The Epidemic Diseases Act, 1897 Needs An Urgent Overhaul

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The Epidemic Diseases Act, 1897 is a colonial era legislation that is still used as the primary law to control a mass epidemic. The act, most recently, has been invoked by a number of Indian states to fight the COVID-19 pandemic. This article aims to understand the existing scheme under the act, its limitations, judicial scrutiny and the need for a new holistic law from a public health perspective.

The Epidemic Diseases Act (hereafter referred to as the act) was enacted in 1897 to control the outbreak of the deadly bubonic plague in Bombay. As the plague assumed epidemic proportions, the colonial response was typical—one driven by panic, high handedness, ill planning and extreme measures. The Epidemic Diseases Act was a result of “stringent measures,” which Queen Victoria had directed her government to take, in order to tackle the plague outbreak (Kumbhar 2020).

Legal frameworks are important during crisis situations as they augment a government’s response to public health emergencies and also the rights and duties of citizens. It is thus important to review the act with reference to its current relevance, its adequacy to tackle deadly virus outbreaks, surveillance and privacy issues and, most importantly, its limitations.
Scheme under the Act

The act is one of the shortest legislations in the country, containing four sections only. Section 2 of the act empowers the state governments to take such measures and prescribe temporary regulations as may be required to control an epidemic disease. Section 2A empowers the central government to inspect any ship leaving or arriving in port and for the detention of any person sailing or arriving therein. Section 3 provides for punishment under Section 188 of the Indian Penal Code (IPC) for any person disobeying the act. If any disobedience by a person causes or tends to cause danger to human life, health or safety, then they may be punished with imprisonment upto six months and/or fine upto Rs 1,000. Section 4 provides legal protection to persons for anything done under the act (Ministry of Law and Justice 2020).

The Act during the Coronavirus Pandemic

As the coronavirus pandemic engulfed the country, this 123-year-old act was invoked, along with provisions of the Disaster Management Act, to control the spread of the virus. Most Indian states, such as Delhi, Uttar Pradesh, Maharashtra and Bihar, notified regulations under the act authorising government officials to admit, isolate and quarantine people in certain situations. Drawing from the act, many states took measures, such as the closing of schools, malls, gyms, institutional and home quarantine, in order to mitigate the crisis.

The act was amended by way of an ordinance in April 2020. The amendment aimed primarily at protecting healthcare personnel engaged in combating the coronavirus and expanded powers of the central government to prevent the spread of such diseases. It made acts of violence against healthcare personnel and damage to property, including a clinical establishment, quarantine facility or a mobile medical unit, during an epidemic punishable with imprisonment upto five years and fine upto Rs 2 lakh. Persons convicted of such offences will also be required to pay compensation to the victims (PRS India 2020). The ordinance was introduced as a bill in the recently concluded session of Parliament. It was passed by both houses of Parliament and received the assent of the President on 28 September 2020, thereby bringing into effect the Epidemic Diseases (Amendment) Act, 2020, which incorporates the afore-discussed changes (PRS India 2020).

Limitations of the Epidemic Diseases Act

Despite recent amendments, the act has major limitations in this era of changing dynamics in public health emergency management. Communicable diseases and their spread have changed over the years. Novel viral diseases, which are more virulent and potent in form, pose constant challenges for us. There is increased international travel, global connectivity, greater migration, closed urban spaces, climate and ecological changes and more pressure on natural resources. The act is not in consonance with the changing requirements of modern-day epidemic disease prevention and control.
The act fails to define a “dangerous epidemic disease.” There is no clarity on the criteria that need to be applied for declaring a disease as “dangerous” or “epidemic.” It is silent on variables such as the magnitude of the problem, the severity of the disease, distribution of affected population across age groups, possible international spread, or the absence of a known cure. Further, the act contains no provision on the dissemination of drugs/vaccines and quarantine measures to be taken. The act was formulated at a time when concepts like constitutional principles, fundamental rights and basic human rights did not exist. There is no underlying dissemination of fundamental human rights that need to be observed during the implementation of emergency measures during an epidemic (Tewari 2020). The act focuses on government’s powers during an epidemic, but does not specify its duties in controlling/preventing an epidemic, nor does it enunciate any rights available to the citizens in the event of an outbreak.

There are concerns about disease surveillance and risk of privacy breach under the current epidemic disease response regime. Under the Integrated Disease Surveillance Programme, each district has a surveillance unit and a rapid response team to manage the outbreak of a disease. To augment surveillance activities and response mechanisms, a wide network of health professionals and state functionaries has been put in place, further bolstered by an information technology (IT) based dissemination of data. When there is already a system in place for disease surveillance, the provision in the act for devolution of power to “any” person makes little sense.

In a landmark judgment of the Supreme Court, *Justice K S Puttaswamy (Retd) and Anr v Union of India and Ors* (2017), the right to privacy was held to be an intrinsic part of the right to life under Article 21 of the Constitution. The Court laid down a few tests for limiting the discretion of the state while impinging on the right of privacy, which included procedural guarantees against abuse of interference that may be necessary for a legitimate aim. It is to be noted that the Epidemic Diseases Act does not provide for procedural guarantees against any abuse of state power regarding privacy infringement. There is a fear of the law being misused for profiling, mass quarantine and targeting of individuals. There is blanket legal protection to public servants who function under it. Therefore, the act does not pass the tests of reasonable restrictions on privacy infringement and is, thus, grossly inadequate when weighed against the scales of privacy rights.

**The Question of Judicial Scrutiny**

The act has, on multiple occasions, been examined through the lens of judicial scrutiny by various courts. The Calcutta High Court in *Ram Lall Mistry v R T Greener* (1904) evaluated the scope of Section 4 of the act. The issue before the court then was whether the chairman of the Calcutta Corporation was protected from liability arising out of a demolition of a building done under the plague regulation to curb the spread of the plague. The court clarified that Regulation 14 of the plague regulation imposed such liability and hence, the building owner must be compensated. However, such non-payment of compensation is not
Disobedience of orders under the act attracts a penalty under Section 188 of the IPC. However, under this section, *mens rea* or an intention to harm is not important. It is sufficient that the person knows of the order which they disobey. The Orissa High Court in *J Choudhury v The State* (1963) held a medical practitioner liable for contravening regulations under the act, by refusing to undergo vaccination for cholera. The Court observed that the intention of the said doctor was irrelevant, his disobedience in itself was punishable under the act. The 248th Report by Law Commission of India, 2014 placed the Epidemic Diseases Act under the category of laws recommended for repeal by various commissions but not undertaken for repeal by the government (Law Commission of India 2014).

It is evident that the act is merely regulatory in nature and lacks a scientific approach to tackle epidemics like COVID-19. It is also silent on the ethical aspects and human rights principles, which deserve to be protected even during an epidemic outbreak. Individual liberty, autonomy and privacy should be respected to the greatest extent possible (Rakesh 2016).

**Towards a Holistic Law**

There have been attempts by the government to bring an adequate legal framework for providing essential public health services and to better handle outbreaks of epidemics/communicable diseases. One such proposed legislation was the National Health Bill, 2009, which aimed at providing protection and fulfilment of rights in relation to health and well-being. It made a clear distinction between the obligations of the centre and state governments in relation to health. It further laid down individual and collective rights in relation to health, which included the right to health, access, right against discrimination, right to dignity, right to the use of healthcare, etc. However, the same could not be passed as health is a state subject (PRS India 2009).

Most recently, the government introduced the Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism and Disasters) Bill, 2017. Its aim was to fill the lacunae in the archaic Epidemic Diseases Act and was expected to replace it. The bill clearly defines “epidemic,” “outbreak,” “bioterrorism” and “public health emergency.” It envisions measures like social distancing, quarantine, isolation, diagnosis and guidelines for treatment, instead of segregation and detention of people under the 1897 act. It enumerates various diseases falling in the category of epidemic-prone diseases and also contemplates a public health emergency of international concern, like the present coronavirus outbreak. As compared to the 1897 act, which contains no provision for appeal against any order and has no mechanism for amendment in the act, the 2017 bill provides for appeal before central, state and local authorities and also gives amending powers to the central government (PRS India 2017). However, the bill has not been tabled before Parliament till now.
A modern law with a focus on robust public health infrastructure is the need of the hour. Preparedness related to planning, coordination, communication, surveillance and rights of citizens during a public health emergency must be addressed by a new holistic legislation. Public-private partnership (PPP) models in healthcare can go a long way in ensuring a strong health infrastructure. The North Arcot district health information surveillance and district-based surveillance programmes in Kerala are classic examples of successful private sector participation in health preparedness, especially monitoring and surveillance (Lancet 1998).

Further, setting up of a public health regulatory authority that lays down standards, uniformity and coordination in measures during an epidemic outbreak is also imperative. The authority may be entrusted with planning a comprehensive lockdown strategy, maintaining supply lines, ensuring essential services, relief and support to those in distress. It may also be given its own dedicated cadre of personnel, on the lines of the National Disaster Response Force (NDRF).

The new act must contemplate adequate autonomy to states to design and enforce responses as per their local assessment and magnitude of the outbreak. Effective micro-level management at the district, block and panchayat level is needed.

Most importantly, the new act must ensure proportionality and reasonableness in the state’s response, whether it is quarantine, isolation, surveillance or data collection. Transparency and accountability in actions, combined with a clear boundary between emergency laws and resumption of ordinary laws, will go a long way in strengthening public trust. Even in emergencies, rights and laws must not be ignored.

In Conclusion

It is clear that India has fallen short in ensuring a modern legal framework to tackle a pandemic. Instead of relying upon colonial-era laws, using brute force in enforcing quarantine/lockdown measures and resorting to provisions like Section 144 Code of Criminal Procedure (CrPC), a new law is required to address the lacunae in the existing structure. History tells us that oppressive measures during the Poona plague outbreak led to disaffection and resentment among the populace. Therefore, the time is ripe to repeal this colonial law and replace it with a more comprehensive, modern and ethically robust law, which focuses on a rights-based, public health-oriented approach.

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