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Pandemic, Pandemonium and Public Health Care

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ABSTRACT

The outbreak of the novel Coronavirus has posed serious introspection to many aspects of our life. It has also had a debilitating effect on the health and economy in the global and individual scale. It poses a big cruncher question on the state in which today's public healthcare system stands in defying the odds put in by the pandemic. The epidemic has also cast light on the disparities and obscurities that are present in today's public healthcare system not only in the national but international level also. With a middle income country like India, having vast population and considering the changes brought into this sector by reforms in recent years, it is axiomatic that achieving universal health care will not be a mirage anymore if for further effective improvements being under taken in this sector. The article gives a retrospective glimpse into the state of public healthcare in India with respect to the global level and also touches on the aspect of how certain countries efficiently tackled the first phase of COVID-19 with their public health care systems. It further articulates the imminent steps and measures India has taken in its battle against COVID-19 in the national and state level as well as the legislations that acted as a panacea in resolving the pandemic.

I. INTRODUCTION

India's health system mostly comprises two integrants public and private. The public health system consists of three tiers namely, primary, secondary and tertiary level. The bottom of this tier pyramid is occupied by the primary health care centers, sub centers, community centersetc. which facilitates free and accessible healthcare to rural people. The second tier is usually a little complex structure than the former ones which includes district hospitals, taluk hospitals etc. generally located in the urban areas. This facilitates and supports the primary health centers and is more of a relief to the urban poor. The third tier usually consists of central level institutions like AIIMS, medical college hospitals, and other regional and specialized hospitals. These institutions are generally located in urban areas and facilitate super specialty treatments. Healthcare services in India are still coping up with the workforce shortage, inadequate funds, indigent

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infrastructure, quality and affordability of Healthcare. Being a country with nearly 1.3 billion people mostly constituted by the rural poor and middle income families, the reliance and need of a public healthcare is a necessity for the vast majority's medical treatment. But when certain required aspects are not satisfactory they resort to private corporate hospitals for a better treatment option envisioning that the infrastr-ucture influences medical outcome unquestio-ning the faith in private providers. The public healthcare activities provided by the state and central government is an indispensable action, the primary goal being to improve, protect and restore the health of the population and COVID-19 has been an eye opener for us to reflect into our healthcare system. The changes brought in and implementing new public health care schemes will certainly decrease the vulnerability to future pandemics and public health emergencies. Public healthcare system in India is an efficient system which has the potential to serve efficient, quality and affordable services to the entire population. With systematic and comprehensive reforms made to the sector it is sure to evolve out of the rickety state.

II. A COMPARATIVE ANALYSIS ON CER TAIN FACETS OF PUBLIC HEALTH CARE

Health expenditure:

[3]According to the report by economic co-operation and development (OECD) on an average a large number of OECD countries like New Zealand, Chile and Korea spend about 8-10% of towards healthcare and a relatively few countries like Mexico and turkey spend less than 6%. The average health expenditure among OECD countries were found to be 8.8%.[4]According to the National Health Profile 2019 (NHP) India's health expenditure as a part of its GDP(2017-2018) accounts for about 1.28 percent which is relatively low accounting to less than one percent when compared to other developing countries like Brazil which spends 7.5% of its GDP on health, Bhutan spends 3.6% and Bangladesh allocates 2.2%.[5]The U.S tops the list as it spends a whopping 16.5% of the GDP in healthcare followed by other developed nations like South Korea 8.1%, Japan 10.9%, France 11%, Germany 11% devoting a high share toward the health expenditure. This shows that a majority of countries have increased their health expenditure spending, leveraging better healthcare access and facilities to achieve the goal of universal health care. The NHP has thrown light on how India stands lowest even when compared to the low income countries in their expenditure towards healthcare.

Out of pocket expenditure:

[6]A 2018 lancet study published in the British medical journal showed that in 2011-12 nearly 38 million Indians fell below the poverty threshold because of the high out of pocket

[3]Organisation for economic cooperation and devolepment, Health expenditure and financing, (15 Nov 2020), https://stats.oecd.org/Index.aspx?DataSetCode=SHA

[4]Government of India, National Health Profile, 2019, 14th Edition, http://www.cbhidghs.nic.in/showfile.php?lid=1147

[5]Supra 1.

[6] Supra. 2.

expenditure spending on healthcare and medical costs alone. [7]According to national health estimates 2016-2017 the household pocket expenditure in India accounts to 58.7% of the total health expenditure. The out of pocket expenditure constitutes about 53.2% of the current health expenditure according to the report. This shows prefacelythe high spending on health is due to the low insurance coverage and a shambling public health system. Most people in India resort to the private health care providers for better and efficient treatment. This has brought a stark importance on the much needed private and public health sector cooperation in serving its citizens better, affordable and quality healthcare.

Access and availability of healthcare:

[8]According to the global burden of disease study published in the lancet the health and quality index score of India in 2016 is 41.2 which is least when compared to neighbouring states like Bangladesh (scored 47.6) and Sri Lanka(scored 70.3). India's score when compared to the health care index released in 2000 by the world health organization has shown some improvements. According to the study Finland, Norway, Australia and Netherlands showed high standards of healthcare access and quality. India is also the least scorer among the Brics nation ranked 145th out of the total number of 195countries. Within India, Goa and Kerala were among the top scorers and the worst being in Uttar Pradesh. The statistics also reveal the long points gap between one state to another indicating the revitalization needed in this sector. The NitiAayog health index report of 2018 describes Kerala as taking the first place followed by Punjab, Tamil Nadu, Gujarat in terms of health care access and availability. The bottom places are occupied by Rajasthan,Bihar, and Odisha.

Pandemic preparedness:

[9]The Global Health Security (GHS) Index, a report from the Johns Hopkins Center for Health Security and the Economist Intelligence Unit in 2019 measures pandemic preparedness on a score of 1-100. It mainly assesses a countries ability to handle crisis and preparedness for pandemics and other biological catastrophes with 100 being the highest level of preparedness in the scale.the top scorers were found to be US with a whooping score 83.5 followed by other countries like UK, Netherlands, Australia, Canada and other European countries. India was seen as a middle scorer taking 54th rank behind its neighbor China which took the 51st rank. So of the important findings of this assessment came to be that no country is fully prepared for a pandemic attack and identified the existence of preparedness gaps. The report also showed that

[7] Government of India, National Health Accounts Estimates, 2016-2017(Oct.2019), http://nhsrcindia.org/sites/default/files/FINAL%20National%20Health%20Accounts%202016-17%20Nov%202019-for%20Web.pdf.

[8]SwagathaYadavar, India worse than Bhutan, Bangladesh in healthcare, ranks 145thglobally, (May.24, 09:16 P.M), https://www.business-standard.com/article/current-affairs/india-worse-than-bhutan-bangladesh-in-healthcare-ranks-145th-globally-118052400135_1.html.

[9] Building Collective Action and Accountability, GLOBAL HEALTH SECURITY INDEX, (Oct. 2019), https://www.ghsindex.org/wp-content/uploads/2019/10/2019-Global-Health-Security-Index.pdf

at least 75% of countries scoredlow for biosecurity, emergency response operations, linking public health and security authorities, and dispensing effective medical measure during the biological catastrophe. Additionally, most countries do not demonstrate the practice of linking public health and security authorities for a better performance.

Healthcare workforce ratio:

[10]According to the health ministry data released in 2019 (NHP) the ratio of doctor to patient equates to 1:1404 which means there is one doctor for every 11,082 people. The world health organization recommends a healthy ratio of 1 doctor per 1000 people. The stats show that we are over ten times the doctor patient ratio recommended which brings into the picture the problem of shortage of workforce. The intensity of this problem has enlarged because of the pandemic. [11]The OECD report 2017 also shows that India along with Indonesia and South Africa have significantly less than one doctor to 1000 population compared to the average of 3.5 doctors per 1000 population that the OECD countries maintained. The ratio of nurses to doctors ratio among the OECD countries like Japan, U.S, Finland was found to be more than four and certain countries like Chile, Turkey, Greece had a ratio of 1:1. In India the ratio is reported to be at 2:1. [12]The WHO report in 2016 states that 53.7% doctors in India are self-claimed and do not possess the necessary qualification lacking professional training and expertise. The pandemic has called for more number of medical professionals churned out with accurate skills and expertise.

Ratio of beds:

[13]According to the national health profile 2019 the total number of beds available in the government hospitals sums up to 7,13,986 including 35,699 in intensive care units, and 17,850 ventilators for 1.3 billion people. This amounts to 0.55 beds per 1000 people which is relatively low when compared to china 4.34 and Russia 8.05, Bangladesh 1.1, Indonesia 2.11.the data suggest that the ratio of beds remain the same as that of 2017 which also indicates the stagnancy in allocating budget for healthcare infrastructure. With the surge in COVID cases the shortage of beds poses serious problems and calls for timely response to deal with the crisis.

Health insurance:

Health insurance in India is a growing sector. There is a need to expand the insurance coverage to the vast section of population in India. [14]According to the NSS (2018) nearly 86% of the rural population and 81% of the urban population are still not covered under any health insurance schemes. The NSS 2014 stats also infer that not much has changed from 2014-17 but only difference in 1 percent of urban population being covered by health schemes. This indicates

[10] Supra.1.
[11] Supra.2.
[12] Samarth Bansal, WHO report sounds alarm on 'doctors' in India, Jul.18,2016 https://www.thehindu.com/data/WHO-report-sounds-alarm-on-%E2%80%98doctors%E2%80%99-in-India/article14495884.ece
[13] Supra.1.
[14] Government of India, Key Indicators of Social Consumption in India: Health, (July-2017-June-2018), http://www.mospi.gov.in/sites/default/files/publication_reports/KI_Health_75th_Final.pdf.

the awareness and health literacy necessary in the country. [15] According to the OECD report most of the countries have leveraged towards achieving universal coverage by modifying their financial schemes to attract national health systems and social health insurance. Certain countries like Switzerland and Netherlands achieved this universality making private health insurance compulsory which is supported by public subsidies and legislative backing making it easily accessible for the poor households. Greece has achieved universality by covering the total population by social insurance funds and a strong voluntary private healthcare system which provides complementary voluntary health insurance coverage to 15% of the population. This way citizens can benefit from additional services like supplemental insurance and they are also enabled for faster access and also have a choice for service providers choosing whichever serves their interest best. Over eight OECD countries like France, Belgium, Korea and Netherlands have opted for additional private healthcare coverage covering half of the population. Countries like the UK, Denmark and Sweden the regional or local government schemes account for nearly 80% and the rest is covered up by out of pocket payments. In the US the uninsured usually tend to be the working adults of low income or education strata and with the arrival of affordable care act the percentage of uninsured population proved to be at downward slope from about 13% in 2013 to 9% in 2015 and maintaining the same level till now. It is seen that most countries which were successful in tackling the COVID-19 to an extent had a powerful insurance scheme covering a vast population under one roof. In this way no person is denied the fundamental right to health care. India has also taken some serious measures in the health insurance arena inching towards the goal of providing free quality healthcare to all its citizens.

III. COMBATING COVID-19

With COVID-19 spreading like a wild fire day to day even the high income countries with great infrastructure have been hit hardly. But certain countries with their stringent responses and effective strategies were able to cope up with the pandemic and were able to show an exemplar system to be put into use.

SPAIN

[16]The Spanish government in an unprecedented move has brought all the hospitals in the private sector under the public control by throwing open to the public free of cost in its fight against the SARS virus. The move is to be applauded for the government's timely response to the understanding that the existing public healthcare facilities will not cope up with the sudden hike in the number of cases. The nationalization of private health institutions has pioneered the tackling of upsurging cases in Spain.

[15] Supra.2.

[16] BS Web Team, Spain nationalizes all hospitals as it scrambles to curb coronavirus, (Mar.17,2020, 21.44 IST) https://www.business-standard.com/article/international/spain-nationalises-all-hospitals-as-it-scrambles-to-curb-coronavirus-120031701665_1.html

TAIWAN:

Taiwan, one of the countries locatednear the virus origin domain mainland China has also been successful in controlling the COVIDcases. The success is mainly attributed to the timely implementation of its epidemic response plan which was established after a similar SARS outbreak in 2003. The disputed country's national health insurance is a single payer system under which all its citizens and even the foreigners residing there for at least six months are covered by one government insurance plan. [17]It has reported only a few hundred cases and was able to contain efficiently with early testing, tracking user data with the help of technologies, efficiently handling and enforcing quarantines and monitoring the patients. The nationalized healthcare system in the country provides its citizens with a digital health card enabling the hospitals to efficiently control and report symptomatic patients as well as coordinating and sharing the information with islands major medical centers.

SOUTH KOREA:

[18]After the first case was reported in January the country developed a rapid diagnostic kit and started testing millions of people for free.They even started several drive through testing centres with a network of 96 public and private laboratories which nearly conducted 20,000 tests every day to ease the testing machinery. The government also specified certain hospitals for COVID treatment and barred the people from visiting these hospitals for medical care other than the COVID patients.

NEWZEALAND:

New Zealand's public health response to the pandemic is a one to look at. Taking some stringent measures at an earlier stage helped the country to combat the virus. With this elimination strategy New Zealand was able to show results within 102 days of the first emergence of case. It has shut down its borders completely and also implemented strict measures regarding the easing of lockdown were also taken. There are several lessons from New Zealand's pandemic response. [19]Rapid, technology and science-based risk assessment linked to early, decisive government action was critical in the battle against the virus. Healthcare in New Zealand is primarily centrally controlled and public funded. They mainly focused on speed of contract tracing. They went by the ideology that the government takes a fundamental role in providing healthcare and it should be accessible to each and every one. New Zealand also showed the importance of health literacy among the people. Health communication at the time of crisis is essential.

SOUTH AFRICA:

The estimated population of South Africa in the year 2020 is nearly 59,62 million[20] and GDP per

[17] Jason Socrates Bardi and Thomas J. Bollyky, Taiwan's response to COVID-19 and the WHO, https://www.thinkglobalhealth.org/article/taiwans-response-covid-19-and-who

[18]Laura Bicker, Coronavirus in South Korea: How 'trace, test and treat' may be saving lives,BBC News, (Mar 20.2020), https://www.bbc.com/news/world-asia-51836898

[19]Anna Jones, How did New Zealand become Covid-19 free?, BBC News,(Jul.10,2020), https://www.bbc.com/news/world-asia-53274085.

[20]Department: Statistics of South Africa, Republic of

capita is 7346 US dollars in 2019[21]. The GDP rate of South Africa has been considerably decreased from the past years. Due to the COVID-19 pandemic countries like India, Africa, Russia etc. are experiencing steep decrease in their GDP growth rate. Certain measures that are taken by South Africa had been highly appreciated by World Health Organisation, it includes protecting the health workers using Plexiglass and two holes through which the health workers can insert their hands to take the swab test. When all other countries are facing the COVID-19 challenge South Africa has double test of fighting with HIV also. Over 20% of the total population of South Africa is carrying the HIV virus and is posing a great threat to the public health sector of the country. But their ability of tackling the virus with novel tool of Biotechnology should be adopted by other global nations.

AMERICA:

Despite ranking 1st in healthcare infrastructure and pandemic preparedness even contributing the highest percentage of GDP to health expenditure America has still not achieved universal health coverage leaving around 8.5 percent of the population to go uncovered even after the implementation of the American affordable act. The affordable care act implemented in 2014 mandated the compulsory insurance scheme for the unaffordable and penalized for not adhering to it with the coming of the act the number of persons being uninsured becameless.However, the Trump administration tried to pull this plug off citing the fiscal burden it levies on the federal government. In America the health sector is a mix of public and private and mostly private dominating the sector. [22]Nearly two third of the population opts for private insurance in healthcare either purchased individually or insurance given by the employer. And only one third of the population goes for public insurance scheme namely Medicare and Medicaid where the former covers the insurance of elderly people and differently abled persons and the latter covers the low income families (theinsurance nearly covers 22 percent of the population), though having better healthcare standards they failed to implement appropriate measures. The country did not ascent the capacity in hospitals or markedly increases medical supply. The testing was also delayed for weeks and the health officials could not get an accurate picture of the disease spread. The US government funds the public health care providers but does not run a hospital system. The problem here is that people are not able to cover up the insurance premium for their medical bills. Hence there is a inequality among varied population groups in accessing health care resources. America has opted for a value based payment type that does not cover the much needed unlike the United Kingdom's National Health Service where the government owns most of the hospitals and employs medical providers.

South Africa, (9th July 2020). http://www.statssa.gov.za/

[21]Trending Economics, South Africa GDP per capita, World Bank, (1960-2019) Data. https://tradingeconomics.com/south-africa/gdp-per-capita.

[22] Lindsay Maizland and Claire Felter Lindsay, Comparing Six Health-Care Systems in a Pandemic, (Apr.15, 2020), https://www.cfr.org/backgrounder/comparing-six-health-care-systems-pandemic

In fact the situation has shown that a coherent response with a steer and clear direction is the key. America gives a clearer picture of how healthcare cannot be left largely into private medicines.

IV. INDIA'S TAKE ON THE PANDEMIC

Health schemes:

The pandemic has prompted the country to take a big step towards providing health insurance to all citizens of India. The union government has initiated various schemes to attain the envisioned, Universal Health Coverage. Ayushman Bharat Pradhan Manthri Jan Arogyayojana (AB-PM-JAY), a flagship scheme of the Government of India was launched as recommended in the National Health Policy 2017, to achieve Universal Health Coverage (UHC) and aims to benefit 50 crore beneficiaries in India by providing Rupees five lacks as the medical insurance amount to each family per annum. This scheme has been developed to meet the objective of 'Sustainable Development Goals' ensuring medical insurance to the poor, lower section of the society, and the vulnerable population.

The AB-PM-JAY has been implemented in 7 union territories and 26 states in India. Amongst them, Arunachal Pradesh, Jammu and Kashmir, Jharkhand, Ladakh, Meghalaya and Mizoram have the highest number of eligible families. In contrast Assam, Chandigarh, Goa, Sikkim, Tripura, and Uttar Pradesh, have minimum beneficiaries. But, the effective implementation of this scheme comes under jeopardy as the beneficiaries covered under this scheme are very meager in amount. This scheme could only be regarded as the smidgen of attaining the herculean target of bringing every Indian citizen under one umbrella of Health Coverage. An insurance cover of INR 50 lacs for the frontline health care and sanitation workers under Prathan Mantri Garib Kalyan Yojana (PMGKY) is considered as a paradigm shift in addressing the grievances of COVID warriors.

The latest National Digital Health Mission which was announced by the Prime Minister of India during the 74th Independence Day celebration and was officially launched on 27th September 2021 also comes under the AB-PM-JAY. As the term 'National Digital Health Mission' denotes the main aim of this scheme is to digitalize all the medical data of patients in a single health card. The health card includes lab reports, prescriptions, previous discharge summaries and diagnosis reports from registered medical practitioners and laboratories. Summarizing all the data of the patients into one card paves way for easy identification of vulnerable groups, persons with comorbidities and who were in close contact with COVID-19 patients as well. This scheme certainly eases the time consuming procedures followed in hospitals and ensures better understanding of the treatments given and ailments suffered by the patients. The major impediment in enforcing the 'National Digital Health Mission' all over India is the low internet penetration rate and minimal digital resources in rural India.

AB-PM-JAY also covers the scheme called Rashtriya Swasthya Bima Yojana(RSBY) or National Health Insurance Programme. This

programme was initiated in the year 2008 exclusively for the people who are below the poverty line (BPL). The RSBY or the National Health Insurance Programme can be availed by the beneficiaries only during their hospitalization period and it does not hold any applicability when the patients get treatment as an out-patient. As the poor people are disinclined to get admitted in hospital and get treatment as an in-patient due to their economic constraints, this scheme doesn't serve its purpose as envisioned by the government. Moreover, many hospitals under this scheme are reluctant to admit the patients who are beneficiaries of this scheme, as it is taking a lot of time by the government for reimbursement of the amount spent to the patients. [23]As per the study conducted in 2017, Kerala, Chattisgarh and Karnataka top the list of the Indian states that covered maximum households under the RSBY scheme. This scheme will be a catalyst in providing health insurance to the people who are below the poverty line and requires hospitalization due to any diseases including the COVID-19 if this scheme is implemented efficiently.

The Ministry of Health and Family Welfare has also multisectorally constituted empowered action groups that have been at the forefront regularly releasing clinical and non-clinical guidelines and protocols based on the latest evidence and restructuring themselves based on the developments. Accredited Social Health Activists also Known as ASHA volunteers who comes under the National Health Mission, played an enormous role in compacting COVID-19 along with the state governments COVID-19 containment plans. The union Social Justice and Empowerment Ministry also launched a 24/7 toll-free mental health helpline exclusively for providing support to those persons who are in need of aid with regards to COVID-19. It will provide support to people facing anxiety, stress, depression and suicidal thoughts ensuring the strengthening of mental health of the population amid COVID-19 scare. E-Sanjeevani OPD app is an applaudable initiative by the central government launched under AB-PM-JAY scheme for providing online medical consultation to patients during the pandemic period. It helps to prevent direct contact between the doctor and patients during the COVID wide spread. This scheme aids the patients who are suffering from serious illness and need frequent medical attention. Jharkhand, Kerala, Punjab and Tamil Nadu crest the list of states that are effectively implemented this scheme.

Role of Ayush in augmenting Indian medicines:

The Ministry of Ayurvedha, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) plays a vital role in mitigating COVID-19 widespread in India by means of Indian traditional medicines. At its very inception on 15th March 1995 it was regarded as the Department of Indian System of Medicine and Homeopathy (ISM&H) and later known as Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy. A

[23]Coverage of Rastriya Swastiya Bhima Yojana, by State, rsby_desktop by India Spend, (Oct.16,2017), https://public.tableau.com/app/profile/farah.thakur/viz/rsby_desktop/Dashboard2

separate ministry for AYUSH has been formed on 9th November 2014 to augment the use of primitive medicines in India.

AYUSH medicines such as KabasuraKudineer, AYUSH-64 etc., have been accepted and followed by many countries as good immunity boosters for fighting against the deadly COVID-19. In India COVID specialty hospitals have been set up for providing the medical care under the AYUSH ministry. Asymptomatic patients showing mild symptoms of COVID-19 are being admitted in these hospitals and they are producing good recovery rates across the country. It is considered to be one of the greatest perks that India has received in public health care. This has also been an additional weapon in the country's fight against COVID-19. The second wave of COVID-19 pandemic which is being spread across the country can be efficaciously averted, if the AYUSH medicines are used in a proper manner. Distribution of AYUSH medicines such as AYUSH-64 and Kabasura Kudineer across the country for tackling COVID-19 is regarded as a welcome move.

Frontliners care

India must posses a robust Public Health Care system to augment the health infrastructures and to protect the health care providers from the pandemic. The way people treated Doctors and other para- medical staff during the wake of the pandemic is barbaric and could witness heart-wrenching visuals from many states such as Assam, Karnataka, Manipur, etc. beating doctors up to death by the vicious relatives of the deceased persons who succumbed due to COVID-19. After witnessing the increased happening of such incidents many Doctors and Social Activists had come forward to protect the rights and dignity of the Doctor fraternity by filing petitions before the Constitutional Courts. One of the Nagpur based Doctors Jerryl Banait filed a petition before the Hon'ble Supreme Court to safeguard doctors and other medical workers who take care of the COVID-19 patients. [24]While answering a plea filed by Nagpur based Doctor Jerryl Banait, the court passed interim directions for the safety of doctors and other health care personnel taking care of COVID-19 patients. The apex Court in the instant case directed the central and state government to provide security to doctors and medical staff treating COVID-19 patients. [25]During the current COVID- 19 pandemic, members of healthcare services have been subjected to persecutions and ostracization and have been targeted and attacked by scoundrels, thereby obstructing them from doing their duties. These inhumane practices and hatred shown on them lead to the non-execution of COVID-19 containment plans which were structured and implemented by the healthcare service personnel conscientiously. This alarming trend reinforces the need for improved measures to protect health care from acts of violence, therefore the principal act of 'Epidemic Diseases Act, 1897' has been amended through the promulgation of Ordinance

[24]JerrylBannait v. Union of India, SCC OnLine SC 357, S.C (2020)

[25] India Legal Bureau, Role of Supreme Court in the Era of COVID-19, (Jun.13, 2020), https://www.indialegallive.com/top-news-of-the-day/news/role-of-supreme-court-in-the-era-of-covid-19/

called 'Epidemic Disease (Amendment) Ordinance 2020' by the President of India. [26]Section 2B has been inserted through this amendment it states that 'no person shall indulge in any act of violence against a healthcare service personnel or cause any damage or loss to any property during an epidemic'. These stringent legislative enactments abridged assaults on the health care providers by the reprised relatives of the COVID patients.

In Dr. Arushi Jain vs. Union of India[27] in which the petitioner moved to the Apex Court with the plea to allocate separate accommodation facilities near the hospitals and to provide appropriate emoluments and salary to the Doctors who treat COVID patients. The Hon'ble Apex Court in this case emphasized that well being of Doctors and Health Care Workers are matter of concern in this crucial hour of pandemic and directed the central government to issue appropriate direction. The apex Court in [28]Sachin Jain vs. Union of India while addressing the plea regarding the private hospitals charging colossal amount from the COVID patients thus creates a crevice between beneficiaries covered under AB-PM-JAY scheme and those who are not covered. The Court in the sagacity of public interest questioned the Centre why private hospitals which had been given land free of cost is unable to treat COVID-19 patients free of cost and also ordered the Central government to pin point the hospitals with all the required facilities for treating the patients affected with COVID-19 at free of cost or minimal cost.

The Hon'ble Apex was motivated by the letter sent by former Law Minister Ashwani Kumar to take suo moto cognizance on the inhumane act of pipsqueaks dumping the dead bodies of the persons who were succumbed due to COVID-19. The Supreme Court while dealing with the issue of disposal of dead bodies of COVID-19 patients, lashed out at state governments and hospitals for the manner in which the COVID positive bodies were dealt in an unprotected and lethargic manner and directed to adopt a proper mechanism to dispose of the dead bodies without letting the virus to affect others including the hospital workers who deal with the mortal remains.[29] Analyzing all the judicial pronouncements given by the Constitutional Courts, it is a need of the hour to encompass the frontline warriors of COVID-19 by formulating legislation in order to protect them from being targeted and ostracized.

Eclipsed Statutes into the Field:

Dual statutes namely the Epidemic Diseases Act, 1897 and Disaster Management Act, 2005 helped the administrators to effectively tackle the novel Virus and avoided serious repercussions during its initial phase of spread. Under our constitutional framework, these two laws provide the center and state the statutory basis for initiating action against the negligent public who infract the law. The earliest National Lockdown

[26] The Epidemic Diseases Act, 1897, Section 2B, (2020)

[27]Livelaw, Dr. Arushi Jain vs. Union of India, https://www.livelaw.in/pdf_upload/pdf_upload-379706.pdf

[28]Indian Kanoon, Sachin Jain vs. Union of India, 31st August 2020, https://indiankanoon.org/doc/104401487/

[29] Suo Moto Writ Petition (Civil) No. 7/2020

was imposed under the Disaster Management Act, 2005 as per order dated 24-03-2020 of the National Disaster Management Authority to take measures for ensuring social distancing so as to prevent the spread of COVID-19. The Disaster Management Act, 2005 also mandates setting up a three-tier Disaster Management Authority at the national, state and district level to formulate plans during any natural calamities. The Epidemic Diseases Act, 1897 is a 123 years old statute drafted by the British colonials without a proper administrative mechanism. In the wake of COVID-19 and to control its spread the government of India has made an amendment to the Epidemic Diseases Act, 1897, commonly known as The Epidemic Diseases (Amendment) Act, 2020. Section 1(A) inserted by way of 2020 amendment consists of certain important provisions relating to curbing the spread of COVID-19, it includes definitions of "act of violence" "health care service personnel" and "property". This amendment during the COVID-19 conundrum is a significant one as there was an increased attack on health care workers by the perplexed relatives of the COVID patients as well as general public. [30]Section 3 inserted by way of amendment act, 2020 enunciates that "Any person disobeying any regulation or made under this Act shall be deemed to have committed an offence punishable under Section 188 of the Indian Penal Code (IPC)". [31]According to Section 188 of IPC if any person disobeys the order promulgated by the public servant and if such disobedience causes danger to human life, health or safety, etc., it is cognizable, bailable, non-compoundable and triable by any Magistrate. [32]Section 3(2) of the Epidemic Diseases (Amendment) Act enunciates that "Whoever, i) commits or abets the commission of an act of violence against a health care service personnel, ii) abets or cause damage or loss to any property" then the punishment for those who transgress the law of has been fixed as imprisonment for a term of three months to five years, and with fine of Rs. 50,000/- to Rs. 2,00,000/- failing to pay the prescribed fine leads to further imprisonment.

The Prime Minister of India with a clear vision released the first-ever national plan prepared in the country, the Disaster Management Plan (NDMP) in 2016. The main aim of the Plan is to make India adaptable to future disasters and substantially decrease the risk, losses of life and other aspects caused by catastrophes. This plan played a huge role in controlling the spread of virus in the country. It has also enhanced our preparedness level to face the catastrophes that lay ahead of us. State governments have also taken stringent steps in order to control the virus spread, by doing acts such as imposing fines, seizing the vehicles of the persons who breach the rules and regulations etc., Overall, States have also enough legal power under sections 188 & 270 of IPC in dealing with this biological disaster, including punishments for disobeying the order of a public servant and doing malignant acts likely to spread infection of disease which is dangerous to life.

[30] The Epidemic Diseases Act, 1897, Section 3, (2020)
[31] The Indian Penal Code, 1860, Section 188, (1860)
[32] Supra 26

The National Health Bill, 2009 laid a huge milestone in the nation's healthcare by bringing 'Right to Health' into the ambit of fundamental rights and emphasized that every citizen has the right to get the highest attainable standard of health and well-being without any discrimination. The Constitution of India under Article 21 recognizes the right to life as a fundamental right and places obligations on the Government to ensure protection and make possible the right to health for all. The National Health Bill, 2009 envisages the establishment of National and State- level public health boards to formulate national policies on health, review strategies, and ensure minimum standards for food, water, sanitation and housing. The bill empowers the center and the state to take unified decisions and gives a comprehensive legal structure in the running of a proper healthcare system and successfully addresses all the barriers and underlying determinants of healthcare. These significant provisions in the bill play a major role during this pandemic period and it helps to develop the state of public health care during COVID-19. The states have also enacted a few other state legislations for dealing with the state emergencies like The Madras Public Health Act, The Cochin Public Health Act, The Goa Daman and Diu Health act but they failed to answer the question of equitable access to public health care. The prevalent enactments are regulatory in nature and do not address the multi- faceted dimensions of public health issues prevailing in India during this pandemic. Hence there is a deterrent need to update the laws and formulate a new and effective public health bill that will guarantee each and every citizen the protection and fulfillment of their fundamental right of right to health envisaged under Article 21 of the Indian Constitution.

V. CONCLUSION

With the cases re- emerging across countries and the adaptability of vaccine to the new mutation of the virus being examined, the only way to take control of the contagious spread is to have a strong responsive public health care system. Although India has succumbed to the pandemonium of the virus, yet placed with the other countries it has handled it far better compared to the countries with the best healthcare structure, financing and stronger audacity to treat the patients. Schemes like Ayushman Bharat and Taiwans national health insurance propagate that a proper and effective implementation of insurance schemes frantically will make the public health care machinery more versatile and efficient. Examples of New Zealand and Kerala reiterate the importance of health literacy. The example of Spain nationalizing private hospitals might not be a better way to accelerate the fight against the virus in India but a strategic partnership between the public and private sector might prove to be effective. The number of rising cases each day there is also a diring need for a better healthcare structure and frame work. Though there are grievances regarding discrimination and lack of medical aid, under section 72 of the Disaster Management Act, 2005 there is bar on jurisdiction of courts and there is no grievance redressal mechanism to settle up the disputes arising in this regard. Having assumed the role of sentinel on the qui

vive *State of Madras Vs. V.G. Row*[33], 1952, the Hon'ble Supreme Court of India held that it is obligatory on all the Constitutional Courts in the country to suo moto register PIL's and closely monitor the implementation of Disaster Management Act, 2005 to safeguard the rule of law and protection of human rights as enshrined under the Constitution of India.

The COVID-19 pandemic is a great eye-opener to the whole world to know about their level of pandemic preparedness, health insurance coverage among their own citizens, access and availability of health care, availability of health care work force ratio etc,. COVID pandemic has taught many lessons in order to prevent further Catastrophes. Among them Contact tracing is considered as one of the most important epidemic control measure and most of the Indian states effectively tackled the spread of the virus by strictly following the contact tracing strategy. The novel tool of artificial intelligence is being used in foreign countries to combat the pandemic in very effective manner. It helps in diagnosing the disease via the use of diagnostic robots, to predict which patients will likely develop severe symptoms requiring immediate emergency care, to developing drugs etc. Such kind of innovative measures not only curb down the spread of virus but also decrease the mortality rate. One of the most significant scheme of Digitalization in health sector by the Government of India which include Digitalized form of patient information, vaccine certificates, details of the persons administered vaccines, etc. plays a vital role in lifting the standard of public healthcare system of India to the next level. Amidst the complaints regarding lack of tests the ICMR's latest advisory provides for testing on demand to 'ensure high level of testing'. A more subtle way of approach to testing guidelines is therefore necessary. The most vulnerable sections of the COVID-19 are the people with comorbidity and people who are above the age of 60. Therefore, reverse quarantine has been suggested as the best plan to prevent the spread of COVID-19 among those vulnerable groups. With the invention of the COVID-19 vaccination the government has successfully curbed the rate of spread of the virus among the vulnerable groups and eventually it decreased the mortality rate among them. Health is considered as the most exquisite entity of a human being hence it is necessary that every nation should have a proper and unwavering health laws in order to protect the health of individuals and population. The objects of the health care laws must be correctly laid down before executing an act and should be capable enough to serve its purpose. In this context India needs to examine its outdated health laws and update it. It should focus on the welfare of the people and examine the existing scenario before enacting any public health laws and bring it into force. India's public spending needs a boost for employment of effective strategies like comprehensive testing mechanisms and free treatment to all at private hospitals with subsidized rates and establishing an effective surveillance mechanism to monitor the schemes

[33]AIR 1951 Mad 147, (1951)

and reporting any deterrence. [34]India had administered more than 96.1 crore doses of vaccination to its citizen's till date and more than 27.3 crore people are fully vaccinated. India's surmountable effort in administering the COVID vaccine was applauded by the World health Organization.[35] Therefore learning lesson from this pandemic and upgrading the public health care system of the nation surely reduce the pandemonium of further vis majors.

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[34] Our World in Data, https://ourworldindata.org/covid-vaccinations?country=OWID_WRL, (last visited Oct. 13,2021)

[35] Ravi Prakash Kumar, mint, Covishield and Covaxine: WHO chief Tedros applauds India's decisive action (Oct 13,2021, 9.50 PM), https://www.livemint.com/news/india/covishield-and-covaxin-who-chief-tedros-applauds-india-s-decisive-action-11609821901613.html