**Scope of Work**

Mentor-Mentee Program

Need for a Public Health Act and Regulation

A study of the ongoing pandemic response, Epidemic Diseases Act - 1987, **Public Health (Prevention, Control and Management of Epidemics, Bioterrorism and Disasters) Bill - 2017 and the Disaster Management Act - 2005**

The ongoing COVID-19 pandemic has heightened the need of an adequate public health regulation to deal more effectively with outbreaks of infectious diseases. Over the past year, the Government of India relied upon the Epidemic Diseases Act of 1897, Section 144 of the Indian Penal Code, and the Disaster Management Act of 2005 to tackle the novel coronavirus. However, these laws are deficient to deal with an epidemic that has the ability to spread as much as the Coronavirus. The Epidemic Diseases Act is dated, it does not define a disease or an epidemic. There is no clear distinction between ‘isolation’ and ‘quarantine’ and there is no provision ensuring medical care and support to those who are affected. On the other hand, the Disaster Management Act used to invoke the national lockdown is not designed to address medical emergencies. COVID – 19 was declared a notified disaster. The ‘unlock phase’ guidelines are issued by the Ministry of Home Affairs and section 144 of the Indian Penal Code is deployed to prohibit public gatherings. This warrants an immediate need for an overarching legal framework.

The legal architecture surrounding health policies in India is perplexing, more so, because health is a state subject. There have been attempts to design a collaborative federal framework for the health system as a whole, for instance, the Model Public Health Act - 1955, the National Health Bill – 2009, The draft Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism and Disasters) Bill - 2017. however, these bills could not be passed in the parliament as the states did not approve of it. Even though, there is no uniform law, several states have their own health legislations, for instance Andhra Pradesh, Tamil Nadu, Goa, Uttar Pradesh, Madhya Pradesh and Assam have their own public health acts. The challenge is not multiple legal structures, rather a lack of universal one.

Given the implications of COVID - 19, there is an opportunity to introduce a National Public Health Bill incorporating learnings over the past year, building on global experiences and supplementing it with adequate devolution of powers, empowering states and local bodies to take requisite action.

Take, for example, the Canadian health system. Canada relies upon the Emergency Act of 1988, the Emergency Management Act 2007, Public Health Agency of Canada Act 2006, Quarantine Act of 2005. The provinces have their own health acts however they function in close coordination with the central government during an exigency. These legal provisions empowers the Canadian health system to take scientific steps during a health crisis, the laws envisage regulating movement of people, requisition and disposition of property, distribution of essential goods, establishment of emergency hospitals, and imposition of fines. Similarly, in England, the Public Health Act of 1984 provides a clear hierarchical chain in which the primary, secondary and tertiary responders operate when dealing with a health crisis. The responsibilities from the local level up till the national level are clearly defined.

The new Public Health Act must clearly define diseases, epidemics, pandemics etc. The law needs to be establish identification, categorization and benchmarking indicators for contagious diseases. It must account for factors such as scale of the disease (affected population), distribution (age, gender), geographical spread (local, national, international), the severity (mortality, morbidity), and availability of requisite medication. Although the Government of India did a commendable job with sequestering and sequencing of vaccines, however, the public health bill should ideally delineate scientific steps, government’s duties, quarantine measures to control an epidemic. Consider, for instance, the 1897 Epidemic Diseases Act provisions for devolution of power to “any” person during an exigency. This clause by iteslf causes arbitration in devolution of power. The new law must balance public interest while maintaining adequate privacy of its citizens.

The bill should improve upon the fragmented care delivery towards a more integrated care model. In an epidemic, the entire health system should ideally function as a single unit. In India, the National Centre for disease control leads the Integrated Disease Surveillance Programme, the National Health Mission caters to primary health care, while the National Health Authority acts as a pillar to supplement India’s tertiary care needs. Although, Ayushman Bharat, National Health Mission, and IDSP have played a pivotal role during the pandemic, these structures continue to function in silos. Taking example of the the Public Health Agency of Canada, the body is envisaged to deal with prevention and control of infectious diseases among other objectives such as promotion of health, prevention and control of chronic diseases, and preparation and response to public health emergencies. A similar structural reform may be required in India as well. The Government of India is aiming to bridge the information gap with the National Digital Health Mission, however, including components of integrated service delivery in the National Health Bill will improve it significantly. Consider this, incorporating telemedicine guidelines in the law can deliver much effective outcomes, as already demonstrated in the past year. A significant emphasis needs to be on bio-security as a defence against bio-warfare. The novel coronavirus has been labelled a quasi-biological war in its scale, scope, duration, and impact. A lack of immediate bio-defence and a long time lag between finding a treatment or vaccine brings high morbidity and mortality rates. Containment measures such as lockdowns have brought even the strongest countries to their knees and halted their economies. In order to establish a quick response labs, medical facilities, and hospitals should be made re pursuable such that they may be used for testing and therapeutics development. Therefore, public-private partnerships must be encouraged. Tech based solutions such as telemedicine, surveillance technologies, information networks, and contact tracing apps are important bio and health security measures.

The public health bill can create a single comprehensive legislation including segments from Indian Ports Act, Livestock Importation Act, Aircraft Rules, Drugs and Cosmetic Act, Disaster Management Act, the Essential Commodities Act, etc that can restrict rights to liberty, privacy, movement, and property while ensuring right to health. Additionally, there is need to address denial of medical assistance, shortage of hospital beds and ventilators, prices of face masks, sanitisers etc. It is necessary to balance the rights and interests of

patients, healthcare workers and other stakeholders, comprehensively. Therefore It is imperative to develop a comprehensive umbrella law, despite its challenging nature.

Methodology:

This study aims to undertake a literature review of existing laws governing the response to the current COVID–19 pandemic in India. The study will review the following laws:

1. Epidemic Diseases Act of 1897, (Amendment 2020)

2. Model Public Health Act - 1955, the National Health Bill – 2009,

3. The Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism and Disasters) Bill - 2017

4. Section 144 of the Indian Penal Code,

5. Disaster Management Act of 2005

6. Essential Commodities Act 1955

7. Drugs and Cosmetic Act 1940

8. Unlock Guidelines, Ministry of Home Affairs

Further, the paper aims to prepare comparative case studies of countries that have a robust response mechanism to tackle pandemics, and lastly identify conceptual framework governing laws on

1. Health emergencies and federal coordination

2. Bio-terrorism and national security

3. Surveillance and privacy

In addition to the secondary research, telephonic interviews with policy makers, high court/supreme court judges, policy think tanks and academic institutes will also be undertaken to gain perspective on the identified conceptual notions and the National Health Bill - 2009, and the Public Health Bill - 2017.

Timeline:

| Week 01 | Inception of the study |
| --- | --- |
| Week 02 | Literature Review of exisitng laws |
| Week 04 | Prepare Case studies |
| Week 06 | Identify conceptual framework |
| Week 08 | Telephonic Interviews |
| Week 10 | Finalise draft |
| Week 12 | End of study |

Aspired mentor:

Dr. Indranil Mukhopadhyay, Associate Professor, O.P. Jindal Global University. [imukhopadhyay@jgu.edu.in](mailto:imukhopadhyay@jgu.edu.in)

**Compensation**

The Consultancy fee for this engagement is USD 5,000(Inclusive of all indirect taxes). The payment will be disbursed in three instalments, in the proportions given below and the consultant should provide the invoice against each deliverable.

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| --- | --- | --- | --- |
| **Instalment** | **Percentage** | **Amount (USD)** | **Deliverable/ Milestone** |
| 1 | 25 | 1250 | On Signing Contract |
| 2 | 25 | 1250 | On submission of literature review and methodology (including stakeholders for a qualitative interview and analysis plan) approved by the Mentor, and |
| 3 | 50 | 2500 | On submission of the final deliverable approved and accepted by the Mentor & AHI Team. |

**Term**

This engagement shall commence upon execution of this Agreement. The Agreement shall continue in full force and is effect from **September 15, 2021** to **December 15, 2021** and is extendable based on the review of Consultant’s performance by the Foundation and mutual concurrence on revised terms of engagement.