Natural Resources for Human Health
eISSN: 2583-1194

Original Research

Received 03 July 2026
Revised 10 Aug 2026
Accepted 25 Aug 2026

Natural Resources for Human Health 2026, Vol. 6 (19s): 490–495

KEYWORDS:
Healthcare System, Disaster Management, Health Law, Floods, Disaster Management System

Disaster Law and the Right to Health: Strengthening Legal Frameworks for Resilient Healthcare Systems During Natural Disasters

[1]Dr. C. Fowmina, [2]D. Deva, [3]R. Samraj David, [4]P. Jyothi, [5]Hema Varsshini C

[1]Associate Professor Vinayaka Mission's Law School, Chennai. Vinayaka Mission's Research Foundation (Deemed to be University)
[2]Research Scholar Vinayaka Mission's Law School, Chennai. Vinayaka Mission's Research Foundation (Deemed to be University)
[3]Research Scholar Vinayaka Mission's Law School, Chennai. Vinayaka Mission's Research Foundation (Deemed to be University)
[4]Research Scholar Vinayaka Mission's Law School, Chennai. Vinayaka Mission's Research Foundation (Deemed to be University)
[5]Assistant Professor of Law School of Law St Joseph University

ABSTRACT: The vulnerabilities of India's healthcare system are most apparent when the need for support is highest; in times of natural disasters. In this study, we examine the relationship between India's Disaster Management Act (DMA) and the right to health as guaranteed under the Indian Constitution. We contend that the existing legislative framework considers the provision of healthcare services during a disaster to be secondary to the disaster response, rather than as an essential element of that response. Through a doctrinal analysis of relevant statutory provisions, constitutional law cases, institutional structures and real-world examples, we have identified structural weaknesses and suggested amendments to create a distinct, specialized disaster-related health law framework for India.

INTRODUCTION

In the past few years, we have seen an increased number and strength of natural disaster events (i.e. flooding, typhoons/cyclones, earthquakes) and/or health-related crises (i.e. pandemics) in India. Some examples of these types of events include the 2018 Kerala Floods and the COVID-19 pandemic. Both of these events clearly indicate that disaster management is not a main focus of the healthcare system; rather, the healthcare system is usually overwhelmed with the same stressors it would be managing during a disaster. This conflict of interests is what prompted me to conduct this study. The Indian Constitution does not explicitly provide the right to health. However, the courts have interpreted this right as part of Article 21 (Right to Life). Disaster governance in India is governed by the Disaster Management Act, 2005, which provides for a multi-level institutional framework for disaster preparedness and response.[1] This statutory framework was developed primarily to respond to disaster situations and provide assistance, rescue, relief and rehabilitation. This framework does not address the issue of whether individuals will continue to receive healthcare services as a right during or after a disaster.

STATEMENT OF THE PROBLEM

The constitutional recognition of the right to health and the establishment of an administrative body specifically tasked with managing disasters has not resulted in a sufficient level of legal/institutional capacity to address the post-disaster health care

[1] The Constitution of India, Article. 21; *see* Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 S.C.C. 37

needs of individuals who have experienced a disaster in India. Specifically, there are no existing provisions that provide for continuing health care after a disaster; appropriate levels of resources are available prior to a disaster; and there is a system in place to facilitate the coordination of EMS after a disaster. As such, many individuals die unnecessarily after a disaster; many individuals lose access to health care after a disaster; and, overall, systems fail to effectively respond to emergencies. It is therefore imperative to analyze these deficiencies and create a model for disaster resilient health care that can be enforced legally.

REVIEW OF LITERATURE.

1. **Subhradipta Sarkar, "The Right to Sanitation as a Challenge for Post-Disaster Scenarios," Christ University Law Journal, Vol. 2, No. 1 (2013), pp. 97–11, ISSN 2278-4322**
   This paper will examine the previously unexamined connection between sanitation, and the general right to health, housing and water in India after disasters. The author uses the government's response to the 2004 Indian Ocean Tsunami and Cyclone Aila (2009) to demonstrate how poor drainage, non-functioning toilets, and restricted availability of safe drinking water in disaster relief shelters led to unhealthy and unsafe conditions for those who were displaced from their homes. Sarkar notes that even though the Supreme Court of India has judicially recognized a "right to sanitation" as part of the right to life guaranteed in Article 21, and the Disaster Management Act, 2005 includes references to it, there is a large gap between recognizing those rights through legal mechanisms and implementing them on-the-ground.
2. **Aruna Kumar Malik, "The Right to Health," Indian Journal of Human Rights, University of Hyderabad, Volume 8, Numbers 1 and 2, ISSN: 2230-7869**

The article, titled "The Right to Health: A Component of India's Larger Body of Constitutional and Human Rights Law," will be examined for the purpose of analyzing the right to health as part of India's larger body of constitutional and human rights law. The article was published in a special issue on "disaster vulnerability" and is one of the earliest examples of academic research that addresses the relationship between health rights and those affected by disasters or other marginalized populations. While the entire article must be read separately to evaluate the accuracy of any specific claims made within it, its inclusion in the same issue as many other articles concerning disasters indicates that, at least since 2004, there has been a growing academic awareness that health rights and disaster preparedness are interrelated issues in the context of human rights discussions in India.

3. **Nabamita Paul Ray, "The Right to Health: A Study on the Indian Experience," Indian Journal of Law & Justice, Vol. 8 No. 1 (March 2017) pp. 59-68. ISSN 0976-3570.**

The study examines how a right that was not originally present in the text of the Constitution became legally effective by means of judicial interpretation. The study was published in the Indian Journal of Law and Justice. It appears to relate to the evolution of Article 21 and the role of the judiciary in transforming health from a policy objective as part of the Directive Principles to a legally enforceable aspect of the right to life. As such, it establishes a doctrinal foundation for arguments regarding the state's responsibility to deliver healthcare.

4. **"The Right to Health Care in India: A Study of Constitutional Guarantees," Indian Journal of Law and Justice, Vol. 7, No. 2, pp. 158-172, ISSN 0976-3570**

This article is primarily going to look at the constitutional provision(s) and principle(s) that collectively make up the right to healthcare in India. It is also very likely that the article will focus on the connection between the Directive Principles of State Policy and Article 21 of the Indian Constitution, as a means of establishing healthcare as a constitutional right as opposed to simply being a policy objective. Finally, it appears as though this article is a follow up to Ray's 2017 study that was published in the same journal and therefore part of an expanding body of doctrinal scholarship that looks at how constitutional language and judicial decision making have defined the scope of the right to healthcare in India.

5. **"Constitutional Perspectives on the Right to Health in India: A Study," IUP Journal of Law Review, IUP Publishers, ISSN 2231-3095.**

This paper will explore how India's founders originally incorporated the right to health as part of the non-justiciable Directive Principles of State Policy, and how the courts have since interpreted that right as a fundamental right pursuant to Article 21. This paper will further assert that health is an integral aspect of each human right, and therefore when someone has their health

denied they have also been denied several of their other rights. Finally, this paper will also claim that the best method to ensure individuals have reasonable access to health care is via legislative action (e.g., legislation, programs, services) as opposed to reliance on court-based interpretations, which is particularly relevant to advocates seeking a separate right to health law in India.

OBJECT OF THIS STUDY.

The object of this paper is to examine how the right to health has been created through both constitutional and statutory laws in India.

RESEARCH QUESTION:

1) How adequate is the existing legal system in India regarding protecting people's right to health in times of disaster?

HYPOTHESIS:

India's current disaster management laws do not include all aspects of a citizen's right to health care. Thus, responses to healthcare requirements caused by natural disasters are fragmented and non-integrated into the legal framework of disaster management as a continuous system of care.

RESEARCH METHODOLOGY

The research for this project will utilize a doctrinal methodology. The researcher will examine relevant provisions of the Constitution, statutes, judicial decisions, and international agreements and treaties as well as conduct case studies on a number of major disaster events which have taken place within India. While the researcher plans to compare the Indian legal system with those of some foreign countries, the focus of the research remains on the Indian legal system and how it applies to disaster management. The researcher does not plan to gather data through primary empirical fieldwork.

CONCEPTUAL FRAMEWORK FOR DISASTER LAW & THE RIGHT TO HEALTH

The Disaster Management Act (DM Act) defines a disaster as an extreme catastrophe produced by either man-made or natural causes that can result in mass casualties or extreme human suffering. Therefore, "disaster law" refers to all of those statutory and regulatory laws related to disaster prevention, mitigation, preparation, response, and recovery. Compared with the right to health, which is not a separate constitutional right in India, but has been judicially interpreted to fall within the scope of the right to life. There is a major area of overlap between disaster law and the right to health at a conceptual level. Disasters pose one of the most serious threats to the realization of the right to health, yet disaster laws traditionally have focused on logistical support (i.e., sheltering people, feeding people, evacuating people), and less so on protecting the individual's right to access to health services. This conceptual split between a rights-based health model and an administrative disaster model is the primary tension that we will explore in this paper[2].

THE BASIS FOR INDIA'S "RIGHT TO HEALTH" IS FOUND WITHIN THE CONSTITUTION OF INDIA.

Article 21 of the Indian Constitution says that every citizen has a right to exist and a right not to be deprived of his/her life or personal freedom except as provided by law. In addition, the Indian Judiciary continues to broaden the definition of 'right to exist,' stating that existence is not just about survival but also existence with dignity. A way of existing with dignity is by having access to the medical services and health care facilities necessary for maintaining your health. In 1996, the Supreme Court of India in the case of Paschim Banga Khet Mazdoor Samity v. State of West Bengal[3], ruled that the failure of a government operated hospital to provide emergency medical treatment to an individual following an accident violates Article 21. The ruling set the precedent that the Government must create adequate medical care facilities for citizens requiring immediate attention.

Furthermore, the Right to Health is also based on other articles of the Directive Principles of State Policy such as: Article 38 - Promote Social Welfare; Article 39 (e) - Protect Workers' Health; Article 41 - Provide Public Assistance to Individuals when Sick or Disabled; Article 47 - Improve Nutritional Status and Public Health. These articles are not legally binding on individuals to have a right to health, but rather they provide guidance for future legislation and policies regarding health. Thus, the above

[2] The Disaster Management Act, No. 53 of 2005
[3] 1996 SCC (4) 37

articles create a strong foundation from which to consider the Right to Health as a constitutional entitlement that can be protected and/or expanded during periods of disaster when populations are extremely susceptible to health risks.

THE INTERNATIONAL LAW GOVERNING HEALTH AND EMERGENCY RESPONSE.

Beyond its own constitutional law, India is also bound by other international agreements. As a signatory to the International Covenant on Economic, Social, and Cultural Rights (ICESCR), India is obligated to work towards providing the maximum attainable standard of health for each of its citizens, as specified in Article 12. Similarly, the World Health Organization (WHO) Constitution establishes health as a fundamental human right and obligates all member states to establish and support strong health care systems and be prepared for emergencies.[4]

The Sendai Framework for Disaster Risk Reduction (2015-2030) was adopted at the UN World Conference in Sendai, Japan. The Sendai Framework explicitly called for increasing resilience of the health sector to disasters, as well as incorporating health into disaster risk reduction plans. While India has been a signatory to the Sendai Framework and has created several national policies that align with the goals outlined within the Sendai Framework, there remains a large gap between India's international commitments and its ability to enforce them within India. A significant reason for this delay is that the commitments made through the Sendai Framework are non-binding.

DISASTER MANAGEMENT FRAMEWORK OF INDIA

The Disaster Management Act of 2005 remains the primary statutory basis for addressing disaster management throughout India. It provides a definition of responsibilities among federal, state and local disaster response agencies, and mandates each level of government to prepare disaster management plans. Although the Act includes several provisions concerning health, the focus of those provisions is mainly on administration (i.e., authority to seek help/resources and coordinate disaster response activities), as opposed to being rights-based i.e., the Act does not establish an enforceable right to receive uninterrupted medical care from disaster response agencies.

The Epidemic Diseases Act of 1897 was enacted when India was still under British rule. It has been used widely by states in India throughout the COVID-19 pandemic to authorize the use of extreme measures to prevent the spread of infectious diseases. However, the Epidemic Diseases Act was not designed to address the public health problems we are currently experiencing nor did it have the protection of individuals' rights as we do today. On the other hand, the National Health Policy of 2017 outlines what should be achieved in terms of universal health care; however, the National Health Policy is a non-binding policy document and as such does not contain any disaster-specific enforcement mechanisms.[5]

The existing legal framework for responding to emergencies (disasters, epidemic outbreaks, and public health policies) is disjointed and unconnected to each other. As a result of this disjunction, there is no single, cohesive body of law that can address the multiple aspects of emergency response. The lack of connection between the different legal frameworks that apply to emergency response creates significant gaps in the accountability of the health care system when responding to emergencies.

THE INSTITUTIONAL STRUCTURES

Institutional structures are: National Disaster Management Authority (NDMA), State Disaster Management Authority (SDMA), District Authorities, and Health Care Coordination.

The Disaster Management Act creates a three-tier institutional structure. The first level of this structure is the National Disaster Management Authority (NDMA), which is headed by the Prime Minister. The NDMA is responsible for creating national policies and guidelines, including sector-specific guidelines on medical preparedness and mass casualty management. These guidelines, however, are non-binding. The second level of the structure includes the State Disaster Management Authorities (SDMAs). Each SDMA is responsible for translating national policy into action based upon the specific requirements of that state. In addition, each SDMA is responsible for coordinating with the health department of that state. There is a great deal of difference between states as to how well-integrated their SDMAs are with their state health departments. One example of a

[4] International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3
[5] Revi, A. (2012). Climate change risk: An adaptation and mitigation agenda for Indian cities. In Adapting Cities to Climate Change (pp. 311-330). Routledge.

state that has created a highly integrated model for disaster health coordination is Kerala. Many other states, however, have demonstrated little or no integration.[6]

The District Disaster Management Authority (DDMA) is a first responder organization operating at the grass roots level. Its close ties to District Collectors and Chief Medical Officers allow it to coordinate local health care resources. However, this is also the most challenging aspect of its work, as there are often personnel shortages of trained individuals, delays in activating disaster response protocols, and lack of accurate mapping of available resources.

Disaster responses are coordinated across various levels of government, such as the Ministry of Health and Family Welfare, the Integrated Disease Surveillance Program, and the National Disaster Response Force; as well as other health agencies on an "as-needed" basis. There currently exist no laws that mandate the use of real-time data sharing and/or standardization of operating procedures for hospital disaster preparedness. These lack of mandates lead to uncoordinated disaster response efforts by hospitals and other health care providers rather than coordinated actions by institutions.

TRENDS IN THE COURTS AND ANALYSIS OF TRENDS THROUGH HISTORICAL CASE LAW.

The judiciary has had to intervene at times when there was a gap between what the Legislature and Executive were doing. After the decision in Paschim Banga Khet Mazdoor Samity, there has been an exponential increase in judicial intervention after the onset of the COVID 19 pandemic. Both the High Courts and the Supreme Court have entertained several Public Interest Litigations (PIL) concerning inadequate supply of oxygen, lack of hospital beds and other essential drugs. Courts have ordered the Government to ensure equitable distribution of oxygen supply and develop national guidelines for allocating oxygen, thereby serving as an interim emergency regulatory body in the absence of adequate statutory authorization.

Judicial intervention provided a short-term solution to help people get the care they needed; however, this intervention also showed how the present judicial system is structurally weak. That is, because there was no way to enforce access to health care under the disaster law, the court systems had to use many different types of "ad hoc" solutions. While there were certainly times when the court system needed to step in and act as an activist, we cannot allow the court system to substitute for a larger, comprehensive legislative plan.[7]

CASE STUDIES: HOW THE HEALTH CARE SYSTEM RESPONDED TO MAJOR DISASTERS IN INDIA

The 2018 floods in Kerala showed us what we can accomplish when we coordinate our healthcare efforts at a local level i.e., when we have strong community and local government involvement, we are able to minimize some of the failures experienced, but the disruptions in the supply chain, as well as the outbreak of waterborne illnesses that occurred after the floods, show us that there were major gaps in our post-disaster health surveillance. Cyclone Fani (Odisha, 2019) demonstrated how effective our evacuation planning was; but it also demonstrated how poorly we were able to restore primary care services after the cyclone.

The COVID-19 pandemic which I am going to call a health disaster is the prime example of what happens when there are no legal frameworks to establish additional hospital capacity, oxygen supply chains and manage hospital beds, and therefore, the courts and states have to create rules for the first time. All three of the examples above show a similar pattern namely, that the disaster management system in India is capable of reacting rapidly to emergencies, but without being legally required to maintain health care delivery throughout the entire duration of a crisis, it cannot guarantee continued access to health care.

COMPARATIVE STUDY OF GLOBAL BEST PRACTICES

The above-mentioned comparative jurisdictions are other good examples of how a nation can create a comprehensive disaster health law system. Because Japan experiences many disasters, they have created laws that mandate all hospitals to have disaster preparedness plans in place, created national stockpile systems for disaster supplies, and clearly defined the relationship between

[6] Thomalla, F., & Larsen, R. K. (2010). Resilience in the context of tsunami early warning systems and community disaster preparedness in the Indian Ocean region. Environmental Hazards, 9(3), 249-265. https://doi.org/10.3763/ehaz.2010.0037

[7] vuckovic, d., & slavkovic, m. (2024). The impact of the sendai legal framework on the disaster risk reduction and emergency management system in the republic of serbia. Researchgate. Retrieved from https://www.researchgate.net/publication/386598719_the_impact_of_the_sendai_legal_framework_on_the_disaster_risk_reduction_and_ emergency_management_system_in_the_republic_of_serbia.

their disaster management agencies and their health departments. Likewise, the United States has passed numerous laws (Stafford Act, Public Health Service Act) which authorize federal emergency health authority and trigger the use of federal resources.[8]

The main difference between India's system and the other systems mentioned above is that there is no direct legislative connection in India to the area of disaster management and the continued provision of health care services. Additionally, unlike India's systems, the requirements described above are statutory requirements for health care facilities rather than just suggested guidelines. A similar legislative integration may improve India's disaster management system, which is currently uncoordinated and based on policies.

CONCLUSION

While there is an institutionally strong disaster laws system in place in India, as of now there are no formal links between this system and the constitutional right to health. As such, whether or not health-care services are able to operate during disasters will be determined by various elements such as discretionary authority of public officials; the judiciary making decisions; and how much capacity each locality has to respond to a disaster. There are no formal legal obligations that exist to determine if or when health-care services can continue operating during a disaster.

RECOMMENDATIONS:

1. The DM Act should be revised to include a statement in law that states health care will always continue to be available.
2. A state-mandated legal requirement for hospitals to create and maintain disaster preparedness plans similar to those currently utilized in Japanese health care systems.
3. Each NDMA, SDMA and DDMA can create a dedicated Health Disaster Coordination Cell.
4. The development of formal legal mechanisms that facilitate the timely sharing of information between various types of emergency responders (e.g., those who respond to natural disasters) and public health organizations.
5. The state must pass a disaster health law to incorporate the health rights in our state constitution into the current disaster management structure.

Therefore, developing a robust legal system for disasters in India that is consistent with the right to health is not merely a question of public policy; it is a constitutional mandate. In order to realize the true meaning of the right to life as protected under Article 21 of the Indian Constitution, there must be a strong and functioning health care system that is protected by law against the negative effects of disasters.

REFERENCES

[1] Aruna Kumar Malik, *Right to Health*, 8 Indian J. Hum. Rts. 98 (2004).
[2] *Constitutional Perspective of Right to Health in India: An Analysis*, IUP J.L. Rev. (IUP Publ'ns).
[3] International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3.
[4] Nabamita Paul Ray, *Right to Health: A Study in the Indian Perspective*, 8 Indian J.L. & Just. 59 (2017).
[5] National Health Policy, 2017, Ministry of Health and Family Welfare, Government of India.
[6] Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 S.C.C. 37 (India).
[7] *Right to Healthcare in India: A Study of Constitutional Guidelines*, 7 Indian J.L. & Just. 158 (2016).
[8] Subhradipta Sarkar, *Right to Sanitation: A Challenge in the Post Disaster Situations*, 2 Christ U. L.J. 97 (2013).
[9] The Disaster Management Act, No. 53 of 2005, INDIA CODE.
[10] The Epidemic Diseases Act, No. 3 of 1897, INDIA CODE.

[8] Thomalla, F., & Larsen, R. K. (2010). Resilience in the context of tsunami early warning systems and community disaster preparedness in the Indian Ocean region. Environmental Hazards, 9(3), 249-265. https://doi.org/10.3763/ehaz.2010.0037