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# Seven Governance Issues Raised by COVID

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## Abstract

Covid-19 has caught India, like the rest of the world, unawares. Given its geographical area, population and level of development, India has handled the pandemic remarkably well. Nevertheless, the pandemic provides an opportunity to identify measures to improve the state of preparedness for future crises. This paper underlines Constitutional and governance issues to prepare the country for such emergencies in the future.

To ensure more accurate data on mortality rates and their attribution to the pandemic, the paper underlines the need to improve the Civil Registration System. Another issue relates to the confusion arising from the faulty detection of cases when Rapid Antigen Tests (RAT) and RT-PCR tests do not provide consistent results. This has required the ICMR to issue a press release to reconfirm in the case of negative reports in symptomatic patients when RAT is used. The paper also emphasises the need to link fiscal transfers under the National Health Mission to performances in terms of specified deliverables by the States. Another issue is the need to amend the Constitution to place 'Public Health' in the Concurrent List to enable more significant role for the Union government in fighting pandemics like COVID-19. The paper also argues for the creation of a separate local body list in the Seventh Schedule and ensure legal consistency in the assignment across different levels of government in the country. Given the important role of the Union government, 'Management of Disasters and Emergencies, natural or manmade' should be an item included in the Concurrent List of the Seventh Schedule as recommended by the Second Administrative Reforms Commission. This enables congruency and cohesion in dealing with disasters between different levels of government.

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## Introduction

Covid-19 caught the entire world, not just India, unawares. With India's population, it is not surprising that the number of infections should be high. In 1968, there was an exhibition of Andy Warhol's works at Moderna Museet in Stockholm. On that occasion, Andy Warhol remarked, "In the future, everyone will be world-famous for 15 minutes." Covid-19, with its uncertainty, brought fleeting and dubious fame to several people, for more than fifteen minutes. Between 18th March and 21st March 2020, Dr Ramanan Laxminarayan, Director of the Center for Disease Dynamics, Economics and Policy projected that India would have 700 to 800 million infections and 2 to 2.5 million dead (Laxminarayan 2020) (India Today 2020). This projection was at one end of the extreme. At the other extreme, a model presented by a Member of Niti Aayog projected there would be no new cases after 16th May 2020 (Koshy 2020). Both extremes, the excessively pessimistic and the excessively optimistic, were wrong and the fame lasted no more than the fleeting fifteen minutes. In the jargon used by economists, there is a difference between risk and uncertainty. In the case of risk, the probabilities of events are known. In the case of uncertainty, probabilities are unknown, and this makes decision-making difficult. Uncertainty also makes modelling difficult, and in the absence of data, values of variables imported from other countries often lead and have led, to fallacious results. In that state of uncertainty, the Union government imposed a lockdown on 25th March 2020. In various phases, the lockdown lasted till 31st May 2020, and given the need to revive livelihoods and the economy, there has been a staggered process of un-lockdown from 1st June 2020.

There are different metrics to evaluate the spread of the pandemic in India. At the time of writing, by any reasonable extrapolation, India will become the country with the largest number of cases in the world. Normalised by population, cases and deaths are low. The case fatality rate, at the time of writing, is 1.63%, as published by the Ministry of Health and Family Welfare, India. The first national serosurvey (conducted in April and May 2020) showed that the infection fatality rate is between 0.5% and 0.6%, lower than in Europe and the USA. "The findings of the first national population-based serosurvey indicated that 0.73 per cent of adults in India were exposed to SARS-CoV-2 infection, amounting to 6.4 million infections in total by early May 2020. The seroprevalence ranged between 0.62 and 1.03 per cent across the four strata of districts" (2020). The intention of this essay is not to get into such metrics. Instead, the intention is to flag certain governance issues raised by Covid.

## Governance Issues

**First**, a pandemic is about mortality and morbidity, capturing the requisite data on both and evolving suitable policy responses. If general data on deaths are inaccurate, specific data on Covid-related deaths are also likely to be deficient. Vital statistics mean data on births, death, marriages and divorces. Today, in most countries in the world, including India, this is done through a civil registration system (CRS). The legislative support for this is provided through the Registration of Births and Deaths Act of 1969, which requires mandatory registration of births and deaths.[1]

The law clearly identifies responsibility for registration and specifies penalties for violation. CRS is akin to a complete population census. There has been a sample registration system (SRS) since 1969 to validate the CRS and test its efficacy. "As per the annual report of CRS for 2015, the number of registered deaths reached 6.27 million in 2015 as against an estimated 8.25 million deaths (an estimated three-fourths of all deaths)" (Krishnan and Das 2019). 25% of deaths were simply not registered, and we did not count them. Of course, death registration has improved over time, but not as much as birth registration has. In 2018, compared to 2015, the level of death registration increased to 86%, but in a State like Bihar, the

registration level was still 34.6%, while in Jharkhand, it was 54.9% (2020). Given this, in all States, does one expect all Covid-related deaths to be reported and registered? That sounds unlikely.

**Second**, reporting and registering death is one thing. Ascribing the cause of death is another. There is a process for medical certification of cause of death (MCCD). The latest report, published in 2020, reports figures for 2018 (Report on Medical Certification of Cause of Death 2020). There is an international classification of diseases (ICD) and MCCD must conform with this, empowered by the Registration of Births and Deaths Act of 1969, mentioned earlier. With an urban lens, one often tends to assume that certification of cause of death is universal. As a quote from the 2020 report will illustrate, it is anything but that. "The MCCD under Civil Registration System has been implemented in the States/UTs in a phased manner to provide data on cause of death. However, it has so far been implemented in only certain hospitals, generally in urban areas which are selected by the Chief Registrar of Births & Deaths. Thus, the scheme covers mostly those deaths, which occur in medical institutions located in urban areas. The coverage under the scheme in terms of percentage level of medical certification as well as the type of hospitals covered has not been uniform across the States/UTs. Some of the States have notified only teaching and specialised hospitals under it, whereas, in others, only district hospitals and Primary Health Centres (PHCs) have been brought under its ambit." Therefore, medical certification of cause of death is hardly universal, a point worth remembering when one talks about deaths ascribed to Covid. For the entire country, out of deaths that are registered, only 21.1% are medically certified and the figure is 4.6% in Jharkhand and 5.1% in UP. One should not presume that this is only because of deaths in non-institutional settings. There is also the wrong attribution by physicians. Physicians and medical workers who certify the cause of death are not necessarily familiar with the 14,000 codes for various diseases under ICD. For example, in the 2018 report, 13.1% of total medically certified deaths were classified as "symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified". The eighth highest cause of death in India is something that cannot be pinned down. Consequently, in cross-country rankings of the quality of vital statistics and CRS, India does not perform that well.[2] By no means is this a problem caused by Covid. However, Covid flags the inadequacies very starkly.

**Third**, in connection with Covid, ICMR (Indian Council of Medical Research) has various advisories and protocols, on testing and other matters. How binding are these on States? For example, on 22nd April 2020, ICMR wrote to the Chief Secretaries of all States (Toteja 2020). "I am writing to you, with respect to issues raised by a few states about rapid antibody tests. In its advisory dated 17th April 2020, ICMR had laid down the scope, purpose and usage of the rapid antibody tests. ICMR has always emphasised that the confirmatory test for diagnosis of COVID-19 infection is RT-PCR test of the throat and/or nasal swab, which detects virus at an early stage. I would again reiterate that rapid antibody tests are largely to be used as a tool for surveillance with respect to formation of antibody in persons exposed to the virus. .... We have been given to understand that many States have procured such kits and on State's request, ICMR has also arranged and made available rapid antibody test kits with the clear understanding that these tests cannot replace the RT-PCR tests to diagnose the COVID-19 cases....In view of this, States are advised to follow the prescribed protocol for these tests and use it for the purposes for which these are meant. It is reiterated that to contain Corona Virus infection, RT-PCR tests must be continued vigorously as the principal diagnostic tests." The implication is that this was not being done. The issue goes beyond the false negative of a rapid antigen test (RAT). On 10th September 2020, Union Health Ministry urged States to follow the prescribed protocol. "Union Health Ministry has noted that in some large States,

symptomatic negative cases tested by Rapid Antigen Tests (RAT) are not being followed up by RT-PCT testing. The Guidelines of ICMR as well as the Union Health Ministry clearly state that the following two specific categories of persons must necessarily be retested through RT-PCR tests: (1) All symptomatic (fever or cough or breathlessness) negative cases of Rapid Antigen Tests (RAT). (2) Asymptomatic negative cases of RAT that develop symptoms within 2 to 3 days of being tested negative. In this background, the Union Health Ministry and ICMR have jointly written to all the States/UTs and urged them to ensure that the all symptomatic negative cases of RAT are mandatorily retested using the RT-PCR test. This is necessary to ensure that such symptomatic negative cases do not remain untested and do not spread the disease among their contacts. This will also ensure early detection and isolation/hospitalisation of such false negatives. It has also been reiterated in the joint letter that while the RAT is being used to increase access and availability of testing in the field, RT-PCR remains the gold standard of COVID tests. The Union Health Ministry has also urged the States/UTs to urgently establish a monitoring mechanism in every district (a designated officer or a team) and at the State level to follow up such cases. These teams shall analyse details of RAT conducted daily in the Districts and State and ensure that there are no delays in retesting of all symptomatic negative cases. The aim of States/UTs should be to ensure that no potentially positive case is missed out. They have also been advised to undertake an analysis on a regular basis to monitor the incidence of positives during the RT-PCR tests conducted as a follow up." Had this not become a pervasive problem, there would have been no reason for a press release in the public domain.

**Fourth**, there is a Seventh Schedule in the Constitution, which sets out three Lists – Union List, State List and Concurrent List. In the Seventh Schedule, in the State List, Entry Number 6 mentions "public health and sanitation; hospitals and dispensaries", while Entry Number 10 mentions "burials and burial grounds; cremations and cremation grounds". The health issues we have mentioned are squarely in the State List. They are not even in the Concurrent List. The only exception is Entry Number 30 in the Concurrent List, "vital statistics including registration of births and deaths". With this structure of the Seventh Schedule and with health in the State List, what degrees of freedom does Union Government possess? Since health features in the State List, should the Union Government spend on health? The answer is not axiomatic, because the untied share in the divisible pool of taxes devolved to States through Finance Commissions is meant to be spent on items, such as health, that are in the State List. The obvious counter is that health is important. Therefore, the Union government should spend on health, regardless of what State governments do. There are of course trade-offs and competing claims on scarce financial resources. Ignoring those, it is because health is important that one has Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (PMJJAY). NHA (National Health Authority) implements this flagship health insurance/assurance scheme.[3]

It is because health is important that one has Centrally sponsored schemes like National Health Mission (NHM), with part funding by the Union government. Had it not been for PMJAY and NHM, health outcomes would have been worse. As a counter-factual, the adverse implications of Covid would have been worse. However, to link it to the specific question, if there is Union Government funding, it should naturally be expected that Union government fund flows should be specifically linked to deliverables by States. The result-based funding of NHM does contemplate this, partially. "In 2018-19 this initiative received a big boost when the Mission Steering Group of National Health Mission under the Chairmanship of Health Minister decided to increase the Performance based incentive/penalty from 10% to 20% of the NHM budget. This sent a clear message to all the States that good performance would

be monitored, acknowledged and rewarded. This meant that while 80% of the resource envelope earmarked for the State would be assuredly available, 20% of the resource envelope would depend on State's performance on agreed conditionalities. The States which do not fulfil the criteria could lose up to 20% of funding under NHM" (Health System Strengthening – Conditionality Report of States, 2018-19 2019). Ideally, the performance-based share should be much higher than 20%.

Of what is this 20% a function? There are seven indicators, with differing weights, as indicated in the table below. There is no indicator in this list that measures and quantifies registration of deaths and certification of causes of deaths. The cited Niti Aayog composite health index has 23 indicators. Registration of births is one of these indicators. However, registration of deaths, not to mention the status of MCCD, finds no mention in this evaluation. At the very least, Covid should focus some overdue attention on the quality of death statistics. Various countries, not just the more advanced ones, have developed tools for monitoring the quality of mortality statistics.[4] Such tools can, and should, be used to validate the quality of mortality statistics collected by States and linked to any Union government funding on health.

**Table 1: Showing the indictors of performance under National Health Mission**

| SL No. | Indicators | Weightage |
|---|---|---|
| 1 | Improving Incremental performance based on the NITI Aayog Report | 40 |
| 2 | Operationalizing Health and Wellness Centres (HWC) | 20 |
| 3 | Implementing Human Resource Information System (HRIS) | 15 |
| 4 | Grading of District Hospitals* | 10 |
| 5 | Mental Health Services in Districts as per framework | 5 |
| 6 | Screening of 30+ population for Non-Communicable Diseases | 5 |
| 7 | Rating of PHCs (both Urban and rural) on their functionality | 5 |

**Fifth**, the fourth point is based on the assumption that the Seventh Schedule remains as it stands, with health squarely in the State List. Though the basic structure of the Constitution cannot be changed, amendments can occur and the Seventh Schedule has also been amended since 1950, though only in marginal aspects. The Seventh Schedule, and indeed the entire Constitution is part of a historical evolution process. In so far as Union-State relationships are concerned, the Constitution draws its legacy from the Government of India Act of 1935 and its precursor, the Government of India Act of 1919. As Union-State relationships evolve, and they have changed quite a bit because of GST and because of dismantling Planning Commission's role in devolution of funds, logically, the Seventh Schedule should also be examined. Such changes in entries have been proposed, for instance, for public order, police and agriculture, all three of which are in the State List. Recently, a comprehensive exercise was undertaken by Vidhi, on revamping the Seventh Schedule (Sohini Chatterjee n.d.). Covid is a public health issue. But as of today, nothing on public health is in the Union List. From the State List, we have entry 6 (public health and sanitation; hospitals and dispensaries, entry 9 (relief of the disabled and unemployable) and entry 10 (burials and burial grounds; cremations and cremation grounds). From the Concurrent List, we have entry 16 (Lunacy and mental deficiency, including places for the reception or treatment of lunatics and mental deficient), entry 18 (adulteration of foodstuffs and other goods), entry 19 (drugs and poisons) and entry 29 (Prevention of the extension from one State to another of infectious or contagious diseases or pests affecting men, animals or plants). Given a situation like Covid, would we like the Union government to do something? Assuming we do, beyond entry 29, on inter-State spread, the Seventh Schedule of the Constitution confers no powers on Union government to act.

**Sixth**, from an epidemic, Covid has moved to the pandemic stage and there are scale differences between an epidemic and a pandemic. However, let us use the two words synonymously. The relevant piece of legislation is old. It is the Epidemic Diseases Act of 1897. Since people are often unaware of the minute details of statutes, it is necessary to quote Section 2 of the Epidemic Diseases Act. "(1) When at any time the State Government is satisfied that the State or any part thereof is visited by, or threatened with, an outbreak of any dangerous epidemic disease, the State Government, if it thinks that the ordinary provisions of the law for the time being in force are insufficient for the purpose, may take, or require or empower any person to take, such measures and, by public notice, prescribe such temporary regulations to be observed by the public or by any person or class of persons as it shall deem necessary to prevent the outbreak of such disease or the spread thereof, and may determine in what manner and by whom any expenses incurred (including compensation if any) shall be defrayed. (2) In particular and without prejudice to the generality of the foregoing provisions, the State Government may take measures and prescribe regulations for the inspection of persons travelling by railway or otherwise, and the segregation, in hospital, temporary accommodation or otherwise, of persons suspected by the inspecting officer of being infected with any such disease." Notwithstanding ICMR, Union Health Ministry and NHM, the right and responsibility for acting against something like COVID vests with States alone. Union government's right and responsibility is limited to Section 2A of the Epidemic Diseases Act. "When the Central Government is satisfied that India or any part thereof is visited by, or threatened with, an outbreak of any dangerous epidemic disease and that the ordinary provisions of the law for the time being in force are insufficient to prevent the outbreak of such disease or the spread thereof, the Central Government may take measures and prescribe regulations for the inspection of any ship or vessel leaving or arriving at any port in the territories to which this Act extends and for such detention thereof, or of any person intending to sail therein, or arriving thereby, as may be necessary." Except for action taken at the border (seaports and airports), there is nothing that Union government can do. This can hardly be satisfactory.

Consequently, regardless of the Union government's template on lockdown or un-lockdown, States possess the legal right to have their own templates, which can be at variance with what the Union government proposes. This adds to the clutter, legally speaking. Many public goods and services are delivered at the local level, not at the level of Union or State governments. A valid argument has been advanced about India's governance being excessively centralised. Therefore, a revamped Seventh Schedule should have a Local Body List. To that end, but still falling short of it, the 74th Constitutional amendment in 1992 introduced a Twelfth Schedule, mentioning powers, authority and responsibilities of municipalities. Entry 6 in that List reads, "public health sanitation, conservancy and solid waste management". Legally speaking, who decides on lockdown or un-lockdown? Will it be Union government? Will it be State government? Will it be the municipal government? Will it be the District Magistrate, invoking, and subsequently not invoking, Section 144 of the Code of Criminal Procedure? This does not contradict the requirement of zeroing in on geographical areas where infections are high, such as containment zones, and not generalising based on red States or red Districts. The point that is being made is a more fundamental one, about a lack of legal consistency in powers granted to different layers of government. The one country argument should not be only for purposes of indirect taxes like GST but should equally apply to situations of national emergency.

This is not a new issue. It is worth quoting from the Constituent Assembly Debates in September 1949.[5] To quote H. V. Kamath, "While commending my amendment seeking to transfer public health, sanitation, hospitals and dispensaries to the Concurrent List, I should like to state that public health has been the Cinderella of portfolios in the Cabinet of our country. During the British Regime, it was especially so, very sadly neglected and not much provided for: as a result of which the health of the nation

has fallen to C-3 standards, it is the object of our government today to raise the health of the nation from C-3 to A-I standard. If this were the aim of our government, we could not do better than make public health a Concurrent subject... I know, from my experience of certain provinces, that the health schemes that are launched by provincial Governments while commendable as regards their good intentions-, fail to achieve the desired consummation, because of the lack of direction and coordination from the Centre." Brajeshwar Prasad endorsed this view. "I do not understand the opposition of provincial ministers in this respect. If they feel that they are in a position to deal with all problems of public health and sanitation, if they are of the opinion that hospitals and dispensaries can be run on efficient lines without the help and co-operation of the Government of India, they are welcome to hold their opinions....If you go to a general hospital you will see that flies and bugs are multiplying, that the clothes of the nurses are dirty, that phenyl and medicines are not available and the patients are not treated well. There is utter neglect and deterioration in efficiency. Therefore, I feel that public health, sanitation, hospitals and dispensaries should be included in List I." It is impossible not to empathise with these views. Undoubtedly, the fear of excessive centralisation should not apply to situations like a national epidemic.

To take a related example, entry 81 in the Union List reads, "inter-State migration; inter-State quarantine". In the course of Covid, a problem faced was that of inter-State migrants. The Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act has acted since 1979. Among other things, this specified the responsibility of the contractor. "(a) to furnish such particulars and in such form as may be prescribed, to the specified authority in the State from which an inter-State migrant workman is recruited and in the State in which such workman is employed, within fifteen days from the date of recruitment, or, as the case may be, the date of employment, and where any change occurs in any of the particulars so furnished, such change shall be notified to the specified authorities of both the States; (b) to issue to every inter-State migrant workman, a pass book affixed with a passport size photograph of the workman and indicating in Hindi and English languages, and where the language of the workman is not Hindi or English, also in the language of the workman, - (i) the name and place of the establishment wherein the workman is employed; (ii) the period of employment; (iii) the proposed rates and modes of payment of wages; (iv) the displacement allowance payable; (v) the return fare payable to the workman on the expiry of the period of his employment and in such contingencies as may be prescribed and in such other contingencies as may be specified in the contract of employment; (vi) deductions made; and (vii) such other particulars as may be prescribed". Under the Seventh Schedule, the responsibility is with the Union government, but implementation and enforcement vests with the States. Had the intent of the legislation been enforced, there would have been a register of migrant workers, with portability of welfare benefits for returning migrants. Nevertheless, the statute was not enforced.

**Seventh**, in fairness, one should mention the Disaster Management Act of 2005. Covid is a disaster and there can always be other natural and man-made disasters. As a reaction to Covid, Union Home and Health Ministries have invoked the Disaster Management Act. Under the legislation, there must be national plans, State plans, and even district plans to handle disasters. Though all States and union territories have disaster management plans now, in addition to the national one, the quality of these leaves a lot to be desired, and most districts still do not have district-level disaster management plans. Therefore, in the unfortunate event of the country facing another disaster, natural or man-made, the country is still not adequately prepared. One reason for that may be legal. Any piece of legislation must obtain support from the Constitution. Does the Constitution have an entry on disasters? Under what provision was the Disaster Management Act therefore passed? The Report of Rajya Sabha's Standing Committee tells us,

"The proposed legislation is relatable to Entry 23 (Social Security and Social Insurance) in the Concurrent List of the Constitution. This will have the advantage that it will permit the States also to have their own legislation on disaster management" (One Hundred and Fifteenth Report on The Disaster Management Bill 2005). Legislation on disasters under the umbrella description of social security and social insurance cannot possibly sound right.

It is worth quoting from the third report of the Second Administrative Reforms Commission (2006): "Parliament has enacted the Disaster Management Act, 2005 by invoking entry 23 namely 'Social security and social insurance, employment and unemployment' in the Concurrent List even though all aspects of crisis management cannot be said to be covered by this entry. Similarly, some States have also passed laws governing disaster management... Disaster management encompasses all activities including preparedness, early warning systems, rescue, relief and rehabilitation. The term disaster includes natural calamities, health-related disasters (epidemics), industrial disasters and disasters caused by hostile elements such as terrorists. There are already various entries in the three lists, which deal with some aspect or other of disaster management. 'Public order' finds a place in the State List, as does Public Health. Entries 14 and 17 in the State List deal with Agriculture and Water respectively. Environment and Social Security are included in the Concurrent List. Atomic energy and Railways are part of the Union List. In addition, after the 73rd and 74th amendments, all civic powers have been delegated to local bodies. Due to the cross-cutting nature of activities that constitute disaster management and the vertical and horizontal linkages required which involve coordination between the Union, State and local governments on the one hand and a host of government departments and agencies on the other; setting up of a broadly uniform institutional framework at all levels is of paramount importance. The legislative underpinning for such a framework would need to ensure congruence and coherence with regard to the division of labour and responsibilities among the agencies at the Union, State and other levels. This could best be achieved if the subject of Disaster Management is placed in the Concurrent List of the Constitution. Unlike in other cases of proposals for inclusion in the Concurrent List, State Governments may also welcome this, as this will also enable them to have legislation without ambiguity regarding the entry." Hence, there was the recommendation that "A new entry, "Management of Disasters and Emergencies, natural or man-made", may be included in List III (Concurrent List) of the Seventh Schedule of the Constitution." It is impossible to disagree with this, though our view, articulated in this essay, is that there should be a comprehensive review of the Seventh Schedule.

## Conclusion

Covid, emanating from outside, caught India unawares, as it did the rest of the world. It was an exogenous shock and Union, State and local governments, and citizens, have coped as best as they can. By any indicator, given India's geographical area, population and level of development, India has handled the pandemic remarkably well. At the time of writing, we are still in the midst of the pandemic and the tapering off and subsequent economic recovery are both somewhat uncertain. However, Covid also provides a trigger for the country to evaluate its state of preparedness for future crises, health-related or otherwise. This essay has highlighted seven legal and governance issues that bear examination.

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## Notes

[1] There have been convincing arguments, and a Bill, for mandatory registration of marriages, but that has not yet become law.
[2] See, for example, Mikkelsen et al (A global assessment of civil registration and vital statistics systems: monitoring data quality and progress 2015)
[3] https://pmjay.gov.in/
[4] Analysis of National Causes of Death for Action (ANACONDA), developed at the University of Melbourne, is an example of this.
[5] These quotes from the Constituent Assembly debates are taken from https://indiankanoon.org/doc/282475/