MAHARASHTRA NATIONAL LAW UNIVERSITY AURANGABAD

COMPARATIVE LAW E-NEWSLETTER

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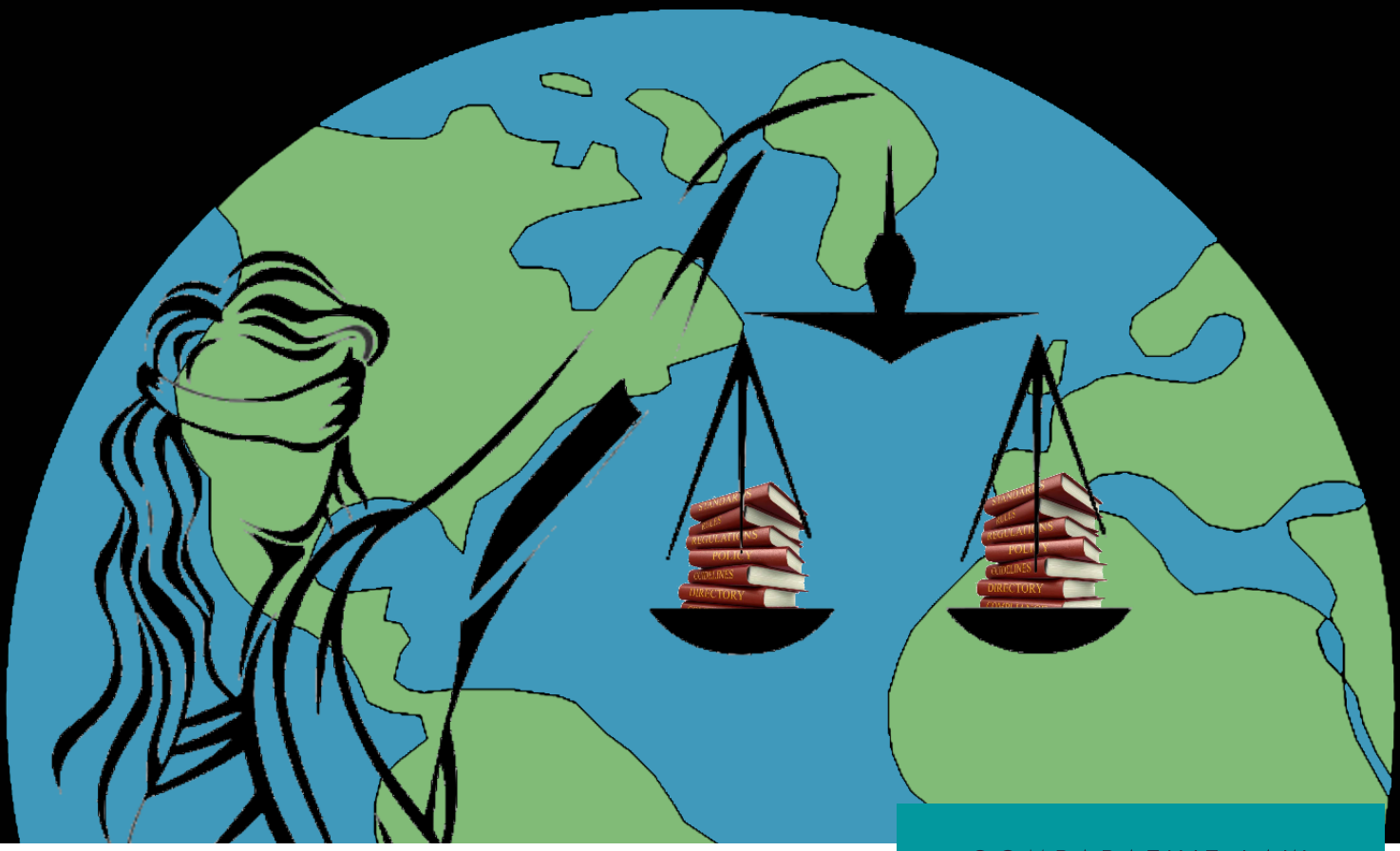
PUBLIC HEALTH FRAMEWORK: LAW AND SOCIETY



ABOUT THE NEWSLETTER

Devoted to the study of comparative and transnational laws and legal systems, the Comparative Law e-Newsletter (CLN) is an open access, peer-reviewed and referred newsletter published bi-monthly with six issues per year, by Maharashtra National Law University Aurangabad. It embraces analytical, theoretical, empirical and socio-legal attempts surrounding the public and private law aspects of various legal systems. It aims to encourage comparative legal studies in the transnational context of legal history, theory, philosophy, legal cultures and traditions, by tracking the developments in the field across the world. The newsletter seeks works that are dynamic and interdisciplinary in nature with specific display of comprehensive knowledge on the subject matter.

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FROM THE VICE-CHANCELLOR'S DESK

Maharashtra National Law University, Aurangabad is established by Maharashtra National Law University Act, 2014 (Act No. VI of 2014) passed by State Legislature of Maharashtra. The University commenced its operation in the year 2017 having its headquarters at Aurangabad, Maharashtra and since then has been thriving to achieve academic excellence. The University has in the past hosted national level seminars and conferences and has been visited by legal luminaries who have enhanced and furthered the objective of making this institution of national importance.

I strongly believe that it is the students, faculties and the non-teaching staff who plays a pivotal role in the over-all development and growth of an institution. It is under able guidance and constant support of judges, eminent legal practitioners and academicians that the institution is on its path of achieving excellence in the field of legal education. This newsletter is one such initiative undertaken by the faculty members and students of Maharashtra National Law University, Aurangabad. This newsletter aims to bring about various discourses related to comparative laws. It will be theme-based bi-monthly newsletter which will promote and enhance academic deliberations from the members of legal fraternity. In an era where development is rapidly taking place and law is ever-expanding and growing, the need for such inter-disciplinary approach has to be seriously undertaken.

I am glad to present this newsletter to the legal fraternity and civil society and encourage young scholars, academicians and students from various law schools in the country to contribute actively to be a part of this journey and make this effort a grand success.

I congratulate the team for their untiring efforts during this pandemic situation in bringing this newsletter to light and wish them a success in their vision and endeavour to reach a wider audience and facilitate scholarly discourse in this area.

Wishing you all the very best !

Regards,
Prof. (Dr.) K. V. S. Sarma
Vice-Chancellor,
MNLU, Aurangabad.

MESSAGE FROM THE TEAM

We are enthralled to launch the very first newsletter by Maharashtra National Law University, Aurangabad. This occasion marks release of the First Volume, Fourth Issue of the Comparative Law Newsletter. The newsletter is an initiative undertaken by faculty members and students of Maharashtra National Law University, Aurangabad. It is an effort to discuss and bring forward various contemporary discourses and issues related to the domain of comparative laws. We really acknowledge the sincere efforts made by Mr. Anubhav Kumar, Ms. Sayali Sawant LL.M students of MNLU Aurangabad, Ms. Soumya Thakur, Ms. Aishwarya Pandey, Ms. Jidnyasa Sakpal, Ms. Mehek Wadhwani, Mr. Ansuman Misra, Mr. Anubhav Mishra, Ms. Kavya Singh, Mr. Soham Bhosale and Mr. Sulabh Gupta B.A.LL.B students of MNLU Aurangabad for this edition of newsletter.

We hope you would have enjoyed reading the issues of the newsletter in the past. The theme of the First Volume, Fourth Issue of the newsletter is Public Health Framework: Law and Society. The theme was very carefully thought off and agreed upon by the team members in the light of recent and related events and developments around the world pertaining to this area. The First Volume, Fourth Issue is based on contributions by faculty members, students and practitioners; however, we look forward and comprehend, that the upcoming volumes and issues will also be based on submissions by academicians, lawyers, young students and other esteemed members of the legal fraternity.

We imbibe upon this journey together, and hope to develop a positive outcome with this effort undertaken to develop a never-ending era of learning and growing. We would like to thank the support and encouragement received by Hon'ble Vice-Chancellor, Prof. Dr. K.V.S. Sharma, under whose able guidance this newsletter has been released. We acknowledge the untiring efforts made by the faculty in-charge and the student members who were behind the scene working for the timely release of this newsletter. We would especially take up this opportunity to take a few names, without whose efforts this newsletter would have never become a reality, our student team comprising of Ms. Soumya Thakur, Ms. Nikita Mohapatra, Ms. Aastha Chahal, Ms. Chetna Shrivastava, Ms. Aishwarya Pandey, Ms. Simranjeet Kaur, Mr. Abhishek Singh, Mr. Husain Attar, Mr. Devansh Kathuria, Mr. Anubhav Mishra, Mr. Anuj Agarwal, Mr. Sulabh Gupta, Mr. Rohan Kapoor, Mr. Pranay Bhattachayra, Mr. Ansuman Mishra, Mr. Anant Choudhary, Mr. Abhishek Jha, Mr. Sumant Jee, Mr. Narendra Singh Jadon, Mr. Abhijeet Mittal, Mr. Indronil Choudhry, Ms. Pranshi Gaur, Ms. Pranali Kadam, Ms. Shreyashi Srivastava, Mr. Siddhant Vyas, Ms. Riya Mehla, Ms. Pavitra Pottala, Ms. Kavya Singh, Mr. Soham Bhosale, Ms. Mehek Wadhawani and Ms. Jidnyasa Sakpal.

This newsletter is special and memorable for all of us considering that even during this pandemic situation and the challenges we faced in form of lack of physical communication between us, still, our resolve and dedication resulted in the timely release of the newsletter as decided. We are utterly grateful and thankful to everyone who has been a part of this initiative in any form.

Hopefully you will enjoy reading it and keep supporting and encouraging us in the near future.
Thank You.

Enjoy Reading and Keep Growing!

Ms. Neha Tripathi and Ms. Soumya Rajsingh,

Faculties In-charge, Comparative Law Newsletter

Student Team: Ms. Soumya Thakur, Ms. Nikita Mohapatra, Ms. Aastha Chahal, Ms. Chetna Shrivastava, Ms. Aishwarya Pandey, Ms. Simranjeet Kaur, Mr. Abhishek Singh, Mr. Husain Attar, Mr. Devansh Kathuria, Mr. Anubhav Mishra, Mr. Anuj Agarwal, Mr. Sulabh Gupta, Mr. Rohan Kapoor, Mr. Pranay Bhattachayra, Mr. Ansuman Mishra, Mr. Anant Choudhary, Mr. Abhishek Jha, Mr. Sumant Jee, Mr. Narendra Singh Jadon, Mr. Abhijeet Mittal, Mr. Indronil Choudhry, Ms. Pranshi Gaur, Ms. Pranali Kadam, Ms. Shreyashi Srivastava, Mr. Siddhant Vyas, Ms. Riya Mehla, Ms. Pavitra Pottala, Ms. Kavya Singh, Mr. Soham Bhosale, Ms. Mehek Wadhawani and Ms. Jidnyasa Sakpal.

Padma Shree Awardee
Dr. K. K. Aggarwal

President at Confederation of Medical Associations of Asia and Oceania, Heart Care Foundation of India and IJCP Group

1. COVID-19 19 pandemic has brought to light that the epidemic disease act was insufficient to tackle the COVID-19 19 pandemic as it does not even define the word epidemic let alone a pandemic. In such situation, shouldn't there be a legislation that specifically tackles such unprecedented situations?

Pandemic never came in India before. It came around 1900s and 1800s. The pandemic act is also very old. There is a need for revision of the pandemic act. I do agree that the government did pass one or two resolutions and they came out with certain directors, not only the pandemic epidemic act now it should be defined as a pandemic act. One should also come back where the state laws under the medical council of India and the national disaster act all needs to be modified depending upon the experience we have gained. Example there are lots of discrepancies in the pandemic act or the diseases epidemic act even the national disaster act which does not differentiate the management of the government sector and private sector. So whatever facilities they are giving it to the government sector are not there in the private sector. I personally feel that pandemic and epidemic can't be managed by the state and center differently. There has to be a unison. The laws should be one.

Every state was behaving differently in terms of management of the pandemic. That cannot be done. I feel the act should give powers to the center to take control of all the activities so that uniform policies can be applicable. Had that been happened, we would have tackled the situation more efficiently. There was and still is a need for uniform laws.

2. Despite public health being a state subject, the central government is the key actor is designing health policies and programs which was predominantly visible in the management of COVID-19 19 where many states objected to the invocation of disaster management act. How do you see the future of constitutional relationship of center and state specially with emphasis on public health?

We can take Example of USA. The reason why USA failed was because there the states were independent in managing the COVID-19 19 pandemic. The reason Russia China Thailand succeed was because there was uniform law. And they could manage the disease much better than the USA where there was the federal structure. If you allow the states to work pandemic differently, the pandemic cannot be managed efficiently. Hence, I am of the firm opinion that government should come out with a legislation that in any future pandemic the center and state have to work in harmony with each other and governed by the center and not by the states.

3. Accessibility and affordability of health services with time has not been uniformed which is often considered to be one of the reasons for increased health deficiencies in this pretext do you think the existing mechanism of public health cares need to be revisited and something on lines of Mohalla clinic should be done to bring health at our door?

When you build a Mohalla clinic, you build a health care center in a residential area now here i have a problem. On one way the law says you can't have a health care center in the residential area. On the contrary you are talking about creating a Mohalla clinic. This dichotomy needs to be removed. The government should come out with a policy that if they are proving a service make it an option available to the private sector also. Either let the government provide or let the private sector uniformly provide the same facilities supported by the government. Unless you do that, things are not going to improve. Delhi government paid 40 rupees per patient to the doctor is a successful model. Along with that you are also giving them a minimum guarantee. Same thing in Ahmedabad where the government gave a minimum guarantee to the hospitals to reserve the COVID-19 19 beds. Which is the good way to flood the country with Healthcare facilities. There will be a time when the pharmaceutical companies will start opening health care centers all over the country and that way, they will be able to sell their medicines at a generic price and also provide services where doctors Don't exists.so we need numbers and if the numbers are available, I don't think that infrastructure will be a problem. So, when it comes to affordability and sustainability, affordable medical care basically means that you are playing with the numbers. If the numbers are small affordability can never be achieved.
Japan has a structure where there is complete interaction between private and public sector, it is also economical there the government has frozen the prize of everything but the business given is guaranteed.

4. Recently the vaccines we ruled out and given approval for usage by CDSCO and a controversy arose in the name of transparency or politically induced decisions. Do you think in such matters which strictly deals with health and science the council shall not succumb to bureaucracy and should work in harmony? How do you see this?

I agree with you. Even today there is no transparency because even today we don't know the COVID-19 app is not transparently available of the website. We know from 1st of March people who are 50 years of age will start getting vaccinated. Yet there is no transparency. I firmly believe that there should be transparency in whatever government does in this matter and make it as fast as possible, take away all the bureaucracies and give it to the people

5. The ministry of home affairs has capping the treatment cost of COVID-19 19 for private hospitals in the national capital. The decision was based on suggestions by a committee led by Nitti Ayog member dr. V K Paul along with representatives from Delhi Government and AIMs Dr. Randeep Guladiya. With access and affordability of health care as a great concern, do you think it's time for India to have a Medicare bill and restrict the flouting price by private hospital?

Not to forget the fact that our best hospitals are still hundred times cheaper than the care given in the USA and the UK. You must star the hospitals where the charges may differ. The problem of flouting comes when the poor ends up in that facilities. He feels that he is flouted but there are people who have abundant money they would have paid 10 times the amount of money by going to Singapore. For them it a very cheap service. So, the government is failing here because everybody wants to goes to those hospitals and then they get the bills and start weeping. So there has to be a graded system so the person knows where he is going. Capping of price is justifiable only for special situations when you have a community public health disease. You cannot justify caping of price in a private set up where the person is willing to pay, he wants 100% privacy he wants best of the service and doctors 24/7 watching over him. In that situation if the doctor is charging more money, I don't find any reason. Five-star hospitals came only to reduce people going abroad and getting surgery and saving the foreign exchange. So that should not be taken away. So, having five-star hospital is fine for those who can afford them. Now these five-star hospitals have a differential pricing for Mediclaim and ordinary man that should not happen. Example in a plan there are different rates for different facilities like economic, 1st class or business in the similar way there is generic drug and branded drug. If you are a generic hospital, you can cap the prices but let the private hospitals decide their prices According to the facilities unless it is a medical catastrophe. Other way is to cap the essential surgeries but not every service, come out with the national lists of surgeries and procedures which are essential and which are caped not others.

6. We know that COVID-19 19 has exposed the deficiency in health care sector. One such exposed deficiency is the mental health. Reports suggests that mental health is considered as stigma what are your views on it and why is mental health not on government's priority?

Mental health has to be in every home. It has to be treated by GP. See only 10% of the people require drug and 90% require counseling. So we need more and more of counselors and today after so much of electronics mental health will become more accessible because you are not bothered about the privacy that I'm going to a doctor's clinic. So government should promote mental health in terms of counseling and cognitive behavior therapy in terms of help given to the people and basic drugs can be given by the government so unless you promote the general practitioners and empower them, things are not going to change remember what is mental health is basically five needs. Physical body, mental need, intellectual need, egoistic need and spiritual need.
Earlier mental health was not given important because we had a joint family system. But today with nuclear family system, you have more and more of mental pressure so mental health is nothing but satisfying or guiding a person for their mental intellectual social egoistic and spiritual needs. For that general practitioners need to come in, all systems of medicine need to come in, psychologists need to come in, even the religious bodies need to come in.

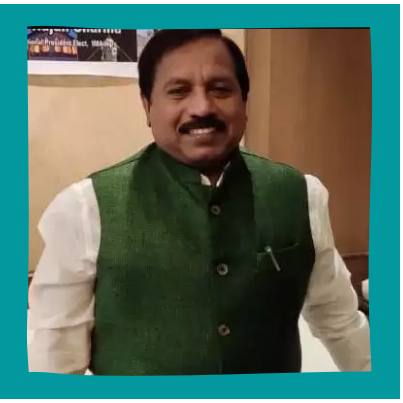
7. What are the reasons for health care facilities and structures inside the Indian prison is degrading day by day? Whether the recent example where more than thousands of prisoners was tested COVID-19 positive and inhuman living conditions inside the prison shows the inability of the authorities to act inadequately. Does this show that the authorities are acting inadequately?

As on today the public's perception of prison is punishment. If this continues then there will be more of such situations. If we see prison as a reformation as per Vedic philosophy whatever you do 100 times becomes your habit so one of the Reformation is community service or parole so in one year you can totally change your body so if we have reformation prisons no one needs to be behind the bars for say 7 years and more after Reformation give them a year’s break. I believe 99% of the crimes are due to emotions, that needs reformation and the other 1% with criminal mentality require treatment. The COVID-19 situation as far as prisoners are concerned have happened all over the world. If you have a community living, if 1% gets it rest for going to get infected. So, there is no point blaming the government for COVID-19 spread in the prison.

8. The purpose of granting patents itself is to not only encourage innovation but also ensure that the inventions are worked in India and are made available to the public in sufficient quantity at reasonable prices. To identify the breach of responsibility the Patents Act 1970 mandates the patent holder to provide full disclosure with respect to the extent to which they have worked and implemented their inventions for the public benefit. But the provisions in the new amendment remove this requirement altogether making the disclosure policy an anti-disclosure policy. Would such an amendment not make it difficult for the government to issue a compulsory license for the generic drugs thereby directly and severely affecting the public health of a developing country like India which faces a severe healthcare crisis. ? Would you like to throw some light upon this issue?

The Patent Amendment Rules 2020 contravene the beliefs and expectations of the people. It is necessary to understand the existing mindset and to this end, the legality of the use of 'secret medicine' in modern medicine and Ayurveda medicine may be discussed. The Modern medicine Code of ethics proscribes the prescription of a secret medicine the pharmacology and side effects of which are not known. Conversely, the Code of ethics of AYUSH allows the Ayurveda to use and prescribe secret medicines. This essentially means that the Ayurveda practitioners are not obligated to disclose the composition and effects of this secret medicine. The justification provided for this is that Ayurveda medicine is based on centuries of traditions and culture and it is the secret medicine that makes it a revered form of medicine. The modern practitioners opine that the use of secret medicine contravenes the right of an individual to know the contents of the drugs and the possible side effects before he is prescribed the same. A similar issue has arisen due to the amendment in the clause that earlier required disclosure. The clause has been amended to benefit certain people seeking the monopoly of certain drugs and this is contradictory to the democratic belief of the country. We live in an era where the system is comparatively more transparent due to the citizens themselves exercising their right to know the workings of the system. Modern medical practitioners welcome this and accordingly all the drugs that are available or patented are open source available. Therefore, the amendment is anti-public and must be challenged.

INTERVIEWS



Prof. Dr. J. A. Jayalal

M.S, FRCS (Glasgow), DLS (Germany), FIAGES, MBA (HA), Ph.D (Surgery)
National President, Indian Medical Association, New Delhi
National Head - IMA UNESCO Bioethics Chair District Governor - Y's men International District 3 SWIR

1. The Indian Medicine Central Council(Post Graduate Ayurveda Education)Regulations, 2016 which are framed in exercise of the powers conferred by Section 36(1)(i), (j) and (k) of Indian Medicine Central Council Act, 1970 and in supersession of the Indian Medicine Central Council(Post Graduate Education) Regulations, 1979 and the Indian Medicine Central Council(Post Graduate Ayurveda Education) Regulations, 2012 has ignited controversy and confusion among medicos and other stakeholders in the health sector in the country, according to you is this move a means to an end, because during the pandemic there was a deficiency of medicos especially in the rural areas?

There is an apparent myth created in the country pertaining to the deficiency of doctors in rural India during the COVID-19 Pandemic. A perusal of the statistics and studies will make it clear that it is not the rural areas, but cities like Mumbai, Chennai, Delhi, Bangalore where the maximum number of patients were found. The virus, fortunately, spared the rural areas as the death rate and prevalence of the number of infected people was comparatively less in these areas. Generally speaking on the deficiency of doctors in these areas, it is to be noted that it is not only the doctors that are lacking in rural areas and they are deemed to be rural because of a plethora of other factors, including the quality of infrastructure, lack of administrative offices, Courts, etc. This answers the second limb of the question.

Next, we must ascertain the reasons behind the move. The Indian Parliament in its wisdom and discretion has created two systems of medicine, i.e. the Modern Medicine and Indian Medicine. Modern Medicine is well defined by the Parliament in the Indian Medical Degrees Act, 1916 and Indian Medical Council Act, 1956. In the latter act, under section 2(f) medicine has been defined as “modern scientific medicine in all its branches and includes surgery and obstetrics, but does not include veterinary medicine and surgery.” Conversely, Indian Medicine, defined under section 2 (e) of the Indian Medical Central Council Act, 1970 means the system of Indian medicine commonly known as Ashtang Ayurveda, Siddha whether supplemented or not by the modern advances. Therefore, while modern medicine explicitly includes surgery, Indian medicine does not, and the two systems have their distinct domains and different custodians.

The National Medical Commission under the National Medical Commission Act, 2019 which replaced the earlier Act of 1956, is the custodian for modern medicine. These custodians must act within the domain of the Acts under which they are constituted. Taking an example of an Indian citizen who wishes to obtain a visa for visiting a country, he will be given such a visa by the foreign government only and not the Indian government. Equally, if someone wants to practice modern medicine the permissions and the license have to be issued by the modern medicine custodian and for practicing Indian medicine by the Central Council of Indian Medicine(CCIM). The CCIM passed a notification for Amendment to their Act having the effect of allowing the people trained in Ayurveda to be able to practice modern medicine and conduct surgeries. This is an encroachment into the domain of modern medicine and therefore, the IMA is opposing it legally.

2. The Indian Medical Association (IMA), an apex body of doctors in India, called for a nationwide strike on (Dec. 11) to express its opposition to the government's decision to allow Ayurveda practitioners to perform medical surgeries. What are the issues with the government's emphasis on "mixopathy" and will it affect not only the doctors but the patients too? How do you see this issue reconciling now?

The doctors will not be affected by the Ayurveda medicine practitioners entering into the domain of surgeries. It is the common man, however, who will be misguided and suffer as a result of the similar title given to both the practitioners, i.e. the Master of Surgery. The individuals of the two different fields of Indian medicine and Modern medicine have different qualifications. The individual pursuing an MS general has to pass the NEET-UG exam to enter into the medical education system and after 5 years of strenuous studies has to write the NEET-PG. Thereafter, to obtain the master's degree the individual must again undergo 3 years of training. On the other hand, an individual after obtaining a seat in an Ayurvedic college has to study for 4 years and without NEET enters into a 2-year course for the master's degree. The education system prevailing in India envisages 2 years for a diploma degree and 3 years for a master's degree. Bypassing this the government of India is proposing 2 years of training to get a Master of Surgery, which is traditionally a 3-year course for modern medicine doctors.

Further, peculiarly the government by Amending the Indian Medicine Central Council (Post Graduate Ayurveda Education) Regulations, 2016 has provided that Ayurveda Practitioners will study and practice only 39 general surgery procedures and around 19 procedures involving the eye, ear, nose, and throat. To comprehend the absurdity of this it is essential to understand that the human body is a pandora's box. Consider a hypothetical situation where the Ayurveda Practitioner with the license to perform surgery on the appendix opens the abdomen only to discover a problem in the surrounding organ. With a license and knowledge to operate only 39 procedures, he has to close the abdomen. Therefore the common man, selecting between a fully trained MS general surgery and a 39 procedure trained MS general surgery, will not be able to make an informed choice because of the titles being the same. The Government of India in reply has informed that these practitioners will perform surgeries only on the rural people. The distinct standards of healthcare and safety, varying on the sole parameter of the individual belonging from the urban area and the rural area violates the Constitutional Protection available to such people. It is this dichotomy that is being opposed by the IMA. The most significant reason for such opposition is that this acts in the peril of the common man.

3. The Coronavirus pandemic has been an eye-opener for the entire nation. Considering the multifaceted dimensions of public health issues that the country is currently facing, Do you think it has centre-staged the need for an effective public health system and an inclusive public healthcare law?

The Pandemic has unquestionably been an eye-opener for the entire world as it highlighted the unfortunate conditions of the healthcare systems of even the most developed nations. The Indian government has regrettably not realized the same. It has been one of the long-standing demands of the Indian Medical Association (IMA) that the government raises the spending on the public healthcare system. A perusal of the Budget of the Indian government shows that less than 1 % of the GDP is utilized on public healthcare. In contrast to this, western countries like the UK and the USA allocate almost 7-10 % of their GDP to the public health system. The Pandemic demonstrated that the development of the healthcare system is vital, however, the 2021 Budget of the Indian government has 'merely played with words' instead of taking a positive step towards this. The Government has shown to the world it has raised the allotment for healthcare by 135%, from the initial 98 thousand crores to 2.23 lakh crores. A detailed analysis of the same will indicate that out of this 2.23 lakh crores, 60 thousand crores are for water sanitation, 10 thousand crores for nutrition, 35 thousand crores for Covid-19, and the allotment for public health per se is the same as the previous budget allocation. Therefore, as a medical practitioner it is unfortunate to note that even after realizing that the public healthcare system has to be improved in the aftermath of the Pandemic, the government has not adequately addressed the same. It can be said that by involving Ayurvedic doctors and playing with the healthcare laws, the government is further putting the lives of its citizens in peril. Therefore, it is advisable that each system of medicine may work within the boundaries of their system, and following their principles develop techniques to help in the aftermath of the pandemic. The encroachment by the Ayurvedic practitioners into the domain of modern medicine is not tenable. Further, the argument of violation of fundamental rights of the Ayurveda practitioners raised to defend their entry into the domain of modern medicine surgery may not be sustained. The judgment of the Hon'ble Supreme Court of Indian in the case of ***Mukhtiar Chand v. The State of Punjab, (1998) 7* SCC *579*** may be noted in this regard, wherein the court noted the necessity to balance the right to life under Article 21 of the Constitution with the right to practice any trade or occupation under Article 19. Therefore the advice as given by most modern medical practitioners to their colleagues in the Ayurveda field is that they must not get swayed by the superficial glittery' in modern medicine and instead work on developing their systems. Ayurveda itself believes in purity in its system and the practitioners must adhere to the same principles.

4. How does mixopathy affect the existing quality of care for the patients to avail of good health services? And what is your opinion of the integration of AYUSH schools of medicine into modern medicine?

Modern medicine practitioners work based on certain principles that underlie the system and such principles are distinct from those followed by the Ayurveda practitioners. The 'mixing' of the two systems that are based on a different philosophy is bound to produce disastrous consequences. Therefore, this mixing or adulteration is not a sound option. Further, there are two concepts, integrated medicine, and integrative medicine. Taking an illustration, of individual seeking treatment for chronic joint pain, he can be prescribed ayurvedic medicine. Further, if the patient seeks diabetes treatment he can be prescribed modern drugs along with naturopathy for the treatment. These multiple systems of medicine can be integrated and used by a person and the same is acceptable. India being a pluralistic country, needs a plural system of medicine. However, the concept of integrated medicine for the government is different than the view taken by modern medicine doctors who promote a multiple pluralistic polymathy instead of a mixopathy. The government envisages that integrated medicine involves a single doctor learning and practicing all the systems of medicine. Modern medical doctors on the other hand propose an entirely different method wherein each system is given the opportunity to develop their purified doctors and as such, the multiple doctors can help the individual. It is the right of the individual to chose the system of medicine he wants. But producing a single doctor practicing all the systems is possible only in the lower setups.

5. Ayurveda has a long tradition of surgery, Sushruta, the sage from 500 BC known in India as the "father of surgery". "In his treatise Sushruta Samhita, he had even referred to over a hundred kinds of surgical instruments," Sushruta has given the techniques to the world." So what is the difficulty to give Ayurveda permission to practice? And how is it contrary to the law?

Traditionally the legal system in India comprised of the old Panchayats, however, today it is not prudent to expect the system to regress and allow the traditional system to dispense justice in lieu of the Courts. Similarly, the modern system of medicine is starkly different from the system that existed in ancient times. To substantiate this assertion one must note the journey of medical surgery from the traditional practice of 'strapping a patient on the operating table to perform surgery' to the modern techniques of local anesthesia or regional anesthesia. This modern system of medicine owes its existence to dedicated research and development over centuries and the practitioners recognize the significance of the works of Sushruta. The Ayurveda has not done the research to bring their traditional practices to the modern level and therein lies the predicament. Therefore, the primary objection raised by modern doctors is not against surgery being performed by the Ayurveda practitioners, it is against the mixing of the two distinct systems. The graduates of Ayurveda, are employing techniques, equipment, and drugs used in modern medicine which are not accepted traditionally under the principles of Ayurveda. It can be said that Ayurveda is going against its ethics by adopting modern medicine. While the mixopathy is against the ethics of the system, Ayurveda cannot be deemed as a system that is lacking in discipline. However, the individuals are getting carried away by the glory of modern medicine and have discovered a 'sideway' to enter into Ayurveda and thereafter use that as a means to practice modern medicine. They have received the support of the Central Government promoting the Make in India concept. Therefore, instead of degrading the wisdom based on rich Indian traditions by adopting the modern medicine principles, the Ayurveda graduates should come forward to research and develop on their tradition and culture and start practicing and propagating the same.

Further, elaborating on the fact that the students are taught how to use the tools in Ayurveda as well, it can be noted that while this is accurate, it cannot substantiate any argument in their favor. A surgeon should not only know how to operate but also when not to operate. Surgery is not just cutting and suturing as it requires the knowledge to make a thorough pre-operation assessment. Therefore while they may have been taught how to use the tools, they cannot be given the title of Master of Surgery based on this. Modern medical practitioners have opposed the same.

6. Why is it illegal for Ayurveda surgeons to perform surgery when there isn't much difference, it seems, between the approaches to surgery in modern medicine and Ayurveda? "The techniques are similar, although allopathy often uses advanced technology". In fact surgeries in Ayurveda are mostly minor and moderate, and often cost less than private allopathic hospitals.

There are a plethora of judgments, most notably in ***Mukhtiar Chand v. The State of Punjab, (1998) 7* SCC *579*** and ***Poonam Verma v. Ashwin Patel & Ors (1996) 4* SCC *332*** wherein it was observed by the court that if an individual has learned and qualified in one system of medicine, he must practice in that system only. In the latter mentioned case wherein a Homeopathy doctor prescribing modern medicines was punished, the Supreme Court categorically noted that anyone who practices medicine which they have not learned, and which is not confined to them is always a quack. Equally, the Ayurveda practitioners, who have not studied modern medicine, and are practicing modern medical surgeries, will do so illegally. Therefore, the IMA has moved the honorable Supreme Court against the CCIM.

Second, it is incorrect to state that the techniques or principles of surgery in the two systems are similar. This can be illustrated by the fact that the anesthesia given by modern medicine is entirely different from the intoxicants that were used by Sushruta. Further, the approach taken by the practitioners belonging to the two systems will be completely different. One of the 39 procedures mentioned is the removal of a foreign object from the body and therefore if an individual with a coin in his stomach approaches the Ayurvedic practitioners he will operate by opening the abdomen, whereas the modern medicine practitioner will simply make use of an endoscope for the same procedure. The procedures which have been neglected by modern medicine as 'stone-age procedures' are mentioned within the 39 procedures. Third, it is a myth that Ayurveda or naturopathy is the more affordable system of medicine. The quacks and the Ayurveda practitioners often charge higher for the medicine itself. On the other hand, the expenses in modern medicine are not due to the surgical treatment or medicine, but for the infrastructure. Lastly, the observation that during Covid-19 there was a lack of doctors to perform surgeries and it is due to this that the government has allowed the Ayurveda practitioners to perform surgeries, is entirely incorrect. During the Pandemic, the total surgeries were reduced to less than 10% as only the emergency surgeries were performed.

The Ayurveda doctors did not have a role to play in these emergency surgeries and their requirement was confined to the preliminary care of the asymptomatic patients who did not require any acute management. Further, in extreme circumstances when there is a lack of doctors to perform surgery, the modern medicine practitioner must not involve the Ayurveda practitioners as the Code of Ethics by the Medical Council of India prevent the use of non-allopathic practitioners for the pursuance of medical practice. In such circumstances, the staff nurses, paramedics, students, postgraduates who have studied modern medicine and are qualified to assist are given preference over the Ayurveda doctors.

7. What are the changes that have taken place in Ayurvedic surgery from the time of Sushruta? And According to a government statement in Parliament in 2019, there is only one modern medicine doctor for every 1,445 Indians. The World Health Organisation's norm is one doctor per 1,000 people. So in a country like India which has an ocean of diseases we need a helping hand from all specialties to run the show in India. So what is your opinion on the same?

It is incumbent to note at the outset of this discussion that it is a myth that there is a lack of doctors in India and the same is being propagated by the Government. Every year India has 85 thousand MBBS graduates and therefore in 5 years, there are nearly 4 lakh doctors. India has 12 lakh modern medical doctors and 7. 5 lakhs Ayurveda doctors. There is another set of 1 lakh doctors who, after graduating from foreign countries appear in the Foreign Medical Graduate Exam (FMG) to practice in India. Therefore, there are enough doctors in the country and it is only the failure of the government in appointing and calling for the posts. It is often the situation that for one post, hundreds of individuals apply. Nevertheless, if the government feels that there is a lack of doctors in the country it must take steps to rectify this by proper planning, and a five-year proposal instead of looking for instant relief. The second myth that exists, in light of the WHO statists, is that one doctor is needed per 1,000 people. The WHO in the study carried in the UK and the USA, almost ten years ago introduced these norms, which has no practical application in India. In the former countries, the general practitioners are mandated to spend 15 minutes with 1 patient whereas in India the practitioner gives 5 minutes to 2-3 patients. Further, the ratio of 1 doctor for 600-650 patients in Tamil Nadu and Kerala depicts an excess of doctors. It must be noted that the deficiency of doctors in some of the remote areas is not due to the lack of doctors in India. The IMA is further willing to Indian to provide a cadre of doctors to serve in any part of the country. The Government however is risking the lives of the common man by mixing the two fields of doctors to overcome the WHO criteria. The IMA, therefore, stands in protest of the mixing of the untrained practitioners into modern medicine, despite there being plenty of qualified doctors to fill the vacancy.

8. Since the world health organization declared COVID-19 19 as global pandemic, health care system across the globe even in the developed countries have fallen apart. The denial of treatment to patients by medical authorities and private health institutions and in some cases, patients have lost their lives due to denial of admission or treatment is a gross violation of individual basic human rights mentioned under various international instruments. The denial of human rights is not limited to this but also includes the manner of disposing the bodies of COVID-19 19 victims so how the denial of treatment to COVID-19 19 patients is an abuse of funded rights and the failure of state and authorities to ensure basic human rights of the citizens and the world health care system needs a reboot.

It happened all over the world and no one was prepared for such an eventuality. There was fear when Italy sent a message about a thousand deaths and there is no place for burying them and that time everyone defaulted, quick guidelines couldn't come, everyone was in fear, private hospitals were not ready to admit the patients because they also feared. We lost 700 doctors in our country. This could be ignored if China revealed how they treated their patients. There was no international cooperation. If the way China treated their patients in November December January if they would have made it transparent on their website so many people across the world would not have died. Every country is learning through their own experiences and I can't blame anyone for the pandemic. Still India's recovery rate was better.

9. What are the steps that India will take if at all a new pandemic comes?

India has to come with its own Research and Development, genomic labs and communicable diseases set ups early treatment and early vaccinations. You can't have a WHO vaccination for a disease, you can't have UK and USA deciding the vaccinations for diseases. Considering our population and geography we need a vaccine within 3 months of its arrival. Vaccine jointly developed by Indian council of medical research , national institute of Biology and Bharat biotech has been recently approved by the India's drug regulator DGCI for administration against Covid 19 without clearing the 3rd phase trial so this question is divided in two parts.

10. What is the legality of authorizing the administration of the vaccine without having cleared the third phase trail the sole purpose of which is testing efficacy. Could it not be said that it is because of this lack of transparency and proven efficacy that has produced vaccine hesitancy among the population? Should the government be held accountable for promoting such unhealthy practices of giving clearance to a vaccine which lacks scientific backup

I absolutely disagree with this question. These are killed vaccines. Killed inactivated vaccine can be prepared in one to three months. Even government waited for 8 to 9 months long. China made it and opened it with the phase two trial. Russia made and opened it to phase two trial. So phase 3 trial is not need in the pandemic. If the people are dying you can't wait for the evidence you decide which one is safe, the disease or the vaccine.

Dr. Vinay Aggarwal

Director, Crosslay Remedies Ltd,
Past President-CMAAO,
Past National President-IMA,
Member- MCI,
Executive Member, DMC

1. The pandemic has exposed the vulnerabilities of India's health care system and India spending less than 2% of its GDP in the health sector despite being the state duty to provide a better health care system as mentioned in Article 42 and Article 47 of Part IV of the Constitution. According to you, will FDI in healthcare system be a boon or a bane to India?

I do not agree that the pandemic has exposed the vulnerability of India's health care system. As a matter of fact, the robust public health framework could take on the pandemic head on. This is compared to many systems which spend much more. In many countries there were tertiary care hospitals without any worthwhile public health system. India's Government infrastructure acted as the shock absorber while the secondary care and tertiary care private hospitals did the backup mopping. People had a choice as well. At no stage the situation went out of control though in some cities at some point near saturation of facilities did happen. FDI in Health Care system will be a bane in India. India's requirements are primary care and public hospitals. Adequate number of For-Profit hospitals do exist and there is no dearth of domestic funding. FDI in Health Care runs the risk of escalating the cost as well.

2. Right to health and affordable healthcare facilities falls under the purview of article 21 and yet there is a glooming gap in having access to the same, according to you what are the changes that can be brought about to fill these gaps?

Right to Health falls under the purview of Article 21. It doesn't speak of affordable health care facilities. Right to Health entails Universal Health Care for all citizens. This can mean that the Government is responsible for providing a minimum basic package. It can be expanded to the Government purchasing care for below poverty line population from private sector especially in tertiary care. The gaps are in:

Inequitable access based on poverty, ignorance, geography, gender and marginalization.

Lack of Government investment in public Hospitals and Human Resources.The changes to be brought in are self evident. Non insurance based Universal Health Coverage with Public Hospitals providing the anchor and purchase of care for the BPL families from private sector especially tertiary care.

3. According to you, has the government taken the shield of directive principles of state policies over the knight in shining armor i.e., Article 21, even when the supreme court has time and again reiterated that right to life means having all those rights which makes one's life meaningful i.e., right to health & healthcare?

I don't think there is an intentional hiding by the Government. The Government might have compulsion in prioritizing expenditure. The pandemic has given the urgency and priority

4. The regulation of abortion in under MTRP 1971 is historically considered to be liberal and progressive but it still does not allow reproductive autonomy to women. Do you think with this is the time to allow the women choice in abortion especially post Right to Privacy Decision?

The MTP Act is the most liberal and pro woman Act in the whole world. How can an abortion act provide reproductive rights to women? The Act provides for the post Right to Privacy

5. India is a party to the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. The Supreme Court held that Article 21 of the Constitution of India in relation to human rights has to be interpreted in conformity with international law, Further, Article 25 [2] of the Universal Declaration of Human Rights and Article 7 (b) of the International Covenant on Economic, Social and Cultural Rights have been cited by the Supreme Court while upholding the right to health by a worker. In Practice we have seen this is not realised, what do you think is the reason of this abysmal situation?

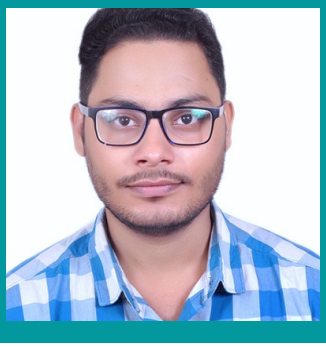
Rights and privileges bestowed on anyone need social, economic and educational empowerment to translate into reality. India is a country which lives simultaneously in three centuries. 74 years of independence is a brief period in the life of a nation.

6. As adolescents is not a homogenous category, within the broader umbrella of health, the priorities of young people changed between age groups. For those in the age bracket of 15 to 19 years, understanding and managing substance abuse and mental health are their key areas of concern. On the other hand, getting more information about sex and sexuality, and access to affordable sexual health services such as contraception and treatment of sexually transmitted diseases (STDs) are also important. How do you see this with youth as a main stakeholder with population around 600 Million?

Substance abuse is a serious issue amongst the adolescents. Yet may not be the top priority. Mental Health in youth is all about stress related to studies and career. Sex education, access to sexual health services are culturally sensitive issues and should be handled accordingly

7. The amount of Healthcare waste being generated is increasing dramatically. During the time of COVID-19 19 pandemic, ensuring reliable and safe municipal waste management (MSWM) services was a must for all local governments to protect public health and contain the spread of the virus. So how in your opinion it is causing high risk to cities in low to middle countries, where waste management service provision is immature and with a high percentage of informality in the waste and recycling economy.

Municipal Solid waste management and biomedical waste management are two important sectors which impact Health. The scope and profile of the Health ministry should be included to involve sanitation, drinking water and waste management.



-Dr. Shankul Dwivedi

QUESTIONS ON ROLE OF YOUTH IN FRAMEWORK OF HEALTHCARE POLICY AND CHALLENGES FACED BY THEM

1. A global pandemic is creating two extremes for many doctors—either they are swamped with COVID-related patients in a hot spot or are struggling financially because patients are afraid to come in for appointments. So in what ways the Covid-19 pandemic fallout is exacerbating a growing burnout problem in the profession, and how doctors have become the targets of politicians looking to shift blame.

Now typical day at work for junior doctors lasts for around 36-48 hours. COVID has demanded extraordinary proactive involvement of Resident & Junior docs, and we have carried out duties sincerely throughout. It won't be exaggeration, if I say that the battle against the COVID-19 pandemic would be lost if it were not fought by our resident/junior docs.

Working for hours in PPE kits, under extreme conditions, was and is a challenge, its dehydrating, some had to wear adult diapers along, as one kit was available/day initially, and we couldn't have allowed wastage. It was something new, we had never experienced before. Over and above the physical discomfort, fearing spread, many of us had to stay in separate accommodations away from family, and were not able to see & meet them for days, drained us emotionally. This was harder especially for those colleagues who were married or those who had young children. Limited manpower, shifting dependency on tertiary care hospitals, physical & emotional draining, exhausting working hours in a high-pressure environment have contributed to development of burnout among Health care workers.

Then there were cases of violence, stone pelting, on team of docs visiting localities for contact tracing, this further added to our mental suffering.

We have strongly responded to the call of the hour and served mankind, in ways which generations to come will appreciate. Entire nation has lauded the efforts, any blame and comments on our role thus stands self defeated. And whenever such comments are made, it is to hide the deficiencies of existing healthcare infrastructure and not an attack on functioning of doctors per se.

2. Independent practices, especially primary care practices, have been particularly vulnerable to the devastating economic effects of this pandemic. So does it cause worry about long-term viability of independent practices, and what needs to be done to save them?

No single healthcare model seems to be completely immune from the dire effects of corona virus. Independent practitioners were worried about sailing through this COVID-19 challenge. Financial struggles, primarily due to decreased patient volumes was concerning. People practiced strict discipline during the beginning of the pandemic, stayed at home and therefore stopped coming to doctors for routine & primary care services. Many institutions and practitioners were forced to pursue different models of healthcare delivery. Some adopted telemedicine and other followed virtual or remote clinical visits. Given the situation at hand, the future seems uncertain for smaller physician groups and practices. With time, normalcy is being restored and hopefully our physicians are now more adapted.

3. What changes need to be made in the curriculum of the medical studies so as to make the future doctors more efficient to deal with such pandemics?

In response to the COVID-19 pandemic, educators around the globe are scrambling to adapt in ways that facilitate the ongoing knowledge and skill development of the next generation of health professionals. Therefore changes need to be made in medical education curriculum that makes medical students and fresh graduates more future ready to deal with such situation in times to come. Students need to acquires competencies in handling not only the illness but also the social, legal and other issues arising from such disease outbreaks. We need to introduce infection control practices, sample collection techniques, public health preventive strategies at an early stages to better train UGs. In this regard it is interesting to note that the apex regulator of Medical Education in the country, National Medical Commission (NMC), has prepared revised regulations on Graduate Medical education and Competency based undergraduate curriculum and has introduced a module on pandemic management. This will enable them to be prepared for the unknown - to be able to understand, investigate, treat and prevent new and emerging diseases as clinician, community leader and scholar.

4. There is widespread uncertainty and disagreement about the appropriate roles for medical students during a pandemic, student participation in clinical care has varied across institutions. Some schools forbid any patient interaction, whereas others have recruited students for hospital-based roles or even graduated medical students early so that they can serve as frontline clinicians. So can allowance of medical students to serve in clinical roles may benefit patients overall or that medical student involvement should be reserved for critical health care personnel shortages.

The COVID time was an unprecedented one and it required active measures from Medical Profession. It was more like a war front which required extraordinary response. And, like in war the reserve forces are called, so were the medical students. It was on need basis, that the, individual state governments & institutions deployed medical students in COVID related duties. It was a good idea to enroll them for basic patient care and contact tracing, but it was premature to enroll them on ICU duties, given the insufficient competency based training among second and third year students to deal ICU like settings. Rather a prior sensitization and a weeks training could have made them more confident in serving at the COVID wards. Given urgency and shortage of manpower it was important to enroll them at some point of care in COVID management. And this was specially beneficial where students went outdoors on contact tracing, so that residents and senior doctors can have time to attend patients in wards/icu/emergency. It was a good opportunity for medical students to too, to get such an exposure at an early stage.

Does India need a bullet proof affordable healthcare policy?

We have to be dynamic & holistic in our approach when designing healthcare policy. Healthcare data as evident from COVID times, needs to become a policy focus for India. Data driven care ensures equitable if not equal care for patients. National Digital Health Mission will amalgamate data collection, assessment and then generate healthcare plans and deploy healthcare services in real time to those who need it the most.

We have to be dynamic & holistic in our approach when designing healthcare policy. Healthcare data as evident from COVID times, needs to become a policy focus for India. Data driven care ensures equitable if not equal care for patients. National Digital Health Mission will amalgamate data collection, assessment and then generate healthcare plans and deploy healthcare services in real time to those who need it the most.

There are two major aspects when it comes to patient seeking care- Healthcare delivery points & finance. Deficiencies during pandemic (lack of beds, ventilators, oxygen cylinders, testing labs and equipments..etc) have laid bare several fissures in India's public health infrastructure & investment, before we address these it would be difficult to achieve affordable care. Absence of strong public health infrastructure forces patients to switch towards private and corporate setups, which has a lot of effects on economic expenditure of middle class family. So policy needs to focus on strengthening these infrastructure and secondly Telemedicine can be another policy reform which can help us improve in terms of healthcare delivery points and thus it requires special focus. Expansion of Ayushman Bharat to allow incorporation of large volumes of citizens as beneficiaries can answer the financial aspect of the patient seeking care.

Further, given the burden on urban healthcare systems, budgets need to be expanded to improve healthcare infrastructure supply aligned with the disease progression in cities. This must result from greater decentralization of finances and responsibilities, as well as revenue from health tourism.

6. A majority of India's population consists of today's youth, especially those working in the healthcare sector/medical field and those providing such facilities, especially in the rural part of India and they face a lot of challenges, such as less ICU or NICU facilities and even the conditions in the government hospitals are very basic and hence even though well trained they are not well equipped due to less government funds and hence many patients die , according to you, should the government take active help of the young population in this sector to overcome these challenges and formulate a uniform policy after a detailed review or investigation?

Those framing the policies usually sit in air conditioned cubicles and are far from the ground realities which the younger generations are facing in real times. Lack of funds limits the availability of devices, equipments and other necessary deliverables which are necessary for the basic patient care. Referral is the only option left at remote areas in such limited scenarios. Therefore while framing policies it is necessary to interact with youth serving rural areas to develop and formulate plans which are better suited to their needs and the patient needs. Dialogue and two way flow of thoughts improves the outcomes. Youth has better ideas based on experiences they undergo, accommodating them in decisions making will be game changing and reforming when it comes to healthcare delivery.

7. In general shouldn't there be a cap on medical bills in private hospitals, as they charge exorbitant fees, irrespective of a pandemic or not

Essential drugs, equipments do need special control and government is already regulating this by maintaining index of such essentials. Fee regulation, alone can't be the answer to a complex problem of costly healthcare, since it is driven by diverse factors. Cost of bills is split into various sections and we need to understand and convey that while it is possible to regulate major section (those including drugs,equipments), it is difficult to put cap on services and expert care being provided to patient at these private hospitals. A lot of investments are made by owners towards land acquisition, infrastructure development & maintenance and machinery purchase, all this eventually adds upto patient bill. Therefore Patients need to make informed choices, matching their needs and finances, luxurious and skilled care from top most physicians in the country will certainly incur more expenditure. We can buy a pen for as low as 3 rupees and as high as in lakhs. One sector alone couldn't managed needs of a country as huge as ours. I agree and advocate Quality care and therefore propose a balanced system where both corporate and patients flourish without exploiting each other. So on one hand the government should spend aggressively to strengthen the public healthcare infrastructure & ensure affordable and quality care and to reduce reliance on corporate system. Corporate setups, on other hand, need to be more transparent on cost of treatment, so that patients easily understand and make informed choices.

8. How do you see the issue of quality of medical education in India with increased fees and protests across country on it. Do you think it is time for a reform in Medical Education and make it accessible and affordable?

One of the purpose to introduce a new regulatory body for medical education in India (The NMC) was to ensure fee regulation of the private medical colleges and to provide quality and affordable medical education in the country. This however has failed till recent times. Medical Students from Punjab, uttarakhand and several other states have been on roads protesting against inhumane rise in fee, but all their voices have been unheard. The impact has been felt this year during NEET counselling, where several seats went vacant on account of high fee in certain institutes. They are beyond paying capacity of a scholar student. Such situation have limited their capacity to enrol in these courses and has paved way for richer, less on merit students. It is high time that the regulatory body becomes proactive in its role and purpose for which it was established. More government medical colleges is one solution but regulation is certainly the best reform required.

9. The universal health care system is relatively new in the arena of international law, what could be its trajectory in the scholarship of international market and international forums?

Prefer not to answer due to less expertise and knowledge about the same.

ARTICLES

THEORIZING PRIVACY IN THE PANDEMIC- AAROGYA SETU APP: A CONUNDRUM BETWEEN PUBLIC HEALTH AND PRIVACY

-Ayush Negi, B.A. LL.B. (Hons.), 3rd Year, NLU Delhi

In his dissenting opinion, Justice Khanna wrote that - "The greatest danger to the liberty lies in insidious encroachment by a man of zeal, well-meaning but lacking due deference to the rule of law". Such statement inferred the Government's blatant disregard for the law by taking the excuse of catastrophe. Again, India is experiencing such déjà vu in present times caused by the minuscule virus, which is probably the worst public health crisis in centuries. These unprecedented times led the Government to adopt unconventional and unusual measures to combat covid-19.

However, the Government's efforts to control the corona outbreak have brutally bruised the fundamental right of privacy of Indians. The Government developed Aarogya Setu App (App) to identify and track infected and possibly infected individuals. The App stored personal data of Indians, including their occupation, medical and travel history. A dichotomy existed between individual privacy and public health in the times of the pandemic. The Government's drastic measures to control the outbreak violently targeted individuals' privacy and placed private information for public scrutiny. In some states like Punjab, Kerela or Rajasthan, infected persons' data were put in the public domain.

Further, the Aarogya Setu app sparked intense debate due to its adverse effect on users' privacy. The 'Terms and Conditions' of the App absolved Government from any liability arising out of unauthorized access to the users' data stored in the App. Later, the Government issued Data Access and Sharing Protocol for the App. However, users' personal data is still vulnerable as revealed by recent RTI which disclosed that National Informatics Council operating under the Ministry of Information Technology was unsuccessful in implanting pivotal safeguards provided under the protocol.

THE APP AND ITS CONSTITUTIONAL VALIDITY

In these turbulent times, the Government's endeavour to fight the virus require a constitutional examination on the touchstone of proportionality tests as laid down in KS Puttaswamy which gave four criteria to assess whether the restrictions on the fundamental right to privacy are justified. These four criteria are a) Legality- the existence of the law to justify the encroachment on the fundamental right to privacy, b) Legitimate aim, the intervention with privacy shall be for pursuing legitimate State aim and c) Proportionality, infringement of privacy should not be disproportionate with respect to the State's aim. The fourth element of 'Procedural Safeguards' was inserted by Justice Kaul in the same case.

Testing the App on these four elements shows that the App fails to meet the criteria set up in the Puttaswamy case. The State launched the App, which is run by the Ministry of Electronics and Information Technology without any support from law, regulation or ordinance, thus indicating the absence of any legal basis. While there is a legitimate aim of preserving public health, the proportionality status of App can come under the shadow. The fourth element, that is, the Procedural Safeguards is also not met as the Government has broad and arbitrary discretion with regard to usage of personal data with no accountability.

Therefore, it is evident that the App is not in consonance with the fundamental right to privacy. Given the tremendous amount of data collected through the App, it can easily target people. There is sufficient research that shows that even anonymous data can be re-purposed and re-identified to target and abuse specific communities and certain sections of society.

POSSIBLE SOLUTION AND WAY AHEAD

There is no denying that fundamental rights are not absolute and are subject to certain restrictions on certain grounds, such as public health or security. In these pandemic times, the imposition of certain limitations on people's civil liberties for preserving public health cannot be denied. Still, having democratic machinery in function in countries like India, it is certainly expected that all the State functions are performed with transparency entrusted with accountability. Privacy and public health are two legitimate State aims that can be reconciled through suitable policy.

It is suggested that the Government can bring several reforms in its fight against the covid-19, which at the same time also inclines with protecting the privacy of people. The Government can ensure minimal necessary collection and processing of personal data which is also in accordance with the constitutional rights. The process shall be transparent, and an individual should be informed about their private data's purpose and usage. The data stored shall have a limited life, and data retention beyond pandemic should not be allowed. It is essential to set up accountability in collecting and processing personal data.

CONCLUSION

The sword of coronavirus is hanging over humanity. Public health and individual privacy are in a direct faceoff with each other. Collection of personal data of an infected individual is necessary to fight the virus. Still, the same does not give blanket authorization to the Government to collect and process personal data in any manner it wishes. Rights are forged in crisis, and history itself supports this adage. For example, the end of the Second World War led to the recognition of human rights. Though fragile at the time of the pandemic, peoples' basic civil and fundamental rights can never be completely effaced. This challenging time requires unprecedented and unconventional measures but not the unconstitutional ones.

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UNDERSTANDING DRUG ABUSE DURING COVID-19: INDIAN SCENARIO

-Prapti Bhattacharya,B.A. LL.B., 3rd Year, Asian Law College, Noida

Introduction

Drug and substance abuse is one of those most complex phenomena with several social, cultural, geographical, economic perspectives. Over the time, the slow growth in the industrialization, urbanization, the breakdown of a healthy joint family system, lack of parental care in nuclear families, inability to handle stress etc. have provoked people to take drugs to escape hard realities of life.

The categories of drug usage in India are as follows:

General Material: cough syrups, pain killer ointments.

Intoxicating Material: alcohol, tobacco, cocaine, heroin, cannabis, opium.

Intoxicating Material but neither alcohol nor drugs: glue, colophony, paints, whitener.

Since at the outset of the NDPS Act, the Ministry of Social Justice and Empowerment has conducted two commodious drug surveys, in 2004 and 2019; which show Opioid use has hiked from 0.7% to more than 2% in the current report, but in terms of the total population, the hike is from two million to almost 23 million. Unfortunately heroin has substituted the natural opioids (opium and poppy husk) as the most ordinarily abused opioids.

The survey has pointed out the lacunas in the existing system, which can be reduced by implementing the following laws:

Statutory Provisions in India

India has an international obligation to combat the national and international drug abuse problem because it has signed the Convention on Narcotic Drugs, Psychotropic Substances, and Illicit Traffic in Narcotic Drugs and Psychotropic Substances in 1961, 1971, 1988 respectively. In the light of these international treaties, the legislature has drafted some central laws like the Narcotic Drugs and Psychotropic Substances Act, 1985 and the Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988.

Problems faced by substance abusers in the lockdown

During the nationwide lockdown, the population suffering from substance use disorder (SUD) has found it very difficult to reach health care facilities. This has been most alarming for patients who are on a regular dosage of opioid substitution medication.

The lockdown resulted in the complete closure of licensed liquor shops. Due to liquor's unavailability, the daily alcohol users resorted to homemade liquor, and drinking caused drastic alcohol withdrawal symptoms. In the past also, we have seen the instances of problematic alcohol withdrawal cases due to forced liquor ban during elections.

The opioid substitution treatment centers were not transparent as well. Thus, to curb down the patients' visit during the lockdown, National Drug Dependence Treatment Centre suggested dosing Buprenorphine (take-home doses for 1–2 weeks) and methadone (biweekly refill) on March 25, 2020.

The current most and revolutionary health service delivery system introduced during COVID-19 is the telehealth services. But most treatment centers did not have any dedicated helpline number and trained staff who could be part of telehealth services as prescribed by the Indian Psychiatric Society. Additionally, no measures were taken to enlighten patients to take help of such services effectively.

The rehabilitation centers released the patients untimely without thinking that partially treated patients with SUDs are at higher risk of relapse. When the crisis is over, people will be involved in the overdose of such drugs.

Recommendation to stop the menace of Drug Abuse

After a thorough analysis of the present scenario, the following recommendations are given:

- Effective communication is required between parents and the victims.
- Psychological therapy is required to regulate the behaviour of consistent abusers.
- The national policies should be amended and drafted, keeping in mind the youth's lifestyle with whom our country is mostly comprised of. The policies should have the potential to dampen the societal, psychological, educational pressure mainly.
- The production, dissemination, and international trade of chemicals allegedly used in making drugs must be regulated with highest possible taxation policies.
- From the behavioural and working pattern of an individual in any educational institutes or job sector, it is necessary to segregate the drug users to take preventive steps at the earliest.
- The NDPS Act does not have any provision distinguishing between a casual drug user, a habitual addict, an occasional peddler. So the distinction should be prominent to give customized solutions for all these four categories.
- Since the NDPS Act fails to differentiate between hard and soft drugs, people often resort to hard ones. Thus different penal provisions must be introduced for using soft and hard drugs.

Following this recommendations we also need to remember that the substance abuse can be regulated at the individual level, by making people aware of the physiological degradation due to the abuse with the detailed analysis of socio-cultural factors influencing such habit and at the national and international level, there has to be a conjoint effort of all the countries who have always been on the spotlight for the drug abuse trends balancing the local socio-cultural and political scenarios.

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Legislative Response to Covid 19 Pandemic: Comparative Analysis of India, South Korea and Canada

-Rashi Dubey, LL.M- Corporate Laws, MNLU-A

The legislations developed in India and across the world , in response to Covid-19, can entail the development of an Epidemic Diseases legislation which provides guidance in lieu of actions to be taken in case of local outbreaks or any resurgence involving public notifications, fund disbursement, compensation packages to the informal sector/ agriculture related workers and availing the required equipment and infrastructure to curb the spread of highly communicable and life threatening diseases.

India

The Epidemic Diseases Act 1897 was enacted by the Imperial Legislative Council, in the former British India to tackle the bubonic plague in Mumbai. It was enacted for containment of the epidemic by giving special powers for the implementation of the containment measures to control the spread of the disease. Recently, there was an amendment in the act in 2020 namely The Epidemic Diseases (Amendment) Bill, 2020 which was introduced for criminalizing and punishing those who attack the healthcare professionals or their property. Both the legislation as well as its amendment provide a structure for the State and Central Government in issuing the ad-hoc notifications and conferring unfettered powers to control the spread of a chronic, infectious and fatal outbreak.

Comparative Analysis of Legislative and Legal Framework:

Let's observe the legislative framework and the mechanism of dealing with the health emergencies by the legislative acts and the government framework in two countries, which has managed to deal with the COVID 19 outbreak quite satisfactorily: South Korea and Canada.

South Korea

There are two laws in South Korea to deal with the epidemics. The first one being the Infectious Diseases Control and Prevention Act 2009, which caters to the measures involving prevention of the spread of infectious diseases and contract tracing. It was further amended in March 2020 to increase fines on the violation of social distancing measures and providing the right to treatment for patients as well as masks for children and elderly population. The second legislation is the Quarantine Act providing extra measures to prevent the spread of infectious disease by the travelers coming from other countries. South Korea also has a Centre for Disease Control monitoring the spread of any infectious disease.

Canada

Canada's epidemic response is basically delegation of duties between the federal and the provincial government. The mechanism under the federal government is stipulated under the Emergency Act of 1998 along with the Emergency Management Act 2007. On the other hand, the provincial governments have the states to act upon the prevalent health issues. One of the major considerations can be pondered upon the Public Emergency Act, the federal government can regulate the movement of people, impose fines and also establish temporary health facilities. Also, there is a legislation named the Quarantine Act, 2005 which is in general invoked during emergency allowing the federal government in establishing the quarantine facilities and designating officials to deal with management of epidemic response. The Public Health Agency of Canada is an agency having the responsibility of promoting health and controlling all the major chronic and infectious diseases.

Road Ahead for India

The Epidemic Diseases (Amendment) Bill, 2020 suggests that physical harm and damage of property are the major threats faced by the medical professionals on duty. Nevertheless, these professionals suffer from other severe risks too like contacting the disease while treating the patients, lack of hygiene and safety, lengthy working hours, prolonged delay in the payment of salaries, etc. The Amendment Bill, therefore, failed to address these important issues on the part of the executive machinery in protecting the frontline workers especially in the healthcare sector. For a rational, prudent and pragmatic approach towards dealing with a pandemic a lot more is needed, wherein all the stakeholders involved in dealing with the mechanism of preventing the pandemic should be taken care of and it is very important to give them the legislative backing to ensure their safety and well-being. It can never be said that since one country is benefitting from a set of legislations or methodology then copy pasting the same mechanism would render the same benefit. Each and every country has its own demographic and social mechanisms and focusing on reducing the impact of the pandemic includes meticulously reaching out to the sufferings of the people and the stakeholders of the health sector and giving it a firm legislative backing in order the confine the pandemic. We should also not forget the police personnel who were day in and out continuously working, many of whom contracted the disease while on duty. Therefore, the process of regular monitoring of the pattern of the disease must be established. The Amendment Bill did not address any of the major concerns by merely by increasing its stance on the violence against the healthcare service personnel, there is no doubt that there were instances in which the healthcare workers were attacked while performing their duties, however there are larger issues regarding a lack of legal framework in dealing with any kind of public health emergencies in India, and a more robust, effective and efficient healthcare legislations is the need of the hour.

SHORT-ARTICLES

IS CURE BETTER THAN INEFFECTIVE PREVENTION? - THE UNRESOLVED VACCINE DILEMMA

-Aishwarya Pandey, B.A. LL.B. (Hons.), 4th Year, MNLU-A

The outbreak of the (SARS-CoV-2) Coronavirus disease-2019 has spread to over 216 countries across the globe with approximately 10,69,91,090 confirmed cases including 23,20,497 deaths, reported to WHO.
Recently the Central Drugs and Standards Committee (CDSCO) has formally granted the approval to two Covid-19- Vaccines – Covishield and Covaxin, developed by the Serum Institute of India and Bharat Biotech respectively. The indigenously produced vaccine could have helped India emerge as a leader in the vaccine development against the virus but its failure has now become evident as the government has missed the key aspect of testing the therapeutic efficacy of the vaccines. It more likely seems to be a rushed gamble risking the lives of the individuals in the fight against the virus

The Triple Phase Test Involved in Proving the 'Efficacy' of the Vaccine:

This could be understood by explaining the three phases which any vaccine has to mandatorily go through before its rollout in order to qualify as a safe an effective measure against the disease. In the first phase the vaccine is administered on healthy individuals in order to check the safety of the vaccine by studying the physiological changes it might induce of the body. The seconds phase tests the immune response of the vaccine by checking if it is producing enough anti-bodies which are required for defense against the actual virus. The third phase which is in fact the most important of all three stages involves a double blinded test where some of the volunteers are administered with the vaccine and the others are administered placebo without disclosing the nature of administration to the volunteers and the doctors. The method used in this phase scientifically backs the efficacy of the vaccine.

Failure of the Government in Establishing the Efficacy:

The vaccine Covishield manufactured by the Serum Institute of India has furnished the data based on the phase three trial conducted in U.K. and Brazil and has not disclosed how the vaccine was effective on the Indian Volunteers. The results become even poorer when it comes to Covaxin produced by Bharat Biotech where the phase three trial has not been finished as it failed to recruit the required number of volunteers. Although the data submitted by both these vaccines proves the safety of the vaccine, what they fail to establish is the therapeutic efficacy which is the foundational basis for the conducting the trials.

Issues of Concern: The Scientific and Ethical Dilemma

The ethical dilemma which now poses a cause of concern over the efficacy of the vaccine is about the possibility of the third phase trial actually being able to be finished. Due to the rollout the completion of the trial seems almost impossible as the volunteers would now know the possibility of actual vaccine administration which is merely 50 %. This would affect the entire nature of the third phase trial, which is a double blinded process and would invite lesser participants as they now have the option of having the real dose available elsewhere.
The decision-making policy of the government made for the general public always lays its foundation upon the trust the public has on it and this trust can only be imbibed by transparency. Only when the government is transparent in its functioning can the public trust its decision and only when the public trust is gained, can the policy be effectively implemented. It is unethical on the part of the government to subject its citizens to the administration of a vaccine whose efficacy rate has not been established. This has thrown light upon the opacity on the part of government in effectively communicating with the public. If this continues and the efficacy data is not provided to the citizens before administration, it would only cause vaccine hesitancy amounts the populace and lead to distrust against the government.

While addressing a press conference the Union Health Secretary backed this practice by comparing it with all the other countries across the globe. But he failed to highlight where India lacked in comparison to all those other countries which is in terms of its failure to establish the data for therapeutic efficacy. The Covaxin has been shown a green flag for restricted use under the clinical trial mode as a matter of abundant precaution but what qualifies as a 'clinical trial mode' has not been made crystal clear by the approving authorities. There is also a lack of clarity on whether any compensation of medical aid will be provided to the persons in case of any uncalled adversities.

The Risks Exposed: Making the Government Answerable

The high risk – groups, prioritized to receive the vaccine will have no option to choose between the two approved vaccines. Although since the Covid-19 vaccination has not been made compulsory, the participants may opt out from being vaccinated. This again exposes the risk upon the individuals who back out due the distrust upon Covaxin. This may seem to be merely involving risk upon the health of one person on the individual level but a higher risk of vaccine hesitancy on the larger picture. It is unethical to administer one recipient with a vaccine whose efficacy is known and the other with a vaccine which is yet to establish its efficacy when both belong to the same high-risk zones. This shows the lack of uniformity and equality in administration of vaccine as no individual is at a lesser risk of infection as compared to their co-workers. Is it not the duty of the government to provide 'effective' vaccination to the high-risk individuals who have denied the vaccination on account of lack of data? Similarly, if it is found at a later stage that the vaccine was only efficient at a 50% or a lesser rate, will the individuals be immunized with other vaccine of a greater efficacy?

The Unresolved Dilemma:

When we talk about the public health and safety framework, only the measures with highest proven efficacy with least effect on the well-being of the members of the society should be considered in priority. Rolling out a vaccine without adequate data for this efficacy might create a false sense of security among vaccine recipients. Amidst the chaos the author fails to find any logical reason of an incompletely studied vaccine being included into the immunisation programme in a country which has recorded second highest number of infections in the world.

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ACCESSIBILITY & INNOVATION IN PUBLIC HEALTH: A TRILATERAL SPECTRA

-Brincy James George, B.A. LL.B. (Hons), NUALS Kerala

Introduction: Answering the call to unified action

The need to view healthcare, trade and competition arenas in a singular lens has never been of greater importance till the outbreak of the pandemic, this demand has arisen in a manner like never seen before. Last year, World Health Organization (WHO), World Trade Organization (WTO), and World Intellectual Property Organization (WIPO) released, 'Promoting Access to Medical Technology and Innovation: Intersections between public health, intellectual property, and trade (Second edition)'. This 352-page study showcases a holistic move dealing with the intricacies in global healthcare efficaciously, including, being aligned with Right to Health, Millennium Development Goals, and responsive to the SARS-CoV-2 virus pandemic crisis. The trio of theses pioneer organizations advocate a unified perspective and provides a kaleidoscopic spectrum of possibilities. An extraordinary unison in the comparative analysis of the interdisciplinary nature of Health, Intellectual Property Law, Trade Law, and Competition Law, the book resonates with an aim to be instrumental in supporting developing countries and for enhancing regulatory responses.

As rightly remarked by Richard Horton, editor of the Lancet, 'the pandemic has dismantled global health', the effects of the pandemic have been debilitating to humanity and survival. We can also witness how public health concern is related to a vast array of issues such as inequality, national security, obstacles in humanitarian settings, demanding a dire need for proper governance and preparedness.

A unilateral mechanism will be insufficient to mitigate a pandemic, a multidisciplinary cooperation stands necessary. Novel strides made in public health can be seen such as the Strategic Public Health Planning (SPHeP) models introduced by the Organization for Economic Co-operation and Development (OECD), introduced the tool for informing strategic planning in public health, aiming to cover broad areas from diseases to mental health ailments, the tools include microsimulation model and agent-based model, and adaptable by all the countries in the world. The WHO-WIPO-WTO cooperation has been holding strong ties since 2010, with the conduct of the technical symposia covering cutting edge deliberations on matters ranging from medical innovation to sustainable goals. The recent trilaterally integrated publication includes the key takeaways in policy intervention, innovation, and accessibility as follows:

The Policy Spectrum

While formulating public health policy procedures, the publication refers to dual tiers of intersections: legal and policy interpretation to facilitate effective measures in public health

the accommodation of data from a variety of sectors to be viable for public healthcare, medical technologies, and trade activities

The policy sectors of public health identified in the publication are innovation, research mandates, human rights paradigm, public health framework, regulatory mechanisms, intellectual property mandates, international commercial sectors encompass the access to medical technologies. With the outbreak of the COVID-19, the policy spectrum faces challenges in the fields of monitoring and containment of the virus spread, mobilization of resources, implementation of the efficient healthcare system, availability of equipment, manufacture development, and facilitation of egalitarian accessibility.

The OECD SPHeP Models, similarly, delve into key areas that are addressed to the policy-making fraternity which include investment, impact on healthcare, labor, economies, and the time for achieving results. The policy adherence is essentially key to software licensing and procurement mechanisms transparency procedures, and sustainable finance.

The Innovation Spectrum

The focus on the global intellectual property paradigm has increased tremendously due to the pandemic. The WHO Solidarity Call emphasizes transparency in R&D and providing information to enhance accessibility and accuracy. Furthermore, WHO introduced the R&D Blueprint and the COVID-19 Tools (ACT) Accelerator to promote global coordination. Several moves of novelty introduced by WIPO, include PATENTSCOPE database and the COVID-19 Policy Tracker, where the role of Intellectual Property offices in disseminating information during the pandemic plays a fundamental role. In the patentable spectrum, due research exceptions and marketing compliances are provided. Repurposing comes in the forefront to foster expediency in licensing with available policy measures. The need for immediate innovation for accelerating effective measures and sharing information for the public is also mandated. Patent pools in developing countries and partnerships as the COVID BOX are being available to the public domain.

The Accessibility Spectrum

It has been necessary to impart an efficient international trade system with matters concerning tariffs and how the trade plays a significant role in stimulating competition. Ensuring a level playing field for developing countries, cross-border flows, and trade facilitation mechanisms simplifying customs procedures have gained wide approval. The role of trade has been indispensable during the unprecedented pandemic situation particularly in handling the sudden surge in medical equipment demand, according to the WTO report, an increase of 29 percent occurred in the trade sector alone. Within the enlarged scope under the WTO General Agreement on Trade in Services (GATS), ‘telemedicine’, bridges the gap caused due to the geographical barriers and social distancing practice has been envisaged. Recent trends gaining prominence include the issuance of special and social compulsory licenses, manufacture, technology transfers, patent review, and copyright procedures enabling access to enhance R&D, particularly for tracking and predicting the virus spread.

Conclusion: the way ahead

Along with the comprehensive outlook provided by the publication, it has left room for improvement in analyzing regional free trade agreements. The WHO-WIPO-WTO combined efforts shed light on the integral need for action in togetherness. Dialogue between researchers and policymakers is vital as emphasized by Michael P Kelly and Natalie Bartle in the chapter, “Evidence into policy; the case of public health”. Facilitating enhanced collaborative strategies for public health is the need of the hour. Prevention of working in silos amongst government bodies, participation from grass root to global governance must be encouraged. Consistent collaborative actions are necessary for safeguarding vulnerable disadvantaged groups, improving digital infrastructure, fostering social innovation, and ensuring universal access to healthcare.

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Abortion laws from the prism of Reproductive autonomy and Privacy

-Anubhav Kumar, LL.M, MNLU-A

In January of 2020, an attempt to amend the Medical Termination of Pregnancy Act (MTPA) 1971, which regulates abortions in India, was made. It extended the gestation period of abortion from 20 to 24 weeks on recommendations1 through the Medical Termination of Pregnancy (Amendment) Bill 2020. It also for the first time places unmarried and single pregnant woman on the same pedestal as of married woman thus expanding the original scope of MTPA. However, the bill which is yet to be passed by Rajya Sabha disregards 'reproductive autonomy' of women in abortion and thus has attracted a backlash from different corridors.

While many experts believed that MTPA has been a progressive law but in reality it reflects the patriarchal understanding of family planning as a measure of population control and not reproductive autonomy of woman2, instead it enables formation of medical boards to allow 'abortion'. The disclosure surrounding abortion laws in India always hinges on extreme *pro-choice or pro-life,* i.e., the reproductive autonomy of a woman or her exercise of choice and duty of state to protect every life. It is quintessential in this pretext to read observations by constitutional bench on reproductive rights, principle of liberty, autonomy, and dignity in the context of abortion in *KS Puttaswamy v. Union of India3.* It has now ignited a pertinent debate in the legal corridors and has broadened the scope of reproductive rights and woman autonomy in India which the new law fails to take in account.

Regulating Abortion in India:

Abortion was legally restricted in almost every country by the end of the nineteenth century.This regressive approach worldwide was a product of not only ethical, religious or medical callings but an ideological struggle contesting meaning of life, family and sexuality.4 It was only after *Roe v. Wade*5 when the world started taking a liberal stand on abortion and permitting abortion in some cases. For India it was only in year 1971 when it provided, on recommendations of Shantilal Shah Committee, exemptions for abortion under Medical Termination of Pregnancy (MTP). Pre MTP in India abortion was a criminal offence under the colonial Indian Penal Code. “Causing Miscarriage” was criminalised under sections 312-316 under the Penal Code which was dependent on different weeks of gestation.6 With recent MTPA 2020 Amendment, the gestation period has been increased for abortion but this is not as simple as it sounds, it has its own share of tangled legal-medico and technical nuances. The provision comes with certain qualifications, it allows abortion only “if continuing the pregnancy would involve a risk of grave injury to the women’s physical or mental health or there is a substantial risk of foetal “abnormalities”.If a pregnancy is caused by rape or a failure of contraception, then it is presumed that the continuation of pregnancy could constitute grave injury to a woman’s mental health.7 While placing an unmarried woman in a similar position to married in MTPA is a welcome step, however the question of autonomy of a woman over her body in pretext of her choice is still not available as the law continues to shackle a woman’s decision to abort by requiring endorsement by one or two medical practitioners8 for an abortion within 20 or 24 weeks, respectively. Even within the 24-week period, a woman can only seek abortion for the reasons set out in the law and not on request, as available in Singapore or Canada.9

In this regard Supreme Court in *Suchitra Srivastava v. Chandigarh Administration*10 took a liberal stand and upheld reproductive right of women relying on "best interest standard" but this never was exercised in essence on grounds neither by courts nor by subsequent governments.

Right to Privacy and Reproductive autonomy

Recently in 2017, in the Puttuswamy Judgement, Justice Chandrachud traced how access to contraception and abortion are intrinsic in due process and specifically focused on 'decisional autonomy 'for abortion as part of Privacy. While reading liberty as element of privacy, he cited that there cannot be 'unreasonable' restriction on liberty and shall be permissible in curtailment of any fundamental right which satisfies the constitutional test of reasonableness. However major challenge against this constitutional right is India's pathetic health infrastructure and low literacy which restricts exercise of 'pro-choice' right of a woman raising a question, whether a constitutional right of liberty can be restricted on this ground? Severyna Magill says, "Puttuswamy has failed to take into account how majority of woman due to non-availability of quality infrastructure are negatively impacted on reproductive health."11 Woman's right to make a reproductive choice is a dimension of Personal liberty which is recognized in Article 21 of the constitution, reaffirmed as an intrinsic part of "Right to privacy" in Puttaswamy and yet the MTPA has failed to recognize abortion on choice or reproductive autonomy as a right.

Conclusion:

India needs to correct its patriarchal understanding on abortion laws and let the woman chose for her bodily autonomy but does The onus is on the state to provide a safe health infrastructure and a right on reproductive autonomy as, howsoever, the recent amendments are 'progressive', but the women are still being denied right to privacy and liberty to exercise reproductive rights and autonomy for abortion on demand which in future may be the mooting pointy in the light of declaration of Right to Privacy as a fundamental right.

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RESERVATION IN PRIVATE HOSPITALS FOR ECONOMICALLY WEAKER SECTION

-Bhoomika Agarwal, 4th Year, Amity Law School Delhi

Right to health though has not been made a fundamental right explicitly in our constitution but it can be read into Article 21 i.e. Right to life and liberty. The intent of our Constitution makers to ensure healthcare to all is evident under DPSP which casts an obligation upon the state to ensure economic and social justice. Article 39(e) talks about protecting the health of all workers and children. Article 43-A directs state to ensure the people public assistance in cases of sickness. Article 47 imposes a duty on the state to improve public health.

In Union of India v. Moolchand Khairati, the SC in a landmark decision directed the private hospitals built on government allocated lands to provide reservation for the economically weaker section. The decision found its rationale in the policies framed during independence. In 1949, the country was crumbling under financial pressure leading to a scarcity of basic facilities. In an attempt to boost the economy and for societal interest, the government decided to allot lands to charitable institutions, particularly hospitals and schools, at highly concessional rates. This step also found a place in the Delhi Development Authority Rules, 1981. As per rule 5, the charitable institutions were to be allotted lands at pre-determined prices, instead of market prices. Rule 7.6, as provided below, was incorporated to ensure that the hospitals fulfilled their purpose of serving the public good.

"Allotment of land to private hospitals:

7.6 On the suggestion of Director General Health Services, Govt. of India and Delhi Administration the following conditions are incorporated for allotment of land to private hospitals at concessional rates as determined by Govt. of India from time to time:

1. The institute shall serve as a general public hospital with at least 25% of the total beds reserved for free treatment for weaker sections and another 255 will be subsided."

Moreover, section 2 of the Charitable Endowments Act, 1890, defines 'charitable purposes' to include relief to the poor and medical relief.

However, despite the explicit provisions, the hospitals failed to provide reservations as specified. A report in 2013 found that 72% of the population that largely comprised rural areas, had access to only one-third of the hospital beds. In 2001, a committee was constituted headed by Justice Qureshi to inspect the compliance of the rules by the hospitals. The report submitted by the committee came harshly upon the hospitals. The report, further, suggested a series of measures to ensure compliance. In 2002, disappointed with the neglect of the authorities and condition of the poor, Social Jurist, a lawyers' group moved to the Delhi High Court. In 2007, the Court ruled that all private hospitals built on public land would provide free treatment to the poor. It directed hospitals to reserve 25 percent of their out-patient department (OPD) capacity and 10 percent of their in-patient department capacity. After a decade of non-compliance by the hospitals, the matter went to the SC in 2017, wherein the Court upheld the HC's decision and directed hospitals to file yearly compliance reports.

In Consumer Education and Research Center v. UOI, the SC reiterated the right to healthcare as a fundamental right. However, amidst the ever-widening gap between the haves and have nots, its implementation remains a faraway dream. The increasing challenges concerning public hospitals make it necessary to make private healthcare accessible to the economically weaker section. The long waiting lines, non-availability of medicines, absence of doctors, unethical practices by doctors, poor sanitation are a few to name. As per the 60th National Social Survey, around 47% of people were not satisfied with government hospitals. The statistics paint a devastating picture. There is only one government hospital bed for every 2,046 people, one state-run hospital for every 90,343 people. Moreover, just 1.1 lakh health personnel i.e 11% , work in the public health sector and cater to India's nine hundred million rural population.

The decision in Moolchand Khairati hasn't brought much change in the circumstances. Last year, with the inception of the COVID-19 pandemic, we got to see the harsh reality of the Indian healthcare system. Amidst the lockdown, one of the private hospitals built on public land came up with a circular setting arbitrary costs for COVID-19 patients. With such unreasonable costs, treatment in a private hospital for a person from economically weaker sections of the society seems next to impossible. In the USA, when private hospitals were found to deny free treatment to indigent persons, thereby increasing the burden on public hospitals, the U.S. Congress brought legislation titled Consolidated Omnibus Budget Reconciliation Act of 1986 ('COBRA'). The Act barred private hospitals from transferring patients to public facilities, violation of which attracted penalties.

"The regulations framed by the Medical Council of India under the Indian Medical Council Act, 1956 imposes a duty on the medical institutions and professionals to render service to humanity without consideration for financial gains. However, institutions despite utilizing the benefits of concessional rates have failed to hold their side of the bargain. Ensuring reservation in private hospitals would be a step towards achieving social and economic justice. To speed up the compliance process, the government should consider enacting legislation similar to COBRA. To deprive a person of adequate healthcare facilities because of his financial status defies the very grundnorm of socialist democracy.

1. Central Bureau of Health Intelligence: National Health Profile, 2017, pp 271-272 <http://www.indiaenvironmentportal.org.in/files/file/NHP_2017-1.pdf>
2. The Wire, 'Delhi HC Refuses to Pass Direction to Ensure No Overcharging by Private Hospitals' (12 June, 2020) <https://thewire.in/law/delhi-hc-refuses-to-pass-direction-to-ensure-no-overcharging-by-private-hospitals>
3. Delhi Development Authority Rules 1981
4. Moolchand Khairati Ram Trust v Union of India [2018] 8 SCC 321
5. Consumer Education and Research Center v UOI 1995 (3) SCC 42
6. The Hindu, 'Study reveals India gets only one third of hospital beds', (19 July, 2013) <https://www.thehindu.com/sci-tech/health/study-reveals-rural-india-gets-only-13rd-of-hospital-beds/article4931844.ece>

NEWS JACKING

VACCINE PASSPORT: A MATTER OF OPTIMISM OR CAUTION?

-Indronil Choudhry, B.A. LL.B. (Hons.), 3rd Year, MNLU-A

At present time the travel restrictions have been imposed many countries and airlines who have instituted requirement of verification of international travellers aren't infected with SARS-CoV-2, but these regulations vary from place to place and so far, there's no universally homogenous and systematic mechanism to supplement such program. The inception of a "vaccine passport" would provide as a must requirement verification, previously known as the International Certificate of Vaccination or Prophylaxis.

One and half month in 2021, the COVID-19 Vaccine Passport has become the most vital document to facilitate international travel. While nations are reopening borders, the pressing need for a universally-accepted digital Vaccine Passport has become louder.

Zurab Pololikashvili, secretary general, United Nations World Tourism Organisation (UNWTO), has urged for the global implementation of vaccination passports as part of wider measures for facilitation safe resumption of international travel and to get the world in motion once again. The recent United Nations World Tourism Organisation UNWTO meeting called for international health and travel bodies to institute the coordination and create a harmonised and digitised system, as well as standardised testing protocols.

Massive number people are being vaccinated against Covid-19 every day, it is said with infectious pragmatism that the old normal life is not a so distant by bringing called "vaccine passport" an easily accessible and verifiable certification that a person's been inoculated. Private companies are already beginning to look at making shots mandatory for people who want to get on planes, cruise ships or attend events such as concerts. A handful of projects from governments, private firms and international associations are currently underway. But the idea raises scientific and ethical questions.

Given the prevalence, contagiousness and devastation of Covid-19, many are suggesting the need for a more modern, digital and secure record. Ideally, it would provide proof of vaccination status and document recent virus test results, which would serves as reassurance to border security agents and to fellow travellers. The Vaccination Passport could serve as a major influence for people to get vaccinated. It has been argued that they are not necessarily a proportionate way to achieve mass compliance for vaccine, which can be better secured by providing accurate information to the people.

By getting a vaccine certificate, individuals who have been restraint to access to certain work opportunities by the pandemic could get huge benefit. Vaccine passport can undo considerable restrictions on the freedoms of the population, and this is a sure shot way in which individuals might get the chance to reclaim those basic freedoms that is greatly valuable to them. The vaccine passports could also offer value in the account of international travel, being vaccinated means an individual will be unlikely to suffer from Covid-19 disease that might need hospitalisation abroad.

Vaccine Passport has its own short comings, impairing the social mechanism is one of them. The demand for such verification and documents has led to falsified and counterfeit paper issuance of vaccine certificates.

It is undisputed that the vaccines deployed till now have shown to have impressive efficacy and promise in reducing the risk of hospitalisation and death for symptomatic variant of Covid-19. Even at this point there is no concrete evidence that they can conclusively thwart transmission. There is a danger in the assumption that because of being vaccinated, one cannot then spread Covid-19, and this fact is not a good scientific basis for evaluating the policy of passports. Most countries are in the early stage of the vaccine rollout, and considering the major concerns associated with relatively new variants, in order for the vaccines to offer protection, it would be premature to introduce the passport system.

Vaccine passports is new instrument that will be used to give permission to people who have been vaccinated and presumably have acquired immunity to be differentiated from those who have yet not been vaccinated. Given the fact that the vaccination is being rolled out based on a priority system, some people will be prioritised vaccinated before others. It is equally possible that who do not chose to be vaccinated owing to some fear or not diagnosed with covid may also lose out on opportunities. Further there is a danger of stigmatisation individuals who lack certification, which is equivalent to penalising people who are already at a disadvantaged position because of certain inequalities and major factors involved.

The passports could encourage desperate people who have yet not been vaccinated or have opted not to be vaccinated to Fastrack and forged certification on the black market. So, if passports have to viable bona-fide practice it must be done in a way which is not subject to fraud. Moreover, typically, health information such as vaccination records is stored by the national health services or interest holder. These passports could mean that data is shared with outside companies, which could be used in ways that may be unfair and stigmatising, is prejudicial to the interest of individuals it belongs to. The Vaccination Passport raises ethical questions on practical effect of its widespread adoption.

HEALTH SECTOR CRUCIAL IN CLIMATE CHANGE ADVOCACY IN INDIA

- Simranjeet Kaur, 4th Year , MNLU, Aurangabad

Health Energy Initiative-India, in collaboration with data agency, Morsel India conducted a first-of-a-kind study to understand the awareness, behaviour, perception and practise of the health care sector towards climate change. The largest climate change survey ever conducted among 3,062 healthcare professionals in India has reported that the health sector should play a crucial role in climate change action and advocacy in India. More than 85% of respondents felt it was the healthcare industry's duty to combat climate change and reduce its carbon footprint. The healthcare professionals included the doctors, nurses, paramedical staff, hospital administrators, ASHA Workers, health staff of the NGO's and healthcare students between August and December 2020 from across six states – Uttar Pradesh, Bihar, Meghalaya, Chhattisgarh, Maharashtra and Karnataka.

During a webinar organised online, the survey results were published. It revealed that the overall understanding of climate change is as high as 93 per cent across all health workers categories. Doctors were the most aware category of the seven health workers interviewed at 97.5 per cent, followed by 94.8 per cent of health care students and 94.3 per cent of hospital administration employees. ASHA Workers ranked fourth with 92.5 per cent understanding, leaving behind 89.6 per cent of nurses who are at least conscious of climate change, its effects and ties to human health among all health workers. More than 81 per cent of respondents accepted that deforestation, fossil fuel burning, waste production, industrial pollution, and population growth are the key reasons for greenhouse gas emissions, resulting in massive climate change. Nearly 74% of respondents also thought that the public health community is now facing an increased burden of climate-sensitive diseases, affecting healthcare practitioners and facilities directly and indirectly.

88.7% of respondents agree that air pollution-related diseases would have a direct effect on the health sector, rating it as the highest hazard among the heat and cold-related diseases, vector and water-borne diseases, and communicable diseases, mental illnesses, and malnutrition. 68.9% of healthcare staff agree that climate change directly affects the health sector, while 74% believe that the burden of climate-sensitive diseases on populations has risen. 72.8 per cent of those who participated in the survey agreed that the need for time and climate change was necessary and that its health consequences had to be included in India's medical curriculum.

The survey also showed that most respondents did not assume that good plans for dealing with the pandemic were available and that the healthcare system was not even equipped to cope with a mass outbreak in the future. One of the key findings of the post-Covid-19 recovery plan priorities survey was that 83.4 per cent of respondents suggested that activities that prioritise people's health should be high on the post-Covid-19 recovery plan. In comparison, 82.8 per cent of respondents said that actions that strictly concentrate on preserving and protecting the environment are significant. Poorvaprabha Patil, President of the Indian Medical Students Association, said, "The results clearly state that health professionals and students want to be more involved than ever in combating climate change and protecting our communities. The results also show the differences that remain as a group in our understanding that we are determined to work on."
The Deputy Director of the Centre for Environmental Health at the Public Health Foundation of India, Dr Poornima Prabhakaran, said, "Climate change is a health issue, and the study shows that there is a great opportunity to engage professionals in the health sector to embrace climate change mitigation, adaptation and risk reduction practises and embark on a path to climate resilience." The webinar was also attended by Dr. Maria Neira, Director, Department of Public Health, WHO.

SETTLING THE CONFLICT BETWEEN PUBLIC HEALTH AND LIBERTY ONCE AND FOR ALL

- Chetna Shrivastava, 4th Year , MNLU, Aurangabad

Maltreatment of force on the grounds of general wellbeing has been a persistent issue in mankind's set of experiences The historical backdrop of general wellbeing reactions and the maltreatment of common freedoms is alarming. Misuses happen despite the fact that in each time, general wellbeing authorities consistently accept they're making the best choice and acting in accordance with some basic honesty".
The overabundances submitted for the sake of general wellbeing in the past could not hope to compare to the brutalities executed during this pandemic. Recordings of the police beating helpless Indians and tossing food at those in isolate like they would take care of wild canines, have turned into a web sensation. The West has not falled behind.Recordings from Melbourne, , show that the police has acted nearly as severely as India's police and threatened the populace – they beat up a young lady since she didn't have a face veil.
Global pledges have neglected to lessen such monstrosities. The International Health Regulations 2005 determine that "a wellbeing measure does exclude law authorization or safety efforts". A ramifications (at any rate in the actual intent of the law) is that the police should not be utilized for general wellbeing purposes yet police powers have been broadly utilized in late lockdowns.
Article 6 of the Universal Declaration on Bioethics and Human Rights expresses that "Any preventive, analytic and helpful clinical mediation is just to be done with the earlier, free and educated assent regarding the individual concerned, in light of satisfactory data. The assent ought to, where proper, be express and might be removed by the individual worried whenever and under any conditions without burden or bias".

Lockdowns are obviously a precaution mediation and require educated assent in every individual case. Be that as it may, this necessity has been disregarded everywhere on the world besides in Sweden. What is it about general wellbeing that causes governments to mistreat their own kin so without any problem? General wellbeing is obviously not a crisis.

It can never be a crisis. Full planning and examination of various situations ahead of time is completely conceivable. We realize this is so in light of the fact that Sweden has dealt with this pandemic without the smallest frenzy and without abusing its kin. The Swedes were given pertinent data and picked their activities willfully. No police was at any point utilized against them during the pandemic. Supporting its acculturated approach is Sweden's Constitution which doesn't permit the inconvenience of crisis powers (and consequently the suspension of freedoms) with the exception of war.

Summing up its methodology, "Sweden has picked a standard of-law approach instead of a methodology where the Sovereign (for example the public authority) is absolutely excessive in season of emergency". Any limitations on individual freedom in Sweden should be proportionate and dependent on laws ordered ahead of time of a general wellbeing emergency. Its laws determine that the courts should consent to any limitation on every particular individual on general wellbeing grounds.

The CMO needs to appeal to the courts for obligatory testing of a presumed sick individual and on the off chance that somebody is demonstrated sick, at that point the CMO should request of the courts for the seclusion of the contaminated people. The facts confirm that Sweden changed its laws as of late to permit the inconvenience of certain more extensive limitations, for example, on a whole business region, yet the greater part of these forces have not been practiced potentially in light of the fact that these laws would be found by the courts to disregard its Constitution.

Sweden's methodology affirms that there is no premise in a free society for compromises between general wellbeing and freedom. It additionally affirms that it is feasible for countries to consent to the soul of the International Health Regulations and Universal Declaration on Bioethics and Human Rights. In free social orders, the privileges of the sovereigns (residents) should stay fundamental consistently.

In a 260-page report gave on 18 August 2020 entitled, Assessing Legal Responses to COVID-19, 50 law specialists (Parmet is on the publication council) have made proposals to all the more likely react to pandemics. Among the recommended activities is that "State governing bodies ought to change or authorize new general wellbeing enactment explaining the extension and authority of state authorities to restrict individual to-individual cooperation and force terminations, development limitations, gathering boycotts, and physical removing necessities".

Further, the report suggests that "each crisis statement ought to incorporate the accompanying data: explicit epidemiological information supporting the request; explicit necessities for social removing and veil wearing; a clarification of why the request is required; and a clarification of why the request doesn't abuse individual flexibilities". .

As of now a freely dedicated presenting a sacred revision in India to preclude any peacetime crisis powers. We can't allow governments to blame general wellbeing so as to mistreat residents and annihilate their entitlement to occupation (closing down shops and organizations) – successfully taking their property rights. India's general wellbeing laws, for example, the Disaster Management Act and Epidemic Diseases Act permit governments to suspend key opportunities and mistreat individuals. These laws should be totally re-composed once a protected limitation is forced on peacetime crises.

India's future laws on pandemics will likewise have to guarantee the quick and progressing distribution of all "private" records based on which any general public wide limitations on individual opportunity are proposed to be forced. We should guarantee consistently that activities by the leader are sensible, proportionate and in any case defended. Else we will wind up with oppression.

ABOUT MNLU,AURANGABAD

Maharashtra National Law University, Aurangabad is established by Maharashtra National Law University Act, 2014 (Act No. VI of 2014) passed by State Legislature of Maharashtra. The University commenced its operation in the year 2017 having its headquarters at Aurangabad, Maharashtra and since then has been thriving to achieve academic excellence.