RIGHT TO EMERGENCY HEALTH CARE

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ABSTRACT

While scholars worldwide are busily imagining a post-COVID-19 world, no one has a crystal-clear image of the pandemic's effects. Nonetheless, the pandemic has exposed nations' inefficiency in providing adequate healthcare to their citizens. India's predicament is far worse. At the pandemic's height, developed nations worldwide were powerless, because the patient population has outstripped the capability of the public health care system. On the other hand, residents of India, are made helpless to provide adequate medical care owing to private institutions' refusal to participate. During the pandemic, private hospitals refused to treat patients who did not have a COVID 19 negative certificate and refused to expose their infrastructure to COVID-19 patients out of concern for the health of their negative patients. The government's slowness in implementing its writ against private hospitals facilitated private hospitals' lack of cooperation. Due to these perilous situations, everyone should consider an important subject: In India, emergency medical care is available. Do we have a right to emergency medical care as Indian citizens, and is the government doing

enough to ensure that this right is not misused at the whims of private hospital executives? The issue is as perplexing as any other regarding the Indian people's rights as stated in the Indian Constitution since it depicts a utopian state for its residents, similar to the previously cited misunderstanding of what constitutes a good public health-care system. On the other hand, Indians are often awakened to the reality of their rights being violated without recourse by legally formed entities.

Introduction

According to section 215 of the Motor Vehicles Act, 1988, the government of Tamil Nadu created and appointed a Road Safety Commissioner. The Road Safety Commissioner is charged with a number of obligations, including accident restitution. The emergency services infrastructure looks to be inadequate, as does the quality and speed with which critical patients get EMS. In India, emergency medicine (EM) practitioners are in short supply. The healthcare delivery system in India begins at the sub-center level, where around 5,000 people are serviced. With 4 276 Community Health Centers (CHCs), 23 458 Primary Health Centers (PHCs), and 1 46 036 Sub-Centers (S/Cs) in operation in the outskirts of the nation, India has a massive healthcare infrastructure.[1] Regardless, the government has been unable to offer the general public timely and high-quality EMS, especially in distant places. In order to obtain a paracetamol tablet, a villager must travel an average of 2.2 kilometres to the first health post, more than 6 kilometres for a blood test, and close to 20 kilometres for hospital care, according to a report by the National Commission on Macroeconomics and

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[1] The World Bank Data Report.

Health, the Ministry of Health and Family Welfare (MOHFW), Government of India (GOI).[2] Many people look forward to the advent of for-profit health care. The middle and higher classes prefer to use the medical services provided by the private sector. According to India's National Family Health Survey - III, the private medical sector continues to be the principal supplier of healthcare for the majority of families (70 percent) in both urban and rural regions (63 percent) (63 percent). Even the quality of the private sector is questioned.

In the event of a medical or surgical emergency, including those caused by an accident, the patient is generally taken to the closest city hospital. Severe cases may necessitate the patient being transported to a large city for treatment, regardless of the family's ability to pay. In some cases, hospitals in these big cities would send these patients to specialty/super-specialist hospitals for additional care. It becomes problematic when these super-specialty hospitals, which are the final resort for those with little financial resources, fall into disrepair or are poorly, managed.[3] These massive facilities were often found to be completely useless to the average individual in need of aid. Unregulated parallel healthcare delivery systems in India are to blame for this. Whether or not an individual is entitled to certain services is largely determined by his or her financial situation. Not all events needing quick medical assistance contain motor vehicles. The sudden collapse of a patient or an emergency delivery during pregnancy may all result in emergencies, as can car accidents, fires, floods, cyclones, and earthquakes. Road

traffic accidents, on the other hand, are the most common source of death and injury on the planet. This sort of accident is growing at a shocking rate of 3 percent per year. In India, accidents and injuries account for about 10.1 percent of all fatalities. In India, a trauma-related mortality occurred every 1.9 minutes.[4] This expert group was formed in 2004 by India's National Human Rights Commission (NHRC) to assess the current emergency medical care system and make recommendations to the various States/Union Territories and their significant components on the implementation of appropriate emergency medical care protocols. The panel presented a report on April 7, 2004. It examined the current situation and the Centralized Accident and Trauma Services (ATS), stating that each year, nearly 4 lakh people die as a result of injuries, nearly 75 lakh people are hospitalised, and three and a half lakh people with minor injuries receive emergency care at various locations throughout India. However, the country's existing Emergency Medical Support (EMS) system is inefficient and in serious need of modernisation. The study addressed problems in the current EMS and presented various suggestions for short- and long-term adoption. In addition to the states and UTs, the Department of Health and Human Services was also provided with these suggestions.

The Government of India has sanctioned the development of 100 Emergency Accident Relief Centers spaced 50 km apart along all National and State Highways to deliver prompt first aid to accident victims and to coordinate their following medical care in hospitals. Private hospitals, sponsors, and the

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[2] The MOHFW report.
[3] *Ibid*.

[4] The National Human Rights Commission's Report.

government are all working together on this one-of-a-kind initiative. Only 77 of the intended 100 centres are already operating. Passengers and onlookers may report concerns by dialing 108, a toll-free national hotline. In Tamil Nadu, the government created and appointed a Road Safety Commissioner pursuant to section 215 of the Motor Vehicles Act, 1988. The Road Safety Commissioner is responsible for a range of tasks, including accident compensation.

India has a far smaller population than the United States (approximately 150 million people). This has resulted in India becoming the world's second-most populous nation. When India's population increase is compared to the world's most populous countries. India's growth rate is predicted to be 1.13 percent, meaning that it will soon surpass China as the world's most populous nation.

As stated in Article 21 of the Indian Constitution, due to the country's fast population expansion, the necessities for a dignified and respected existence are becoming more scarce. On the other hand, emergency medical assistance falls within the umbrella of the right to life and should be offered to anybody who is in need of it. It's impossible to overstate the necessity of emergency medical help in a nation like India, where everyone is pressed for time and competing for the minimum needs of life. India has 0.7 beds available per 1000 persons, according to research.[5]In its ruling, the Supreme Court of India stated that Article 21 of the Indian Constitution guarantees the right to life, including the right to health and medical care.[6] The right to life involves the right to a healthy life and the enjoyment of all the advantages of the human body.[7]

Supreme Court has reminded the government and other authorities repeatedly of the need of putting people's health first since it gives life purpose, boosts efficiency, and provides the best results.[8] The protection of one's life has been recognised as a major responsibility of the state. It is not just a protected right under Article 21, but also a responsibility placed on the state to supply it under both Article 21 and Article 47.[9]

In India, there is no formal rule compelling the government to provide emergency medical care, and it is commonly considered as a right given under Article 201 of the Indian Constitution by the Supreme Court of India and local High Courts. According to a flood of medical literature on the issue, the 'GOLDEN HOUR' is the first hour during which 'emergency medical treatment' is essential, and the majority of victims die if such care is not made accessible or supplied immediately. Although this is infrequently done, the purpose of emergency medical care is to 'stabilize' the patient.

Initiatives By Apex Court In Case Of Medical Emergencies

In the case of "*Pt. Parmandand Katara v. Union of India and Others*,"[10] the Supreme Court of India first reviewed a medico-legal problem. Article 32 of India's Constitution of 1950 allows for citizens to bring legal action

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[5] The World Bank Report on available beds in India.
[6] M S Chawla v. State of Punjab, AIR 1997 SC 1225.
[7] Mr. X v. Hospital Z, AIR 1997 SC 1225.
[8] Prof. Nagendra Kumar, *Constitutional Law of India*,

pg. 321, 8th Edition, ALA Publication.
[9] Ram Lubhaya Bagga v. State of Punjab, AIR 1997 SC 83.
[10] 1989 SCR (3) 997.

in the public interest. The petition was submitted in reaction to a news narrative of a scooterist who was struck by a vehicle and died owing to a lack of medical aid. After the crash, the scooterist was transported to a nearby hospital but was turned away and transferred to a clinic 20 kilometres away that was licenced to handle medico-legal cases. On his trip to the second hospital, the scooterist died. Article 21 of the Indian Constitution now includes a right to emergency medical care, according to the Supreme Court of India, underscoring the criticality of the "golden hour" period.[11] The Supreme Court has determined that it is both the citizen's right and the state's responsibility to protect life and that physicians at government hospitals must thus give life-saving medical help. This was the Supreme Court of India's first move towards implementing Article 21 of the Constitution.[12]

In "*Consumer Education and Research Centre v. Union of India*",[13] the Supreme Court held that urgent medical assistance is a necessary component of Article 21's right to life. "Social justice, as a means of guaranteeing that life is meaningful and livable with human dignity, requires the state to provide workers with the facilities and opportunities necessary to attain a basic degree of health, economic stability, and civilised living." The Court noted that an essential part of the worker's right to life was his or her health and vigour. Denying it deprives employees of the better things in life, which violates Article 21.[14]

Following that, the Supreme Court of India

heard a serious case, "*Paschim Banga Khet Mazdoor Samiti v. State of West Bengal*,"[15] in "which the victim, an agricultural employee, was refused emergency medical care in five public hospitals before being admitted to a private hospital for which he was asked to pay an excessive charge. After that, the plaintiff filed a lawsuit in India's Supreme Court, alleging that public hospitals had refused him medical treatment in violation of Article 21 of the country's constitution. The Supreme Court was petitioned to determine the availability of treatment facilities in government hospitals for those who had received major injuries. A detailed inquiry into the allegations was launched while the case was still pending in front of the Supreme Court. The Committee's findings indicated that government hospitals are not ready to cope with urgent conditions and gave specific solutions to prevent such disasters in the future. In this case, the Supreme Court found that safeguarding human life is essential since the victim may die or become permanently handicapped if prompt medical care is not provided, rendering a return to the pre-injury state impossible. As a result, when such undesirable things occur, people are powerless to repair them. The Indian Supreme Court has determined that refusing emergency medical care violates Article 21 of the Indian Constitution." As a result, people have a basic right to access free emergency medical care.

The Supreme Court said, "There can be no doubt that financial resources are necessary to offer these services." Nonetheless, one must disregard the state's core duty to provide basic medical care to its citizens. Whatever is

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[11] *Ibid*.
[12] *Ibid*.
[13] AIR 1995 SC 922.

[14] Supra Note 8.
[15] (1996) 4 SCC 37.

necessary to accomplish this objective must be accomplished.

Accordingly, in order to guarantee that beds are readily accessible in an emergency, the Supreme Court advised the State to establish a *Central Bed Bureau*. This capacity should be maintained in government-run hospitals, forming a consolidated communication system. With this method, patients are sent to a hospital where there are open beds for their treatment right away. The majority of fatalities in India may be avoided if this were done since many people die as a result of a shortage of beds or rejection of emergency medical treatment.

Cardiovascular diseases are the biggest cause of death in India, accounting for around 23.3 percent[16] of all fatalities, according to census research. Numerous complaints have occurred during this pandemic that many patients are refused emergency medical treatment after a stroke or when they are in dire need of dialysis, chemotherapy, or another emergency medical care. This has disastrous results, including death of lifelong physical handicap. India's medical crisis has been the most severe since the pandemic is still unchecked there.

The 1986 Consumer Protection Act, which was developed in reaction to this, protects physicians. The Indian Medical Association was strong in its rejection, stating that doctors should be free from the 1986 Consumer Protection Act. While a doctor has the ability to treat anyone he likes, he has a moral obligation to offer emergency medical care to those in dire need. The Supreme Court of

India finally resolved this issue in "*Indian Medical Association v. V P Shanta*",[17] stating that persons obtaining medical treatment came within the concept of "Consumer" and that healthcare is classified as a "Service" under the Consumer Protection Act. There are situations when a patient has no guardian and needs emergency medical treatment, therefore including healthcare services under the Consumer Protection Act is pointless. The lack of immediate access to emergency medical care is a consequence of this.

Emergency Medical Care in The USA

In the United States of America, private hospitals were refusing to offer emergency medical care to accident victims, those in urgent need of medical care, and pregnant women. Due to their inability or unwillingness, the patients were unable to pay for their own medical expenses. As a result, they were thrown into public hospitals, depriving them of emergency medical care and, in many cases, resulting in terrible outcomes. As a result of this circumstance, Congress revised the Omnibus Budget Reconciliation Act of 1985. (COBRA), often referred to as anti-dumping legislation, to create the EMTALA[18] STATUTE (42 USC 1395 DD) (Emergency Medical Treatment and Labor Act). As a result of this legislation, hospitals now have a care to treat patients like these. The Act establishes a comprehensive strategy for screening, stabilisation, and emergency care. Additionally, it covers cases in which a hospital's equipment is insufficient to provide stabilisation or emergency care, forcing the transfer of the patient to another institution. In rare cases, the transfer may be difficult until the patient has been stabilised.

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[16] The Report of Registrar General of India on causes of deaths in India in 2010-2013.
[17] 1996 AIR 550.

[18] Emergency Medical Treatment and Active Labor Act.

Transfers from one hospital to another are covered by many protections under EMTALA. In addition, those who break the EMTALA's rules will face penalties.[19]

In comparison to other nations, the United States' healthcare system is regarded complicated. No universal healthcare is available to the citizens of the United States. Rather than that, a multitude of commercial and governmental organisations exist to cover the charges of healthcare for the American people. While the United States lacks a national healthcare system, there are private and public options. Individuals who can afford private healthcare may select for health insurance. Among the payers are health insurance companies. Their medical care is covered by the healthcare they provide. Insurance companies establish networks of doctors, hospitals, and clinics through which they reimburse the insured's medical expenditures. Despite the fact that a substantial fraction of Americans has private health insurance, a sizable section of the population does not. According to the US Census Bureau, about 46 million Americans lack health insurance. Medicare and Medicaid, which are both sponsored by the federal government, provide financial assistance to low-income persons, but their coverage and choices may be limited in contrast to those of commercial insurance plans. Thirty percent of the population is covered by Medicare and Medicaid. Medicare is a government-sponsored social insurance scheme for adults 65 years of age and handicapped individuals. State-run health insurance for the poor, Medicaid.

EMTALA, implemented by the federal government in 1986, compels hospitals to treat all patients with emergency issues regardless of their ability to pay. It is commonly accepted as a critical component of the uninsured's "safety net," although there is no method for direct payment for such care. Through indirect payments and reimbursements through federal and state government programmes, public and private hospitals have never been completely reimbursed for the full cost of care as stated by EMTALA. Currently, more than half of all emergency care in the United States is uncompensated. Emergency departments are clogged due to the underfunded mandate of the EMTALA, which has caused hospitals to consolidate and eliminate facilities in the previous two decades. Between 1993 and 2003, emergency room visits in the United States increased by 26%, according to the Institute of Medicine, despite a 425 decrease in the number of emergency departments. [20]

Emergency departments and hospitals have a distinct set of issues when dealing with mentally ill individuals. According to EMTALA, mentally ill persons who enter emergency departments are examined for emergency medical issues. Once mentally ill patients attain physical stability, they are sent for assessment to regional mental health authorities. Patients are assessed to see whether they pose a risk to others or themselves. If this is the case, a psychiatrist would likely admit the person to a mental health institution for further examination. Mentally ill persons are routinely imprisoned for up to 72 hours before a court order is necessary.

Following Apex Court and Several High Courts of states' decisions, the 201st Law

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[19] The 201st Law Commission of India Report.

[20] *Ibid*.

Commission Report[21] on Accident Victims and Emergency Medical Care In 2006, the Law Commission, led by Mr. Justice M. Jagannadha Rao, examined the aforementioned challenges and developed a draught model of the Rule. Only in this report on healthcare is an allusion to urgent medical attention made. Victims are often in a precarious position, unable to make sound decisions, and many are uninsured, which makes the case much more compelling. As a result, the Law Commission's proposed law is based on the 1985 Consolidated Omnibus Budget Reconciliation Act's provisions (COBRA). EMS should be regulated to protect patients' rights, according to this research. Emergency medical treatment should be made obligatory for all healthcare institutions, public or private, according to this paper.

The 201st Law Commission Report's writing methodology was not used by the Central Government or any state government after that, and no new laws were drafted after that. The Gujarat Emergency Medical Services Authority was established in 2007 as the state's first emergency medical services agency. (GEMSA). Non-governmental groups and other private companies may now provide emergency medical services throughout the whole state as a result of this new rule.

In terms of both income and employment, healthcare has become one of India's most important industries. In the healthcare industry, you'll find everything from hospitals to medical gadgets to clinical trials to outsourcing to telemedicine and medical tourism. Since public and commercial entities alike are investing in the Indian healthcare system, it is rapidly expanding.

There are two types of healthcare in India: public and private. Secondary and tertiary care facilities in big cities are maintained by the government, which concentrates on providing basic healthcare to rural regions through primary healthcare centers (PHCs). There are a strong concentration of private health care facilities in large metropolitan areas and Tier I and Tier II cities.

Medical professionals with advanced training are a key differentiator for India. In addition, India's costs are lower than those of its Asian and Western counterparts.

The Indian government has taken many key initiatives to promote the Indian healthcare business, including the following:

India, the state of Meghalaya, and the World Bank signed a health initiative worth $40 million in November 2021. The state's ability to respond to future health emergencies, such as the COVID-19 pandemic, will be bolstered by the program.

For the first time since April of this year, India may resume distributing Covid-19 shots to the global vaccine-sharing network COVAX. Co-leader of COVAX, the World Health Organization (WHO), has been encouraging India to keep up with its October 2021 shipment of 4 million COVAX pills to its neighbors and partners.

During the global COVID-19 meeting in September 2021, India's Prime Minister, Mr. Narendra Modi, said that India had shared its vaccine manufacturing capacity with 95 countries and the United Nations military The Indian government plans to market

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[21] Supra note 19.

upgraded COVID-19 vaccinations to other countries, he added.The Ayushman Bharat Digital Mission was launched by Prime Minister Narendra Modi in September 2021. The mission's goal is to link all of the nation's hospitals with digital health technology. Individuals will now be issued a digital health ID, and their medical records will be safeguarded digitally as a result.The Telangana government presented its 'Medicine from the Sky' plan in September 2021 in collaboration with the World Economic Forum, NITI Aayog, and Health Net Global. (Apollo Healthcare). Rural sections of the nation will soon be able to get life-saving drugs and vaccines by drone.In order to improve the country's healthcare infrastructure, the Indian government plans to develop a credit incentive scheme of Rs. 500 billion (US$ 6.8 billion). COVID-19-related health infrastructure in smaller locations will also be supported by government funding, and businesses will be able to use the cash to increase hospital capacity or acquire medical equipment."

It was revealed to the Union Cabinet in June 2021 that India's Indian Council of Medical Research (ICMR) and Myanmar's Department of Medical Research (DMR), Ministry of Health and Sports, had inked an agreement in February 2020. Increased India-Myanmar collaboration in health research was the goal of this Memorandum of Understanding (MoU).

By working with UNICEF to dispel myths about vaccines and vaccinations against the COVID-19 virus and the significance of COVID-19 Appropriate Behavior, India's Union Ministry of Health and Family Welfare held a capacity-building workshop for health reporters and media professionals in Northeastern states in June 2021. (CAB). Indian social media site Bolo Indya joined with the Ministry of AYUSH in June 2021 to spread the word about traditional Indian medicine and treatment, including Siddha, yoga, Unani, and Ayurveda. Nearly the following year, our relationship will help over 10 million people.

In June 2021, West Bengal suggested the establishment of six new medical schools, while Uttar Pradesh authorized the establishment of nine new medical colleges, Telangana authorized the establishment of six new medical colleges, and Punjab declared the making of four new medical institutes.

India's state of Uttar Pradesh has declared plans to introduce an independent pharmaceutical distribution system in June 2021 as a way to improve the state's primary healthcare business and clinical centers. Health ATMs, walk-in medical kiosks manned by medical assistants but equipped with a variety of diagnostic instruments such as basic laboratory equipment, emergency services, cardiology, neurology, pulmonary, and gynaecology tests, have been assigned to the state health department.

It was announced in June 2021 that the government was looking for suggestions on how to utilize unmanned aerial vehicles (UAVs) to transport COVID-19 vaccinations and medications to hard-to-reach places in order to assure last-mile coverage throughout the country.

As of May 2021, the National Digital Health Mission (NDHM) platform has generated 11.9 lakh Health IDs and recruited 3,106 doctors and 1,490 institutions.A new

'Services e-Health Assistance and Teleconsultation' Outpatient Department (OPD) facility was opened by Defense Minister Mr. Rajnath Singh in May 2021 to give telemedicine services to military personnel and veterans.Phase II/III clinical trials for Bharat Biotech Ltd's Covaxin (COVID vaccine) were approved by the Drugs Controller General of India (DCGI) on May 12, 2021, after the recommendation from the Subject Expert Committee (SEC). An anti-COVID drug produced by DRDO's Institute of Nuclear Medicine and Allied Sciences (INMAS) in Hyderabad and Dr. Reddy's Laboratories (DRL) in Hyderabad was released by the Defense Ministry on May 17, 2021.

Amphotericin-B, an antifungal medicine used to treat 'Black Fungus,' was declared in May 2021 by the government to be improved in supply and availability. It has also licensed five companies to produce the medicine in India. The 'Intensified Mission Indradhanush 3.0' campaign was started in March 2021 by various states and union territories to target children and pregnant women who had been left out of the usual vaccination program owing to the COVID-19 epidemic. The goal of this mission-style program is to get more children and pregnant women immunized faster. The National Commission for Allied, Healthcare Professions Bill 2021 was enacted by Parliament in March 2021, with the goal of creating a body to manage and maintain educational and service standards for healthcare professionals.

The entire health sector budget for FY22 was Rs. 223,846 crores (US$ 30.70 billion) in the Union Budget 2021, an increase of 2.37 times, or 137 percent. With a six-year budget of Rs. 64,180 crore (US$ 8.80 billion) for the healthcare sector, the government aims to strengthen the existing 'National Health Mission' by developing primary, secondary, and tertiary care as well as healthcare systems, as well as new and emerging disease detection/cure institutions in the country. The government wants to integrate the Supplementary Nutrition Program and the Poshan Abhiyan (Nutrition Mission) in order to enhance nutritional results in 112 aspirational districts in the Union Budget 2021-22, according to a press release.

Indian authorities have given the "National Health Mission" a budget of Rs 37,130 crore (US$ 5.10 billion) in the Union Budget for the years 2021-22. The Ministry of AYUSH received a budget increase of Rs. 2,122 crore (US$ 291.39 million) in the Union Year 2021, compared to the previous year. India's state of Uttar Pradesh has declared plans to introduce an independent pharmaceutical distribution system in June 2021 as a way to improve the state's primary healthcare business and clinical centers. Health ATMs, walk-in medical kiosks manned by medical assistants but equipped with a variety of diagnostic instruments such as basic laboratory equipment, emergency services, cardiology, neurology, pulmonary, and gynaecology tests, have been assigned to the state health department.

Application Of Emergency Medical Care In Covid-19 Pandemic

The second-largest nation in the world, India, has one of the highest rates of COVID-19 infection in the world. The Indian healthcare system is under great pressure as a consequence of the COVID-19 epidemic. There were 266,598 cases of COVID-19 reported to the Indian Ministry of Health and

Family Welfare on June 9th, 2020, among 32 states. Including instances that were not reported, India had a case fatality rate of 2.8% when it came to COVID-19-related mortality. India is home to 378,075 new cases reported daily by the WHO. More than 47% of all new cases of COVID-19 were found in this region, with an average of 276 cases per million people each day. In certain circumstances, India's whole healthcare system, including emergency facilities, was overwhelmed by the massive demand (EDs). The emergency and critical care systems are being severely hampered by a severe lack of essential resources. Hospital workers, who are already overworked and exposed to unsafe conditions, are also at risk of developing and spreading COVID-19 due to a lack of PPE (PPE). These issues, together with a deficiency of financial resources, have contributed to an increasingly heavy strain on Indian executive directors (EDs).

There was a partial reopening on June 8th, 2020, after a National Lockdown had been imposed on March 24, 2020, in accordance with the 2005 Disaster Management Act. With the help of the government, residents were able to remain at home and preserve their health and well-being. Governments' ability to follow their promises is at the heart of many controversies and arguments. As a result, it would be pointless to bring up issues that people face on a daily basis again. There has been minimal discussion of the discomfort felt by patients who are not suffering from COVID 19 in any of the arguments. Several institutions that had a religious mandate to serve patients began turning away those who needed immediate medical attention as a result of COVID 19. Even non-conscience experts were piqued by the examples of denial of emergency medical

attention to people with life-threatening diseases that were reported by respectable mainstream media sources. Mass migration was sparked by a shortage of emergency medical assistance, which they began to see themselves in.

A precious hour was wasted when hospitals declined to save the lives of persons with non-COVID-19 medical issues. It ranged from safeguarding other patients from COVID-19 to the fact that these hospitals only treat people with COVID-19. As a result of hospitals' negligence, authorities were sluggish to respond. When it comes to emergency medical treatment, even the Supreme Court has been slow to act, rejecting petitions based on not interfering in matters of public policy. COVID 19 is putting enormous strain on our healthcare system. Our health facilities and staff are being flooded with responsibilities related to pandemic management. The basic health services that communities anticipate from the health system may be jeopardized if this is implemented. People may put off getting medical attention because of social or physical barriers, or because they are worried that health care facilities are contaminated. COVID 19-related duties and core services are critical to ensuring public trust in the health system's ability to deliver basic healthcare, as well as lowering morbidity and death from other health issues. Measles, malaria, HIV/AIDS, and TB fatalities rose during the 2014–2015 Ebola outbreaks and outnumbered Ebola deaths, according to data. While ensuring the safety of medical personnel is essential, it is also necessary to focus on providing important health care to certain demographic groups.

There is a need for all of these services to

ensure the well-being of women, newborns, and children as well as the prevention and management of communicable illness and the treatment of chronic disorders to avoid problems in emergencies. It is possible that non-Covid services like health promotion and IEC campaigns; Village Health Sanitation and Nutrition Committee meetings; community-based chronic disease screening; and others may be postponed until the lockdown/restrictions have been lifted. Services like this might be considered valuable.

Conclusion

One of the most divisive topics in Indian politics is access to emergency medical treatment. In the United States, there is no explicit codification of this element of the Constitutional Rights. At this point, the COVID-19 pandemic, is a significant problem. Covid19 negative certificates have been linked to the death of at least one 14-year-old girl, according to one case study. Governments in today's world do not prioritize the lives of their population. Only a tenth of a percent of the total cost is spent on healthcare. Entrusting hospitals with all of one's health care needs has never occurred to the Indian government. Two high courts in India, one in Bombay and the other in Karnataka, have taken up the case. The government has failed terribly to protect citizens' constitutional rights and to carry out the legally assigned obligations, and this is a problem that should be brought before the Supreme Court. Citizens are powerless in a scenario like this, hence the Hon'ble Apex Court should consider these issues. According to Chief Justice Balakrishnan, "The right to health is vital in Indian civilization." As medical experts, as well as

public officials such as administrators and judges, we are responsible for ensuring that the right to health is protected, respected, and fulfilled.

Even though Article 21 of the Indian Constitution (Part III) protects a person's life and liberty, and despite the fact that the Hon'ble Supreme Court has issued appropriate directions that hospitals have a fundamental duty to attend to patients and ensure their safety and well-being in all accident and emergency cases, regardless of the reason, the said directions are ignored and flagrantly ignored. The outcome is that a large number of individuals who are in need of immediate medical attention die as a result of this. Over half of all Covid19-related fatalities in India occur as a direct result of cardiovascular disease, according to official government statistics. As a result, an effective solution to this problem is required, and compliance with the 201st Law Commission Report and the creation of a Central Bed Bureau may be excellent steps towards safeguarding residents' rights.

Suggestions

1. Increase the amount of money committed to healthcare, Since the Indian government has never admitted that relying only on hospitals might be dangerous. While hospitals are responsible for caring for patients and ensuring their safety and well-being, the above requirements are often disregarded. As a result, legislation in this area must be very beneficial.
2. Make it obligatory for all hospitals and physicians to treat traffic accident victims and pregnant women regardless of whether or not they have been compensated initially.
3. Legislation requiring hospitals and

medical practitioners to care for accident victims and those in emergency medical situations, such as pregnant women, is a must.

4. Following the recommendations of the 201st Law Commission and establishing a Central Bed Bureau might be a good start.

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