IN THE HIGH COURT OF JUDICATURE AT BOMBAY
ORDINARY ORIGINAL CIVIL JURISDICTION
[RULE 4(e) OF THE BOMBAY HIGH COURT
PUBLIC INTEREST LITIGATION RULES, 2010]

PUBLIC INTEREST LITIGATION NO. _____ OF 2020

Miss Arshiya James and Miss Dipanita Roy …PETITIONER

VERSUS

State Of Maharashtra And Ors. …RESPONDENTS

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I. SYNOPSIS

The present Writ Petition is being filed in public interest under Article 226 of the Constitution of India by the Petitioners who are students of law and public spirited citizens. The Petitioners are seeking the issuance of the Writ of Mandamus to direct the Respondent No. 1 to cap the prices of medical facilities including essentials such as hand sanitizers, PPE Kits, N-95 Masks etc. That there is a need for Respondent No.1 to step in, intervene and take action in order to mitigate the incalculable number of losses of lives during COVID-19 due to exorbitant rates of the health facilities, unobtainable by most in the society. That the present actions taken by Respondent No.1 is not suffice for all. That the very basis of classification of patients on their economic strength, is a direct violation of human rights and the right to Equality under Article 14. The present petition tries to highlight the deplorable condition of the people of the society, where commerce has taken over lives. This Petition has been filed before this Hon'ble Court so that the appropriate guidelines may be issued by way of which the citizens will be guaranteed their right to life and health under Article 21.

Hence, this petition.

II. LIST OF DATES AND EVENTS

Sr. No.	Date	Annexure	Particulars
1.	30.09.2013	F	As per the survey conducted by Office of the Registrar General & Census Commissioner, India New Delhi titled "Primary Census Abstract for Slum" 5.4 % of India's population and 17.4 % of total urban population are dwellers of slums.
2.	05.05.2014	D	According to a report titled "What Do New Price Data Mean for the Goal of Ending Extreme Poverty?" published by Brookings 6.7% of India's population, lived below the poverty line of $1.25 in 2018–19.
3.	December 2014		Ministry of Health & Family released the Draft National Health Policy, 2015.
4.	December 2019		Coronavirus ("COVID-19") first identified in Wuhan, Hubei, China.
5.	30.01.2020		First case of COVID-19 was reported in India.
6.	30.01.2020		World Health Organization declared the COVID-19 outbreak a public health emergency of international concern.
7.	09.03.2020		First COVID-19 Case found in Maharashtra.
8.	11.03.2020		World Health Organization declared the COVID-19 as pandemic.
9.	17.03.2020		First death due to COVID-19 in Maharashtra.
10.	21.03.2020		Maharashtra Government capped the ceiling price of various medical facilities and equipment's required during COVID-19 as well as reserved 80% beds to be charged on government rates in private hospitals.

11.	24.03.2020		Lockdown for 21 days declared in India.
12.	08.042020		The Hon'ble Supreme Court directed testing for COVID-19 by private laboratories to be free of charge.
13.	13.04.2020		The Supreme Court rectified its order dated 08.04.2020 and clarified that free testing shall only be limited to the beneficiaries of the ***Ayushman Bharat aka Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY)*** Scheme.
14.	13.04.2020		Maharashtra Government to constitute a Task Force of specialist doctors to suggest measures to minimize the death rate as well as for clinical management of COVID-19.
15.	20.04.2020	C	As per the research published by CDDEP and Princeton University, as of 2019 India had approximately 43,000 (Forty-Three Thousand) private hospitals and 25,000 (Twenty- Five thousand) government hospitals.
16.	1.05.2020		Maharashtra government declared free treatment for all the COVID-19 patients registered under the Mahatma Jyotiba Pule Jan Arogya Yojana (MJPJAY).
17.	13.05.2020	E	That 40% of the homeless in India do not have the documents to avail schemes provided for free COVID-19 treatment.
18.	18.05.2020	B	Maharashtra contributes to more than 34.5% of the total infected people by COVID-19 in the entire nation.
19.	21.05.2020		Maharashtra government regulated the rate of medical facilities with specified price for all the facilities needed for a Covid-19 patient It states that the maximum amount for routine check-up and isolation including tests and x-rays for a day should not exceed Rs. 4000

20.	28.05.2020	L	As per the report titled “Impact of Covid-19 on lives and livelihoods: Rapid Study of Slum Dwellers in Indian City” published by NIUA and World Vision the household income of 91.04% Below Poverty Line (BPL) families have been affected due to COVID-19.
21.	02.06.2020	J	As per the report titled “COVID-19 Pandemic: Show cause notice to 4 prominent Mumbai hospitals for flouting rules” published by DNA private hospitals didn’t comply with the regulations of the government.
22.	09.06.2020	K	As per the report titled “How Mumbai's private hospitals are fleecing COVID-19 patients” published by The Week 35 private hospitals have failed to reserve the government mandated number of beds for COVID-19 patients.
23.	12.062020		Number of Cases in Maharashtra crosses 1lakh mark.
24.	18.06.2020	H	As per the report titled “COVID-19: Are Slums In India Conducive For The Outbreak?” published by Outlook the containment zones are heavily concentrated in areas which have a higher concentration of slums in Mumbai, Delhi and Kolkata.
25.	02.07.2020		The Maharashtra Medical Education Minister Amit Deshmukh announced the intention to have specialised doctor taskforce in all districts as directed by Maharashtra government.
26.	29.07.2020	G	As per the report titled “More than half of India's Mumbai slum residents may have been infected with Covid-19, study suggests” published by CNN, there were 627 slums in Mumbai that were once a containment zone

27.	06.08.2020	I	As per a report titled "Number of government and private testing centers for the coronavirus (COVID-19) across India as of August 6, 2020," published by Statista., India had 931 government and 452 private testing laboratories across the country.
28.	09.08.2020	A	Within a span of six months As per the report India has become a host to approximately 22.08 Lakh COVID-19 cases as on **9th August 2020 (ANNEXURE-A)**.
29.	31.08 2020		The current lockdown is enforced in the country till 31.08.2020.
30.			Hence, this Petition.

III. ACTS AND AUTHORITIES RELIED UPON

1. **The Constitution of India, 1950**
2. **Disaster Management Act, 2005**
3. **National Draft Policy, 2015**

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VERSUS

1. **State of Maharashtra, through**)
   The Secretary, Government of)
   Maharashtra, Public Health)
   Department Tarkhela, Nashik,)
   Maharashtra-422002)

2. **State of Maharashtra, through The**)
   Secretary, Ministry of health and)
   Family Welfare, 5th Floor,)
   Main Building Mantralaya,)
   Mumbai-400032)

3. **Municipal Corporation of Greater**)
   Mumbai, Health Department,)
   Through Legal Department, Malad,)
   Navy Colony,)
   Mumbai, Maharashtra-400064)

4. **State Health Assurance Society**,)
   Maharashtra Jeevandayee Bhavan)
   Worli, Mumbai - 400018,) **...RESPONDENT(S)**

TO
THE HON'BLE CHIEF JUSTICE
AND OTHER PUISNE JUDGES
OF THIS HON'BLE COURT
JUDICATURE AT BOMBAY

THIS HUMBLE APPLICATION OF THE APPLICANT ABOVENAMED PUBLIC INTEREST LITIGATION UNDER ARTICLE 226 OF THE CONSTITUTION OF INDIA PRAYING FOR ISSUANCE OF WRIT ORDERS OR DIRECTIONS IN THE NATURE OF MANDAMUS DIRECTING THE RESPONDENTS TO TAKE EFFECTIVE STEPS AGAINST THE RISE IN PRICES OF MEDICAL FACILITIES DURING THE GLOBAL PANDEMIC OF COVID-19.

MOST RESPECTFULLY SHOWETH: -

The Petitioner most humbly and respectfully submits as under:

I. Particulars of the cause against which the Petition is made:

That the petitioner is filing the present Public Interest Litigation Petition before this Hon'ble Court to call for a price cap against the surge of medical facilities for Covid-19 patients on grounds of it being;

a) Violative of the Fundamental Rights guaranteed under Article 14 and 21.
b) Against the spirit of the Directive Principles of State Policy Articles 38, 41 and 47.
c) Against the interest of Constitutional Amendment Bill 2018.
d) Against various international laws and covenants.
e) Against the spirit and objective of availing right to health as a basic human right.

II. Particulars of the Petitioner

1. That the Petitioners are residents of Patna and are currently pursuing law from Shri Vile Parle Kelavani Mandal (SVKM)'s Pravin Gandhi College of Law, Mumbai.
2. That the Petitioners are filing this instant petition at the Bombay High Court.

III. Particulars of the Respondents

3. That all the Respondents are falling under the ambit of the instrumentalities of the State as defined under Article 12 of the Constitution of India and hence, are amenable to writ jurisdiction of this Hon'ble Court. In short, the present Public Interest Litigation/ Petition is maintainable against all the Respondents.
4. That all these Respondents are responsible for the framing and implementing the health policy throughout India so as to protect and safeguard the health related issues of people including awareness campaigns, immunisation campaigns, preventive medicine and public health.

IV. Declaration and understanding of the Petitioner

5. That the present petition is being filed by way of Public Interest Litigation and the petitioners do not have any personal interest in the matter as the issue the welfare of the whole society by everyone having access to health facility during this pandemic.
6. That the entire cost of the petition is borne by the petitioners.
7. That the petitioners realise the need for a universal access to healthcare is a human right and surging prices by hospitals will create disparity between the rich and the poor. And many people will suffer due to unaffordable cost of treatment. Therefore, this petition is in the larger interest of social and economic justice.
8. That to the best knowledge of the Petitioners, the issues raised in this Petition have not been dealt with or decided by this Hon'ble court and neither a similar nor an identical Petition has been filed by the Petitioners elsewhere.
9. That the Petitioners understand that in the course of hearing this Petition, the Hon'ble Court may require any security to be furnished towards costs or any other charges and the Petitioner shall comply with such requirements.

V. Facts in brief constituting the cause

10. That the entire human race around the world, is suffering through the outbreak of an infectious disease known as Coronavirus or COVID-19. In **December 2019**, the first traces of the virus were found in Wuhan, China. Eventually, in even less than a month, the World Health Organization (WHO) identified it as a potential health risk i.e. on **30th January, 2020** and later declared it to be a pandemic on **11th March, 2020.**
11. That according to Section 2(m) of The Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism And Disasters Bill, 2017) "epidemic" means the occurrence in a community or region of cases of an illness, specific health related behaviour, or other health related events clearly in excess of normal expectancy;

12. That taking a cue from other countries where COVID-19 had already struck fatal blows, the most significant of such steps taken by the government, had been the announcement of a national lockdown for 21 days from **March 24, 2020** restricting the movement of the entire population of India. Such lockdown has further been extended time and again in phases of 19, 14 and 30 days and is presently in force till **31st August 2020** for containment zones, which the District Collectors/Municipal Commissioners have been authorised to identify. Series of regulations in the COVID-19 affected regions have been and are being enforced.
13. That the **Indian Council of Medical Research (ICMR),** the apex body in India for the formulation, coordination and promotion of biomedical research, has time-to-time issued several advisories/guidelines, as part of its plan of action, for regulation and containment of this epidemic.
14. That India found its first COVID-19 case on **30th January, 2020** and within a span of six months is the host to approximately 22.08 Lakh as on **9th August 2020 (ANNEXURE-A)**. The curbs that were imposed did initially result in containment of the pandemic but several other factors contributed to a surge, so much so that as on date India has been rated as the third worst Corona affected country in the world.
15. That despite the efforts of the Central and State government the contagion has spread beyond control only to prove that the epidemic was unprecedented and that the nation lacks the resources needed to protect its citizen. Apart from all the obstacles the biggest one is the lack of adequate health and medi-care facilities. That considering the outbreak of COVID-19, the Government of Maharashtra in its Public Health Department decided on implementation of all emergency measures to control the communicable disease in the State of Maharashtra.
16. That concerned about the increment of COVID-19 cases detected in Mumbai and Mumbai Metropolitan Region being higher in the State than the national average, the Chief Secretary to the Government of Maharashtra, by an order dated **13th April, 2020**, conveyed the decision of the Government to constitute a Task Force of specialist doctors to suggest measures to minimize the death rate as well as for clinical management of COVID-19, particularly critically ill COVID-19 patients in the six specialist designated hospitals mentioned therein. The Task Force, under the Chairmanship of Dr. Sanjay Oka, consisted of a total of 8 specialists and they were required to work on the specified terms of reference and to submit its recommendations to the Chief Minister on urgent basis. On **2nd July, 2020** the Maharashtra Medical Education Minister Amit Deshmukh announced the intention to replicate the above stated taskforce in all districts. The objective of the force will be to coordinate and supervise the treatment given to COVID-19 patients and implement various measures, including treatment protocol adopted by the district administration to prevent the spread of the virus.

17. That in contrary to all the measures advanced, Maharashtra accounts for **50, 30, 84 (Five Lakh Thirty Thousand and Eighty Four)** cases which more than is 34.5% of the total infected people in the nation **(ANNEXURE-A)**. The number of causalities in the state at present stands at **17,365 (Seventeen Thousand Three Hundred Sixty-Five) (ANNEXURE -B).**
18. That as of 2019, India had approximately **43,000 (Forty-Three Thousand)** private hospitals and **25,000 (Twenty- Five thousand)** government hospitals **(ANNEXURE-C)**. Thus, as the disease proliferated in the entire nation even after the imposition of various lockdowns by the government and prima facie the private hospitals outnumbers the government hospitals a consequent damage the citizens had to face was the rapid increment in the costs of medical facilities.
19. That 17.7% of the entire world's population is constituted by India, whereas based on ***2019's PPPs International Comparison Program to the United Nations Millennium Development Goals (MDG) programme***, 88 million people out of 1.2 billion Indians, roughly equal to 6.7% of India's population, lived below the poverty line of $1.25 in 2018–19 **(ANNEXURE-D)**. India is home to 1.77 million homeless people and around 41.60% of these people have no access to health care facilities **(ANNEXURE-E).**
20. That as per the Census of 2011, 5.4 % of India's population and 17.4 % of total urban population are dwellers of slums **(ANNEXURE-F)**. Dharavi in Maharashtra is known particularly for its highest number of COVID-19 cases. However, it is also known for being **one of Asia's largest slums.** As of **July 2020**, there were 627 slums in Mumbai that were once a containment zone **(ANNEXURE-G)**. The containment zones are heavily concentrated in areas which have a higher concentration of slums in Mumbai, Delhi and Kolkata **(ANNEXURE-H).**
21. That as per the NSS Report 2019 ***"NSS KI (75/25.0): Key Indicators of Social Consumption in India: Health"*** on an average an Indian has to pay approximately a sum ranging from four thousand to thirty thousand depending on upon the selection of the type of hospital. As of **6th August 2020**, India had 931 government and 452 private testing laboratories across the country **(ANNEXURE-I).** With the worsening of the situations due to COVID-19, the health sector of the country especially the private sector turned into a money minting machine. Maharashtra, being one of the worst hit state by the virus removed the ceiling price for COVID-19 tests from **Rs. 4500** ***(Four Thousand Five Hundred)*** to **Rs.2200** ***(Two Thousand Two Hundred)*** for private hospitals, the government on the other hand provides a cost-free test.
22. That various private hospitals started taking undue advantage of such critical situation and charged their patients lakhs of bills for providing COVID-19 medical facilities. Due to this various state government including that of Maharashtra, in notification. **No. CORONA-2020/C.R.97/Aro-5** dated **21st March, 2020** capped the ceiling price of various medical facilities and equipment's

required during COVID-19 as well as reserved 80% beds to be charged on government rates in private hospitals.

23. That private hospitals like Bombay Hospital, Jaslok Hospital, Hinduja Hospital and Lilavati Hospital did not comply with the same **(ANNEXURE-J)** and were asked to show cause for returning patients stating unavailability of bed, however the reality was contradictory. Private hospitals keeping profit at a higher pedestal, use such manoeuvre to over-charge patients during their crisis. Further, 35 private hospitals have failed to reserve the government mandated number of beds for COVID-19 patients **(ANNEXURE-K).**
24. That essentials whose prices are not being regulated by the government, are being over-charged by the private hospitals. Essentials like N-95 Masks, Hand Sanitizers, PPE Kits etc. are being sold at exorbitant rates. Rates are being increased by including additional heads in the bills such as Hygiene, Staff Maintenance etc. According to a survey conducted by the ***National Institute of Urban Affairs (NIUA)*** the household income of 91.04% Below Poverty Line (BPL) families have been affected giving rise to a new class of poor **(ANNEXURE-L).**
25. That according to ***Draft National Health Policy, 2015*** released by the Ministry of Health & Family in **December, 2014** if health care costs are more impoverishing than ever before, almost all hospitalization even in public hospitals leads to catastrophic health expenditures, and over 63 million persons are faced with poverty every year due to health care costs alone, it is because there is no financial protection for the vast majority of health care needs. In 2011-12, the share of out of pocket expenditure on health care as a proportion of total household monthly per capita expenditure was 6.9% in rural areas and 5.5% in urban areas. This led to an increasing number of households facing catastrophic expenditures due to health costs (18% of all households in 2011-12 as compared to 15% in 2004-05).
26. That on **8th April, 2020**, the Hon'ble Supreme Court had directed testing for COVID-19 by private laboratories free of charge but later on, by an order dated **13th April, 2020** it was clarified that the authorities may extend the benefit of free testing to the beneficiaries of the ***Ayushman Bharat aka Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY)*** Scheme. At the same time, the Central Government was left free to take a call whether other weaker sections of the society could be extended the benefit of free testing. No decision has been taken by the Central Government in this behalf and thus the State Government ought to be directed to consider extending the benefit of free testing to the poor and the members of the backward classes.
27. That on **1st May, 2020** the Maharashtra government declared free treatment for all the COVID-19 patients registered under the ***Mahatma Jyotiba Pule Jan Arogya Yojana (MJPJAY)***. However, neither of these schemes cover a strata of the society known as the ***"middle class".*** The people belonging to this strata of the society might even not have the means to approach and get a check-

up at the government hospitals. These people who have an annual income of a few lakhs, and runs a basic nuclear family won't be able to make ends meet even if they burn the candle at both ends.

28. That in this entire COVID-19 fiasco a consistent downfall has been witnessed in the plight of the middle class people of India: The largest chunk of the Indian population. That on the *prima facie* the elite class; the smallest segment of the Indian population, are economically sound enough to be self-reliant in in financing their medical requirements. The government is doing its bit in providing financial and other assistance to the patients and their family and hence easing if not eradicating their trouble in these needful times. Among all this, it's the middle class who are becoming latent due to societal connotation of being financially stable. However, during this time of job retrenchment, plunging global economy, rising inflation coupled with lack of government and charitable hospitals drags a middle class under the pile of medical bills in this desperate times solely dependent on their meagre savings, insurance or investment is all has not already been exhausted before the treatment is over.
29. That the present schemes of the government has an ***"Exclusion Category"*** which includes a household income limit of **Rs.10, 000 *(Ten Thousand),*** however as per notification no. **No. CORONA-2020/C.R.97/Aro-5** on **21st May, 2020** the Maharashtra government regulated the rate of medical facilities. That the threshold of family income is very low as compared to number of masses getting alienated from the medical help required due to financial constraints. That even the present subsidized rates are unaffordable by many.
30. That at present, Maharashtra hosts the highest number of Covid-19 case and in lieu of demand of healthcare services, a sharp rise in medical bills has been observed. The right to health is a fundamental right and it is for the State to ensure that such right of its citizen is not infringed in any manner. That there are many patients who are being denied treatment and succumbing to death due to economic crises.

VI. Grounds for filing the Petition

31. **Under Regulated Health Sector**

    31.1 That private hospitals with the latest technologies and facilities play a crucial role during desperate times. The private hospitals are over charging their patients for various necessities during these times of hardships. Private players in the medicine fraternity have included various other heads in their bills in order to over-charge their patients and the government has not provided any checks and measures for the same.

    31.2 The Maharashtra Government in vide of its notification **No. CORONA-2020/C.R.97/Aro-5** on **21st May, 2020** has specified the price for all the facilities needed for a Covid-19 patient. It states that the maximum amount for routine check-up and isolation including tests and x-rays for a day should not exceed Rs. 4000 (Four Thousand). However, families having an income

above Rs. 10, 000 but not enough economically sound to avail health facilities are not under the ambit of the scheme.

32. **Violation of Article 21 of The Constitution of India**

32.1 That disease is a natural catastrophe that fells its victims unpredictably. That Art. 21 enshrined in Part III of the Constitution of India i.e. **"Right to life and Personal Liberty"** is an alienable, transcendental basic right of an individual. That Right to health is embodied in Art.21 as a fundamental basic human right the core obligations of which are non-derogable. The same became the law of the land with judgement of ***State of Punjab v. Mohinder Singh Chawla (1997 AIR SC 1125 at 1227)*** where it was held that right to health is integral to the right to life.

32.2 That the gravity of Right to health has been well concealed by the court of law in the matter of ***Kranti v. Union of India and Others (2007 6 se c 744)*** when the Apex court acted upon the suggestion of the petitioner directed the authorities to take immediate action in order to suffice for enough doctors the need of the state and if necessary airlift from neighbouring states. The following was directed**.**

32.3 That The State has to ensure the basic necessities like food, nutrition, medical assistance, hygiene, etc. and contribute to the improvement of public health. Right to life includes right to health as observed in ***Consumer Education and Research Centre v. Union of India (1995 AIR 922)*** where the Supreme Court had expressly opined that right to health was an integral factor to lead a meaningful life and for the right to life under Part III. The court also stated that health includes the access to medical care for the highest attainment of living standards.

32.4 That according to the report of ***Centre for Budget Governance and Accountability (CBGA). (2020). Numbers on the Edge: Assessing India's Fiscal Response to Covid-19. New Delhi(CBGA)***, India provides a very exiguous amount of less than 0.04% of the GDP for immediate public health expenditure. It is the obligation of the government to provide for its citizens especially in the times of crisis. That the situation the nation is now faced with, i.e., of fighting an invisible enemy, cannot prove to be an excuse for the government authorities to proceed in ignorance of the principles regarding judicial review of policy matters pertaining to "public health".

32.5 In ***Paschim Banga Khet Mazdoor Samity ((1996) 4 SCC 37)*** this Court has observed that the Constitution envisages the establishment of a welfare State. In a welfare State, the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare State. The Government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail of those facilities.

Preservation of human life is thus of paramount importance. Government is duty-bound to provide timely care to persons in serious conditions. Medical facilities cannot be denied by the Government on the ground of non-availability of bed. Denial of medical assistance on unjust ground was held to be in violation of right to life under Article 21 and the State was directed to pay the compensation of Rs 25,000 to the petitioner and requisite directions were issued by this Court. The State cannot avoid its constitutional obligation in that regard on account of financial constraints and was directed to allocate funds for providing adequate medical infrastructure.

32.6 In ***Navtej Johar (6 September 2018)*** when a 5-judge bench of the Supreme Court decriminalised homosexual intercourse, in his concurring opinion, Justice Chandrachud pertinently held:

"Article 21 does not impose upon the State only negative obligations not to act in such a way as to interfere with the right to health. This Court also has the power to impose positive obligations upon the State to take measures to provide adequate resources or access to treatment facilities to secure effective enjoyment of the right to health."

32.7 That all the hospitals whether private or public are considered moral agent and hence have a moral responsibility. The country with more than a million case, has a health care sector dominated by the private players. The responsibility to act in certain ways falls upon those who may make up these hospitals bills of lakhs of rupees are being raised and a poor patient and family may find it extremely difficult to raise the necessary funds. That the 21st Chief Justice of India Raganath Misra in ***Parmanada Katara Vs UOI (1981 AIR 2039)*** reckoned that

"..preservation of life is the most importance, because if one's life is lost, the status quo ante cannot be restored as resurrection is beyond the capacity of man''.

32.8 That the petitioners are of the view that financial constraints should not cause restrains to an economically deprived person from reaching out for medical facilities. That Healthcare access is the ability to obtain healthcare services such as prevention, diagnosis, treatment and management of diseases, illness disorders, and other health impacting conditions. That the entire medical community owe a sense of duty, responsibility and play a critical role in national and legal response to the emergencies such as the one we are facing today.

32.9 That by virtue of Article 21of the Constitution of India, the State is under a legal obligation to ensure access to life saving drugs to all the patients. A reasonable and equitable access to life saving medicines is critical to the promoting and protecting of the right to health. That the petitioners are of the panorama that during these times of hardships we must realise that a helpless individual who has no means to get himself treated in a private / government hospitals

is being charged exorbitant fees for their basic fundamental need of health facilities in order to continue their existence.

33. **Violation of Article 14 of The Constitution of India**

33.1 That as per the Principle of "Urban Commons", we are all looking for a society that works towards the inclusion of all, in order to provide for all the people in the society. That according to ***Mary Dellenbaugh Losse in "What makes urban commons different from other commons?" (Urban Policy. Retrieved December 28, 2017)*** urban commons present the opportunity for the citizens to gain power upon the management of the urban resources and reframe city-life costs based on their use value and maintenance costs, rather than the market-driven value. Thus medicine is an urban common and ought to be regulated by the government.

33.2 That all citizens irrespective of birth, religion, sex, or race are equal before law; that is to say, there shall not be any arbitrary discrimination between one citizen or class of citizens and another. *In* ***E.P Royappa v. State of Tamil Nadu & Another (A.I.R. 1974, S.C.555),*** it was held that Article 14 is one of the pillars of the Indian Constitution and hence cannot be bound by a narrow and inflexible interpretation. Article 14 should thus be given the widest interpretation possible, which also includes reasonableness and arbitrariness of certain provisions of the legislations.

33.3 That as per the **Test of Reasonable Classification** the differentiation if made must be based upon intelligible differentia that distinguishes persons or things that are grouped from others that are left out of the group. This differentia must have a rational relation to the object of classification. The same is followed in Article 14, which classifies people for the application of law in order to keep their best interest at stake. However, the categorization should not be ***"artificial, arbitrary or evasive"*** which is contradictory to the actions of the present government proving to be evasive in nature.

33.4 The new dimensions of Article 14 have been developed by the judiciary and the main purpose of Article 14 is to remove any arbitrariness which may exist in the actions of the State and thus this Article has a much wider scope in the present time as compared to its scope at the time of enactment of the Constitution. Thus, the scope of this article has been enlarged by various judicial pronouncements. In the case of ***Bachan Singh v. State of Punjab (1982 AIR 1325),*** explaining the new dimensions of Article 14, Justice PN Bhagwati had observed that Rule of law permeated the entire fabric of the Indian Constitution and it excludes arbitrariness. According to him whenever there is arbitrariness, there is a denial of Rule of Law. So, every action of the State should be free from arbitrariness otherwise the Court will strike the act as unconstitutional.

33.5 The expansion of the Ayushman Bharat also known as Pradhan Mantri Jan Arogya Yojana for cases of Covid-19 is a noble step taken by the government but is discriminatory against the people who are currently in a financial crunch but are not registered member of the scheme. Moreover, the scheme coverage includes 3 days of pre-hospitalisation and 15 days of post-hospitalisation expenses and a coverage of Rs 5 Lakh. With the current surge seen in the bills for treatment of Covid-19 patient there are possibility of that even after going under the scheme a patient may incur liability to the hospital.

33.6 That in order to be a beneficiary of the schemes various documents are required like ration cards which are not available with 40% of the homeless in India **(ANNEXURE-E)**. That the basic human right to healthcare facilities is being violated by the government for not being able to comply with the law. That no one should be condemned to a life below the basic level of dignified human existence.

33.7 Due to current scenario a lot of people have lost jobs and facing a financial crisis and are not able to afford the costly treatment. With no protective scheme infected people are not just vulnerable to death but also their families are prone to get the virus and losing their means of livelihood. The capping of price is needed as the monetary factor is an hinderance in curbing the virus. With the lack of money infected person unaware of them being infected are spreading the virus to other who are in contact of them. A minimum amount for the medical facilities will encourage the citizens to get themselves tested and treated which would successfully identify and restrain the spread of the contagion.

33.8 That in the matter of ***Jan Swasthya Abhiyan and Anr. Vs State of Maharashtra and Ors. (PIL-CJ-LD-VC-21/2020),*** a PIL concerning with the rights of migrant workers was filed in the Bombay High Court. That this very court held the view that:

> *"Before venturing to embark on our task of dealing with the*
> *points raised by the petitioners, we need to remind ourselves that despite nearing seventy-five years of our independence, despite the guarantees that Part III of the Constitution envisions and despite the goals engrafted in Part IV of the Constitution which the State ought to strive to achieve, a society which can provide equal opportunities to all is yet a distant reality. That misery of this degree could be brought about by the pandemic was indeed unimaginable. The pandemic and the resultant lockdown have destabilised the Indian economy, while wrecking the 'haves' and the 'have nots' alike. It has shown how pitiable the conditions of migrant workers in India are. India, as things stand now, can hardly think of a fair and just society any time in the near future."*

34. **Violation of Directive Principles of State Policy**

34.1 That the Directive Principal of State Policy enshrined in Part IV of the Constitution puts burden on the Respondents to to ensure the creation and the sustaining of conditions congenial to good health. Prof (Ms) SK Verma in his book Legal Framework for Health Care in India (***Lexis Nexis, Butter Worths, Legal Framework for Health Care in India, 1, 2002)*** opined that:

"Health Services' is not a mere charity or the privilege of a few but a right to be enjoyed by all."

34.2 In another case of ***Akhil Bharatiya Soshit Karmachari Sangh vs. Union of India' (1 SCC 246 (1981)),*** Supreme Court has pointed out that, "the Fundamental Rights are intended to foster the ideal of a political democracy and to prevent the establishment of authoritarian rule but they are of no value unless they can be enforced by resort to courts. So, they are made justifiable. However, it is also evident that notwithstanding their great importance, the Directive Principles cannot in the very nature of things be enforced in a Court of Law, but it does not mean that Directive Principles are less important than Fundamental Rights or that they are not binding on the various organs of the State."

34.3 **Article 38** of the Constitution lays down the responsibility of the state to secure social order for the in promotion of the welfare of public health. **Article 41** of the constitution imposes a primary duty of the state in improvement of public health, in securing of justice, providing humane conditions of work for the workers, extension of benefits pertaining to sickness, disability, old age and maternity benefits. In the case of ***Vincent Panikurlangara v Union of India (AIR 1987 SC 990: (1987) 2 SCC 165)***, the court opined that public health should be ranked higher as they are the factors responsible for the betterment and growth of the society and in the building of the nation and therefore deserve high priority.

34.4 In the case of ***Bandhua Mukti Morcha v. Union of India (AIR 1984 SC 802)*** the Supreme Court has held that the right to live with human dignity, enshrined in Article 21, derives from the directive principles of state policy and therefore includes protection of health. Further, it has also been held that the right to health is integral to the right to life and the government has a constitutional obligation to provide health facilities. Failure of a government hospital to provide a patient timely medical treatment results in violation of the patient's right to life. Similarly, the Court has upheld the state's obligation to maintain health services.

34.5 Under **Article 47**, State has to make constant endeavour to raise the level of nutrition and the standard of living and to improve public health. It is also one of the fundamental duties enshrined in **Article 51-A (h)** to develop the scientific temper, humanism and the spirit of inquiry and reform. It would be inhuman to deny a person who is not having sufficient means or no means, the life-saving treatment, simply on the ground that he is not having enough

money. Due to financial reasons, if treatment is refused, it would be against the very basic tenets of the medical profession and the concept of charity in whatever form we envisage the same, besides being unconstitutional would be violative of basic human rights.

34.6 In ***Ram Lubhaya case***, while examining the revolving around the issue of right to health under Article 21, 41 and 47 of the Constitution of India, the court observed that right of one correlates with the duty of another. Hence, the right entrusted under Article 21 imposes a parallel duty on the state which is further reinforced as under Article 47.

34.7 All these provisions only showcase the importance given to health and that it is synonymous to life. It is the duty of Central and the State government to ensure that each citizen has the access to proper healthcare. In times of pandemic the needs for healthcare has become an integral part for the survival of the society as a whole.

35. **Responsibility of the government**

35.1 Though the Constitution of India is silent on the subject 'disaster', the legal basis of the **Disaster Management Act, 2005** is Entry 23 of the Concurrent List of the Constitution ***"Social security and social insurance".*** Entry 29 of Concurrent List is ***"Prevention of the extension from one State to another of infectious or contagious diseases or pests affecting men, animals or plants,"*** It is the responsibility of the Central and State government to make laws for the protection of the people.

35.2 Disaster Management Act 2005 is a national law that empowers the Central government to declare the entire country or part of it as affected by a disaster and to make plans for mitigation to reduce "risks, impacts and affects" of the disaster. The Epidemic Disease Act, 1897 does not provide such powers.

35.3 Under the Disaster Management Act 2005, **Section 36 to 40** deal with the responsibility of the Central and State government in the wake of a disaster. **Section 39** implies an obligation on the State government to ensure that the people are provided drinking water, essential provisions, healthcare and services in an affected area. It is the responsibility of the State to supply healthcare services irrespective of one's financial status.

36. **Against the spirit of Constitutional Amendment Bill 2018**

36.1 That **YSR Congress MP V Vijayasai Reddy** has proposed an amendment in the Constitution by introducing a new **article 21 B** for making right to health a fundamental right. The bill intends to make right to health and healthcare services a fundamental right. It states that -After article 21A of the Constitution, the following article shall be inserted, namely,

"21B. The State shall provide a mechanism for protection of the health of all Indian citizens which includes prevention, treatment and control of diseases as well as access to free of cost or affordable medical treatment, diagnosis and essential medicines in such manner as the State may, by law, determine."

36.2 The state shall provide a system of health protection to all citizens, including prevention, treatment and control of diseases and access to essential medicines, the bill proposes. It states that all citizens should also have access to basic health services, emergency medical treatment and mental healthcare. These only highlights that even the law makers have the intention of making health a Fundamental Right.

37. That apart from violations in the domestic law, International conventions are also be infringed by the surge in prices due to Covid-19. India being a signatory to the WHO and other conventions is obligated to fulfil its duties as given under –

37.1 **Violation of WHO Constitution**

That the basic principle embedded in the preamble of the WHO constitution is –

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

37.2 **Violation of Universal Declaration of Human Rights(UDHR)**

That **Article 25(1)** of the UDHR states the following:

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control".

37.3 **Violation of International Covenant on Economic, Social and Cultural Rights**

ICESCR Rights is a multilateral treaty adopted by the United Nations General Assembly on **16th December,1966** through GA Resolution 2200A (XXI), and came into force on **3rd January, 1976. Article 2(2)** of the ***1966 International Covenant on Economic, Social and Cultural Rights provides:***

"The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

That **Article 12** of the ICESCR state the following:

*"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:(a) The provision for the reduction of the still birth-rate and of infant mortality and for the healthy development of the child;(b) The improvement of all aspects of environmental and industrial hygiene;(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases,**(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness**."*

38. The above - mentioned provisions prove that the right to medical service is not just an obligation of the government but a human right. No state has the right to deny medical attention to a patient on the mere basis of his financial position. That the citizens have reposed their trust and faith with the Respondents to rescue them in catastrophic conditions such that health should be kept supreme than finances and the court of law has held so.
39. That the petitioners would like to highlight that pertaining to the current scenario of the lockdown a lot of relevance has been placed to newspaper articles. Although newspaper articles are considered secondary evidence and hearsay in the court of law, an investigation related to the ground realities could not be done due to the restrictions of movement in plight of the current lockdown. That the petitioners humbly requests the court to consider this an extra-ordinary situation, and look into the broader picture to investigate into the truth of these media reports.
40. That Justice A.A Syed in the matter of ***Jan Swasthya Abhiyan and Anr. Vs State of Maharashtra and Ors. (PIL-CJ-LD-VC-21/2020),*** where a similar circumstance the one existing with the current PIL, regarding the use of newspaper articles opined that:

    "After all, it is justice that should prevail over technicalities in times such as these and it must be left to each Court, dealing with the PIL petition, to decide in exercise of judicial discretion the weight that ought to be attached to the relevant media report. We end this discussion by observing that extra-ordinary situations deserve extra-ordinary treatment and in these times of test, inviting the attention of the judiciary to newspaper reports for taking cognizance of the plight of the unfortunate sufferers and requiring a party to share the details for the Court to suggest corrective measures, in the absence of the report or a part thereof being disputed, is not an impermissible course of action."

41. The petitioners further most respectfully submit that the petitioners do not have any alternate remedy, much less, an efficacious one than to approach this Hon'ble Court in the instant matter under Article 226 of the Constitution of India invoking its extraordinary writ jurisdiction.

42. The petitioners herein further most respectfully submit that the petitioners have not approached this Hon'ble Court or Hon'ble Supreme Court challenging the impugned action any time before. Hence, the present Petition.
43. The Petitioners will rely upon documents, a list whereof is annexed hereto.

Hence, this Petition.

VII. Prayer for Relief;

The Petitioner humbly prays that this Hon'ble Court may kindly be pleased;

1. Issue the Writ of Mandamus or any other appropriate writ, order or direction to increase the threshold of maximum income for AB-PMJAY and other similar schemes active in states.
2. Issue the Writ of Mandamus or any other appropriate writ, order or direction to evolve a special system in order to regulate and restrain misuse of the inevitable power in the hands of the Private Sector of Medical Industry.
3. Any further relief may be granted in favour of petitioners in the interest of Justice.

Date: 10th day of August, 2020

Place: Mumbai

Advocate for the Petitioner Petitioner

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
ORDINARY ORIGINAL CIVIL JURISDICTION
[RULE 4(e) OF THE BOMBAY HIGH COURT
PUBLIC INTEREST LITIGATION RULES, 2010]

PUBLIC INTEREST LITIGATION NO. _____ OF 2020

Miss Arshiya James and Miss Dipanita Roy …PETITIONER

VERSUS

State Of Maharashtra And Ors. …RESPONDENTS

SOLEMN AFFIRMATION

We, ARSHIYA JAMES and DIPANITA ROY, Petitioners above named do hereby declare that what is stated in the foregoing paragraphs are true to my knowledge and based on information I believe the same to be true.

Solemnly declared at Mumbai)
Dated 10th Day of August, 2020)

Identified, explained and interpreted by me

Petitioner

Advocate for the Petitioner Before me,

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
ORDINARY ORIGINAL CIVIL JURISDICTION
[RULE 4(e) OF THE BOMBAY HIGH COURT
PUBLIC INTEREST LITIGATION RULES, 2010]

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LIST OF DOCUMENTS

SR. No.	ANNEXURES	DATE	PARTICULARS
1.	**A**	**09.08.2020**	True copy of the report titled "Live Updates: Maharashtra's Covid-19 tally crosses 5 lakh with record 12,822 new cases" published by Mumbai Mirror is attached herewith at page no. .
2.	**B**	**18.05.2020**	True copy of the report titled "India's COVID-19 epicentre: Three Lockdowns later, Maharashtra accounts for 34.5% of nation's Confirmed cases, its worst recovery rate." published by First Post is attached herewith at page no. .
3.	**C**	**20.04.2020**	True copy of the research titled "COVID-19 in India: State-wise estimates of current hospital beds, intensive care unit (ICU) beds and ventilators" published by CDDEP and Princeton University is attached herewith at page no. .

4.	**D**	**05.05.2014**	True copy of the report titled "What Do New Price Data Mean for the Goal of Ending Extreme Poverty?" published by Brookings is attached herewith at page no. .
5.	**E**	**13.05.2020**	True copy of the report titled "1.77Mn Indians Are Homeless. 40% Of Them Are Getting No Lockdown Relief" published by Indiaspend is attached herewith at page no. .
6.	**F**	**30.09.2013**	True copy of the survey titled "Primary Census Abstract for Slum" published by the Office of the Registrar General & Census Commissioner, India New Delhi, is attached herewith at page no.
7.	**G**	**29.07.2020**	True copy of the report titled "More than half of India's Mumbai slum residents may have been infected with Covid-19, study suggests" published by CNN is attached herewith at page no.
8.	**H**	**18.06.2020**	True copy of the report titled "COVID-19: Are Slums In India Conducive For The Outbreak?" published by Outlook is attached herewith at page no.
9.	**I**	**06.08.2020**	True copy of the report titled "Number of government and private testing centers for the coronavirus (COVID-19) across India as of August 6, 2020," published by Statista is attached herewith at page no.
10.	**J**	**02.06.2020**	True copy of the report titled "COVID-19 Pandemic: Show cause notice to 4 prominent Mumbai hospitals for flouting rules" published by DNA is attached herewith at page no.
11.	**K**	**09.06.2020**	True copy of the report titled "How Mumbai's private hospitals are fleecing COVID-19

			patients" published by The Week is attached herewith at page no.
12.	**L**	**28.05.2020**	True copy of the report titled "Impact of Covid-a9 on lives and livelihoods: Rapid Study of Slum Dwellers in Indian City " published by NIUA and World Vision is attached herewith at page no.

BEFORE THE HIGH COURT OF JUDICATURE AT BOMBAY ORDINARY ORIGINAL CIVIL JURISDICTION PUBLIC INTEREST LITIGATION NO. _____ OF 2020

ARSHIYA JAMES and DIPANITA ROY

IN THE HIGH COURT OF JUDICATURE AT BOMBAY ORDINARY ORIGINAL CIVIL JURISDICTION [RULE 4(e) OF THE BOMBAY HIGH COURT PUBLIC INTEREST LITIGATION RULES, 2010]
PUBLIC INTEREST LITIGATION NO. _____ OF 2020

Miss Arshiya James &
Miss Dipanita Roy ...PETITIONER

VERSUS

State Of Maharashtra And Ors.
…RESPONDENT

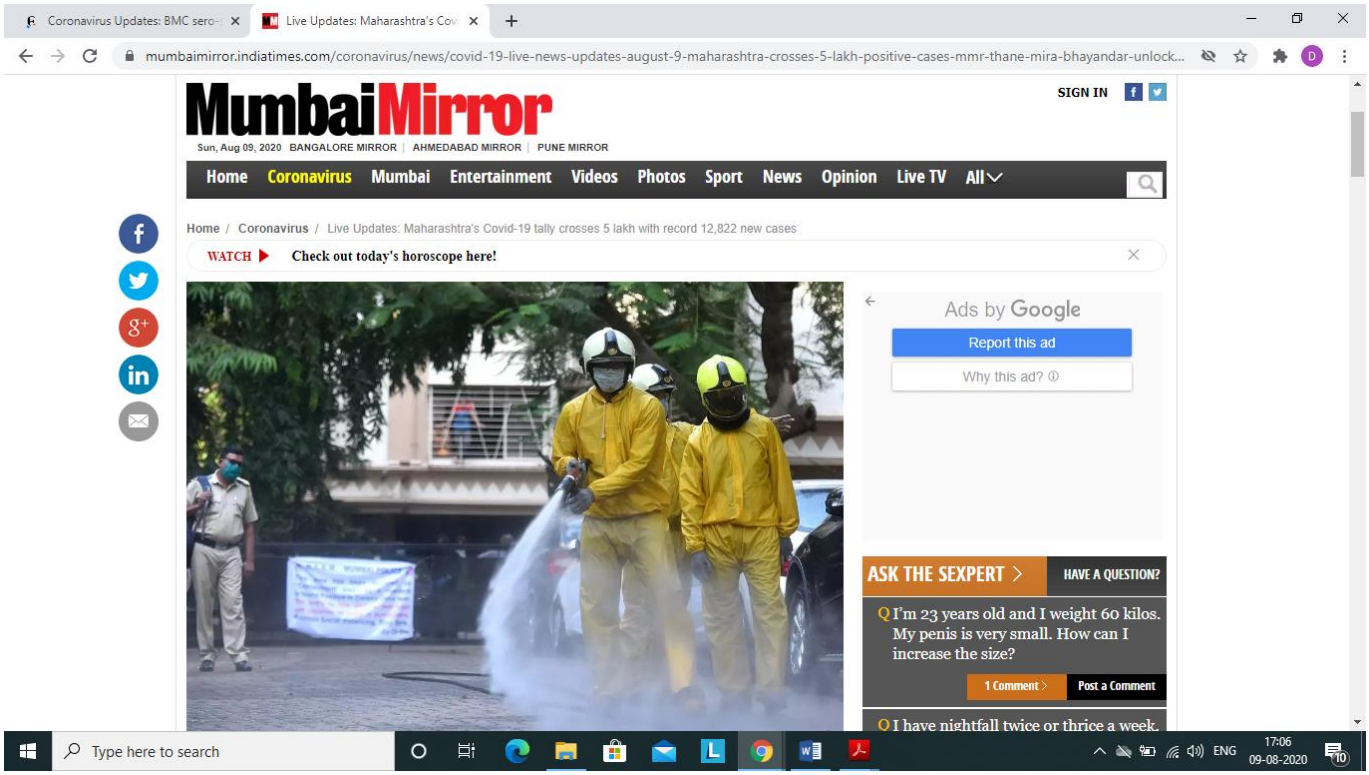
PUBLIC INTEREST LITIGATION

Dated this 10th day of August 2020

APPLICATION

ANNEXURES

ANNEXURE-A



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mumbaimirror.indiatimes.com/coronavirus/news/covid-19-live-news-updates-august-9-maharashtra-crosses-5-lakh-positive-cases-mmr-thane-mira-bhayandar-unlock...

MumbaiMirror

Sun, Aug 09, 2020 BANGALORE MIRROR | AHMEDABAD MIRROR | PUNE MIRROR

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1 Comment Post a Comment

Q I have nightfall twice or thrice a week.

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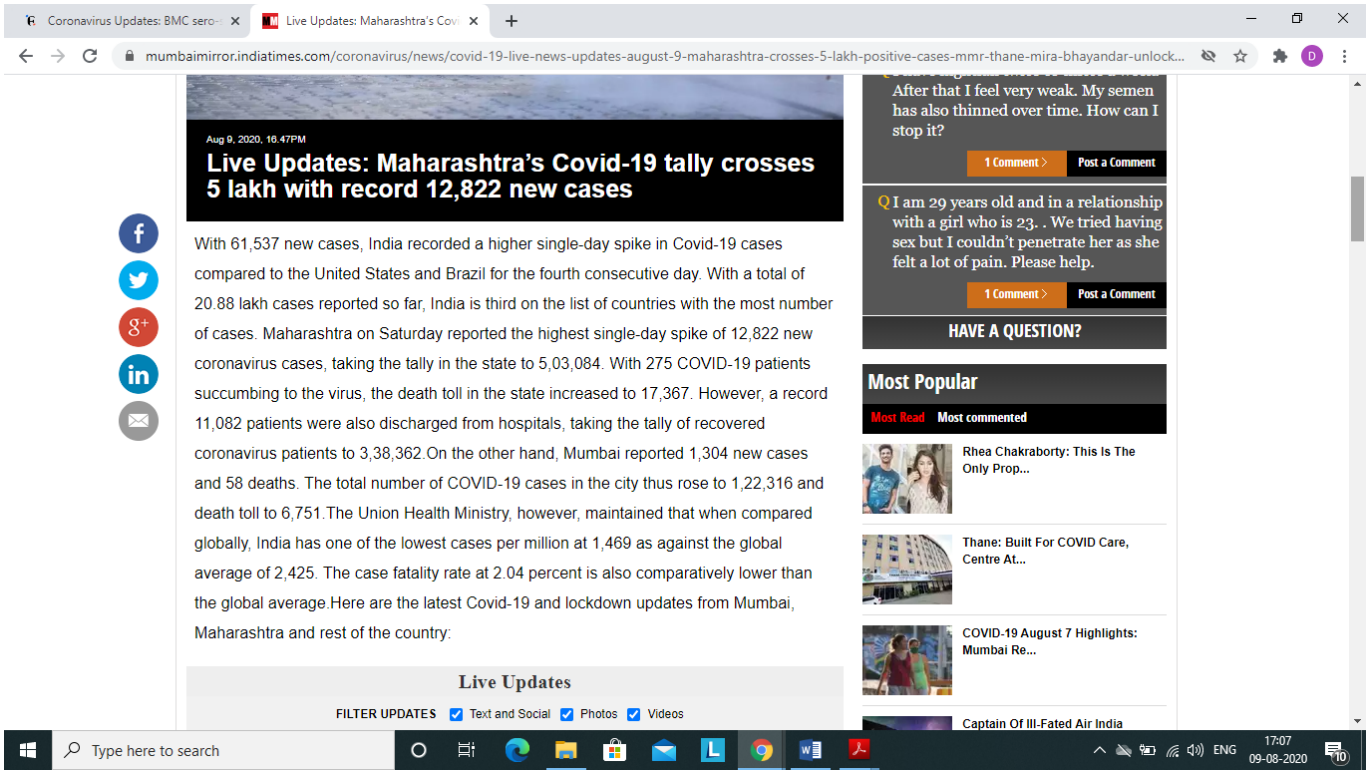

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mumbaimirror.indiatimes.com/coronavirus/news/covid-19-live-news-updates-august-9-maharashtra-crosses-5-lakh-positive-cases-mmr-thane-mira-bhayandar-unlock...

Aug 9, 2020, 16.47PM

Live Updates: Maharashtra's Covid-19 tally crosses 5 lakh with record 12,822 new cases

With 61,537 new cases, India recorded a higher single-day spike in Covid-19 cases compared to the United States and Brazil for the fourth consecutive day. With a total of 20.88 lakh cases reported so far, India is third on the list of countries with the most number of cases. Maharashtra on Saturday reported the highest single-day spike of 12,822 new coronavirus cases, taking the tally in the state to 5,03,084. With 275 COVID-19 patients succumbing to the virus, the death toll in the state increased to 17,367. However, a record 11,082 patients were also discharged from hospitals, taking the tally of recovered coronavirus patients to 3,38,362.On the other hand, Mumbai reported 1,304 new cases and 58 deaths. The total number of COVID-19 cases in the city thus rose to 1,22,316 and death toll to 6,751.The Union Health Ministry, however, maintained that when compared globally, India has one of the lowest cases per million at 1,469 as against the global average of 2,425. The case fatality rate at 2.04 percent is also comparatively lower than the global average.Here are the latest Covid-19 and lockdown updates from Mumbai, Maharashtra and rest of the country:

Live Updates

FILTER UPDATES Text and Social Photos Videos

After that I feel very weak. My semen has also thinned over time. How can I stop it?

1 Comment Post a Comment

Q I am 29 years old and in a relationship with a girl who is 23. . We tried having sex but I couldn't penetrate her as she felt a lot of pain. Please help.

1 Comment Post a Comment

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ANNEXURE-B

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HEALTH

India's COVID-19 epicentre: Three lockdowns later, Maharashtra accounts for 34.5% of nation's confirmed cases, its worst recovery rate

As it stands, 34.5 percent of India's COVID-19 positive cases and almost 40 percent of India's coronavirus-related deaths are from Maharashtra

FP Staff | May 18, 2020 15:09:19 IST

Use the arrow buttons to navigate between slides

1 of 5

A Flourish data visualization

When India announced the first lockdown on 25 March, the nation had seen a total of under 700 cases, of which Maharashtra accounted for a little over 100. At the same time, India reported 11 deaths, of which two were from Maharashtra.

Flash-forward seven weeks and the Uddhav Thackeray-ruled state's figures make for dismal reading. The chief minister was among those to request Prime Minister Narendra Modi for a lockdown extension (the fourth edition got underway today) and will be hoping things begin to look better at the end of it.

As it stands, 34.5 percent of India's COVID-19 positive cases and almost 40 percent of India's coronavirus-related deaths are from Maharashtra. The state also has the country's lowest (in terms of states that have recorded over 100 positive cases) recovery rate at 23.3 percent.

Follow the latest coronavirus updates here

Updated Date: May 18, 2020 15:09:19 IST

TAGS: Coronavirus Outbreak | Coronavirus Toll in Maharashtra

9 / 10

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ANNEXURE-C

State-wise-estimates-of-current-

cddep.org/wp-content/uploads/2020/04/State-wise-estimates-of-current-beds-and-ventilators_24Apr2020.pdf

CDDEP Disease Dynamics, Economics & Policy — PRINCETON UNIVERSITY

Hospitals in States/UTs

India Total	Number of hospitals in public sector	Number of hospitals in private sector	Total number of hospitals (public+private)
	25,778	43,487	69,265

	States/UTs	Number of hospitals in public sector	Number of hospitals in private sector	Total number of hospitals (public+private)
1	Lakshadweep	9	4	13
2	Chandigarh	9	4	13
3	Dadra & N Haveli	12	6	18
4	Puducherry	14	6	20
5	Daman & Diu	5	21	26
6	Andaman Nicobar Islands	30	6	36
7	Manipur	30	8	38
8	Sikkim	33	8	41
9	Nagaland	36	13	49
10	Goa	43	22	65
11	Mizoram	90	23	113
12	Jammu & Kashmir	143	14	157
13	Tripura	156	8	164
14	Delhi	109	67	176
15	Meghalaya	157	28	185
16	Arunachal Pradesh	218	20	238
17	Chhattisgarh	214	182	396
18	Andhra Pradesh	258	670	928
19	Madhya Pradesh	465	506	971
20	Himachal Pradesh	801	235	1,036
21	Uttarakhand	460	829	1,289
22	Jharkhand	555	809	1,364
23	Gujarat	438	970	1,408
24	Assam	1,226	503	1,729
25	Haryana	668	1,480	2,148
26	West Bengal	1,566	697	2,263
27	Punjab	682	1,638	2,320
28	Tamil Nadu	1,217	1,222	2,439
29	Odisha	1,806	695	2,501
30	Bihar	1,147	1,887	3,034
31	Maharashtra	711	2,492	3,203
32	Kerala	1,280	2,062	3,342
33	Telangana	863	3,247	4,110
34	Rajasthan	2,850	2,794	5,644
35	Karnataka	2,842	7,842	10,684
36	Uttar Pradesh	4,635	12,468	17,103
37	Ladakh	NA	NA	NA

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Number of hospitals in private sector are estimated values
States/UTs have been arranged in increasing order of total number of hospitals (public & private)

PRINCETON UNIVERSITY

India Total	Number of hospital beds in public sector	Number of hospital beds in	Total number of hospital beds (public+private)

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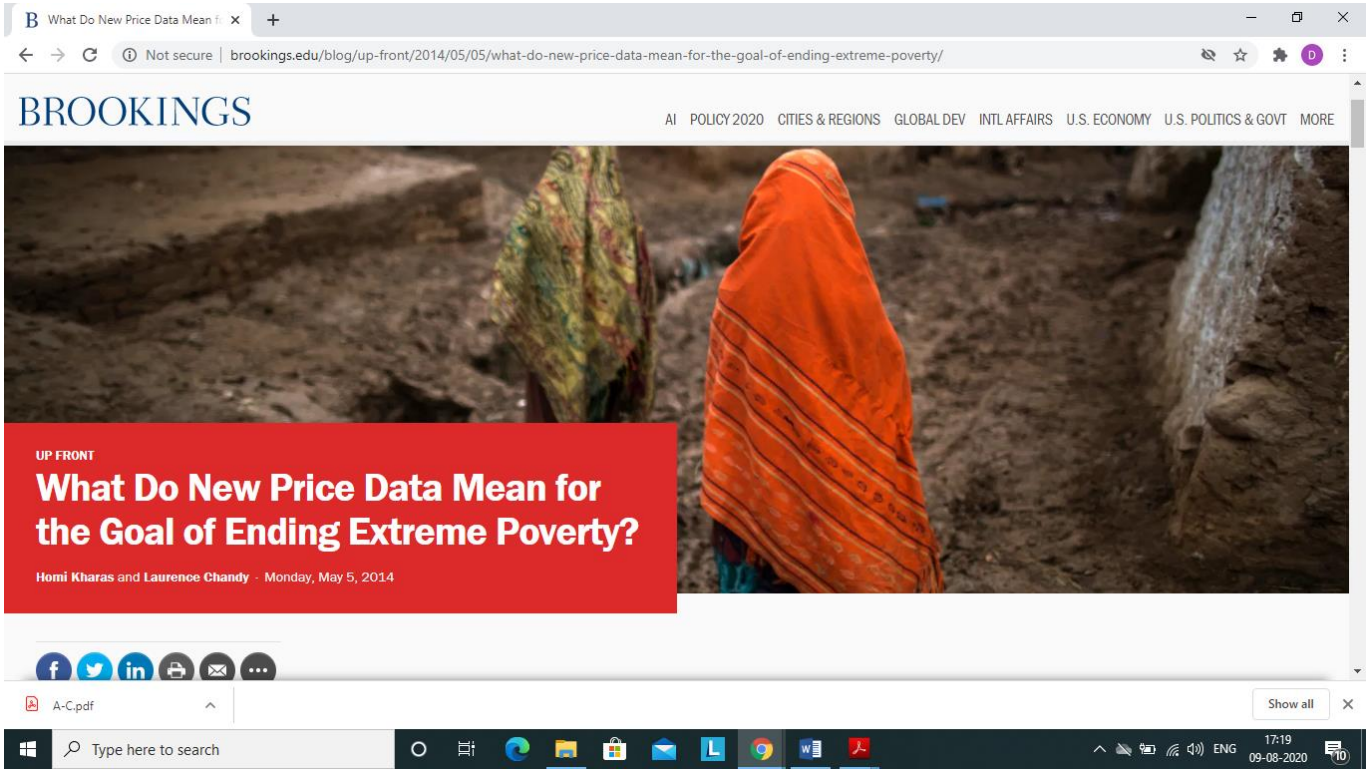
ANNEXURE-D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What Do New Price Data Mean for the Goal of Ending Extreme Poverty?
Homi Kharas and Laurence Chandy · Monday, May 5, 2014
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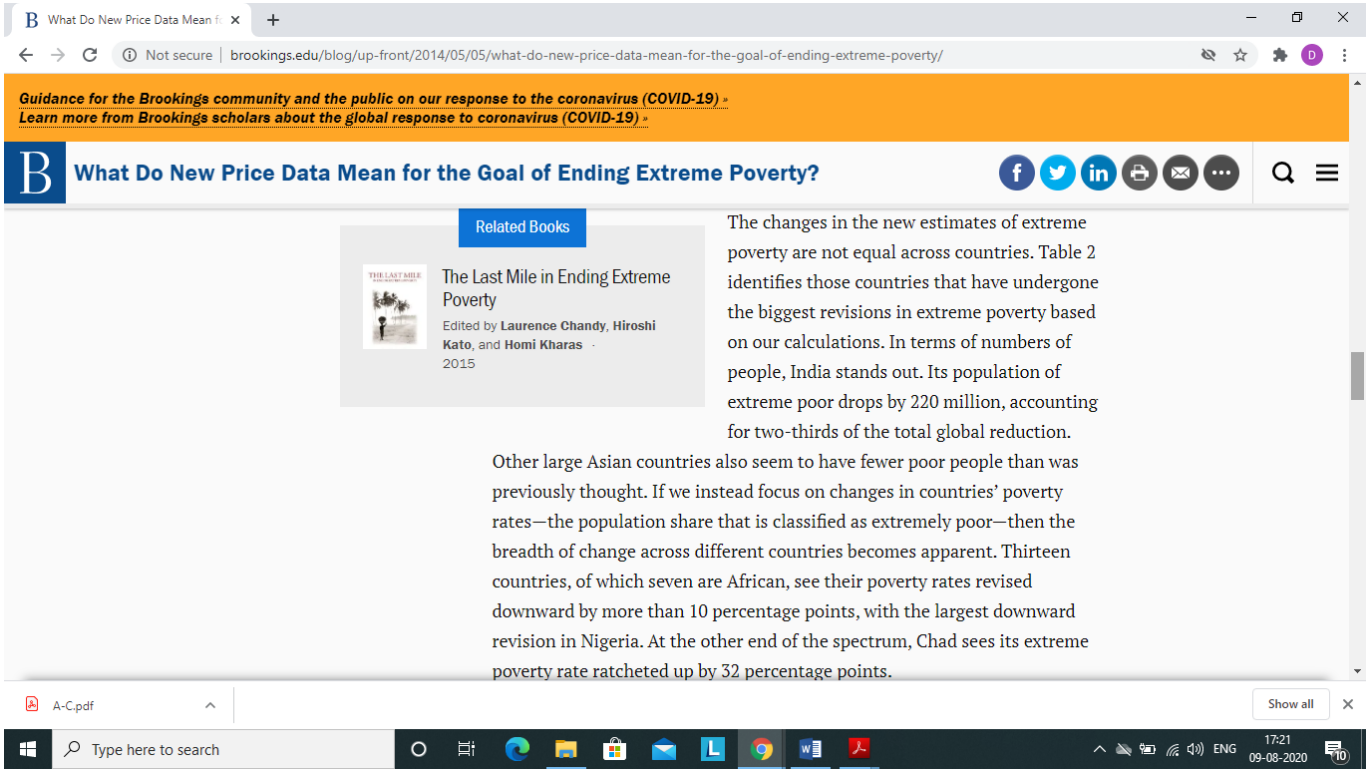
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Guidance for the Brookings community and the public on our response to the coronavirus (COVID-19) »
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The Last Mile in Ending Extreme Poverty
Edited by Laurence Chandy, Hiroshi Kato, and Homi Kharas · 2015
The changes in the new estimates of extreme poverty are not equal across countries. Table 2 identifies those countries that have undergone the biggest revisions in extreme poverty based on our calculations. In terms of numbers of people, India stands out. Its population of extreme poor drops by 220 million, accounting for two-thirds of the total global reduction.
Other large Asian countries also seem to have fewer poor people than was previously thought. If we instead focus on changes in countries' poverty rates—the population share that is classified as extremely poor—then the breadth of change across different countries becomes apparent. Thirteen countries, of which seven are African, see their poverty rates revised downward by more than 10 percentage points, with the largest downward revision in Nigeria. At the other end of the spectrum, Chad sees its extreme poverty rate ratcheted up by 32 percentage points.
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What Do New Price Data Mean for the Goal of Ending Extreme Poverty?

Table 2.

Biggest changes in numbers of poor people

	Official	Revised	Change
India	400.1	179.6	-220.5
Nigeria	107.7	67.1	-40.6
Bangladesh	64.3	48.3	-16.0
Indonesia	43.3	32.9	-10.3
China	144.3	137.6	-6.8
Philippines	17.2	11.2	-5.9
Kenya	16.2	10.4	-5.8
Pakistan	23.4	18.4	-5.0
Brazil	10.5	12.5	2.0
Venezuela	1.7	3.8	2.1
Ghana	5.4	7.7	2.3
Chad	5.2	8.8	3.6

Biggest changes in poverty rates

	Official	Revised	Change
Nigeria	68.0%	42.4%	-25.6
Angola	43.7%	24.8%	-18.9
Sao Tome and Principe	19.9%	1.6%	-18.3

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Biggest changes in poverty rates

	Official	Revised	Change
Nigeria	68.0%	42.4%	-25.6
Angola	43.7%	24.8%	-18.9
Sao Tome and Principe	19.9%	1.6%	-18.3
India	32.7%	14.7%	-18.0
Mauritania	24.0%	9.6%	-14.4
Kenya	39.9%	25.7%	-14.3
Timor-Leste	34.7%	21.0%	-13.7
Zambia	74.5%	61.3%	-13.1
Yemen	16.8%	4.1%	-12.8
Haiti	65.3%	52.6%	-12.7
Nepal	24.8%	13.9%	-11.0
Madagascar	81.3%	70.4%	-10.9
Bangladesh	43.3%	32.5%	-10.7
Guatemala	4.4%	11.1%	6.7
St. Lucia	18.5%	25.3%	6.7
Venezuela	5.7%	13.0%	7.3
Panama	6.6%	14.1%	7.5
Ghana	22.2%	31.7%	9.5
Belize	9.6%	21.8%	12.2
Tajikistan	6.6%	23.0%	16.5
Chad	46.4%	78.6%	32.2

Table 3 shows how the composition of the global extreme poor has changed

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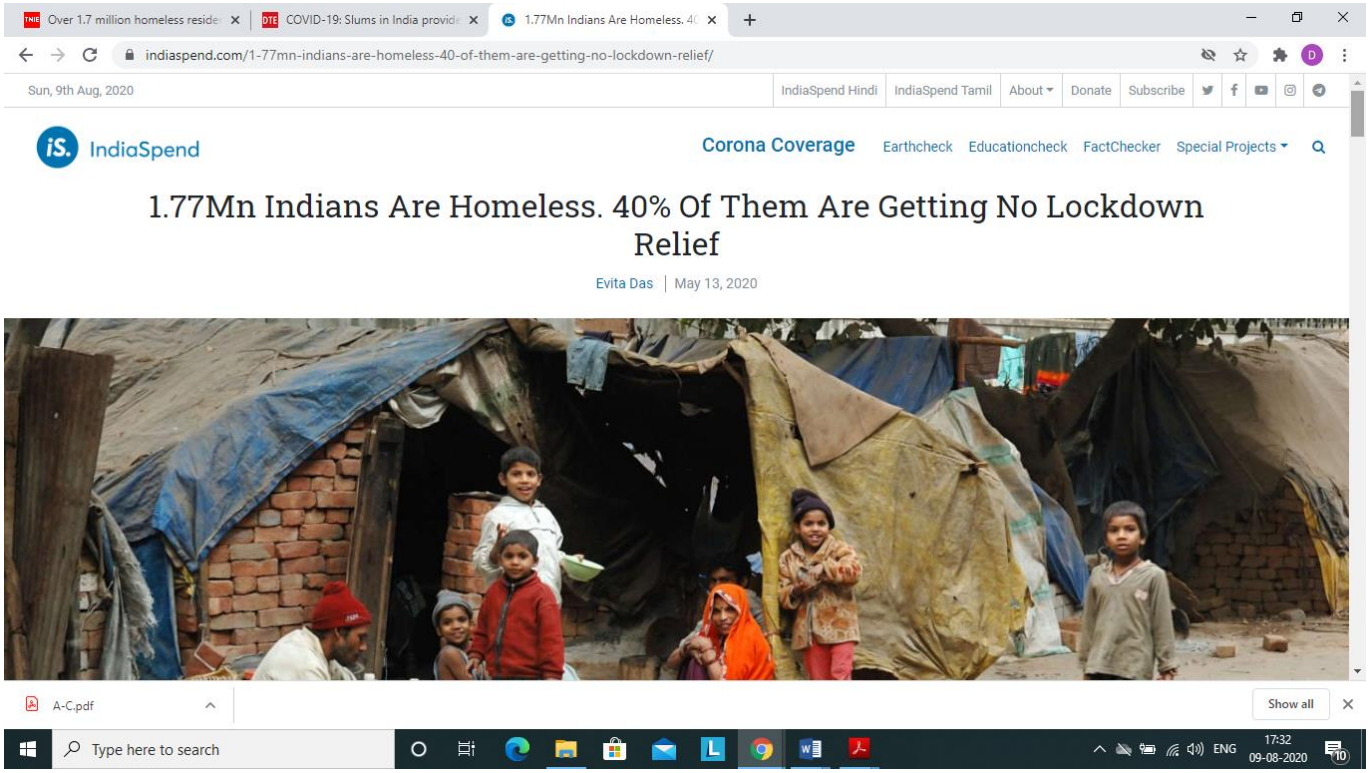
ANNEXURE-E



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1.77Mn Indians Are Homeless. 40% Of Them Are Getting No Lockdown Relief

Evita Das | May 13, 2020

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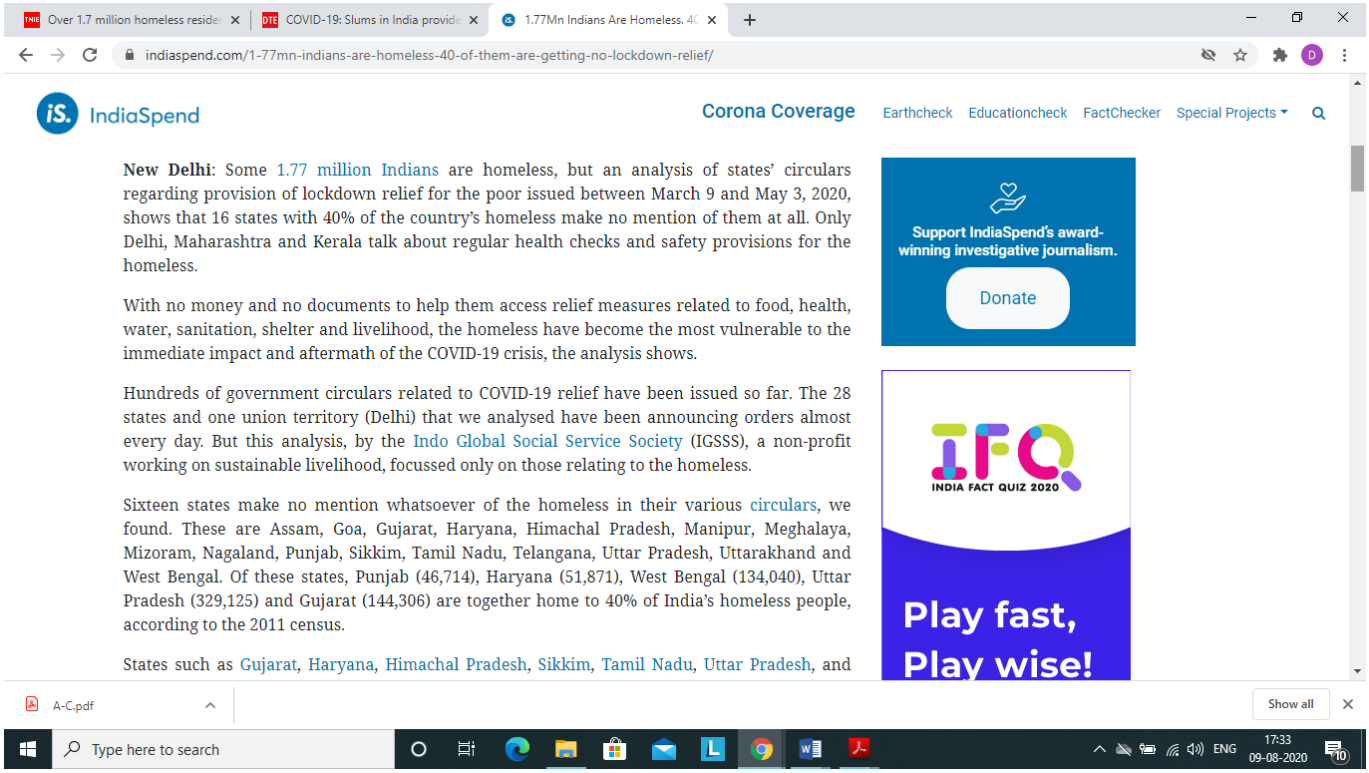

Over 1.7 million homeless reside | COVID-19: Slums in India provide | 1.77Mn Indians Are Homeless. 4

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New Delhi: Some 1.77 million Indians are homeless, but an analysis of states' circulars regarding provision of lockdown relief for the poor issued between March 9 and May 3, 2020, shows that 16 states with 40% of the country's homeless make no mention of them at all. Only Delhi, Maharashtra and Kerala talk about regular health checks and safety provisions for the homeless.

With no money and no documents to help them access relief measures related to food, health, water, sanitation, shelter and livelihood, the homeless have become the most vulnerable to the immediate impact and aftermath of the COVID-19 crisis, the analysis shows.

Hundreds of government circulars related to COVID-19 relief have been issued so far. The 28 states and one union territory (Delhi) that we analysed have been announcing orders almost every day. But this analysis, by the Indo Global Social Service Society (IGSSS), a non-profit working on sustainable livelihood, focussed only on those relating to the homeless.

Sixteen states make no mention whatsoever of the homeless in their various circulars, we found. These are Assam, Goa, Gujarat, Haryana, Himachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Punjab, Sikkim, Tamil Nadu, Telangana, Uttar Pradesh, Uttarakhand and West Bengal. Of these states, Punjab (46,714), Haryana (51,871), West Bengal (134,040), Uttar Pradesh (329,125) and Gujarat (144,306) are together home to 40% of India's homeless people, according to the 2011 census.

States such as Gujarat, Haryana, Himachal Pradesh, Sikkim, Tamil Nadu, Uttar Pradesh, and

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Over 1.7 million homeless reside | COVID-19: Slums in India provide | 1.77Mn Indians Are Homeless, 40

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No access to health facilities

Census 2011 figures put the number of homeless in India at 1.77 million, as we said before, but civil society organisations estimate that the actual number may well be over 3 million.

The IGSSS, as an advocacy for the rights of the urban homeless, conducted a survey in May 2019 across Bihar, Maharashtra, Jharkhand, Andhra Pradesh and Tamil Nadu to study the problems of the homeless. It tried to figure out exactly who the homeless are and to unfold the status of various factors related to their lives--services, entitlements, government policies, access to shelter, violence and challenges specific to women.

Almost 80% of the homeless belonged to the Scheduled Castes, Scheduled Tribes and other backward classes, and 60% were born in the same city where they were found, indicating an intergenerational cycle of poverty, concluded the survey that covered 4,382 people across 15 cities. The exercise was mostly executed in the evenings and at night to ensure that only the homeless were captured in the survey.

Around 41.6% of the homeless have no access to any sort of health services, even though 45% of the homeless live within 1 km of a clinic/hospital, as per the 2019 IGSSS survey.

The problem is especially acute for homeless women who have malnutrition and various other diseases, mental health issues and risky pregnancies. With hospitals overburdened with COVID-19, the issue of accessibility is likely to be worse now.

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ANNEXURE-F

Over 1.7 million homeless reside | Coronavirus in Dharavi | When a | 41.60% of INDIAN HOMELESS ha | PowerPoint Presentation

censusindia.gov.in/2011-Documents/Slum-26-09-13.pdf

Name of State/ Union territoryt#	Towns		Type wise Slum Population			
	Statutory towns	Slum reported towns	Total population	Notified slums	Recognised slums	Identified slums
Assam	88	31	1,97,266	9,163	70,979	1,17,124
West Bengal	129	122	64,18,594	48,918	37,03,852	26,65,824
Jharkhand	40	31	3,72,999	64,399	59,432	2,49,168
Odisha	107	76	15,60,303	0	8,12,737	7,47,566
Chhattisgarh	168	94	18,98,931	7,13,654	7,64,851	4,20,426
Madhya Pradesh	364	303	56,88,993	19,00,942	25,30,637	12,57,414
Gujarat	195	103	16,80,095	0	0	16,80,095
Daman & Diu	**2**	0	0	0	0	0
Dadra & Nagar Haveli	**1**	0	0	0	0	0
Maharashtra	256	189	1,18,48,423	37,09,309	34,85,783	46,53,331
Andhra Pradesh	125	125	1,01,86,934	83,38,154	8,77,172	9,71,608
Karnataka	220	206	32,91,434	22,71,990	4,45,899	5,73,545
Goa	14	3	26,247	6,107	0	20,140
Lakshadweep	**0**	0	0	0	0	0
Kerala	59	19	2,02,048	1,86,835	8,215	6,998
Tamil Nadu	721	507	57,98,459	25,41,345	19,78,441	12,78,673
Puducherry	6	6	1,44,573	70,092	73,928	553

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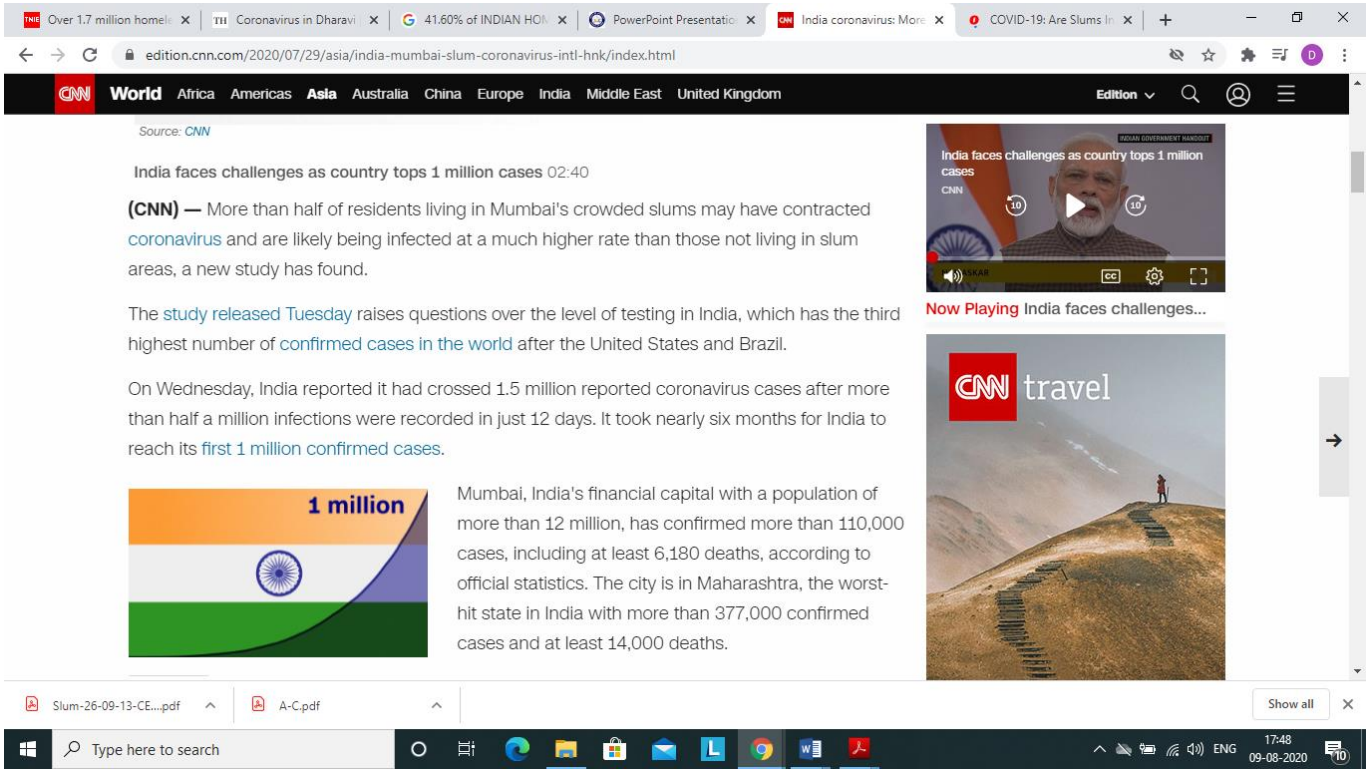
ANNEXURE-G



Source: CNN

India faces challenges as country tops 1 million cases 02:40

(CNN) — More than half of residents living in Mumbai's crowded slums may have contracted coronavirus and are likely being infected at a much higher rate than those not living in slum areas, a new study has found.

The study released Tuesday raises questions over the level of testing in India, which has the third highest number of confirmed cases in the world after the United States and Brazil.

On Wednesday, India reported it had crossed 1.5 million reported coronavirus cases after more than half a million infections were recorded in just 12 days. It took nearly six months for India to reach its first 1 million confirmed cases.

Mumbai, India's financial capital with a population of more than 12 million, has confirmed more than 110,000 cases, including at least 6,180 deaths, according to official statistics. The city is in Maharashtra, the worst-hit state in India with more than 377,000 confirmed cases and at least 14,000 deaths.

ANNEXURE-H

August 08, 2020

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Home » Website » National » Opinion » COVID-19: Are Slums In India Conducive For The Outbreak?

COVID-19: Are Slums In India Conducive For The Outbreak?

Overcrowding in slums makes social distancing and self-quarantine quixotic, and place the slum dwellers at an increased risk of contracting an infection.

Bishwajeet Besra, Nand Lal Mishra, Akancha Singh, Mahadev Brambhankar

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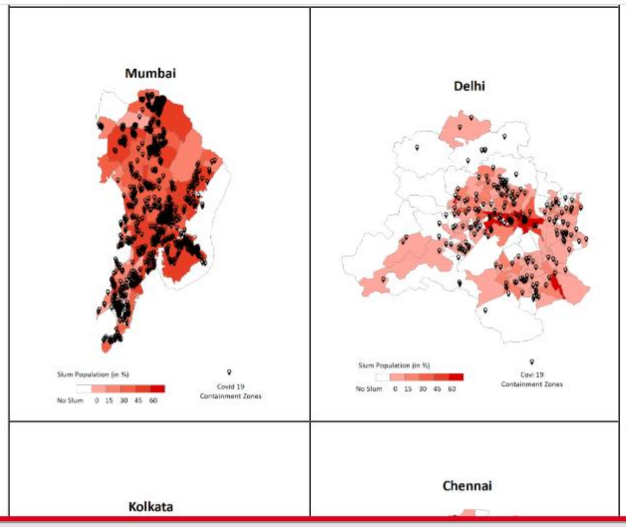
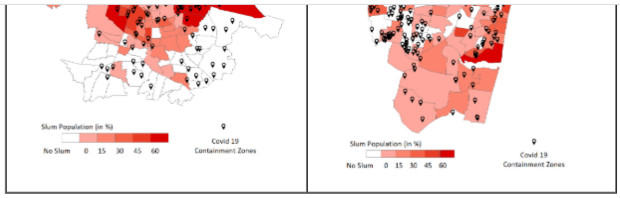
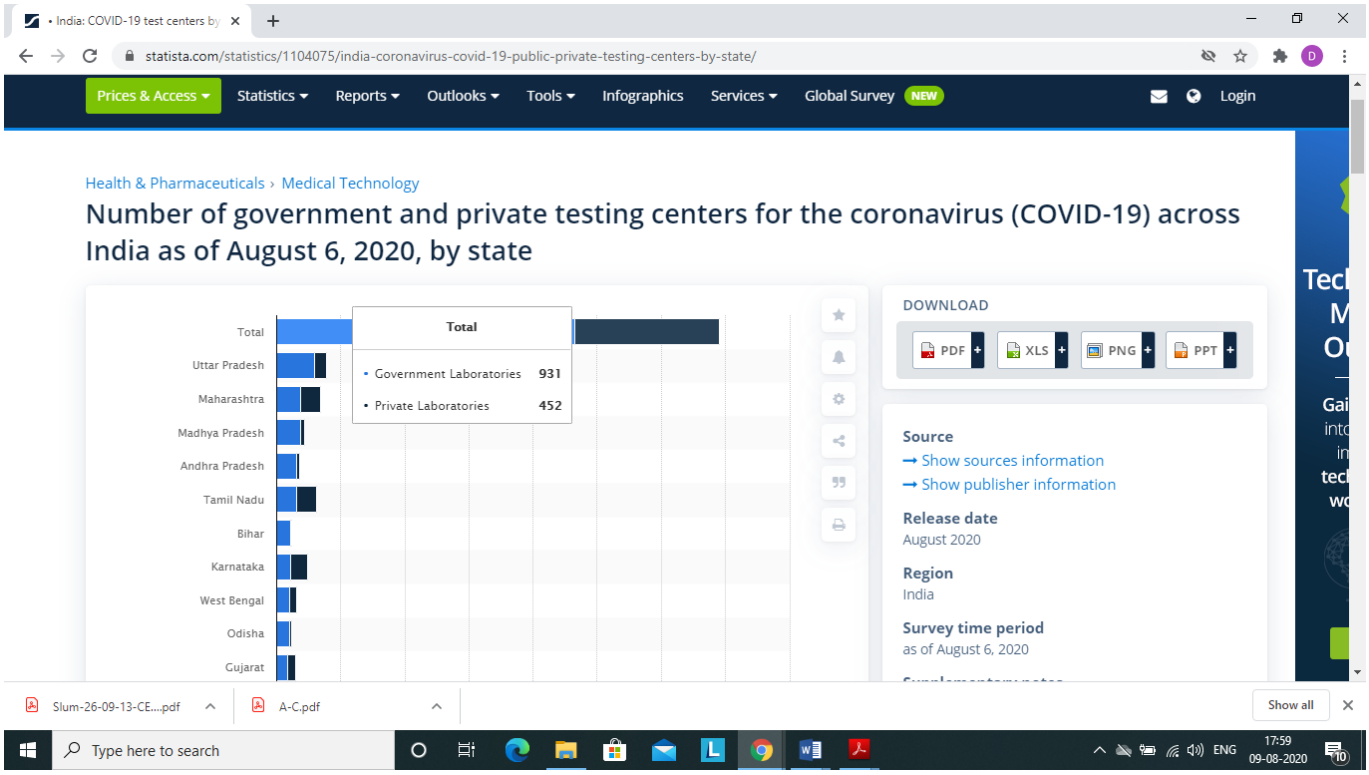




A prima-facie view of the bivariate choropleth maps showing the share of slum population across the wards in selected mega cities of India and the location of Covid-19 containment zones reveals that the concentration of slums is the highest in Mumbai, followed by Kolkata and Chennai. When the containment zones in the maps are reviewed with scrutiny, it is observed that with the exception of Chennai, the containment zones are heavily concentrated in areas which have a higher concentration of slums in Mumbai, Delhi and Kolkata. It is also clearly evident that the maximum number of containment zones have been set up in Mumbai, thus, underpinning the fact that slums are at higher risk of being exposed as the hotspots for the coronavirus disease and any measure to tackle the outbreak without ample assiduity to the culpable factors in these informal settlements would not yield benign results.

Figure 3: Projected cumulative COVID-19 cases by mega-cities

ANNEXURE-I



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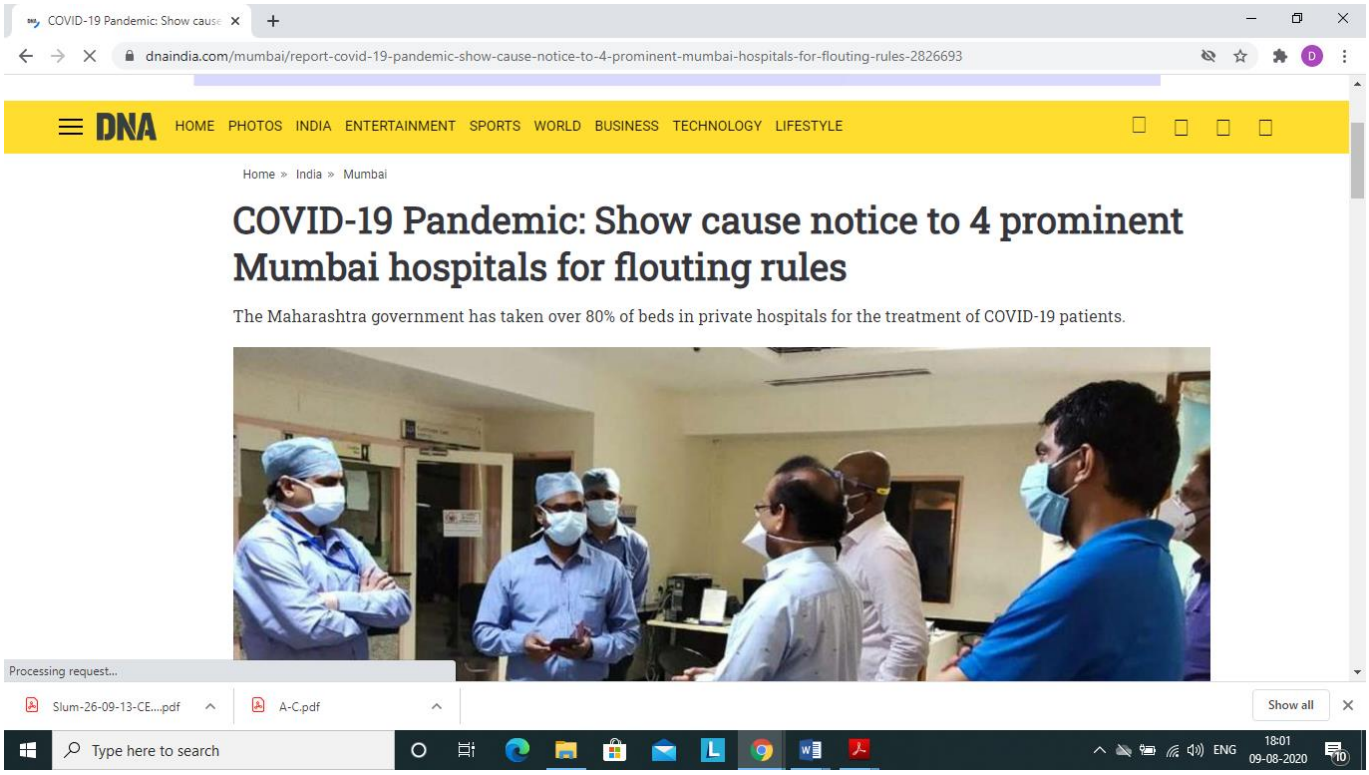

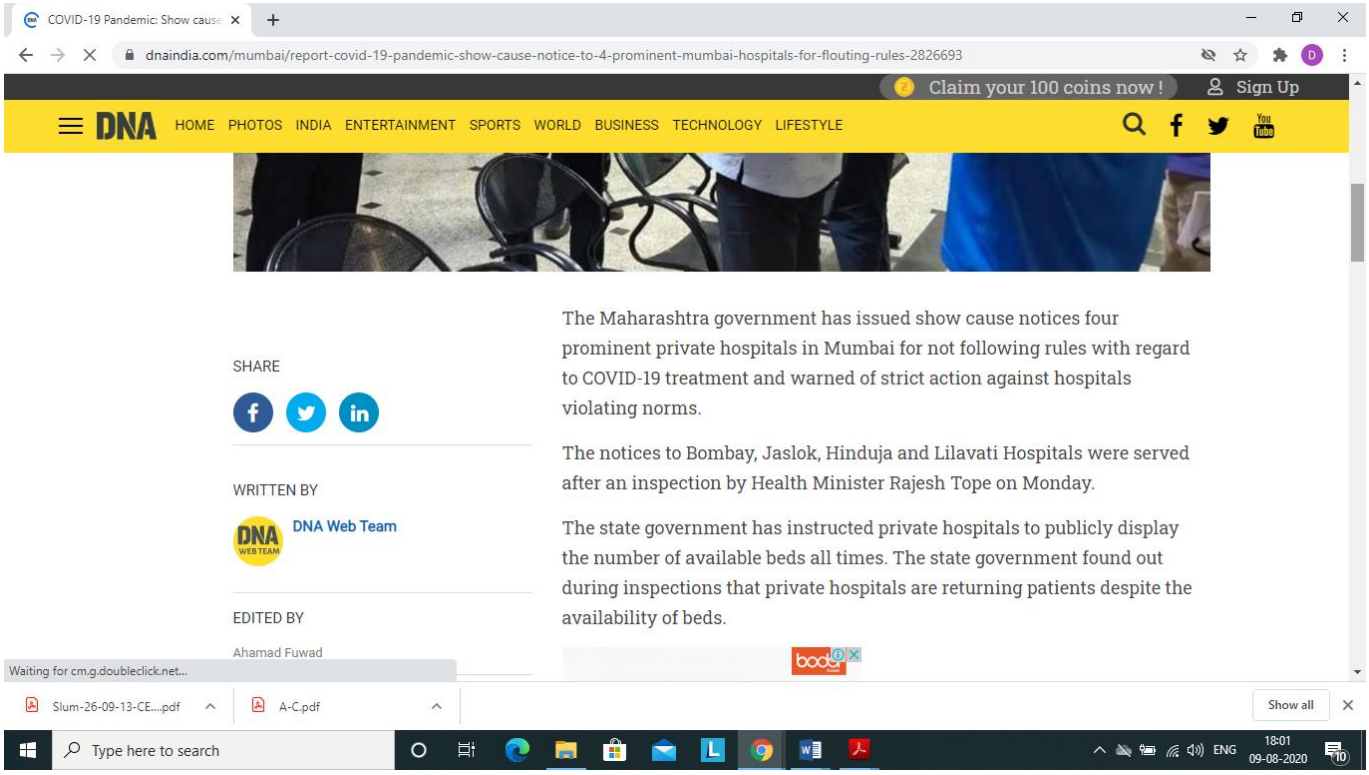

COVID-19 Pandemic: Show cause

dnaindia.com/mumbai/report-covid-19-pandemic-show-cause-notice-to-4-prominent-mumbai-hospitals-for-flouting-rules-2826693

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The Maharashtra government has issued show cause notices four prominent private hospitals in Mumbai for not following rules with regard to COVID-19 treatment and warned of strict action against hospitals violating norms.

The notices to Bombay, Jaslok, Hinduja and Lilavati Hospitals were served after an inspection by Health Minister Rajesh Tope on Monday.

The state government has instructed private hospitals to publicly display the number of available beds all times. The state government found out during inspections that private hospitals are returning patients despite the availability of beds.

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ANNEXURE-K

How Mumbai's private hospitals New Tab

theweek.in/news/india/2020/06/09/how-mumbai-private-hospitals-are-fleecing-covid-19-patients.html

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How Mumbai's private hospitals are fleecing COVID-19 patients

Patients and their families are facing the horrors of mounting hospital bills

By Pooja Biraia Jaiswal | June 09, 2020 22:55 IST

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On June 7, the state government deputed five IAS officers and two auditors to keep track of bed capacity and availability in private hospitals in times of the ongoing COVID-19 pandemic. This, following complaints that 35 prominent private hospitals had not shared enough beds with the BMC for COVID-19 patients as per the government's mandate that 80 per cent of all beds in private hospitals be reserved for COVID-19 patients and other emergency cases. Also, the charges by the private hospitals for these reserved beds were to be as per the rates fixed by the government. The state has acquired 80 per cent of beds across all private hospitals and nursing homes till August 31 this year and has also capped the price of the treatment. The hospitals are free to charge their own rates in the remaining 20 per cent beds.

However, on the ground, the situation looks entirely different.

"While the rule is to reserve 80 per cent of all beds in a hospital, what is actually happening is that the hospitals are reserving 80 per cent of a certain number of beds only. So, this leads to a very small number of beds and even for these beds, the rates charged are not as per the government mandate. A virtual loot is going on," says Brinelle D'souza, faculty at Tata Institute of Social Sciences, Mumbai. At Bethany hospital in Thane West, Dsouza's friend was asked to pay Rs 91,000 for one and a half days his father spent in the hospital's ICU and to add to it, they paid a whopping Rs 10,000 for the ambulance service for barely a distance of 3km from Bethany hospital to Sapphirre hospital in Thane.

The BMC earlier announced that it will create separate email IDs of these officials where one may send across a complaint of overcharging in a hospital with regard to reservation of beds. But it is easier said than done, says Virenraj Thakkar, who was charged Rs 3 lakh for a seven-

How Mumbai's private hospitals | New Tab
theweek.in/news/india/2020/06/09/how-mumbai-private-hospitals-are-fleecing-covid-19-patients.html
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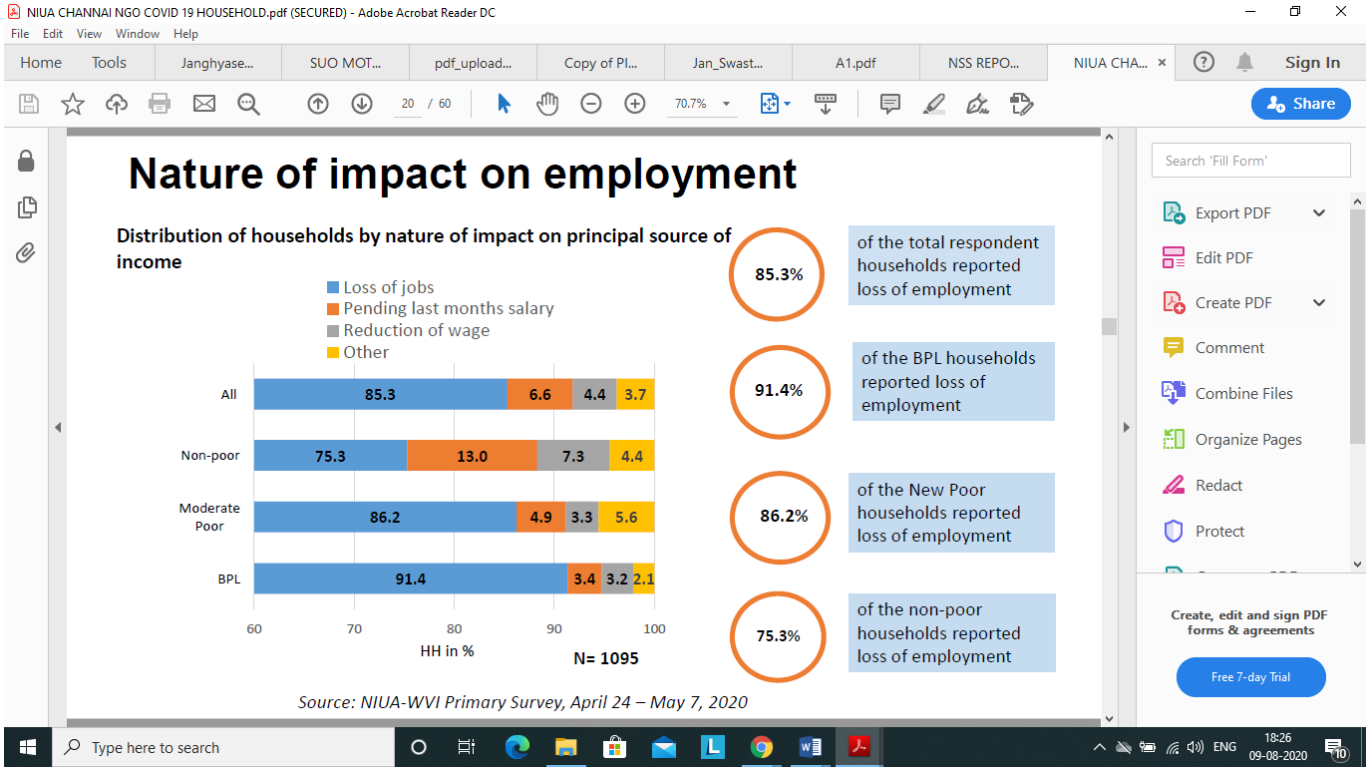
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Nature of impact on employment
Distribution of households by nature of impact on principal source of income
Loss of jobs
Pending last months salary
Reduction of wage
Other
All
85.3
6.6
4.4
3.7
Non-poor
75.3
13.0
7.3
4.4
Moderate Poor
86.2
4.9
3.3
5.6
BPL
91.4
3.4
3.2
2.1
60
70
80
90
100
HH in %
N= 1095
85.3%
of the total respondent households reported loss of employment
91.4%
of the BPL households reported loss of employment
86.2%
of the New Poor households reported loss of employment
75.3%
of the non-poor households reported loss of employment
Source: NIUA-WVI Primary Survey, April 24 – May 7, 2020