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Title: A Study of Public Health Governance and the Law after COVID-19: A Legal Analysis of India's Post-Pandemic Framework

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INTRODUCTION

The COVID-19 pandemic (2020–2022 and its longer tail effects) caused an unprecedented challenge to public health systems worldwide and tested the capacity of legal frameworks to respond to fast moving biological threats. For India, the pandemic was a stress test: policymakers relied heavily on existing statutes some dating to the colonial era while simultaneously crafting emergency ordinances, guidelines and large-scale policy initiatives. This produced an ad hoc but substantial corpus of legal instruments addressing containment, medical infrastructure, economic relief, labour protections, and digital health governance. Even in newly amended criminal laws under BNS the provision was brought it from IPC which deals with offences affecting public health, safety, convenience, decency, and morals. It is a key provision to ensure compliance with public health measures during an infectious disease outbreak[1] which previously was under section 271 of Indian Penal code. At the time of pandemic the major concerns were How did India's legal architecture respond to COVID-19? To what extent do post-pandemic laws and policies remedy pre-existing gaps and respect constitutional safeguards? What normative reforms are necessary to create a resilient, rights-respecting public health governance framework? The analysis proceeds by mapping relevant legislation/ policy, judicial interventions, and international obligations, and then offering a critical legal appraisal with recommendations.

In the aftermath of the COVID-19 pandemic, several critical factors necessitated substantial legal reforms. Consequently, numerous laws, regulations, and policy provisions were amended or newly

[1] BNS Section 273: Disobedience to Quarantine Rule

introduced to strengthen public health governance, ensure administrative preparedness, protect vulnerable populations, and address the socio-economic challenges revealed during the crisis.

I. THE STATUTORY AND POLICY LANDSCAPE: WHAT CHANGED AND WHY

1.1 The Epidemic Diseases Act (1897) and Its Amendment/Ordinance (2020)

India's initial legislative anchor was the Epidemic Diseases Act, 1897 a short colonial statute granting sweeping executive powers in epidemics. In April 2020 the Centre promulgated the Epidemic Diseases (Amendment) Ordinance, 2020, later enacted as amendments to the Act, which introduced stronger safeguards for healthcare workers and made violence against them a cognizable, non bailable offence with enhanced penalties. The ordinance also expanded central powers for controlling the spread of epidemic diseases. These changes were driven by the urgent need to protect frontline personnel and to criminalize obstruction of public health functions. During the current COVID-19 pandemic, there have been instances of the most critical service providers i.e. members of healthcare services being targeted and attacked by miscreants, thereby obstructing them from doing their duties. Members of the Medical community, even as they continue to perform relentlessly round the clock and save human lives, have unfortunately become the most vulnerable victims as they have been perceived by some as carriers of the virus.[2]

Considering historic view 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.[3] 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.

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[2] Promulgation of an Ordinance to amend the Epidemic Diseases Act, 1897 in the light of the pandemic situation of COVID-19, Press Information Bureau, Government of India, Ministry of Health and Family Welfare, 22-April-2020
[3] The Epidemic Diseases Act, 1897 Needs An Urgent Overhaul, Parikshit Goyal, engage, Vol. 55, Issue No. 45, 07 Nov, 2020

Regarding the act there were questions on judicial scrutiny as 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*[4] evaluated the scope of Section 4[5] 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[6] of the plague regulation imposed such liability and hence, the building owner must be compensated. However, such non-payment of compensation is not protected under Section 4 of the act.

Disobedience of orders under the act used to attract a penalty under Section 188[7] 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*[8] 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.

The amendment sought to deter attacks on healthcare personnel and streamline enforcement. However, critics have noted the risk of disproportionate criminalization and uneven enforcement without concomitant investments in hospital security and grievance redress.

1.2 Disaster Management Act, 2005 — Centralised Emergency Response

The government invoked the Disaster Management Act, 2005 (DMA**)** to coordinate nationwide lockdowns and emergency measures, declaring COVID-19 a "notified disaster." The DMA's institutional architecture (NDMA, SDMAs, NEC) provided a legal vehicle for large-scale

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[4] **(1904) ILR 31 Cal 829**.
[5] **No suit or other legal proceeding shall lie against any person for anything done or in good faith intended to be done under this Act**
[6] It allows for actions such as medical inspection, isolation of the sick, and disinfection/disinsectisation of contaminated items.
[7] Penalizes the disobedience of a public servant's lawful order.
[8] **ILR (1963) Cut 714**

restrictions and resource mobilization. Several Supreme Court proceedings during the pandemic examined the scope of DMA powers and the Centre–State allocation of responsibilities.

Over the years, with the greater realisation of the significance of efficient and effective disaster management, the critical role of a comprehensive framework of policy, along with legal and institutional arrangements in the management of disasters have been emphasized by scholars in various parts of the world. As Neil R. Britton points out, "Policy, legal and institutional arrangements form the foundation for any society's approach to disaster management. Policies are based on information reviews that are drawn on to establish appropriate courses of action; legislation identifies explicit decisions about how a particular policy will be conducted and legitimizes those actions; and institutional arrangements identify specific agencies and their relationships for carrying out the missions and duties associated with the policy.[9] Within this triumvirate, the laws that codify legislation are extremely important because they furnish an immutable 'bottom line' on subsequent courses of action."[10] Moreover, laws have also been understood as an expression of a society's power framework and its system of domination.[11] Therefore, it became of utmost significance in different countries, particularly the federal countries, to evolve a fine legal framework for management of disasters.

Using DMA allowed a uniform legal basis for lockdowns and relief schemes, but it also highlighted ambiguities in federal distribution of powers, accountability, and the need for sector-specific protocols for biological disasters.

India has faced numerous devastating natural and man-made catastrophes during the last four to five decades, resulting in significant loss of life, resources, property, and trauma. Until 2005, India had no system or policy for disaster management, leading to a response-based conscious attitude, and there was no structure for prevention or pro-activeness. Policymakers recognised the need for a formalised disaster management strategy after the 2004 tsunami, leading to the adoption of the Disaster Management Act, 2005. To examine the key features of the Disaster Management Act

[9] Legal Framework Of Disaster Management In India, Rajendra Kumar Pandey, ILI Law Review, Winter Issue 2016
[10] Neil R. Britton, "Getting the Foundation Right: In Pursuit of Effective Disaster Legislation for the Philippines" Proceedings of 2nd Asian Conference on Earthquake Engineering 2006, March 10-11, 2006, Manila.
[11] S. F. Moore, "Law" in A. Kuper and J. Kuper (eds.), The Social Science Encyclopedia, 446 (London: Routledge & Kegan Paul, 1985).

2005 of India and identify its key limitations in order to provide appropriate recommendations[12]. A meticulous and comprehensive review of the 2005 Disaster Management Act reveals that while it has established a structured framework for disaster management, it has several limitations. The Act does not appear to put enough emphasis on proactive steps to reduce disaster risk, making it seem reactive. Besides, there are no clear accountability procedures in place, which may result in implementation-related inefficiencies and non-compliance. The Act also lacks financial allocations for disaster management authorities at lower administrative levels (district, block, and village), affecting the preparedness and responsiveness of local responders. Political and economic constraints, bureaucratic inefficiencies, and corruption further undermine the Act's effectiveness. Given these issues, an urgent revision of the Act is imperative to establish a more robust and effective disaster management framework in India.

1.3 Insolvency & Bankruptcy Code (IBC) and Economic Relief

To prevent a wave of insolvencies arising from COVID-related defaults, the government introduced an IBC Ordinance (2020) suspending initiation of Corporate Insolvency Resolution Processes for defaults occurring within a specified window. This suspension was a temporary protection to avoid triggering insolvency for pandemic-related economic disruption.

In 2020, The minimum threshold limit to initiate insolvency process against a corporate debtor has been increased from Rs. 100,000 to Rs. 100,00,000 for the next 6 months, which may be further extended to 1 year. Also, section 10A was inserted in the IB code, 2016, which suspended the initiation of Insolvency Resolution Process for any default arising on or after 25th March, 2020 for a period of six months, which is subject to extension up to one year.[13] A moratorium on new cases was issued in March 2020 due to the COVID-19 pandemic, barring creditors from filing applications.Provisions were added to specify that no applications for initiation of Corporate Insolvency Resolution Process (CIRP) for defaults occurring during the COVID period could ever be filed. A modified version of the IBC was utilized to resolve non-bank finance company

[12] The Disaster Management Act, 2005: A Critical Review, Manindra Singh Hanspal, Sambalpur University, *DME Journal of Law, 5(01), 42–53,* July 10, 2024.
[13] Global Impact of Covid-19 on Insolvency Laws, Lokesh Bulchandani,Associate, Lakshmikumaran & Sridharan, 118 taxmann.com 534 (Article), 27 Aug 2020.

distress—one of the largest cases was the resolution of DHFL and stress of INR 85,000[14]. At present Since the resolution of the last cases, there has been a significant slowdown in the process. The capacity of the Tribunal is a major concern that impacts both speed and quality. Several important amendments, including those concerning cross-border insolvency and pre packs, are currently on hold. The increased use of private credit may necessitate the review and adjustment of upcoming legal frameworks.

The IBC suspension illustrated the use of insolvency law as a macroeconomic stabilization tool but raised issues about creditor rights, moral hazard, and the adequacy of targeted relief to distressed small firms. A comprehensive review of IBC was undertaken last year, and amendments are under consideration of the Government. These amendments are expected to reduce delays and increase the recovery to creditors. The progress we have made over the past eight years is commendable and has earned recognition. However, as we step into the next phase of our journey, continuous dialogue, collaboration, and innovation will be essential to strengthening our insolvency framework. Enhancing the IBC is a vital enabler of economic growth and creating a resilient and sustainable insolvency regime and robust economy.

1.4 Telemedicine and Digital Health: Rules and Missions

There are still many areas of India without proper medical facilities. In such a setting, technology can play a facilitating role, particularly in reaching out to remote locations and offering a greater standard of care at a lower cost. The method of treating and diagnosing patients remotely through communication networks is known as telemedicine. When more patients get access to telemedicine, payers take more notice of how much less expensive it is than traditional medicine, and doctors are aware of its benefits.[15] Telemedicine is a more beneficial technology that can expand access to preventive treatment and may lead to long-term health. Telemedicine has the potential to greatly affect public health.

[14] India insolvency code is a vital growth enabler: Let's enhance it - By Amitabh Kant & Richa Roy, Ex-CEO, Niti Aayog
[15] Role of Telemedicine and Digital Technology in Public Health in India: A Narrative Review, Revathi G Maroju, Edited by Alexander Muacevic, Cureus, 2023 March

Telemedicine was used for various non-mutually exclusive reasons, with the top two reasons being live audio or video consultations (60.4 %) and online payments (19.1 %), and smartphones were the most frequently used device type (60.6 %). Among various benefits of telemedicine, almost all respondents (93 %) recognised the potential for telemedicine to reduce COVID-19 infection risk for healthcare professionals. Interestingly, nearly 45 % of respondents felt that limited and fragmented insurance coverage was an important limitation to the practice of telemedicine in India, and 49 % believed reduced patient fees for teleconsultations could help incentivise telemedicine use.[16]

What are NDHM and DPDPA?

National Digital Health Mission (NDHM):

- Started as part of the Ayushman Bharat Digital Mission.
- It's aim is to establish an ecosystem for digital health in which each citizen is assigned a distinct Health ID (ABHA number).
- Aids in the digital storage of test results, prescriptions, medical records, and hospital visits.
- In order to facilitate treatment, patients can consent to share health information with physicians or hospitals.

Digital Personal Data Protection Act (DPDPA) 2023:

- It is India's first specific data protection law, passed in 2023.
- Safeguards sensitive health information as well as all other forms of personal data.
- Gives individuals the right to know how their information is gathered, saved, and distributed.
- Establishes sanctions for data misuse, with major infractions carrying fines of up to ₹250 crore.

For India's digital healthcare, the combination of NDHM and DPDPA is revolutionary. While hospitals and telemedicine providers are subject to more stringent requirements, patients gain more autonomy and privacy. These regulations seek to improve India's healthcare system's efficiency,

[16] Perspectives and use of telemedicine by doctors in India: A cross-sectional study, Vikranth Nagaraja, Health Policy and Technology,Volume 13, Issue 2, June 2024

safety, and trust over time.[17] Patients will benefit from easier access to digital health records and safer online consultations. It entails adjusting to a new era of accountability and compliance for physicians and platforms.

In addition to legal challenges, there are ethical implications related to the digitization of healthcare in India. The primary ethical considerations concern the issues of informed consent, and these are critical concerns, particularly important for marginalized persons with low literacy rates, as well as communities that have historically been subject to medical exploitation. For the benefits of digital healthcare to reach those farthest removed from access to quality healthcare, there needs to be a comprehensive data protection and informed consent framework in place.

The pandemic accelerated telemedicine. In March 2020 the Ministry of Health and Family Welfare released Telemedicine Practice Guidelines (2020), legitimizing online consultations, clarifying doctor-patient responsibilities, consent and prescription norms. Concurrently, the National Digital Health Mission / Ayushman Bharat Digital Mission (NDHM/ABDM) progressed as a structural digital health initiative to create interoperable digital health records and health IDs.

These frameworks modernize healthcare delivery but also create acute data-protection and governance challenges, requiring robust law on health data privacy, security and accountability. India's digital healthcare transformation holds immense potential to enhance healthcare accessibility and efficiency. With continued policy support, infrastructure development, and public-private collaborations, the country is poised to emerge as a global leader in digital health. Future focus areas include AI-driven diagnostics, blockchain-based health records, and enhanced cybersecurity frameworks.

The Indian government's proactive approach toward digital healthcare infrastructure and policies is shaping a more efficient and accessible healthcare system[18]. **With growing investments in digital health and technological advancements, India's healthcare system is expected to**

[17] Regulation of Digital Healthcare in India: Ethical and Legal Challenges,Dipika Jain, Healthcare (Basel), March 2023.
[18] From Data to Diagnosis, Transforming Healthcare through Digitalization, JAN 2025, Ministry of Health and Family Welfare, PIB Delhi

evolve into a globally recognized model for digital transformation, setting benchmarks for other developing nations.

1.5 Data Protection: From Policy Demand to Statute

Contact tracing apps (e.g., Aarogya Setu) and digital health IDs amplified concerns about privacy. Lawmakers responded with the Digital Personal Data Protection Act, 2023 (DPDP Act) which purports to regulate processing of digital personal data and provide rights to data principals. Later rules and regulatory clarifications in 2024–2025 further operationalized the Act. The DPDP Act marks a statutory turn toward protecting personal data, but questions remain on exemptions for public health and state processing.

On 11 March 2020, the World Health Organization proclaimed the outburst of the deadly virus as a pandemic. The unanticipated flare-up of COVID-19 has overshadowed the routine life as the exponential growth of the virus implored and alarmed the world community. It requires very serious and aggressive efforts to contain the pandemic[19]. Doctors and paramedical staff worked from dawn to dusk to cope with the aberrant crisis. Government agencies who were part of the COVID-19 task force asked for personal details of citizens suffering from COVID-19. In these circumstances, it is extremely important to protect data privacy in order to mitigate risk and also maintain individual harmony in such a challenging time. Emergency does change the priorities of life and underestimate the basic standards of life. The latest developments put forth amid the pandemic infringe one's privacy and other human rights, thereby affecting netizens' personal information transgression and the improper use of data. Unprecedented measures are used to respond COVID-19; the heavy-handed exercise of contact-tracing has been used to contain the dissemination of the deadly virus throughout the world.

Governments must employ a normative approach when selecting and regulating long-lived data technologies to avoid unexpected and potentially disastrous side-effects in the long run. Firstly,

[19] COVID-19, Personal Data Protection and Privacy in India, Mohamad Ayub Dar, OMC, October 2022.

the role of private companies in the development and use of contact tracing apps also needs to be more clearly defined after the pandemic. Conditions such as lack of transparency and changing terms and conditions for personal data use raise serious questions over whether powerful firms would adhere to principles of user consent and protection. The second is the potential misuse the data for other purposes, such as profit or government surveillance. The increased state surveillance and harsher law enforcement tend to "stick" when they are justified by crisis events such in combating COVID-19, effort is needed to strictly adhere to the principles of data privacy after the pandemic. Thirdly, the acceleration of the emerging technologies in combating COVID-19 may undermine the access equity in the pursuit of efficiency. The cases of contact tracing apps raised how to integrate factors of inclusion and accessibility into data solutions, and how to promote their adoptions in places without adequate infrastructure.[20] Finally, public distrust in government could be exacerbated if the development and use of emerging technologies are not carefully executed to meet public needs. Realizing the benefits of digital contact tracing while preventing negative social consequences would ultimately depend on the extent to which citizens trust the governments and private companies involved in the development process. In the future, strategies such as dynamic consent, early public participation, digital literacy improvements, and the appointment of third-party judicial or oversight institutions could be considered to facilitate the co-creation of salient, credible, and legitimate anti-epidemic technologies with mechanisms for transparency and accountability.

A statutory data protection regime is essential to balance public health benefits of digital systems with individual privacy. Yet the Act's carve-outs for state purposes and operational rules require careful oversight.

1.6 International Legal Obligations: IHR (2005)

India's pandemic response must be seen against International Health Regulations (IHR, 2005) an international legal framework obliging States Parties to develop core capacities for surveillance, reporting and response to public health risks. The IHR frame coordination with WHO and cross-

[20] COVID-19, policy change, and post-pandemic data governance: a case analysis of contact tracing applications , East Asia, *Policy and Society*, Volume 41, Issue 1, March 2022

border measures. The pandemic has stimulated proposals to strengthen the IHR and global preparedness.

The International Health Regulations (IHR) 2005 are a legally binding international instrument adopted by the World Health Organization (WHO) in 2005, requiring 196 countries to prevent, prepare for, and respond to public health risks that could spread internationally. Key obligations include developing core capacities for surveillance and reporting, responding to requests for verification, and implementing measures that are commensurate with public health risks while avoiding unnecessary interference with international traffic and trade. The regulations also uphold human rights and provide a legal basis for international cooperation during public health emergencies.

Additional provisions address the areas of international traffic, such as health documents for international travelers and conveyances on an international voyage[21]. The IHR include important safeguards to protect individual rights in relation to the treatment of personal data, informed consent and non-discrimination in the application of health measures under the Regulations.

Beyond the WTO, other institutions could encourage IHR compliance. For example, at various points during the H1N1 pandemic, the FAO, OIE, and WTO together with the WHO issued joint statements discouraging trade restrictions on pork and pigs.[22] It may also be possible to look to the International Court of Justice (ICJ) when one country's active violation of the IHR causes specific damage to either the population or the economy of a second country.

There is still more the WHO could do to signal strong political commitment to IHR compliance. The WHA, for example, could amend Article 48 to elevate temporary recommendations from the Emergency Committee during a PHEIC to a binding status. Even though States Parties could still disregard their international obligations, more binding treaty language could increase pressure to comply. Challenges for the WHO's role include a loss of credibility given the lack of guidance on

[21] World health organization

[22] The International Health Regulations: The Governing Framework for Global Health Security, LAWRENCE O GOSTIN, Milbank Q, May 2016

travel restrictions in earlier stages of the pandemic, as well as widespread disregard for recommendations that were given. In the absence of a multilateral agreement, bilateral or regional arrangements may proliferate, further undermining global governance initiatives. Although some variation between regions is to be expected particularly where, as in Europe, regional arrangements on free movement pre-existed the pandemicthe *IHR (2005)* remain the source of legal obligations applicable to all the WHO member states, enabling a balance of consistency and flexibility[23]. Lessons learned during this period can inform ongoing discussions about how to reform the WHO and the *IHR (2005)* to make them more effective.

IHR compliance implies domestic legal reforms to surveillance, laboratory networks, and reporting obligations areas where India needs systematic strengthening.

II. JUDICIAL RESPONSES AND CONSTITUTIONAL ISSUES

2.1 Fundamental Rights and Proportionality

Lockdowns, restrictions on movement, and closures of economic activity raised questions under Articles 14 (equality), 19 (freedoms), and 21 (life and personal liberty) of the Constitution. Courts applied familiar proportionality and reasonableness tests, emphasizing the need for evidence-based public health measures, procedural fairness, and mitigation of hardship to vulnerable groups. The Supreme Court and various High Courts considered petitions on lockdown relief, migrant labour, and prison decongestion. Judicial scrutiny reiterated that emergency measures must be necessary, proportionate and accompanied by mitigation for socio-economic harms.

In case of **M. Immanvuel v. Government of India (2020),** In this writ petition, the petitioner challenged the nationwide lockdown (imposed via the Disaster Management Act) on the ground that it deprived him of his livelihood and restricted his fundamental rights. **Rights claimed was** Article 19 (freedom of movement, livelihood), Article 21 (right to life), Article 25 (religious freedom), and Article 14 (equality). The **State's defence was t**he government argued that the

[23] The *International Health Regulations (2005)* and the re-establishment of international travel amidst the COVID-19 pandemic, Barbara J von Tigerstrom, *Journal of Travel Medicine*, Volume 27, Issue 8, December 2020

lockdown was necessary to protect public health, invoking powers under the Disaster Management Act and the Epidemic Diseases Act. **On court's reasoning t**he court observed the extraordinary nature of the pandemic and accepted that the state had a duty to protect life, thereby rejecting the argument that the fundamental rights claim could automatically override the lockdown measures.

In case of **Centre for Public Interest Litigation (CPIL) v. Union of India**[24] **(2020)** The Petitioners sought a more detailed, well-structured national plan from the government for handling COVID-19, arguing that the existing plan (NDMA 2019) was inadequate for the pandemic context. They asked for minimum standards for relief camps (shelter, food, medical cover, sanitation), compensation for victims, and special measures for vulnerable groups (widows, orphans). The **Rights invoked** While not a "rights vs lockdown" case per se, the petition raised issues of the **right to life with dignity** (Article 21) and the state's duty under the Disaster Management Act to protect citizens. The **Outcome and significance of t**his case underscores that courts saw the lockdown not just in terms of disease containment, but as a social welfare and rights issue calling for structural protections for those affected.

In Kerala High Court the Aarogya Setu App was Challenged. The writ petitions challenged the mandatory imposition of the Aarogya Setu contact-tracing app for public/private employees. The **Rights claimed that** Right to privacy / data protection, freedom from state overreach. Petitioners argued that under the Disaster Management Act there was no clear legal basis to mandate an app that collects sensitive health and location data. The **Significance is y**his was a crucial digital-rights litigation during COVID-19, highlighting how public health measures can intersect with privacy and fundamental rights.

In many cases, courts showed deference to government policy, recognizing that pandemic management is a policy matter best handled by the executive especially when decisions are rational and based on expert inputs. Much of the litigation came from or on behalf of marginalized groups migrant labourers, daily wage workers who bore the brunt of lockdowns. These cases forced the judiciary to consider not just epidemiological risk but social justice dimensions. There was a

[24] **456 SC**. 2020

consistent tension courts acknowledged that fundamental rights are not absolute. During a public health crisis, they allowed reasonable restrictions, but insisted on minimum standards (food, shelter, dignity). The litigation highlighted gaps in India's legal architecture for public health emergencies. For instance, lack of clear statutory safeguards for data collection, or detailed frameworks for protecting vulnerable populations during a lockdown.

2.2 Centre–State Federalism: Allocation of Powers

Invoking the DMA and issuing central guidelines highlighted ambiguities in the distribution of powers between Union and States in health emergencies. Some judicial orders clarified that while the Centre may issue national policy, implementation (and many regulatory subjects) rests with States—creating a need for clearer statutory frameworks for cooperative federalism in health crises. Sustainable pandemic governance requires explicit statutory delineation of roles to avoid policy vacuums and ensure accountability.

III. THEMATIC LEGAL ANALYSIS

3.1 Public Health Law: Powers, Duties and Restraints

Lawrence Gostin's foundational thesis that public health law balances power, duty and restraint is instructive: law must empower authorities to protect population health while imposing constraints to protect civil liberties and ensure accountability. The Indian response demonstrated power (lockdowns, resource commandeering), duty (welfare schemes), but an uneven application of restraint and procedural safeguards (especially with rapid executive orders and criminal sanctions). Systemic reform must seek a calibrated balance.

3.2 Criminalization and Enforcement Risks

Making offences against healthcare workers cognizable and non-bailable served deterrence aims but introduced criminal law's blunt instrument into complex social contexts (misinformation, panic, resource scarcity). Penal sanctions without parallel investments in grievance redress, public communication and logistical support risk misdirecting enforcement efforts. Empirical study and legislative review are recommended to ensure proportionality.

3.3 Privacy, Health Data and Surveillance

Digital contact tracing, telemedicine, and health IDs create potential for intrusive data collection. The DPDP Act (2023) is a crucial development, but operational rules, enforcement architecture, and clear constraints on state data processing (including necessity, proportionality, purpose limitation and data minimization) are essential. Lessons from Aarogya Setu's early rollout show the need for transparency (open source, purpose limitation), retention limits and independent oversight.

3.4 Telemedicine: Access vs. Professional Accountability

The Telemedicine Practice Guidelines brought legitimacy to remote care, reducing access barriers. Yet medico-legal questions remain: standard of care in virtual consultations, cross-border practice, prescription norms, and liability in misdiagnosis. Professional medical councils and regulators must harmonize codes of practice with patient protection mechanisms.

3.5 Labour Protection and Informal Workers

The pandemic highlighted vulnerability of migrant labour and informal workers. While several labour codes and social security schemes were accelerated, statutory coverage gaps persist for gig economy and platform workers. Legal reform should embed social protection floors, portable benefits, workplace safety standards for biological hazards, and accessible complaint mechanisms

3.6 Economic Law: Insolvency, Relief and Moral Hazard

Suspension of insolvency proceedings provided breathing space for pandemic-hit businesses but did not substitute for targeted fiscal support to small enterprises. Legal responses must distinguish between temporary liquidity crises and structural insolvency, ensuring creditor remedies are not unduly impaired and taxpayers are protected from unlimited moral hazard.

IV. COMPARATIVE AND INTERNATIONAL PERSPECTIVES

4.1 International Health Regulations (IHR) and Domestic Implementation

IHR (2005) obliges States Parties to build surveillance capacity, notify public health events, and cooperate internationally. COVID-19 revealed disparities in preparedness and highlighted that compliance requires domestic legal instruments—clear statutory duties for surveillance, laboratory reporting, and rapid response funding. India's NDHM and public health investments are steps forward, but systematic legislative strengthening (e.g., public health emergency law) would better align domestic law with IHR obligations.

4.2 Best Practices: Legislative Drafting for Emergencies

Comparatively, modern public health statutes in several jurisdictions (e.g., some US states, European countries) embed procedural safeguards: sunset clauses for emergency powers, legislative oversight, judicial review corridors, and compensation mechanisms for commandeered property. Indian law could benefit from similar checks ensuring emergency powers are time-bound, monitored and reviewed. Gostin's work recommends institutionalizing accountability mechanisms in public health law.

V. CRITICAL EVALUATION: STRENGTHS AND SHORTCOMINGS

5.1 Strengths

1. Rapid activation of legal tools and policy innovations**.** India used DMA, amended the Epidemic Act, operationalized telemedicine, and accelerated digital health showing adaptive capacity.
2. Data protection law adoption. The DPDP Act creates a statutory scaffold for personal data protection—critical for health data governance.

5.2 Rapid Changes

1. **Antiquated statutes remain foundational.** Reliance on the 1897 Act and general emergency statutes revealed the need for a modern, comprehensive public health law that integrates scientific evidence, constitutional safeguards and cooperative federalism.
2. **Weak procedural safeguards and oversight.** Emergency orders and penalization sometimes lacked clear procedural protections, remedy channels or independent oversight.

Judicial scrutiny partially addressed this but statutory design must build these protections in

3. **Data governance gaps.** The DPDP Act is welcome but immediate health data-specific rules, independent oversight and clarity on state exemptions are necessary to prevent mission creep.
4. **Labour and social protection incompleteness.** Gig and informal workers remain vulnerable; legal reforms have been incremental rather than transformative.

The post-pandemic legal reforms introduced in India present a mixed landscape of significant progress and notable limitations. On the positive side, the pandemic acted as a catalyst for modernizing outdated public health laws, prompting proposals for a comprehensive Public Health Act and leading to crucial amendments such as strengthened protections for healthcare workers under the Epidemic Diseases (Amendment) Act, 2020. The reforms also expanded social security measures, particularly for migrant and gig workers, and accelerated digital transformation through telemedicine guidelines and digital health initiatives that improved access to healthcare. Additionally, judicial oversight played a vital role in safeguarding constitutional rights, ensuring that restrictions on movement, livelihood, and healthcare access remained proportionate and justifiable under Articles 14, 19, and 21. However, despite these strengths, several shortcomings persist. India still lacks a unified and modern public health law, relying instead on fragmented legislations like the Epidemic Diseases Act, 1897 and the Disaster Management Act, 2005, which created inconsistencies and blurred federal responsibilities during the crisis. The heavy centralization of powers under the DMA raised concerns about weakening cooperative federalism, while the rapid adoption of digital health tools exposed gaps in privacy protections and the absence of a robust data protection regime at the time. Furthermore, legal reforms did not adequately address the systemic vulnerabilities faced by marginalized groups—particularly migrant workers—nor did they fully bridge longstanding deficits in health infrastructure, such as oxygen availability and rural healthcare capacity. Overall, while post-pandemic laws reflect a meaningful attempt to strengthen governance and preparedness, they remain more reactive than preventive. A truly resilient legal framework must balance public health imperatives with constitutional freedoms, reinforce privacy

norms, empower state-level autonomy, ensure inclusive welfare protections, and commit to sustained investment in health infrastructure to better withstand future public health emergencies.

VI. CONCLUSION & SUGGESTIONS

COVID-19 catalysed rapid legislative and policy change in India's public health governance amendments to epidemic law, reliance on the Disaster Management Act, telemedicine rules, the NDHM and a nascent statutory privacy framework. These are important advances, but pandemic experience underscores that law must do more than empower: it must set clear roles, embed procedural and rights protections, and ensure accountability. Enacting a modern public health law, operationalizing health-data safeguards, reforming labour protections and codifying telemedicine standards will strengthen resilience and align India with international public health obligations. The balance of power, duty and restraint the core insight from public health law scholarship should guide reform.

A central theme emerging from the legal developments is the necessity of **balancing public health measures with constitutional freedoms.** The judiciary played a crucial role in scrutinizing executive action, reiterating that even in emergencies, the State cannot act arbitrarily and must adhere to the standards of proportionality, non-discrimination, and procedural fairness. Cases concerning the right to life under Article 21, the right to livelihood, freedom of movement under Article 19, and the right to equality under Article 14 shaped a nuanced understanding of constitutional governance during crises. Judicial interventions in matters such as migrant workers' rights, oxygen supply allocation, vaccine distribution, and access to treatment reinforced the constitutional principle that **public health cannot be secured at the cost of human dignity.** Ultimately, the pandemic revealed that **public health governance is not merely a medical or administrative concern but a deeply legal and constitutional issue.** It underscored the indispensable role of the law in safeguarding lives, ensuring transparency, enabling effective crisis management, and upholding fundamental rights, even in extraordinary times. As India moves forward, the lessons learned from COVID-19 should guide the development of a comprehensive Public Health Act, strengthened Centre-State coordination, and a preparedness framework that respects constitutional liberties while effectively responding to future emergencies.

The post-pandemic legal landscape demonstrates that resilience is achieved not only through robust health infrastructure but also through a legal system that is adaptive, rights-conscious, and grounded in democratic accountability. The evolution of law and public policy in the COVID-19 era must therefore be seen as the foundation for a more equitable, prepared, and constitutionally aligned governance system—one capable of withstanding future public health crises without compromising the core values of justice, dignity, and human rights.

Based on the foregoing analysis, the following legal and policy reforms are proposed:

Draft a comprehensive Public Health Preparedness and Response Act to replace/adapt colonial relics. Key features should include:

- Defined roles for Centre, States and local bodies with co-operative governance mechanisms.
- Procedural safeguards: notice, review, judicial oversight and legislative ratification for prolonged measures.
- Compensation and grievance mechanisms for those adversely affected by public health orders.
- This aligns domestic law with IHR obligations and addresses the Centre–State ambiguities exposed during COVID-19.
- Expand statutory social security coverage to include gig/platform and informal workers, portable benefits, and statutory workplace biosafety standards. Establish fast-track dispute resolution for pandemic-linked employment disputes.

- Create statutory technical committees (epidemiology, ethics, data governance) that must be consulted for major public health orders and whose advice is recorded publicly to ensure transparency and evidence-based policymaking. This enhances trust and legitimizes restrictions on rights.