the new Epidemic

Diseases Act, as the case may be, must include a clear definition of an 'Epidemic'. For taking the appropriate measures to contain and control the epidemic diseases; and to demarcate the power between Centre and State, the stages of the disease must be defined such as an 'Outbreak' which further leads to an 'Epidemic' and a 'Pandemic'. Suggestive definitions, which may be incorporated are provided below:

> ***Outbreak:*** *Sudden occurrence of an infectious or contagious disease limited to a localized area, having the potential to result in an epidemic.*
>
> ***Epidemic:*** *An infectious or contagious disease, or anything resembling a disease cause of which is unknown; resulting in widespread transmission to other people rapidly and such transmission being in excess of normal expectancy.*
>
> ***Pandemic:*** *Any occurrence or transmission throughout a widespread geographical region of an infectious or contagious disease that has the potential to adversely affect the health of the human population and may pose a serious danger internationally.*

6.3. Similarly, the difference between 'quarantine' and 'isolation' should be clarified by appropriately defining these terms. The Epidemic Diseases Bill, 2023 as provided to the Commission by MoH&FW succinctly defines both the terms. The same can be adopted in the amended or new law, as the case may be. The Commission does not find any need to define such terms again.

6.4. Moreover, the Epidemic Diseases Act must include the definition of 'clinical establishment' as mentioned in Section 2(c) of the Clinical Establishments (Registration and Regulation) Act, 2010, which prescribes "the minimum standards that should be abided by the hospitals before declaring it fit to treat the persons suffering from epidemic diseases and take into consideration various aspects such as infrastructure, services, staff, equipment, lighting arrangements and basic facilities available to patients."[114] Defining clinical establishments is essential to properly identify places with appropriate medical infrastructure that may be used for isolation, quarantine or for other preliminary treatments.

6.5. During COVID-19, to contain the spread of infection, various regulations pertaining to social distancing were enforced throughout the country. Hence, it becomes imperative to define such a term in the parent Act itself. The Commission is of the opinion that a more appropriate word, which must be used is 'Physical Distancing' and it may be defined as follows:

> **Physical Distancing:** *An exercise of maintaining sufficient physical distance between individuals to limit the spread of infection.*

B. Decentralization and Demarcation of Power

6.6. The Epidemic Diseases Act should appropriately decentralize and demarcate the power between Central, State and local authorities to

[114] The Clinical Establishments (Registration and Regulation) Act, 2010 (Act No. 23 of 2010), s. 2(c).

regulate an unfolding epidemic crisis. A flexible enforcement mechanism is required for prevention, control and management of epidemic diseases as per the stage of the spread of infectious or contagious disease.

6.7. Since, 'public health and sanitation' is a State subject under the Seventh Schedule of the Constitution and the respective State Government is the nodal authority to manage public health, thus State Governments should be given the primary task of implementation of prevention and management provisions to contain the epidemic. Moreover, the subject of 'prevention of infectious or contagious disease' is mentioned in the Concurrent List, hence, both the Centre and the State have the power to frame appropriate laws in this respect and enact such laws accordingly. To avoid conflict between the Centre and State, and to properly decentralize the implementation power, a dedicated Standard Operating Procedure (SOP) is required to respond against the situation of an epidemic.

i. Standard Operating Procedure (SOP)

a. <u>Outbreak in the State</u>:

6.8. When the State Government is of the opinion that an 'outbreak' of any infectious or contagious disease has affected any part of the State, then the State Government shall have the power to take sufficient measures in consonance with the Epidemic Plan or the Regulations made by the State (as discussed in part C of this Chapter) to effectively prevent, control and manage the epidemic disease. The State Government may empower certain agencies and competent persons to implement the

provisions of the Epidemic Plan and any Regulations framed in consonance with the plan during the epidemic situation.

6.9. Decentralizing the power to district/local authority is important to contain the infectious disease at a micro level. If proper preventive and containment measures are taken by such local authorities at the initial level of the outbreak, then there are high chances of containing the epidemic at the primitive stage itself.

6.10. Thus, if the State Government is satisfied that any district or any particular local area of the respective State is visited or threatened by the outbreak of any new contagious or infectious disease, then it shall empower the district or local authority, as the case may be, to take certain measures and implement regulations in accordance with the provisions of the Epidemic Plan for containing the disease. The nodal authority concerning the public health of the State Government should keep a strict vigil on the functioning of the district authorities and should ensure that such authorities function and take measures in compliance with the Epidemic Plan and Regulations made by the State.

6.11. If during the management of the epidemic by the district/local authority, any contingency arises for which there is no existing guideline in the Epidemic Plan, then the State Government shall have the power to make regulations in public interest in accordance with the guidelines of the Epidemic Plan and the local authorities are to comply with such regulations.

b. Inter-State Spread of Epidemic Diseases/Pandemic:

6.12. When the Central Government is of the opinion that a significant part of the country is threatened with the outbreak and spread of any infectious or contagious disease, causing a sudden state of danger to the health of public in various States; or the country is threatened or likely to be threatened with any pandemic; then the Central Government should have the power to frame regulations for managing the epidemic on the basis of the guidelines and directives as provided in the Epidemic Plan and direct the State Governments and/or the district authorities to implement such regulations and contain the spread of the disease. The State Government or the district authority should act in accordance with the Regulations prescribed by the Union Government from time to time.

c. Extreme Threat from Infectious Disease:

6.13. In the event where the Union Government is of the opinion that the outbreak of any infectious or contagious disease has transformed or is likely to convert into an epidemic or any pandemic, posing extreme threat by affecting different parts of the country and the State Governments are not able to contain the spread of the infection, then it would be expedient for the Union Government to have the power to take measures in accordance with the provisions of the Epidemic Plan in larger public interest. Thus, when the Union Government finds the epidemic to be spreading across various States and posing significant threat to public health; discrepancies and conflicts in the guidelines as well as measures taken by different State Governments; and the need for taking uniform measures throughout the country; then the Union

Government should itself take certain measures or should empower some other central agency to effectively take measures for preventing and managing the disease.

6.14. Hence, by decentralizing and demarcating the powers between Union, State and Local Governments, we can provide a broad framework for functioning of controlling authorities and their nodal agencies. A flow chart illustrating the Standard Operating Procedure (SOP) is enclosed as '**ANNEXURE-I**' along with this Report.

6.15. Such a broad framework of SOP will ensure proper and coordinated response to any epidemic with pre-defined powers and roles in case of a public health emergency. However, every power of the concerned authority cannot be specifically prescribed in the Act and some discretionary rule making power should be given to the Governments for ensuring proper redressal of any exigency.

C. Duty to Frame an Epidemic Plan

6.16. Epidemic situations demand quick and concerted actions by various Government authorities, institutions and other stakeholders. In the absence of a prior planned mechanism, the authorities indulge in un-coordinated actions leading to duplicated efforts and creating confusion among the masses. Thus, there is a need for a proper plan that facilitates cooperation and effective actions. However, such a plan must be flexible enough to allow actions that may be warranted on the basis of the gravity of the situation and nature of the exigency.

6.17. In light of the foregoing, the Law Commission is of the considered opinion that the Central Government should prepare an Epidemic Plan for dealing with all the outbreaks/epidemics/pandemics across the country. Such a plan should be made in consultation with all the concerned Union Ministries such as MoH&FW, AYUSH etc., the State Health Ministries or Health Departments, important public as well as private health institutions, technical & expert bodies and other stakeholders concerning the medical field.

6.18. The State Governments should collaborate with the Central Government in preparing the Epidemic Plan. Later, the State Governments should be empowered to make respective State regulations in consonance with the proposed Epidemic Plan, considering the State-specific health infrastructure and other medical requirements. While making such regulations, the State Governments should consult with the district/local authorities, important medical institutions and other health organizations of the State. During an outbreak in the State, the State Government should be empowered to act as per the regulations made by the State following the directives of the Epidemic Plan.

6.19. The Epidemic Plan should be given a statutory force by the Epidemic Diseases Act. A new provision should be inserted either in the existing Act or in the newly proposed Epidemic Diseases Act, whereby a duty shall be imposed on the governments to prepare an Epidemic Plan. By giving the Plan a statutory force, we can ensure a framework of basic regulations and guidelines prepared beforehand which shall be executed during the epidemic crisis. Moreover, the statute should also

provide for a provision concerning the revision of the Plan from time to time. A time-period should be fixed for reviewing and revising the Plan according to the need and situation.

6.20. For the Epidemic Plan to be comprehensive, it should provide for the measures required to prevent, detect, control and manage the epidemic. Certain necessary and inalienable aspects, which the Union and State Governments should take into consideration while preparing the Epidemic Plan have been discussed below. These aspects can also be given a statutory force by specifically providing for their mandatory inclusion in the Epidemic Plan under the Act itself.

(The list of the following aspects is only suggestive and not exhaustive)

i. Provisions for Quarantine and Isolation

6.21. The Union and State Governments should endeavour to make specific guidelines and general provisions with respect to quarantine of people, animals and objects, who are suspected to be exposed to the disease and have the potential to affect people who are not ill. Such measures are necessary to prevent further spread of infection. In quarantine provisions, only suspected persons should be restricted and separated from the general public.

6.22. Specific measure of isolation is also necessary to separate any person who is actually infected and is suffering from any dangerous disease. The concerned government may also lay down provisions for isolating specific objects and goods, which are contaminated or have been in the possession of an infected person so as to prevent the spread of

contagious disease. Separating the ill and infected person is the foremost step for breaking the chain of infection spread and to contain the epidemic disease.

6.23. The proposed Quarantine and Isolation guidelines must be made in consonance with Indian Port Health Rules (1955),[115] dealing with isolation of infected ships, and Aircraft (Public Health) Rules (1954),[116] which provides for isolation of infected persons in an aircraft. The above-mentioned rules are not comprehensive and deal with a very narrow aspect of isolation and quarantine of infected and suspected people.

6.24. For proper implementation of quarantine and isolation measures, the government may develop a mechanism to establish demarcated quarantine and isolation centres near to major airports, ports, railway stations and other transport hubs, for early detection and separation of infected and suspected people, through which the disease can be contained from spreading further into the cities and districts.

6.25. Such isolation and quarantine measures make it necessary for the people to follow stringent protocols and isolate oneself as per the regulations, if the person concerned is showing symptoms of the disease. Such measures also curtail the right to assemble and prevent various social gatherings as well. Nonetheless, these measures should be strictly considered as reasonable restrictions on the fundamental

[115] Indian Port Health Rules, 1955.
[116] Aircraft (Public Health) Rules, 1954.

rights of citizens in the larger interest of the country[117] as well as the health and well-being of the individuals themselves. Hence, it is necessary for the government to make elaborative guidelines in the Epidemic Plan pertaining to quarantine and isolation, taking into consideration all the necessary measures and precautions contained in such existing rules.

6.26. Quarantine and isolation, while they may qualify as "reasonable restrictions", should be implemented fairly. The government should ensure that such quarantine and isolation is not arbitrary and should try to empower competent people or agencies for isolating the infected persons. The government can also make a provision empowering one of its nodal authorities to keep a check on arbitrary isolation of people and objects. Such an authority will overlook the functioning of the empowered people or agencies in restricting people in various isolation and quarantine centres. This measure will safeguard rights of the people from arbitrary executive action and will also help government agencies to identify problems and challenges in isolating and quarantining people.

ii. Provisions for Lockdown & Restriction on Movement

6.27. Restrictions on movement and imposing lockdowns is essential to stop physical interaction of people by breaking the chain of contagious disease from spreading further. Appropriate measures for imposing lockdown and for carrying out physical distancing are required. The

[117] The Constitution of India, art. 19.

Central or State Government, as the case may be, has been vested with large powers to prohibit any activity or to seal an area which has the potential of causing harm to public health.

6.28. During COVID-19, the provisions of nationwide lockdown were imposed by invoking the Disaster Management Act, 2005 as the current Epidemic Diseases Act, 1897 does not confer such power on the Central Government. Imposing strategic lockdown and restricting the movement of the people was a crucial step to contain the spread of Coronavirus. The importance of lockdown can be understood from the fact that during COVID-19, most of the countries worldwide amended their existing Acts and made separate rules to impose lockdown in their respective countries.

6.29. The Epidemic Plan should contain a broad framework for imposing lockdown and for imposing restrictions on the movement of people and vehicles.

6.30. The Plan should demarcate as well as identify essential and non-essential services and during any epidemic, the concerned authority may impose restriction on such non-essential services by taking guidance from the proposed framework and as per the gravity of the situation at hand.

iii. Provisions for Disease Surveillance

6.31. To effectively manage any epidemic disease, detection is a prerequisite. The public health authorities must follow a robust

surveillance system, which is responsive and can be effectively implemented across the country. The current Integrated Diseases Surveillance Programme (IDSP) is one of the primary and an efficient programme for surveillance mechanisms in the country. The mission of IDSP is to strengthen disease surveillance in the country by establishing a decentralized State based surveillance system for epidemic prone diseases that facilitates early detection of warning signals and initiation of timely and effective public health actions at the Districts, State and National level. The IDSP endeavours to strengthen the laboratory-based IT enabled disease surveillance system for epidemic prone diseases to monitor disease trends and to detect and respond to outbreaks in the early rising phase through trained Rapid Response Team (RRTs).[118] Furthermore, IDSP envisages both active and passive surveillance to enable early detection of the disease.

6.32. The importance of surveillance has also been highlighted by NITI Aayog in its Report of "Vision 2035: Public Health Surveillance in India".[119] The Report suggests mainstreaming of surveillance by making individual electronic health records the basis of surveillance.[120] The goal is to make India's public health surveillance more predictive, responsive, integrated, and tiered system of disease and health surveillance.[121] As per the Report, surveillance should be

[118] Integrated Disease Surveillance Programme, *available at*: https://idsp.mohfw.gov.in (last visited on January 2nd, 2024).
[119] NITI Aayog Report, Vision 2035: Public Health Surveillance in India. A White Paper (2020), *available at*: https://www.niti.gov.in/sites/default/files/2023-03/Vision-2035-Public-Health-Surveillance-in-India.pdf (last visited on January 28th, 2024).
[120] *Id.*
[121] *Id.*

primarily based on de-identified (anonymized) individual-level patient information that emanates from health care facilities, laboratories, and other sources.[122] The Report also emphasizes the need to pay due attention to privacy and confidentiality of the individual and treating these as integral to any process forming part of the public health surveillance system.[123] The ultimate aim is a public health surveillance governed by an adequately resourced effective administrative and technical structure which will ensure that it serves the public good. One of the major goals is to provide regional and global leadership to India in managing events that constitute a public health emergency of international concern.[124] While dealing with disease surveillance these aspects highlighted by the NITI Aayog Report must be considered.

iv. Provisions for Disinfection and Decontamination

6.33. Apart from quarantine and isolation measures, the Epidemic Plan must contain guidelines for proper disinfection and decontamination, treatment of animals, goods, enclosures and any other place or substance to maintain hygiene and prevent any spread from such objects and places. The plan should elaborate safe methods and biologically safe chemicals that may be used for sanitization of humans and animals. Proper sanitation of humans, their belongings and places of living and working is the key to prevent infection from spreading. Thus, it becomes imperative for the Government to

---

[122] *Id.*
[123] *Id.*
[124] *Id.*

categorize and prescribe sanitizers and other disinfectants which are biologically and chemically safe to use.

v. Control of Healthcare & Medical Supplies

6.34. During any epidemic, basic healthcare and medical supplies such as protective gears, medical equipment, testing kits, machineries, serums etc. are essential for any testing, medical procedure as well as treatment. These supplies are necessarily required at every diagnostic laboratory and hospital. During COVID-19, the Supreme Court directed the Government to ensure availability of Personal Protective Equipment (PPE) kits to all the healthcare professionals treating the disease.[125] Hence, it is important for the Government to provide healthcare workers and medical institutions with sufficient amounts of healthcare supplies. To combat shortage of such essential supplies during the peak crisis, it is necessary for the Government to stipulate directives and guidelines for controlling, restricting and regulating the availability of such essential healthcare supplies. The Government may also devise regulations for proper distribution, transportation and sale of the same.

6.35. Likewise, it is also important for the government to provide for regulations which may declare certain sanitizers and other disinfectants as essential commodities in such emergencies so as to control the price and ensure easy availability to the public. A similar practice has been followed by the Central Government during the

[125] *Jerryl Banait* v. *Union of India*, (2020) 20 SCC 686.

COVID-19 pandemic, wherein the Essential Commodities Act, 1955 was invoked to declare masks and sanitisers as essential commodities. By declaring such goods as essential commodities, the price, manufacturing and distribution of these goods were controlled directly by the Central Government thereby ensuring the availability of such necessary medical goods to the masses.[126]

vi. Provisions for vaccination, research & regulation of medicine and drugs

6.36. Vaccines and medicinal drugs are necessary for treating infectious diseases and saving people from its clutches. Epidemics are sometimes caused by unknown virus vectors or disease carriers. In such cases, it is highly probable that any vaccine or drug existing at the time of initial outbreak, may not effectively fight against such virus or bacteria. In such a situation, copious research has to be undertaken by both public as well as private medical research institutes. During the research, these institutes need resources, raw materials and protection over their research on vaccines and other drugs that may be useful in the treatment of such a disease. Hence, the Central Government in its Epidemic Plan should identify the nodal institutes and authorities which shall hold the primary responsibility of research and development of vaccines and other necessary drugs.

6.37. The government should also develop a mechanism to coordinate between public and private medical research institutes, vaccine

[126] Gazette Order, March 13, 2020, *available at:* https://www.mohfw.gov.in/pdf/218645.pdf (last visited on January 30, 2024).

production companies and raw material suppliers so as to effectively manage the chain of vaccine research and its production. Such a broad framework will not only help the government, vaccine manufacturing companies and vaccine suppliers during the epidemic to have a concerted approach but will also be prolific for utilizing a pool of resources from both public and private sector.

6.38. When the vaccine is launched for the public use in the market it becomes probable that due to large demand and shortage of supply, hoarding of vaccines may occur, which denies vaccine accessibility to the citizens. By enacting provisions in the Epidemic Plan, the Central Government should regulate the purchase, supply, transportation, storage, distribution, and sale of such necessary vaccines and life-saving drugs. The Central Government should hold the control and monitoring power with respect to vaccines and should facilitate movement of vaccines and its raw materials through different States as per the requirement during an epidemic situation.

6.39. For accessibility of vaccines and necessary medicinal drugs to all, it is essential for the Government to enact a broad mechanism for supplying vaccines and such medicinal drugs at reasonable prices. The Government should endeavour to frame guidelines for effective price management in consultation with the National Pharmaceutical Pricing Authority (NPPA). Although, exact pricing policy cannot be made before the occurrence of any epidemic, however, the Government should identify various aspects in its Epidemic Plan, to be taken in consideration while pricing such life-saving medicines. The Government shall as far as possible try to provide such vaccines at a

highly subsidized rate or free of cost to vulnerable and poor sections of the society.

vii. Provisions for proper Dissemination of Information

6.40. For an effective management of an epidemic, a collaborative action of the government as well as citizens is required. It is the duty of the government to inform people about the epidemic situation, gravity of the infection, and preventive and protective measures. The citizens must know the symptoms of the disease, the methods by which it spreads and the measures to be taken to contain such an infectious disease. Thus, governments should provide sufficient guidelines in the Epidemic Plan regarding dissemination of important, correct and appropriate information to make the citizens aware of the situation and also to guide them, so that they can properly protect themselves. Further, some guidelines must be prepared by the government agency to control spreading of misinformation, since such information disseminated through various mediums, misguide people and create unnecessary panic amongst the masses. The government should try to disseminate true and official information through various authentic and official channels and available means so that all the necessary information reaches out to all the people living in any part of the country.

6.41. However, while circulating information such as number of reported cases, number of recoveries, testing results, reported deaths and other public health related information, the nodal agency should proceed with great caution as they might be disclosing protected personal

health information. Every person has the fundamental right to privacy.[127] Thus, every person has the right to protect their personal health information from being circulated in the public domain. During an epidemic, there might be some disclosure of personal and other health data in order to effectively contain the spread of diseases and for better testing and treatment. However, the testing laboratories, hospitals, health institutions, government agencies and media houses must be cautious that such disclosures are not excessive; and that right to privacy to each and every citizen for protecting their personal data is ensured. Proper regulations for the disclosure of such protected information will help the citizens in accessing the medical facilities along with ensuring the right to privacy.

viii. Provisions for conducting Medical Testing and Examination

6.42. During any contagious epidemic disease, in addition to post disease surveillance and contact tracing, another big task is to conduct medical examination and testing to detect individuals suffering from the said disease. Thus, physical examination and medical tests are necessary during any epidemic for proper diagnosis and treatment of infected people. The large population of our country and limited resources and facilities for testing and medical examination can prove to be a challenge in this front. Thus, it is necessary for the Government to formulate provisions in the Epidemic Plan regulating the testing and medical facilities in both public and private laboratories. The Supreme Court has observed that private hospitals and laboratories

[127] *Justice K.S. Puttaswamy (Retd.)* v. *Union of India*, (2017) 10 SCC 1.

also have a significant role to play in containing the epidemic and they should extend their services at a reasonable price in the hour of national crisis.[128] Thus, proper regulations for coordinated and cooperative efforts of both public and private labs and hospitals are required to fulfil the testing demand during the crisis.

6.43. Another important aspect with respect to testing and medical examination is the pricing of the test. During COVID-19, an issue relating to the price of screening test was raised and Supreme Court concluded that in this hour of national crisis, screening and confirmation tests, relating to COVID-19 must be conducted in laboratories approved by National Accreditation Board for Testing Calibration Laboratories (NABL) and other agencies approved by ICMR at reasonable price. The Supreme Court also issued some interim directions approving the important test to be free of cost in some approved government and private laboratories, keeping in mind the urgency for testing and paying capacity of the large part of the Indian population.[129] Thus, it is imperative for the government to formulate general guidelines to effectively manage testing prices through government and private laboratories during any epidemic situation, as the testing is vital to control and manage the epidemic.

ix. Provision for safe disposal of infectious waste & infected human remains

[128] *Shashank Deo Sudhi* v. *Union of India*, (2020) 5 SCC 132.
[129] *Id.*

6.44. Infectious Bio-medical waste, if not disposed properly, can also act as a catalyst in spreading infection amongst the people. Hospitals, Testing Laboratories, Quarantine & Isolation centres, even houses (where people remain under home isolation) generate bio-medical waste that has the potential to further spread the infection. Any person coming in contact with such infectious waste is at the risk of being infected.

6.45. Hence, proper treatment and disposal of such infectious waste is of utmost importance. The government should make certain guidelines separately for medical institutions, isolation centres and for households for the collection, storage, handling, transportation, treatment and disposal of such infectious waste. While preparing and incorporating such guidelines in the Epidemic Plans, the government should take into consideration Bio-medical Waste Management Rules 2016,[130] prepared by the Central Pollution Control Board in furtherance of its objectives to manage bio-medical and healthcare waste.

6.46. Another aspect that needs to be considered is the disposal of human remains. Proper disposal of human remains includes various processes such as embalming, transportation, burial, cremation and final disposal of human remains. Any person dying of a contagious disease might pose a risk to other people and hence proper disposal of infected remains is important. The Government should frame specific guidelines, to be incorporated in the Epidemic Plan for safe disposal

[130] Bio-Medical Waste Management Rules, 2016.

of infected human remains. These guidelines should be an extension to the Guidelines on management of the dead in aftermath of the disasters,[131] prepared by the National Disaster Management Authority. The proposed guidelines should contain provisions for identification as well as for labelling of the deceased. The human remains of any infected person dying from a contagious disease should be explicitly labelled mentioning the cause of death and name of the disease. Moreover, the proposed guidelines should also regulate the visiting of family members during the last rites of an infected person, so as to further contain the spread of infection.

x. Multi-Sectoral Emergency Relief Measures

6.47. During COVID-19, the Disaster Management Act, 2005 was invoked to effectively manage the pandemic and a lot of reliance was placed on Section 10(2) and Section 12 of the Disaster Management Act for providing minimum relief to the affected people.[132] Under the said provisions, the Ministry of Home Affairs directed the State Governments and Union Territories to provide food, temporary shelter and other necessities to migrant and daily wage labourers. Moreover, employers were asked to pay wages to their employees during distress periods and landlords were asked to forgo rents from such workers for a stipulated period. If during any epidemic or pandemic, lockdown measures are imposed, then a great financial burden is imposed on such migrant and daily wage labourers and it is

[131] National Disaster Management Guidelines on 'Management of the Dead in the Aftermath of Disasters' (August 2010), *available at*: https://nidm.gov.in/PDF/pubs/NDMA/11.pdf (last visited on January 31, 2024).
[132] Disaster Management Act, 2005 (Act No. 53 of 2005), ss. 10(2), 12.

difficult for them to sustain their living. To avoid such a scenario and be prepared beforehand, the Government should have in place necessary guidelines for giving temporary and minimum relief to people during any epidemic. Such guidelines should be incorporated in the Epidemic Plan and should guide the appropriate authority during the epidemic in providing minimum standards of relief to the people.

6.48. Apart from such relief to the poor and vulnerable section of the society, it is also necessary to ameliorate the financial burden faced by other sections of the society and different sectors of the economy. Taking inspiration from COVID-19 Temporary Measures Act (CTMA) 2020[133] enacted in Singapore, the Government should enact certain regulations in the Epidemic Plan to provide some emergency relief measures to different sectors of the economy during the economic distress caused by any epidemic. To prevent economic devastation and business being destroyed due to prolonged lockdowns and other regulatory measures, it is necessary to provide relief to different sectors of the economy. The Government may think of measures to provide indirect and temporary relief to financially distressed individuals and businesses. Such temporary measures will help economic entities to sustain during such distressed time.

xi. Power of Inspection, Search and Seizure

[133] Covid-19 (Temporary Measures) Act, 2020.

6.49. The concerned government may formulate certain regulations pertaining to inspection and detention. The detention of any form of transport along with any other person, shipment, cargo or any other object must be made only on reasonable apprehension of such things having the potential to cause the spread of infection. Any executive action should only be as per these regulations and not arbitrarily.

D. Enhanced Penalty Provisions

6.50. Currently, the Epidemic Diseases Act, 1897, as amended, provides two types of penalties. First is in respect to contravention of any provision, order or rule made under the Act, which is punishable under Section 188 of the Indian Penal Code, 1860 (IPC). The second penalty was added by the 2020 amendment Act for commission or abetment of violence against healthcare service personnel or causing damage to any property as defined under the Act. Thus, although the existing Act stipulates penalty for contravention of its provisions, the penalty as stated in Section 188 of the IPC is not stringent enough to act as an effective deterrent.

6.51. Apart from the above-mentioned punishments, Section 269 of the IPC (Section 271 of the Bhartiya Nyaya Sanhita, 2023) provides the punishment for negligent act likely to spread the infection of any disease dangerous to life. Similarly, Section 270 of the IPC (Section 272 of the Bhartiya Nyaya Sanhita, 2023) provides the punishment for malignant acts which are likely to spread the infection of any disease dangerous to life. Section 271 of the IPC (Section 273 of the Bhartiya Nyaya Sanhita, 2023) provides for the punishment for disobedience

to quarantine rule.[134] Despite these provisions, there is still a need for stricter punishment for disobedience of guidelines and regulations made by the government during any health emergency.

6.52. Hence, as per the current penal scheme, it is more viable to provide enhanced and stringent punishments within the Epidemic Diseases Act itself. Such a punishment will effectively deter people from acting irresponsibly during an epidemic. During the COVID-19 pandemic, Section 188 of the IPC, providing punishment of imprisonment up to six months or fine up to one thousand rupees or with both, was used against contravention of any provision or order made under the Epidemic Diseases Act. With the enactment of the Bharatiya Nyaya Sanhita, 2023, Section 188 of IPC is replaced with Section 221 of the BNS, 2023 and the punishment has been enhanced to imprisonment of either description for a term which may extend to one year or with fine which may extend to five thousand rupees, or with both.[135] Although there has been a significant increase in the punishment, however in the opinion of the Commission, such punishment should be given a statutory force within the Epidemic Diseases Act itself and the offence should be categorized in two heads; firstly for contravening the provisions negligently imposing lesser punishment; secondly, for wilful contravention, which will entail a stricter punishment. Moreover, the Commission deems it fit that for subsequent or repeat contraventions, the punishments should be enhanced accordingly.

---

[134] The Indian Penal Code, 1860 (Act No. 45 of 1860), ss. 269, 270, 271; The Bharatiya Nyaya Sanhita, 2023 (Act No. 45 of 2023), ss. 271, 272, 273.
[135] The Bharatiya Nyaya Sanhita, 2023 (Act No. 45 of 2023), s. 221.

6.53. For accelerating enforcement of such penal provisions, the Commission proposes to make such offences cognizable and non-bailable, whose investigation and trial should be completed expeditiously.

The Commission recommends, accordingly.

----xxx----

7.2.2024.

[Justice Ritu Raj Awasthi]

Chairperson

[Justice K.T. Sankaran]

Member

[Prof. (Dr.) Anand Paliwal]

Member

[Prof. D.P. Verma]

Member

[Dr. Reeta Vashishta]

Member Secretary

[Dr. Rajiv Mani]

Member (*Ex-Officio*)

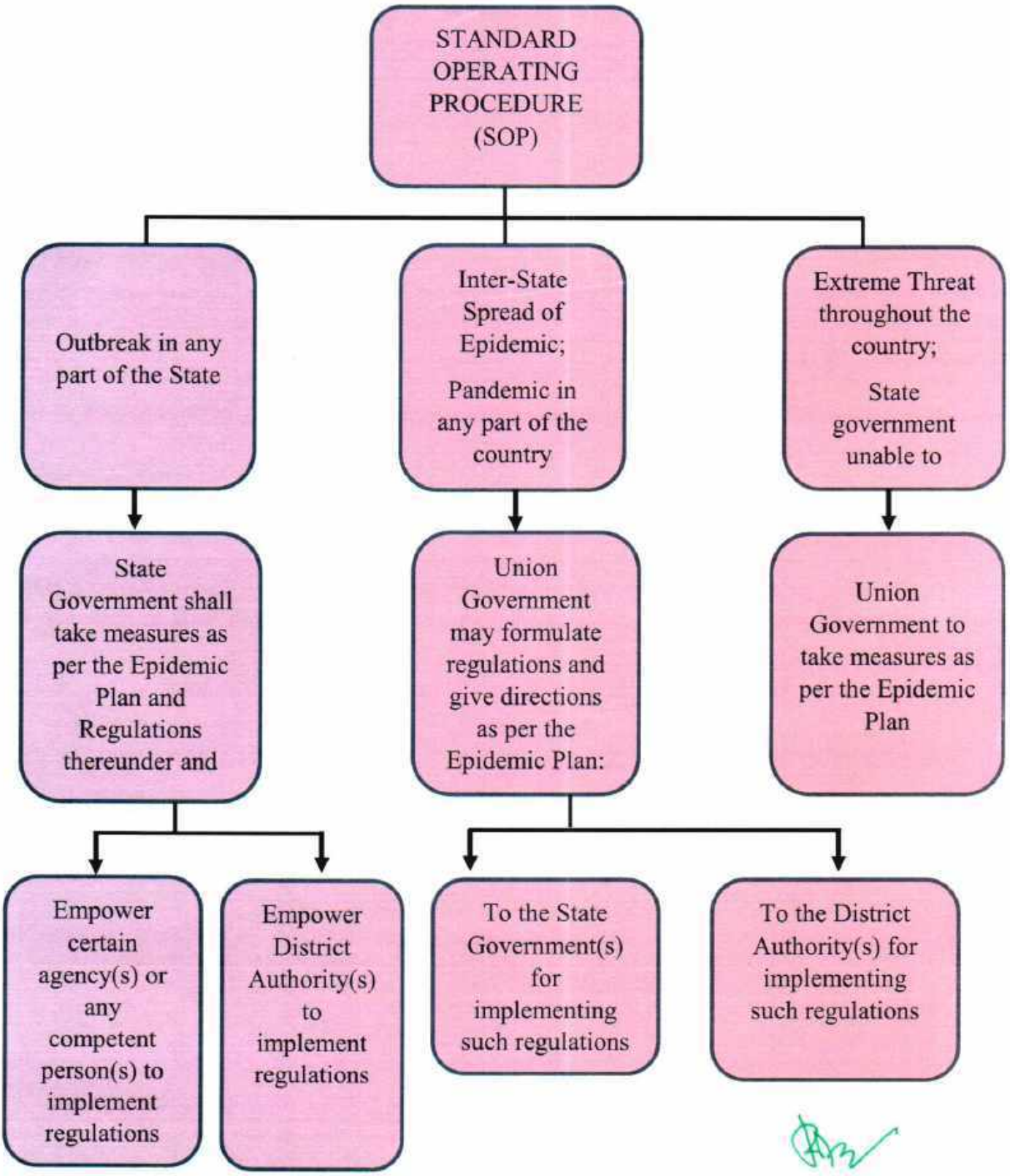
[Mr. M. Karunanithi]

Part-time Member

[Prof. (Dr.) Raka Arya]

Part-time Member

ANNEXURE-I


STANDARD OPERATING PROCEDURE (SOP)
Outbreak in any part of the State
Inter-State Spread of Epidemic;
Pandemic in any part of the country
Extreme Threat throughout the country;
State government unable to
State Government shall take measures as per the Epidemic Plan and Regulations thereunder and
Union Government may formulate regulations and give directions as per the Epidemic Plan:
Union Government to take measures as per the Epidemic Plan
Empower certain agency(s) or any competent person(s) to implement regulations
Empower District Authority(s) to implement regulations
To the State Government(s) for implementing such regulations
To the District Authority(s) for implementing such regulations