SOCIAL CITIZENSHIP, WELFARE AND JUSTICE: SITUATING RIGHT TO HEALTH IN INDIAN CONTEXT

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DECLARATION

I, **Chander Paul Negi,** do hereby declare that this thesis entitled, ***"Social Citizenship, Welfare and Justice: Situating Right to Health in Indian Context"*** is the result of the research work undertaken by me and is being submitted in partial fulfillment of the requirements for the award of the degree of **Doctor of Philosophy (Ph.D)** of Jawaharlal Nehru University, New Delhi under the guidance and supervision of Prof Niraja Gopal Jayal. This is my original work. I further declare that this Thesis has not been submitted either in partial or in whole for any other degree or diploma of this University or of any other University or Institution.

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All the errors and faults in this thesis are mine and solely mine.

- *K. Gopalan v State of Madras* (1950) SCR 88
- *Almitra H. Patel and anr v Union of India and ors (1998) 2 SCC 416 B*
- *Bandhua Mukti Morcha v Union of India* AIR 1984 SC 802
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TABLE OF CONTENTS

CHAPTER 1. INTRODUCTION: SOCIAL CITIZENSHIP, WELFARE AND JUSTICE: SITUATING RIGHT TO HEALTH IN INDIAN CONTEXT 1

CHAPTER 2: SOCIAL CITIZENSHIP AND WELFARE STATE: AN INDIAN CONTEXT 18

MARSHALLIAN FORMULATION OF CITIZENSHIP AND SOCIAL CITIZENSHIP: 18

CRITICISMS OF MARSHALL'S HYPOTHESIS: 25

ON FORMAL AND SUBSTANTIVE CITIZENSHIP: 26

VINDICATION OF MARSHALLIAN PARADIGM OF SOCIAL CITIZENSHIP: 28

ON THE CRISIS OF WELFARE STATE: 32

ON THE DEFENCE OF THE WELFARE STATE: 35

RELEVANCE OF MARSHALLIAN HYPOTHESIS: 38

CHAPTER 3. POLITICAL ECONOMY OF HEALTH RIGHTS: CONCEPTION, FORMULATION, DEMAND, AND PROVISION 42

BHORE COMMITTEE REPORT 1946: 43

THE POLICY FORMULATION FOR HEALTH IN INDIA: FROM NATIONAL HEALTH POLICY 1983 TO NATIONAL HEALTH POLICY 2017 57

POLICY PROCESS AND PRESCRIPTION OF HEALTH PROVISIONING: 58

DEMAND MAKING FOR HEALTH PROVISIONING: 59

NATIONAL HEALTH POLICY 1983: 62

WORLD DEVELOPMENT REPORT 1993: 65

NATIONAL HEALTH POLICY 2002: 68

PRIVATIZATION OF HEALTH THROUGH PUBLIC ROUTE: 69

REPORT OF THE NATIONAL COMMISSION ON MACROECONOMICS AND HEALTH (NCMH) 2005: 74

NATIONAL RURAL HEALTH MISSION (NRHM): 75

NATIONAL URBAN HEALTH MISSION (NUHM): 87

RASHTRIYA SWATHYA BIMA YOJANA: 88

HIGH LEVEL EXPERT GROUP FOR UNIVERSAL HEALTH COVERAGE (HLEG) 2011: 93
THE 12TH FIVE YEAR PLAN: 98
NATIONAL HEALTH POLICY 2017: 103
CHAPTER 4. DILEMMAS OF LITIGATING HEALTH RIGHTS 114
LITIGATION OF HEALTH RIGHTS: 122
IMPACT OF LITIGATION OF HEALTH RIGHTS: 127
CHAPTER 5: CONCLUSION 130
BIBLIOGRAPHY 134

CHAPTER 1

INTRODUCTION: SOCIAL CITIZENSHIP, WELFARE AND JUSTICE: SITUATING RIGHT TO HEALTH IN INDIAN CONTEXT

This research tries to situate the right to health in the social, political and legal arena in India in respect of voicing of these rights in the social sphere and framing and legislation of these rights in political sphere and the adjudication of this right in the judicial sphere. The exercise of this right is influenced by these institutions separately as well as in conjunction by all; therefore, the realisation of actual rights is affected by social, political and legal culture of the society at large. The realisation of the right is also affected to a great extent by another factor; the market system, the role of the kind of market system and financial regime becomes extremely salient in the Indian context because of the effects of processes of globalisation, liberalisation and privatisation in the Indian economy specifically in the health care sector.

To understand the present political, legal and economic scenario in Indian context an excursion into the brief history of Indian social, political and economic development since independence shall be made. This shall serve as the brief overview of the socio-political and legal rationale for the choices and measures taken which have shaped the present discourse of health rights.

Indian society has been termed variously as vibrant, diverse and multicultural. The political system adopted in India is democratic and the Constitution specifies the democratic ideals, in the Preamble to the Constitution, for this nation state as constituted by the people to be a sovereign, socialist, secular, democratic republic. The preamble states that the republic shall secure to its citizens justice in the social, economic and political aspects; and liberty in terms of thought, expression, belief, faith and worship; equality of status and opportunity; and shall promote among the citizens a sense of fraternity which shall be informed by the assurance of dignity of the individual and the unity and integrity of the nation. This is a crucial and landmark development because Indian society is beset with strong social notions, entrenched practices and institutions of social hierarchy in terms of caste, class and gender. This

aspect is not specific to any one religious or social community but is the feature of almost all of the communities.

In the shadow of these dominant considerations but not the only ones; the leaders of the newly independent nation had their task cut out of consolidating, restructuring and working of the nation to the lofty democratic goals envisaged in the Constitution. The Indian National Congress had played a pivotal role in leading the independence struggle against the British colonial rule. Congress had many illustrious and eminent leaders but was characterised by members of myriad ideological persuasions as its history lay in forming an opposition to the colonial rule rather for running a polity on a specific electoral terms and working the state on democratic ideological terms. Nonetheless this facet of Congress was critical and played a crucial role in the formation of the Constitution by bringing in dialectical as well as diverse opinions on the issues discussed and debated in the Constituent Assembly. The dominant ideological and working style adopted by the Indian National Congress in these formative years was of consensus and accommodation of differing views in situations of strong disagreements on issues (Austin 1966). This had the effect of smooth and continuous functioning of government but had adverse long terms affects of fostering an absence of institutional mechanisms of dispute resolution or reconciliation of differences in politics (Kothari 1970). The processes of deliberations and reaching consensus has also been characterised as compromise as resulting in foregoing and postponing of many critical aspects relating to socio-economic rights (Jayal 2013).

The State at centre was envisaged to play a dominant role in social and economic spheres of development. The argument put forth for the same was the socialistic conception of state as well as the absence of a thriving private industry in place to meet the needs of the populace in the market arena. Faced with such predilections the new nation state was envisaged to be an actor which would consolidate all the differences as well as mediate between and through such situations with control. The state was envisaged as an actor actively participating in provision of social goods as well as material goods. Its active role in the market in provision of material goods had the affect of competing with as well as crowding out of the private entrepreneurship for capital as well as labour. In political federational terms the state was conceived as a strong and powerful centre which would control peripheries which had limited

autonomy. This overall development Indian kind of state has been variously conceptualised as command polity and demand polity (Rudolph and Rudolph, 1998: 211-19) or a centralised pro-business state (Kohli, 2010: 23-42) or consociational democracy (Lijphart, 2008: 25-41).

Post-independence the idea of the state was predicated on the necessity of welding together the federal units and pursuing an agenda of development in agriculture and industry. This was sought to be done by enhancing the state capacity to put it at the commanding heights and making it capable of promoting the relevant sectors by playing a leading role in economy, industry and welfare. The conception of a strong centre playing a key role in industrial output by building public sector industries thereby generating employment as well and promoting equity by redistributive measures in land ownership by bringing forth land reforms and uplifting the hitherto discriminated communities of depressed castes and indigenous people by myriad policies including affirmative action in the form of reservations in public sector colleges, universities and jobs.

The emphasis after independence in 1947, from British colonial rule, was to steer the polity, economy and society in a direction that promotes self-reliance in economic terms and to make the nation state modern in industrial and social aspects. The society was beset with endemic poverty with large scale famines and droughts; illiteracy was widespread whereby large section of the population especially the rural populace was bereft of any avenues of education and employment; predominant mode of employment was agriculture mainly employing large numbers of landless labourers and tenants working on the farms of big landed feudal intermediaries such as zamindars. To alleviate these debilitating conditions land reforms in the form of redistribution of land was sought but failed because the burden to realising the reforms was in the jurisdiction of the federal states which were marked by a weak political will to bring in such reforms as at most of the times these were run by and depended on landed aristocracies for electoral victories. The lower castes and classes were thus bereft of any mode of economic sustenance and economic mobility.

Domestic industry was decimated in the wake of discriminatory policies adopted by the colonial rulers to promote British industries and the domestic industry was

fledgling and needed protection and promotion by the newly independent state. This was sought to be attained by import-substitution policies and by establishing, controlling and promoting the heavy-industries by the state. The state in the absence of a developed free market as well as private market players and entrepreneurs was made a key player in the economy. This had the effect of crowding out of the private players by the state as well as the policy of licensing followed later on to grant permission to private players for entry into economic activities led to the perverse practices of collusion as well as rent seeking or corruption. It promoted a culture of *quid pro quo* whereby some established industrial houses or only those who could grease the palms of members of the established government could get licenses through their links. This factor led to the distortion of development of free market in Indian economy. The fallout of this practice led to situation that has been characterised as the development of "pro-business" state, rather than a state promoting free-market environment, whereby some powerful industrial houses have become virtual monopolies in the Indian economy (Kohli 2010).

Constitution provided for the welfare by securing the citizens civil, political and social rights in the form of Fundamental Rights and welfare policies to be guided by the Directive Principles of State Policy (DPSP). The welfare measures were not couched in terms of rights but as guiding principles that the state shall follow in tailoring welfare policies or social rights. This framework has been in place and practice since independence and informs the state action till date.

The outlook of the Indian state towards social citizenship in the years following independence was that of a being the *patrie* and welfare was conceived as an act of state largesse. The idea of welfare was couched, in terms and content, as a means to obviate absolute poverty. It was the abject poverty and squalor which was seen as a nuisance and a picture of shame for the nation that it was sought to be shelved to the dark and invisible corners out of sight. Extreme poverty was looked at not form the point of the suffering of the poor people but extrinsically as "the worst polluter".

This so-called Indian welfare paradigm post-independence and prior to the economic-reforms of 1990s had certain features which make it plausible to put in perspective the directions it took later post-economic reforms of the 1990. Jayal (2013) divides the

development of social citizenship in two time periods, one from independence to the economic reforms of 1990s and another phase after the reforms of 1990s leading to liberalization of economy to the present. This characterisation of two phases of social citizenship and the different characteristics this social citizenship takes is instructive to understand the shifts in the relation between the State and Citizens as well as the interplay of market forces in shaping the same. These are explained in the following paragraphs briefly.

First feature of this regime of social citizenship was characterized by use of the argument of under-development as a replacement for welfare. Welfare could not be provided as the state and the nation lacked the requisite economic and institutional resources to take up the redistributive and social security measures. So the goal sought to be achieved was not economic equity and equitable growth but increasing the wealth of the nation via planning. This argument of lack of resources and progressive realization of welfare was used to justify circumscribing of social welfare selectively to the most vulnerable groups and those in need of special assistance (Jayal 2013: 167-8).

The second feature of this regime of social citizenship was adoption of paternalistic and charitable stance by the state at managing poverty. This outlook towards poverty by the State was argued and justified by differentiating between the political realm and the economic realm although state was dominant actor in both the spheres. In the political sphere the citizens were autonomous and wielded rights whereas in the economic sphere they were rightless and without any remedy or redress. The demands of economic sphere were needs not rights. Thus the method and language sought to address these needs was that of 'relief, charity, and alleviation'. The couching and grounding of claims to welfare in the vocabulary of needs contrary to rights has been characterised as leading to impinging no obligation on the state to provide for them rather evoking appeals to altruistic purposes. This practice has positioned the political representatives in the position of giver and citizen as receiver and their relation as of benefactor and beneficiary (Jayal 2013: 168-9).

The third feature of this regime of social welfare is the creation of categories of exception to classify different sections of population for the distribution of official

welfare goods. These categories of exception are then made eligible to receive the official largesse in times of severe drought, famine or in normal times for the measly benefits accruing from minimalistic food rationing programmes etc. Social welfare defined as provision of welfare to these defined categories of exclusions (scheduled tribes, schedules castes, other backward classes, women, children, senior citizens etc.) still informs the official logic of welfare today. So to be a recipient of official social welfare one has to belong to the officially defined categories of disadvantage. To this was added in 1997 another artificial denomination of exclusion, seemingly based on innocuous criterion of income poverty, termed as Below and Above Poverty Line categories, to selectively target the earlier universal food subsidy signalling the restriction of citizenship rather than making it more universal and further entrenching the hiatus between civic and socio-economic status. This basis of provision of social goods makes the enjoyment of social welfare provisioning 'derivative of and conditional upon, their placement in particular categories'. The rationale for the creation of these categories was that such social provisioning would give greater substance to the equal civic status. In reality, what this artificial construction of categories for welfare entitlement does is what Marshall calls as "class abatement," as it presents two mutually reinforcing forms of separation: "that between *type of rights* (civil/political and social/economic) and that between *social groups* (those that are entitled to social and economic provisioning and those that are not)" (Jayal 2013:170-71, emphasis in original).

The fourth and final feature of the Indian social citizenship regime of this period was creation of the citizen shorn of rights only bearing duties. The emphasis shifted from the duty of citizen to resist the state in pre-independence period to that of productive citizen in free India. The civic duty of the citizen came to be articulated in the language of productivity and making the nation economically strong and self-reliant. Now that the realization of civil and political rights was achieved the realization of socio-economic rights was preponderant upon the nation generating enough wealth and productive goods to cater to all. This meant postponing the task of providing social rights to a distant future. The duties of work and productive citizenship therefore got prioritized over and above the substantive socio-economic rights. It was

hoped that the benefits of economic growth will gradually trickle down and shall bring down economic inequities but this hope proved to be false (Jayal, 2013: 173-4).

In the post-liberalisation era economic development has become the most prioritized goal of the state which is evident from the importance and emphasis attached to indicators such as rate of growth of gross domestic product (GDP) of the economy. The idea is that a free market shall foster economic competition, efficiency and technological development which shall bring forth more revenues to the state to better undertake welfare activities. These ideals have led to the opening up of Indian economy in the form of liberalisation of economy leading to easing of norms for entry and exit of private finance, capital and technology. The globalisation of the liberal market economy ideals has had great bearing on this development. The opening of Indian economy started in mid 80s but gained strong momentum post 1990s. Today Indian economy is open to international finance and capital and the state seeks foreign direct investment (FDI) and foreign institutional investments (FII) for revving up the economic growth trajectory. But the effects of this dramatic economic growth have not translated into socio-economic development of the majority of the population. Widespread poverty, illiteracy, malnutrition, child mortality due to preventable infectious diseases marks the state of social development today as well. State is shrinking in its share of economic activities and is turning to play the role of a regulator and facilitator.

The economic reforms and liberalization of economy in 1990s had another impact on the nature of social citizenship and its relation vis-a-vis the state. First shift in this regime was characterised by redundancy of the argument of underdevelopment and lack of resources on the part of the state to not implement social rights. This period was celebrated in the media and political campaigns as the period of unprecedented economic boom and reflected in the GDP growth figures of the two decades or so. State legislated education into the Constitution as a fundamental right and later food security and right to work in the form of employment guarantee scheme for the rural areas were legislated to be implemented via a statutory Acts. It is interesting and perplexing to note that in this time of market ascendancy there was a spurt in legislation and promulgation of social rights. It is paradoxical as well to see that anti-

welfare sentiment is weakest when welfare spending is heaviest and vice-versa (Jayal 2013: 174-5).

The second shift in the nature of social citizenship regime in India post reform is from charity to rights. The idea of formal equality has dominated the landscape and the doctrines of equality of outcomes and equality of opportunity have come to constitute it and are expressed in the language of caste politics rather than economic opportunity. This period witnessed the widening and deepening of democracy via the political arena. The widening was marked by inclusion of more groups of people designated in the category of economically backward classes to be entitled to affirmative action of the state and deepening was marked by the decentralisation of local governance till the village level and recognition of deliberative political acumen of village folk to decide their political and economic fate for themselves (Jayal 2013:175). The demand for social citizenship now has come to be couched in the language of rights and the state has been receptive to it.

Third characteristic of the contemporary social citizenship regime is the expansion or creation of newer categories of exception to the already present categories. The most debated and contentious instance was the creation by the Judiciary of the new category called the “Other Backward Classes” and the adoption of the same by the state as beneficiary in reservation policies.

The final and definitive change is the production of citizen as a consumer rather a ‘rights-bearing agent’. The market has come to take charge of all the duties of the State related to provision of material goods and services. The duty of citizen is now transformed to consume rather than produce for economic development. Now economic development is fuelled by the consumption by the citizen of the goods and services provided by the market. And in this landscape “rights are for those who cannot afford consumption”. (Jayal 2013: 176). The state is now on the withdrawal and market has come to fill that gap. This period is marked by the creeping in of private players into the state activities by incremental additions via engaging them to undertake the various stages of implementation of social provisioning. This has led to the diffusion and multiplicity of actors and agents involved via Public-Private

Partnerships (PPPs), network governance, and outsourcing of the public services to non-governmental organizations (NGOs) in the name of decentralization.

The post-economic reform era of social citizenship regime is marked by this split, on one hand of assertion of social citizenship in terms of rights and on the other hand the abrogation of language of citizenship to that of customers, clients, and users.

The peculiar feature of this development of social citizenship rights in times of capitalist ascendancy in India is that citizenship in other parts of the world was conceived of as assuaging the affects of capitalism via strengthening of civil and political rights whereas in India the vocabulary of rights is expressed in terms of social and economic rights in times of economic development (Jayal 2013:178).

It is instructive to note that these recent social rights legislations were brought in both in the case of food security and rural employment guarantee schemes at the near end of the tenure of the elected government and just before the next elections. Also, more importantly, the nature of social security these measures provide is reminiscent of the Elizabethan poor laws and do not provide any substantive means of economic or social mobility rather they are measures to check vagrancy and curb the nuisance of poverty. Therefore these measures are symptomatic of class abatement strategies as described by Marshall.

Esping-Andersen (1990) attributes the regime variations and institutionalization of a certain pattern of welfare outlook by the state to society and the constitution and interaction of different coalitions in the society. These involve “first, the pattern of the working class political formations in the society and polity; second, the structuralisation of political coalitions with the historical shift from rural economy to middle class society. The question of political coalition formation is decisive. Third, the past reforms contribute decisively to shaping and institutionalization of class preferences and political behaviour.”

On the class coalition character of the Indian society in the 1990s, it is no secret that middle class, though much smaller than the teeming millions of the poor, has come to occupy the centre-stage in political bargaining and is the biggest consumer in the

economy and is growing. Their sympathies don't lie with the poor[1] and increasingly there is visibility in their separation and disjunction from all aspect which link them to lot of the poor, be it the state provision of social goods, marked by the division of Below Poverty Line and Above Poverty Line criterion, for selective provisioning as well as the segregation of public and private spaces of social consumption as well. Rich and the ascendant middle classes can pay for the avenues of social life and leisure whereas the poor have none. The middle classes live in their segregated gated residential colonies sanitised from the poverty which is considered polluting. Andersen (1990) states that risk of welfare state backlash depend not on spending, but on the class character of welfare states.

In light of this brief and summary background of Indian socio-economic and political landscape the analysis shall be done in the framework of social citizenship perspective whereby the idea of social citizenship as was developed by T.H. Marshall to serve to secure certain basic rights for the citizens to the fullest available in the society and to regulate the market. Marshall's social citizenship framework is interesting because it elaborates the critical problems in developing and securing a welfare right to citizens in a market economy and a hierarchical society. This framework is specifically important to Indian case study as Indian polity and economy are at the crossroads of fining a balance between the market and the State. This framework helps in better understanding the Indian welfare context. This framework is interesting and relevant in the context of India as the demand for state action to secure basic rights is being voiced in the language of citizenship and the respective rights that emanate from the inherent quality of being the citizen. Marshall also posits the development of rights in Britain in similar vein and emphasises that social rights are the crucial and integral link which makes civil and political rights meaningful and realizable. This research

[1] See Fernandes, Leela (2004), The Politics of Forgetting: Class Politics, State Power and the restructuring of Urban Space in India, Urban Studies, Vol. 41, No.12, 2415- 2430. Fernandes characterizes the growth of the new middle class culture with the liberalization of the economy and transformation of State from its traditional character. The state has now come to champion this ascendant middle class and poor and working class are seen as nuisance and polluting. This has been marked by the deliberative spatial reconstruction of the city and public spaces exemplified in the clearing of slums and freeing the paths and streets of hawkers. This disdain of the poor was also seen in the judgment of the Supreme Court in *Olga Tellis v Bombay Municipal Corporation* 1985 (3) SCC 545, dealing with the removal of pavement dwellers from Bombay and in *Almitra H. Patel and anr v Union of India and ors (1998) 2 SCC 416 B* dealing with the clearance of slum in the protected green forest zone in Delhi.

shall investigate the nature of citizenship and specifically the idea of social citizenship to make an argument for health rights in India.

Marshall states that citizenship has become a "legitimate architect of social inequality". The state in its welfaristic fervour employs various policies and programmes of welfare which he calls as methods of "class abatement". These are the measures to curtail the nuisance of indigence or extreme poverty to maintain the efficiency of social machine. The class abatement policies have in themselves an inherent aspect of legitimately creating inequality. These policies have to be universal to be able to curb this unequalising aspect. Class abatement is not an attack on the class system but it is consciously aimed to make class system less vulnerable to attack by alleviating its less defensible consequences. Class abatement pursued officially by the state provides measures which offer alternatives to the rights of citizenship rather than additions to them. Citizenship was the status that replaced class status and thus became the base for construction of social inequalities or "became the foundation of equality on which the structures of inequality could be built" (Marshall [1950) 1992: 21).

Marshall contended that civil and political rights of citizenship did not do much to challenge the competitive capitalism but social citizenship does so by way of policies called 'class abatement'. He believed that social citizenship rights have the capacity to modify the class structure or counteract some of the deleterious consequences of class system. However, class abatement does not mean the end to social classes or inequality. To see whether the social policies are working in the direction of reducing class inequalities Marshall proposes that one needs to consider three indicators of the social policies put in place. The first is the extent to which it manages to compress both ends of the income distribution scale. In other words, the task of welfare policies is to reduce extreme inequalities of income and the social policies have the attributes of the same to be effective as catalyst of economic equity. It should serve the double process of reduction of extreme wealth and extreme poverty. Second is the object of social integration. This Marshall views as development of a common shared worldview arising out of the sense of common national identity. The third, predicated on the last two, entails the enrichment of universal status of citizenship vis-a-vis other aspects of personal identity. This meant that Marshall saw the prioritisation and

promotion of ideals of universal citizenship over and above other aspects of personal identity emanating from other markers.

Class abatement occurs by way of two methods of income redistribution: progressive taxation policies and the provision of access to education, healthcare, pensions, unemployment compensation etc. The latter constitute the social rights and social citizenship is thick or thin depending upon the type of policies the state pursues and the consequences that follow from those policies on the indicators stated above. These welfare states have been classified into regime types by Esping-Andersen based on the type and extent of the redistributive social policies. So social rights can be thick or thin depending upon the type of social policies in place indicated by the content and extent of social rights as indicated by the regime type theory. Class abatement meant two things to Marshall, first, it meant that inequality would not be overcome entirely but it would be replaced by a legitimate functional form of inequality. Second, that if the task of social citizenship is to make the exercise of citizenship equal by making equals of citizens in their role as citizens it would have to put in place policies of redistribution that would prevent unacceptable levels of social and economic inequality to exist (Kivisto P. 2007: 15-16).

Marshall's optimism that the three rights of citizenship over time would get strengthened and institutionalized has been belied and the welfare states are in a process of being shrunk and market and neoliberal forces are replacing the state welfare programmes. Social citizenship has been under attack from neoliberal forces and the welfare state has been rolled back to varying degrees in various industrial economies in the last few decades (Kivisto P. 2007: 15).

Marshall says that social citizenship makes civil and political citizenship meaningful and realisable. It tries to bring down the unequalising aspects of citizenship. Marshall defines social citizenship as "*the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilised being according to the standards prevailing in the society*" (Marshall, [1950] 1992: 7, 8; emphasis added).

Indian constitution has put the social rights under the Directive Principles of State Policy, which though are fundamental to the governance of the country but are non-

justiciable[2]. State has to keep in mind these directive principles while formulating laws for the governance of the country. This scheme of constitution has given rise to a situation whereby the fundamental rights are accorded a superior position vis-a-vis directive principles[3]. This has also engendered a situation of lawlessness as social rights being under the ambit of directive principles are non-justiciable and thus any claim made to secure certain social rights has no corresponding constitutional or legal right to entrench it. In this state of lawlessness[4] courts, especially the Supreme Court, have played a creative role of placing these social rights under the umbrella of 'right to life and liberty' provided in Article 21 of the Constitution[5]. It has also sought to secure these rights by relaxing the procedural rigours of standing and admitting public interest litigation (PIL) or Social Action Litigation (SAL) through public spirited people or activists, and by way of 'epistolary jurisdiction'. The court has also shown creativity in the enforcement of the rulings by creating newer forms of mechanisms to enforce its rulings, such as continuing mandamus, appointing *amicus curiae*, and appointing commissioners to investigate the ground reality and present a report or to oversee the implementation of the orders, thereby supervising and monitoring the gradual implementation of its rulings (Muralidhar 2008; Yusuf 2011). In such a scenario the role played by the courts in recognizing and granting the right to health as an unenumerated right falling under the ambit of Right to Life as provided in Article 21 of the Constitution needs to be scrutinised. Whether this creative and activist judiciary can bring a transformation by translating a non-justiciable legal right into an enforceable claim similar to fundamental rights? (Baxi 1988; Khilnani 2012).

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[2] See Article 37 of the Constitution of India, 'non-justiciability' simply put means any abrogation of these guarantees would not entail a judicial claim to a remedy.

[3] *State of Madras vs. Champakam Dorairajan* (1951) SCR 525. Though this position has changed and judiciary has read DPSPs to be equally fundamental and complementary to fundamental rights in subsequent cases such as in *Keshavananda Bharti vs. State of Kerala* (1973) 4 SCC 225 and *State of Kerala vs. N.M. Thomas* (1976) 2 SCC 310. But still the situation remains that DPSPs are non-justiciable in nature and this aspect engenders a situation of lawlessness on the social rights issues.

[4] To borrow Prof. Baxi's use of 'governmental lawlessness', in: Baxi, U. 1988. Taking Suffering Seriously: Social Action Litigation before the Supreme Court of India. In: Baxi, U. (ed.) *Law and poverty: Critical essays*. Bombay: N. M. Tripathi. The term here means a state of affairs where there is no law or policy legislated by the government on that particular subject and, particularly in the case of health rights the same holds true as there are no laws to guarantee right to health and, judiciary has creatively read this right under the ambit of Article 21 by giving the term 'life' an expansive meaning.

[5]The scope of Article 21 expanded after the ruling in *Maneka Gandhi vs. Union of India* (1978) 1 SCC 248, where the court gave an expansive reading to the scope and content of the 'right to life and liberty'.

This activist role by judiciary also raises questions of constitutionalism, rule of law and separation of powers as well and it has been critiqued as the tyranny of the unelected minority (Bellamy 2007). Bellamy is critical of the undemocratic credentials of the judiciary and questions the wide powers which are vested in judiciary via judicial review and powers to declare law by precedents. He questions the wide powers of judicial review arguing that in a polity where diversity of opinion and disagreements are the rule of the day, which he terms, borrowing from Waldron, as 'circumstances of politics', 'legitimacy of any constitutional or legislative rights will rest on the fairness of procedures employed to resolve people's disagreements about them and their coherence as a package. Instead of constitutional rights legitimating the political system, the constitution of the political system will be the guarantor of the acceptability of system of rights' (Bellamy 2007: 21). The emphasis here is placed on the democratisation of laws that govern people. If any law that affects all should be decided by all and therefore judicial pronouncements of laws are not democratic.

Another issue which is raised and debated about provision of welfare to secure socio-economic rights is regarding the method to provide these rights, either as a social policy and legal rights or by granting them in the form of constitutional rights. Some authors have argued against the constitutionalization of social rights on twin arguments namely: the legitimacy dimension and the institutional dimension[6]. The legitimacy dimension questions the legitimacy of giving social rights a constitutional rights status. And institutional dimension questions the capacity of judiciary to adjudicate social rights. These arguments go in the vein of resisting inclusion of social rights in 'judicial constitutional discourse' and the role of the Constitutional Court and the Supreme Court has been of a reluctant nature to alter and interfere in the economic policies of the governments but have in some instances provided the much needed and encouraging remedies (Thiruvengadam 2007).

[6] Craig Scott and Patrick Macklem, 'Constitutional Ropes of Sand or Justiciable Guarantees? Social Rights in New South African Constitution' 141 U. Pa. L.Rev. 1, 29 (1992) , cited in Arun Thiruvengadam, 'The Global Dialogue among Courts – Social Rights Jurisprudence of the Supreme Court of India from a Comparative Perspective', pp. 264-309 In: C. Raj Kumar and K. Chokalingam (eds) (2007), Human Rights, Justice, and Constitutional Empowerment, New Delhi: Oxford University Press.

Sunstein (2001) takes the other side of the debate and favours according Constitutional rights status to social rights and cites the judicial orders of the Constitutional Court of South Africa in the *Soobramoney* Case[7] , relating to emergency health care; the *Grootboom* case[8], relating to housing; and the *Treatment Action Campaign* case[9], which expands the meaning of right to health.

Sunstein (2001) views a 'good' Constitution as containing both the preservative as well as transformative elements and central element of the Constitution is to put longstanding practices to critical scrutiny. To him democratic constitutions are 'pre-commitment strategies' and thus it seeks to provide answers to the problems those are likely to arise. The creative use of judicial power does not "block" democracy but energises it and makes it more deliberative. Bellamy (2007) thinks that a constitution's role is to provide procedures to work out the differences and disagreements regarding justice by deliberation and to reach a collective decision that could be enforced. Judicial process, for him, lacks democratic character and thus weakens the constitutional attributes and brings inferior practices and mechanisms. Judicial review undermines the equality of concern and respect between citizens and judicial intervention creates conditions of domination. These theoretical and conceptual arguments provide the framework within which the state of health rights in India shall be analysed. In the neoliberal era the state is shrinking in its activities and market is given a greater role to play.

Litigation has brought the health rights in the discursive space and civil society has been engaged in many cases especially those of social action litigation. Litigation has definitely not brought out structural changes in health-care system. It has also been unable to remedy the systemic inequities persisting in the Indian health-care system (Parmar and Wahi, 2011). Whether this 'judicial democracy' (Baxi, 1988), to redress governmental lawlessness via social action litigation, by giving extraordinary remedies in individual cases is sustainable? The malaise of Indian democracy, as correctly identified, is the lack of institutionalisation of economic and social democracy with the institutionalisation of political democracy (Chandhoke, 2005: 5).

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[7] *Soobramoney v. Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC)
[8] *Goernment of Republic of South Africa v. Grootboom*, 2000 (1) SA 46 (CC)
[9] *Minister of Health v. Treatment Action Campaign*, 2002 (5) SA 721 (CC)

The plan of the research is as follows. In the first chapter the development of social citizenship as propounded by Marshall is analysed with the attendant criticisms and defences of this idea. It also argues for the need of social citizenship and its relevance in Indian context.

Second chapter looks at the health rights in India in the context of its development and the present form as has been provided in the Constitution and the how it has developed. It shall look at the role state has played to secure this right. This chapter argues that health rights have developed in haphazard and piecemeal form in India and it lacks coherence because of fragmentation of powers between the Centre and the States and the dominant power of the Central government; overlapping policies in place by the Centre as well as States for similar aspects of health, lack of coordination among different ministries overlooking the same aspect of health etc. This is in great part a result of the apathetic political will as well as inadequate voicing for a universal health right by the civil society and citizens and the attendant inadequacies in the constitutional provisions as well as federal-fiscal arrangements. This resulted in the disorganised and dilapidated state of state sponsored health system resulting in the rise of costly and hierarchical private health market in India. This had the consequences of placing health rights out of reach of the poor and creation of a system of healthcare where share of private individual borne health care costs are amongst the highest in world as close to 70 percent of health related costs in India are incurred by the citizens privately out of their own pockets. This has been documented even by the State agencies leading to pauperization of the poor million due to catastrophic health expenses incurred by them at times leading them to sell their assets and taking loans from informal sources at high interest rates plunging them into inter-generation debt trap.

This chapter shall also look at the federal arrangements for provision of welfare measures in India and how has this scheme of federal-fiscal arrangements impinged and affected the provision and realisation of social rights and specially health rights in India. The chapter argues that the centralised fiscal arrangement which gives central governments higher leverage in financial disbursement and constitutional arrangement which places provision of social rights in the domain of federal states constrains the states' ability to provide for these rights. Confounding the matters is the provision of

social rights by the central government in the form of central sector schemes and centrally sponsored schemes (CSS) whereby the centre also has programmes and policies on social sector areas where state governments have the jurisdiction.

Third chapter looks at the judicial pronouncements on right to health specifically by the Supreme Court and questions the consequences that follow from such pronouncements of rights by the Court especially the feasibility and sustainability of such detailed arrangements devised by the Court in realisation of the health rights to citizens at large. This chapter argues that the activist judiciary has donned the administrative cloak and has outstretched itself beyond its limits to provide for social rights in response to the apathetic attitude of the political class.

Last chapter shall outline the salient observations of the research and attempt to provide the overview and conclusions of this research.

To undertake this research the researcher shall try to find answers to the following research questions:

1. Whether and how is the idea of social citizenship as developed by Marshall relevant to understand the Indian welfare context?
2. What the design of welfare rights in India is as provided in the Constitution and what are the implications of the same from a welfare perspective and specifically in the context of health rights?
3. What is the federal fiscal arrangement in the Indian context and how it impinges and affects provision of welfare by the states as welfare provisioning is largely in the domain of federal states under the Indian constitutional arrangement?
4. How has the Supreme Court posited the right to health in India and whether this approach depoliticises the claiming of welfare rights by citizens and provision by the state? How feasible is such provisioning of rights by a court than by the legislature?

CHAPTER 2

SOCIAL CITIZENSHIP AND WELFARE STATE: AN INDIAN CONTEXT

MARSHALLIAN FORMULATION OF CITIZENSHIP AND SOCIAL CITIZENSHIP:

Citizenship is a nebulous concept of rights and duties; it confers on the citizen certain rights and demands certain duties, which emanate by virtue of his/her membership of a political community or nation state. If membership is the criterion of assigning such rights and duties, then the people who are outsiders or aliens; are not conferred the benefit of these rights and are not expected to perform the duties which accompany such a membership status. "Citizenship, at least theoretically, confers membership, identity, values, and rights of participation and assumes a body of common political knowledge." (Knight-Abowitz and Harnish 2006).

Citizenship, as a theoretical endeavour is limitless and two concepts of citizenship are popularly understood, first, citizenship-as-a-legal-status and, second, citizenship as a desirable goal or activity (Kymlicka and Norman 1996)

T.H. Marshall in his classic essay *Citizenship and social Class* [Marshall (1950) 1992], traces the development of citizenship, through the history of Britain, from 17th century to the 20th century. He seeks to understand the effect of citizenship on social inequality, largely stemming from the class system. Marshall's endeavour in this essay was to see whether there can be an achievement of equality of status, which puts the value of an individual by virtue of being a citizen higher than his economic worth.

Marshall's greatest contribution lies in his exposition of social citizenship and social rights. Social rights pertain to a person's enjoyment of minimum economic well being to full extent of the societal riches.

Thus, it becomes pertinent to put Marshall's work in the framework of present circumstances, where economic inequality is prevalent all around despite of such abundance of riches. The system of governance and advances in science and

technology, have brought well being not seen before but still a large majority of the population continues to live a life of squalor. Marshall says that if we enrich the social rights a person can be raised to certain standards that he can have a status of dignified life though not of economic abundance. Marshall's aim was to bring equality of status rather than economic equality.

T.H. Marshall poses the question that "whether basic equality, when enriched in substance and embodied in the formal rights of citizenship, is inconsistent with the inequalities of social class?" [Marshall (1950) 1992: 7]. Marshall believed that the two are still compatible in the sense that today citizenship itself has become in certain respects a legitimate architect of social inequality. Marshall also raised another crucial question that whether the "basic equality can be preserved without invading the freedom of competitive market?" and also sought to look into the effect of shift of emphasis from duties to rights [Marshall (1950) 1992: 7].

To seek answers to the questions posed, Marshall proposed to analyse historical development of citizenship through British history till later part of twentieth century.

He divided citizenship into three elements as civil, political and social. "Civil element is composed of the rights necessary for individual freedom - liberty of the person, freedom of speech, thought and faith, the right to own property and to conclude valid contracts, and the right to justice" [Marshall (1950) 1992: 8]. The institutions corresponding to the civil element are the courts of justice. The political element meant "the right to participate in the exercise of political power, as a member of a body invested with political authority or as an elector of the members of such a body" [Marshall (1950) 1992: 8]. The institutions corresponding to the political element are the parliament and the councils of local government. The social element meant "the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilised being according to standards prevailing in the society" [Marshall (1950) 1992: 8]. The institutions Marshall linked closest to the social element are the educational system and the social services. It is pertinent to note here that the minimum here is economic welfare and security which extends to a full participation in the life of society according to the highest prevailing standards in society. The minimum economic well

being is thus a precursor or precedes the maximum social achievement here which seems to be linked not *only* to economic well being and prosperity. Thus, there are many other elements and factors which, apart from economic or material prosperity, are essential for a full realisation of life in the society according to the standards prevailing in the society. These factors range from material, psychological to intellectual ingredients which go into making a life fuller and richer.

Evolution of civil rights in the 18th century was mainly due to the handiwork of courts in terms of daily practice as well as in the form of judgments in many famous cases. A crucial civil right in the economic field was right to work, that is, "the right to follow the occupation of one's choice in the place of one's choice, subject only to demands of preliminary technical training" [Marshall (1950) 1992: 8]. Civil rights grew gradually with the addition of new rights to the status that already existed, women were excluded from this status, and the character of this status arose naturally from the fact that it was a status of freedom - democratic and universal. This status was characterised by 'one law for all men' and when freedom became universal, citizenship grew from being a local to a national institution.

Social rights originated out of local community memberships and functional associations. Poor Law and system of wage regulation, supplemented and replaced this original source and, were nationally conceived and locally administered. The system of wage regulation was contrary to emerging concept of civil rights in the economic sphere, where emphasis was placed on right to work and at what you pleased under a contract of your own making. Poor Laws were started as means of suppressing vagrancy and destitution and characterised a kind of primitive social rights. The object of Elizabethan Poor Laws was not to create a new social order but to preserve existing one with minimum social change. Poor Laws as a system tried to adjust the real income with social needs and status of citizen and not solely to the market value of his labour.

The stigma which attached to Poor Relief or social security meant that relief could only be extended to those who detached themselves from the community of citizenship and crossed over the boundary to live as destitute, giving up the civil and political rights. Similarly, the division of the beneficiaries into above poverty line

(APL) and below poverty line (BPL) categories, introduced in India since 1997 for food rationing via Public Distribution System (PDS), on an arbitrary income based test is inefficient economically; stigmatising; against social cohesion and the principles of human rights.

It becomes pertinent here to note, as to, how the content and formulation of social rights be defined, so that they are not detached from the status of citizenship. How the stigma associated with social security measures for the poor can be removed? How, by provision of social rights and social security measures, can the cohesion of community be maintained and the dignity of individual maintained while she is a recipient of social security benefits?

Right to education is, claimed by Marshall as, a genuine social right of citizenship because the aim of education during childhood is to shape the future adult. Marshall characterises the right to education, "not as the right of child to go to school, but as the right of the adult citizen to have been educated" [Marshall (1950) 1992: 8]. He says that in case of right to education, a personal right is combined with public duty to exercise the right. The duty to improve and civilise oneself is therefore a social duty, and not merely a personal one, because social health of society depends upon the civilisation of its members. For Marshall, growth of public elementary education during the nineteenth century was the first decisive step on the road to re - establishment of social rights in the twentieth.

Social right to education, as defined here by Marshall, resonates with the capabilities approach as enunciated by Amartya Sen (2000) and Martha Nussbaum (2006). The right to education as a social right is also an essential entitlement of a person as well as an integral and indispensable capability which renders an individual self-sufficient to take active part in the social life. The emphasis by Marshall on education is also in the similar vein, as it instils in the person qualities necessary for a fuller realisation of citizenship, as social citizenship.

Marshall's primary concern was mainly with citizenship and his special interest lay in its impact on social inequality. Social class occupied a secondary position in his scheme. Citizenship is a status bestowed on those who are full members of a community. All people who possess this status are equal with respect to rights and

duties with which this status is endowed. The urge forward along the path thus plotted is an urge towards a fuller measure of equality and an enrichment of the stuff of which the status is made and the aim is to expand this status to all members of the community.

Social class on the other hand is a system of inequality. Growth of citizenship in England was parallel to the growth of capitalism, which is a system not of equality but of inequality.

Social inequality in society is regarded as necessary and purposeful as it provides the incentive to effort and designs the distribution of power. But there is no overall pattern of inequality, in which an appropriate value is attached, a priori, to each social level. But inequality though necessary may sometimes become too excessive. Poverty incentivises one for effort and riches but poverty also breeds destitution and indigence, a state which renders families to lead an inhuman and degrading life. The more we attach value to wealth as an absolute measure of success and merit, the more we are inclined to consider poverty as an evidence of failure but this penalty for failure, most of the times, is greater than the offence warrants.

Class abatement in such circumstances is pursued as a measure to check or curb nuisance of poverty, not as an attack on class system but to make class system less vulnerable to attack by shedding less defensible consequences of class system [Marshall (1950) 1992: 21].

The benefits received by the unfortunate did not flow from an enrichment of the status of citizenship. Benefits when given by the state were in such manner that took the shape of alternatives to the rights of citizenship rather than being additions to it. Early rights of citizenship, which were granted by the state, were not in conflict with the inequality of the capitalist society; on the contrary, they were necessary to the maintenance of a particular form of inequality.

Differential status, associated with class, function and family, was replaced by the single uniform status of citizenship, which provided the foundation of equality on which the structure of inequality could be built.

Marshall contends that the blatant inequalities in society are not due to defects in civil rights, but due to lack of social rights. The Poor Law was an aid, not a menace to capitalism because it relieved industry of all social responsibility outside the contract of employment, while sharpening the edge of competition in the labour market. Elementary schooling was also an aid, because it increased the value of the worker without educating him above his station [Marshall (1950) 1992: 21].

The later part of the nineteenth century was characterised by recognition of the value of social justice and an appreciation of the fact that formal recognition of an equal capacity for rights was not enough. This happened with the realisation that narrow conception of equality of natural rights were not sufficient but equality was to be understood in broader terms as equal social worth. This shift in attitude of mind has an integrating effect as citizenship is a bond of different kind, characterised by "a direct sense of community membership based on loyalty to a civilisation which is a common possession" [Marshall (1950) 1992: 24].

Social rights entail a sense of duty as well as it seeks to provide oneself a certain standard of civilisation which is conditional on the discharge of the general duties of citizenship. The duties here imply the duties not of certain specific kind but those which lead to the well being of a person as well of the community as a whole, as earlier specified with respect to education. Education is a personal duty as well as a social right of an individual because by educating oneself a person rises above his station as well as contributes to the civilising of the society as a whole.

Marshall, while analysing the social services, as means of class abatement, says that in the provision of these services, the state guarantees a certain minimum of goods and services to the beneficiaries such as medical attention and supplies, shelter and education; or a minimum of money income to be spent on essentials, for example, in case of old age pensions, insurance benefits and household allowances. Marshall says that "the degree of equalisation achieved depends upon four things - whether the benefit is offered to all or to a limited class; whether it takes the form of money payment or service rendered; whether the minimum is high or low; and how the money to pay the benefit is raised" [Marshall (1950) 1992: 32].

The provision of social services is not primarily aimed at equalising incomes. The aim is to bring equality of status than equality of incomes. Marshall says that for social services an individual is considered as a class of its own and thus equalisation is sought between individuals, and he says the aim is to bring a qualitative equality and "what matters is that there is a general enrichment of the concrete substance of life" [Marshall (1950) 1992: 33].

Benefits rendered in the form of services attain a qualitative element. The services rendered in any form such as education have a profound impact on the social differentials and play a double role of social equalisation as well as social differentiation. The aim of providing a guaranteed minimum is to demarcate the difference between the essentials and the luxuries. Benefits in the form of services also create a situation where the right of a citizen cannot be precisely defined. A modicum of rights may be granted but the citizens want fulfilment of their legitimately expected demands. Legislations therefore are stated in terms of policy goals that strive for the attainment of these goals in future. The state has to seek a fair balance between the collective and individual elements of social rights and it is vital for a democratic socialist state [Marshall (1950) 1992: 35].

This balancing act of the state, between individual and collective claims, is more pronounced in the field of education. Citizenship acts as an instrument of social stratification via education and its relations with occupational structure. The status acquired through education is considered as legitimate as it is given by the institution which is designed to give the citizen his just rights. Marshall says that the social rights today are characterised by an invasion of contract by status, subordination of market price to social justice and the replacement of free bargain by declaration rights and all these principles are entrenched within the contract system itself [Marshall (1950) 1992: 40].

Citizenship entails rights as well as the corresponding duties of the citizenship. It means that citizen should act with a lively sense of responsibility towards the welfare of the community. Duties do not mean that citizens forgo their liberties or give in to governmental orders without question. Marshall concludes by providing answers to the four questions he raised in beginning of the essay. He says that with the

enrichment of the status of citizenship preservation of inequality and hierarchy has become difficult. There is less scope for the prevalence and continuation of inequality and if it is practiced there is a greater chance that it shall be challenged. The quest is not for absolute equality and the egalitarian movement moves in a double process. It operates partly through citizenship and partly through the economic system. Aim in both the systems is to remove inequalities which are not regarded as legitimate. The standard of legitimacy in citizenship is social justice whereas in economic system legitimacy is tested on social justice with economic necessity [Marshall (1950) 1992: 45].

Thirdly, the changing balance between rights and duties is analysed. Citizenship rights are precise and have developed almost fully whereas duties are vague and general, barring a few and; they are owed to an indeterminate large community. Amongst all duties Marshall says the duty to work is of paramount importance and though an individual's efforts might seem miniscule to make a dent in the social well being but withholding from discharging that duty might culminate in a large harm to the society [Marshall (1950) 1992: 46].

CRITICISMS OF MARSHALL'S HYPOTHESIS:

There have been theoretical and substantive arguments against the theory Marshall has propounded. The theoretical claims against Marshall's theory are as follows, firstly, it is claimed that Marshall did not give a consistent and coherent causal analysis of the mechanism that triggered the expansion of citizenship. Secondly, Marshall failed to provide a comparative account to the different forms of citizenships which emerged from different historical trajectories and considered citizenship as one coherent and uniform concept. Thirdly, Marshall turned a blind eye to the ethnic and racial divisions in British society in relation to the national citizenship, and finally, as a theory of rights Marshall paid scant attention to the duties and obligations of citizenship.

Yet Marshall's contribution is important because

> [i]t is descriptively one of the best accounts we have of growth of social rights in twentieth century Britain. Second, it provides a theoretical framework within which civil liberties and social rights can be seen as necessary not

> antagonistic elements of citizenship, and it reminds us that no civilized society can exist without common patterns of membership leading to social solidarity (Bottomore 1992: 72).

Many authors have sought to bring in various other types of citizenships, owing to the developments and changes that have taken place after Marshall wrote his essay in 1949. Social citizenship has been subdivided into 'ideological social citizenship' and 'economic social citizenship' (Mann 1993). Ideological social citizenship deals with rights such as right to education and cultural participation whereas economic social citizenship deals with rights such as occupational attainment and to direct economic subsistence. But this subdivision of social rights is not specific and many rights overlap and blur this distinction such as the right to health care, which clearly is a substantive social right of citizenship. Social rights are heterogeneous because a varied assortment of services and facilities fall into its fold and each requires a different sort of allocation to its attainment (Rees 1996).

ON FORMAL AND SUBSTANTIVE CITIZENSHIP:

Marshall's conception of citizenship has received considerable attention from academics and researchers interested in citizenship especially substantive citizenship and many have critiqued his theory and many have made emendations to it. Marshall has been critiqued mainly on the progression of citizenship or the periodization of development of civil, political and social rights; for the Englishness of his account of citizenship; and; for glossing over the struggle for attaining civil, political and social rights. He is severely attacked for completely neglecting women's rights in his account.

There is a distinction made between *formal* and *substantive* citizenship. Formal citizenship is narrow concept of citizenship measured only in terms as a membership of a nation state, whereas substantive citizenship connotes a conception of citizenship similar to that of Marshall's, encompassing an "array of civil, political, and especially social rights, involving some kind of participation in the business of government" (Rees 1996: 66). This conception is influenced by the evolution of the traditions of nationhood and citizenship in that particular nation. Many nations have strict rules and notions about immigration and the assimilation of immigrants as citizens whereas

others have relaxed rules and have assimilated aliens as citizens throughout the history.

Formal citizenship gained force after the post war migrations to the industrial nations as it led to influx of different ethnic and cultural minorities and unskilled or semi-skilled workers to these nations. Formal citizenship is concerned mainly with providing a legal status and a grid of legal rights and duties whereas substantive citizenship is concerned with rights and more specifically social rights and welfare measures. Formal citizenship is neither essential nor a pre-requisite for substantive citizenship. With globalisation and changing contours of citizenship and especially with emergence of notions like 'dual citizenship' and 'European Union', formal notion of citizenship is diminishing but it still holds considerable force (Rees 1996: 84-5).

Marshall like many social scientists of his time neglected gender differences. Civil, political and social rights were all extended to women very slowly and still are unequally distributed. So today it is imperative to keep in mind the perspective of women, who are still in many countries and in many respects treated as second class citizens (Rees 1996: 67-8). Poverty has the characteristic of imposing upon the poor such 'gross and crushing disabilities' as poverty has substantial effects on the quality of citizenship on those affected by it. The poor who receive charity are effectively regarded as second class citizens. Poverty deprives the poor of the capacity to exercise their civil rights as they cannot afford to pay for the fees which the exercise and execution of these rights entail. Many of the political rights also become inaccessible because of their marginalisation (Rees 1996: 70). Also the ethnic migrant communities form the poorest of the members of a nation and thus they get doubly marginalised.

The substantive rights of citizenship are today considered as forming part of human rights spanning across national boundary limits. Their curtailment or breach affects all in similar manner. These rights are in a continuous phase of development and evolution and there can never be finality in their development. They are affected by external factors especially economy and reigning ideology (Rees 1996: 89).

Marshall has also come under attack for ignoring the fact that rights of citizenship have been acquired through continuous struggle by groups of people, organisations, worker unions and many movements over the span of history. Many have imputed on him the charge of Whiggery[10] and some characterised him as an interpreter of British Butskellism[11]. Also Marshall's emphasis that 'in twentieth-century capitalism and citizenship have been at war' is a war of principles than of actors. But this statement is now misleading as 'the spread and success of consumer capitalism seem to have become preconditions for citizenship' (Rees 1996: 22).

VINDICATION OF MARSHALLIAN PARADIGM OF SOCIAL CITIZENSHIP:

Marshall's conception of citizenship and its effect on social class has been considered as a very genuine and original idea by many authors. They have taken up Marshall as their starting point and extended his idea with respect to the later developments. Others have sought to take up the idea and propound similar theory on similar lines but with other factors than class. Marshall has stressed that the quantitative inequality is acceptable but qualitative inequality is not and it is through social rights that qualitative equality can be achieved. Others have construed it as difference of entitlement and provisions. "Inequalities of provisions are acceptable if and when they cannot be translated into inequalities of entitlements" (Dahrendorf 1996: 41).

Citizenship bestows the members with rights and obligations. It is a real social role. It provides entitlements which are essentially rights, such as the right to enter into a free contract, or right to vote, or right to old age pension. The most common obligation is to comply with law. Dahrendorf claims that work cannot be construed as an obligation of citizenship as work is a private contract whereas citizenship is a social contract. Societies which do not have work as a private contract cannot have citizenship either as work without a private contract akin to feudal relations of dependence. "For when the general rights of citizenship are made dependent, on people entering into private relations of employment, these lose their private and fundamentally voluntary

[10] A 'Whig' was a member of an 18th- and 19th-century British political party that was opposed to the Tories.

[11] Term popularized in Great Britain during the 1950s, coined in *The Economist* by merging the names of two successive Chancellors of the Exchequer, Labour's Hugh Gaitskell (1950-1) and the Conservative R. A. Butler (1951-5). Both favoured a 'mixed economy', a strong welfare state, and Keynesian demand management designed to ensure full employment.

character" (Dahrendorf 1996: 33). In an indirect manner labour becomes forced labour. Thus he says that the obligations of citizenship should be general and public as they are. Dahrendorf says that not only are the rights and obligations of citizenship *public* but also *universal*. Also rights of citizenship are not *conditional, but categorical.* The rights which come with the status of citizenship are not dependent on what people are ready to pay for. "Citizenship cannot be marketed." (Dahrendorf 1996: 33).

The issues of balance of distribution of provisions and entitlements can be broken down to analytical issues and normative issues. Analytical issue is concerned with the inter-relation of provision and entitlement and how the increase or decrease in one affects the other. Normative aspect questions the grounds for acceptance of unequal distribution of provisions as long as they do not translate into unequal entitlements (Dahrendorf 1996: 41). "Whatever citizenship does to social class, it does not eliminate either inequality or conflict. It changes their quality" (Dahrendorf 1996: 43, 46). Class and the privileges of status still prevail and many new hierarchies have also come up. Citizenship provides us with a new vantage point to create an equal and egalitarian social structure amid all these hierarchies.

There is an eternal conflict between equality of opportunity and equality of condition when one considers the choices to be made for the exercise of formal rights of citizenship for realisation of substantive rights of citizenship (Runciman 1996: 55). Equality of opportunity and equality of condition are in conflict as different classes demand and desire different entitlements over scarce resources and social services. The dominant class and ideology prevails over the policies which dictate what those entitlements should be and how they should be distributed in the society. This engenders the conflict over these entitlements and at times evokes a backlash or opposition from others who consider that their demands have not been neglected (Runciman 1996: 58-9).

The key principles in social citizenship involve first and foremost the granting of social rights. This entails a decommodification of the status of individual with reference to the market. Second, social citizenship involves social stratification; one's status as a citizen will compete with, or even replace, one's class position. Third, the

welfare state must be understood in terms of the interface between the market, the family, and the state (Esping-Andersen 1990: 92-123).

Workers are as commodities in the market and they entirely depend on the cash-nexus for their welfare. Social rights, if they have to be real, mean a decommodification, that is, provision of means of welfare alternative to that of the market. Decommodification may refer to service rendered, or to the status of the person but it essentially means the degree to which distribution is detached from the market mechanism. The emphasis is on the real disjunction of dependence of individuals from the market for their welfare. Decommodification is quite difficult to achieve by many of the methods employed by welfare states to provide benefits such as means tested benefits, need based assistance and government insurance programs, these all have the characteristics of strengthening markets as these methods are not self sufficient in realising this effect. “In other words, it is not the mere presence of social right, but the corresponding rules and preconditions that dictate the extent to which welfare programs offer genuine alternative to the market” (Esping-Andersen 1990: 107).

> A minimalist definition of decommodification entails that citizens can freely, and without potential loss of jobs, income, or general welfare, opt out of work under conditions when they, themselves, consider it necessary for reasons of health, family, age, or even educational self-improvement; when, in short, they deem it necessary for participating adequately in social community (Esping-Andersen 1990: 107).

Stratification is inherent in the welfare state as any policy mooted by it is bound to create dualisms within the population or working class as some groups will be attracted or included as beneficiaries while rest shall be distanced as they are left out of the purview of benefit of such a welfare measure (Esping-Andersen 1990: 108-11).

Welfare states vary considerably in the way they perceive the principles of rights and stratification. This leads to different arrangements among state, market, and the family. Thus, welfare state variations are not linearly distributed, but clustered by regime types. The liberal welfare state cluster is characterised by a means tested assistance, modest universal transfers, or modest social insurance plans. The entitlement rules in this regime type are strict and often attached with stigma and

benefits provided are modest. The state encourages market either passively or actively. In such societies the decommodification is minimum and social rights though present, do not do much to alleviate the poor. The welfare recipients are mostly working class who are all equally poor depending on the meagre state welfare provisions and market catering to the majority of the middle and upper class clientele. This regime type thus depicts a class-political dualism (Esping-Andersen 1990: 111).

The second regime type is composed of the corporatist welfare states. These are characterised by a state providing social rights and providing for welfare provisions as well. But in these regime types the historical development of social rights and welfare provisions has been such that the status differentials are maintained as well which results in minimal redistributive effects.

The third type is composed of social democratic welfare states. In these states the principles of universalism and decommodification were extended to the middle classes as well. They pursued equality of highest standards rather than the equality of minimal needs as was pursued elsewhere in other regime types. The implications of such a policy were, "first, that services and benefits be upgraded to the levels commensurable even to the most discriminate tastes of the new middle classes, and, second, that equality be furnished by guaranteeing workers full participation in the quality of rights enjoyed by the better-off" (Esping-Andersen 1990: 112). This ends up in providing a mix of highly universal and decommodifying programs that simultaneously caters to differentiated expectations. Most salient feature of this is the fusion of welfare and work. The welfare state is committed to full employment guarantee and is dependent upon this achievement (Esping-Andersen 1990: 113). "The factors which lead to formation of classification of welfare regime types are mainly three, that is, the nature of working class mobilisations, class political coalition structures and the historical legacy of regime institutionalisation" (Esping-Andersen 1990: 114).

This scheme of analysis presents an alternative to the class mobilisation theory of welfare state development. It also provides us with the perspective which reinforces Marshall's theory of social citizenship as being relevant and necessary condition for analysing and studying a welfare state. The constituents of social citizenship rights are

the most essential preconditions for characterising a welfare state and it is this lasting contribution of Marshall which still informs our understanding of a welfare state.

ON THE CRISIS OF WELFARE STATE:

The thrust on social rights and its linkage with the welfare state has engendered a bureaucracy functioning through governmental institutions and at times in alliance with corporations to subject citizens. The police state tends to gather information on the citizens and its surveillance tends to curb the civil liberties of citizens. The welfare state tends to subject citizens in two ways, "first, the modern 'citizen' is not only a citizen, but a subject as well - an individual who, in possessing citizenship rights, has been required to subjugate him or herself to the institutions of the modern state and market. Second, the practice of citizenship helps define modern communities often at a cost to the individual's subjectivity" (Gorham 1995: 27). The welfare state today engages in provision of various goods and services to the citizens either through governmental institutions and organisations or through market or in collaborations with private corporate bodies. "In 'providing' rights, society and the state do not simply give them to citizens *gratis*; citizens must subject themselves to the procedures and institutions necessary to ensure that the state can continue to provide rights" (Gorham 1995: 29). "Social 'provision' means that the state not only provides economic security to the citizen, but exerts control and discipline over the subject. The state rewards the citizen with social rights while asking the citizen to relinquish, on occasion, civil freedoms like the right to privacy" (Gorham 1995: 31). The welfare state in pursuit of social provisioning acts and at times tends to being such a police state.

The welfare state provides social rights so that the economic inequalities, arising out of the free and unbridled play of the market, do not become intolerable. Citizenship discourse only from the point of class relations in society tends to obfuscate other power relations at play. Power relations exist not only in terms of class relations but also between the individual and the state. Citizens have to negotiate with the state and its institutions, most notably, the bureaucracy for the provision of their entitlements (Gorham 1995: 33). Secondly, there is a gender bias. It results, in terms of power relations, in the subjugation of women at these sites. This leads to perpetuation of gender inequality, especially as tied to class. Also this practice of women petitioning

with the bureaucracy has a contrary effect of empowering some of these women especially those who represent these interest groups (Gorham 1995: 34). Thus the welfare state's process of provisioning also tends to further women's dependency on the largesse of the welfare state (Gorham 1995: 33-5). There exists a gender bias in the substantive rules governing entitlement to rights of social citizenship and many times the exercise of these rights takes place in institutions where women have only a subordinate voice. Even the range of universal rights of social citizenship and their means of implementation have been shaped by assumptions about the roles of women in family and community.

The welfare state's tendency to inflate the bureaucracy has also given rise to a government which is too large and inept. Citizenship becomes an experience of negotiating and petitioning with an arbitrary and inept bureaucracy. This is a catalyst of political instability, as it leads to political disenchantment and disillusionment and, at times political indifference amongst the citizenry. Also welfare states of industrial economies have been erected at the cost of the plunder of the colonies. The economic uplift of the lower classes in industrially advanced nations has occurred at the cost of subjection and plunder of the rest of the world (Gorham 1995: 36-8).

The claim of social citizenship to be universal and furthering a civic culture and heritage is also contested. It also tends to be exclusionary than being inclusive. Within a nation there are various different paths of civilising and the idea of 'social heritage' or 'citizenship' also shifts from one region to another as well as from person/community to person/community. Also the concept of rights and duties of citizenship vary across the English speaking nations. So the claim of social rights to be universal seems to be on weak foundations. The claim of citizenship and social rights being universal also are put to question when the foreigners are discriminated against in any nation. The experience of the foreigner is totally incomprehensible to the citizens of that nation (Gorham 1995: 38-46).

Critical enquiry into the historical and ideological roots of citizenship reveals the extent and dimensions of social rights and the tussle between the various interest groups. The attack on welfare rights has also come from two fronts: firstly, the social rights of citizenship tend to make the recipients of welfare services dependents. Thus

welfare state creates not a new kind of citizenship but a new kind of servitude. Secondly, whatever be the character of formal entitlements the reality of welfare provision quite fails to modify the inequalities created by markets (Moran 1988: 397-414). In other words, while some object to the welfare state as being an inadequate guarantor of equal citizenship, others have a philosophical objection to it for trying to do too much.

It has been claimed that social citizenship benefits the rich more than the poor. This conclusion, claim the supporters of welfare state, has been reached due to many deficiencies in the analysis of the redistributive impact of welfare rights. These deficiencies are of three types, namely, "interpretational inadequacies, inappropriate counter-factuals, and illusory expectations" (Moran 1988: 402). Interpretational inadequacies arise because the methods employed to calculate the distributive effects of welfare state are technically flawed and they seriously overstate the regressive effects of the distributional welfare services. There is confusion about the nature and function of the welfare state and this leads to the resort to inappropriate counter factuals by the critics of the egalitarian impact of welfare state. Welfare state functions to distribute the services and provisions equally but not to distribute provisions in such a manner as to modify the social inequalities in certain manner as created by market. Also there is excessive expectation from welfare spending and the redistributive capacities of welfare state and we have to keep in mind the limits on the fiscal powers of the welfare state and also the role of the market where majority of the households earn their remunerations from. In other words this crisis of resources stems from the popular belief that the welfare spending or the 'burden' of welfare state is unacceptable due to various reasons and the state should curtail this unproductive spending and the market should take its place to let individuals partake in this share of the resource.

This resource crisis is also a major component of fuelling the legitimacy crisis. It arises from the belief that the capacity of institutions of welfare state have declined to such an extent that they no longer command any support and obedience. The decline in support for the welfare state is not occurring across the spectrum for all the services and welfare activities that it indulges in. There is considerable support for some services which are seen by citizens as necessary and essential to be left for the market

and there are many services which are considered as wasteful to be provided for by taxpayer's money. This ambivalence is a product of the social location of different people and the ideology of welfare that these individuals form, influenced by their social location in the market society. This leads to cementing of these ideas and thus it results as a slowness to change in social policy or popular belief about the welfare state. The decline in the support for welfare state is evident in political elite and it depends on the intellectuals and political elite, depending upon their ideology and interests, whether they argue for the rightness and justness of the welfare state (Moran 1988: 410-12).

Crisis of welfare state as predicted by the critics has not occurred though there are tensions and stresses of fiscal balance and competing social and economic interests. The welfare states have weathered these storms and have resolved them in their own peculiar ways. Different nations have resorted to different mechanisms to overcome and negotiate the problems and claims arising out of welfare spending characterising various different versions of welfare (Moran 1988: 414).

Welfare provisions have nonetheless been there and carried forward by various nations and still form an integral part of the government plan and expenditure. The role of a government is seen as a providing stability to the plans people make for their lives and also as providing a safety net if those plans do not materialise. Citizenship has come to be associated with a status of member of a community who has the rights to live a life of dignity and state had duty to provide and safeguard such rights. Marshall when he associates social right with citizenship not only gives us a view as to "how welfare should be handled in a society but also how welfare provisions can be defended" (King and Waldron 1988: 415-443).

ON THE DEFENCE OF THE WELFARE STATE:

The normative claims to defend social rights can be from various grounds. One of the grounds is equality, on which Marshall also focussed in his essay. Citizenship for Marshall is about "expanding and enriching society's notion of equality by extending its scope through civil, political and social rights" (King and Waldron 1988: 423). There are two ways to look at citizenship providing a defence to social provision. Firstly, citizenship as traditionally understood as providing for welfare rights and

social rights enriching the quality of life of citizens for the fuller realisation of citizenship. Secondly, even if it is not so then alternatively a concept of citizenship which aims to provide for social provisions for its members is better and preferable and more attractive a notion.

Citizenship as a notion not only connotes political participation or political rights alone but also social and economic standing of the citizens. Equality of citizens, though not absolute economic equality, has been an ideal inherent to the notion of citizenship. This equality amongst members is an ideal to be desired and strived for because it fosters amongst them a sense of solidarity and belonging to the community on an equal worth. Thus it provides stability and solidarity to the society. Apart from this, equality is desired as it tends to breed a sense of independence amongst the citizens. No one is dependent upon the other for his or her survival. This is to say that there should not be rigid equality but this is a case against extreme inequality. No one should be so poor and helpless that they can be bought by the rich. Poverty has been characterised as a hindrance to the effective realisation of the goals of citizenship as poor person cannot participate in the civic duties and deliberations with a free mind. Extreme poverty also corrupts the fabric of society as rich can buy the poor and influence their opinion and choices. This opens the floodgates for corruption and violence in the political realm (King and Waldron 1988: 425-431). “If we take the idea of universal suffrage seriously, then we should not be content simply to give everybody a vote; we should set about the task of giving them the economic security, which... is the necessary precondition for good citizenship” (King and Waldron 1988: 431).

The welfare provisions provided for in a society lead to the formation of legitimate expectations by citizens around them and they plan their life accordingly. To attack these welfare provisions, attacks the very idea of the planning and expectations people build around them. These attacks from the right can be countered on certain grounds which are wound around the activity of welfare provision and the idea behind them.

Firstly, welfare provisions form a part of citizenship as it is understood to be today. The idea of membership is not static but it is subject to change and expandable as

benefits can be distributed in the society relative to the societal configuration and demands.

Secondly, the concept of citizenship as understood here is wider than mere political participation but suggests what it is to be a member of a society. It means how people perceive themselves as social selves and how they organise their lives.

Thirdly, once welfare provisions are established they no longer are confined to the reasons for which they were instituted but people build legitimate expectations around such benefits and plan their lives around it. So to dismantle and break such provisions betrays the legitimate welfare expectations of the citizens (King and Waldron 1988: 431-33). People structure their plans for risks and make their life choices based on the society and the safety net prevailing over there. Generally these plans are long term plans and to disrupt welfare provisions is to radically disturb their plans.

Fourthly, there is a cost incurred when such plans are shattered or disoriented when the welfare measures are disrupted or taken back by the government. The costs involved are not merely financial or economic costs but also the disruption of their plans and long term expectations. The public provision sought or argued for is not some widespread social welfare state bordering socialism but "for public provisions of a minimum level of welfare as universal entitlement, defining a threshold below which people will not be allowed to fall without diminishing their sense and their capacities of citizenship" (King and Waldron 1988: 436).

The normative justification for welfare provisions and a welfare state is also immanent in the social contract theory. People choose to form a society and give up certain inherent rights to the state in exchange for certain roles that the state can play. Social contract presupposes a society which is made to take care of the concerns of the people who come to form that society. And "a person is a member of a society if and only if the design of its basic institutions fairly reflects a concern for his or her interests along with those of everyone else... a society is just, and the people living in it are members rather than subjects, if we can show that its institutions satisfy certain principles that people would have agreed to as basic terms of co-operation, had they been given the opportunity to decide. If the institutions do not satisfy such principles, or if they are based on principles that would not or could not have been agreed to in

advance by those who have to live with them, then they cannot be regarded as just, for they do not embody sufficient respect for the persons they apply to" (King and Waldron 1988: 440).

So the social contract theory conforms to the idea of a welfare state in the sense that the such a "political theory treats people as citizens and as members (as opposed to subjects) only if it concerns itself with what social arrangements those people would agree to and secondly, people would agree only to principles which focused concern on the plight of the poorest members of the society" (King and Waldron 1988: 441). Such a theory presupposes a welfare state and may be even more. This provides a strong argument to connect citizenship or membership as such with at least basic welfare provision. Marshall's conception of social citizenship embodies the essence of a welfare state.

RELEVANCE OF MARSHALLIAN HYPOTHESIS:

Social Citizenship, as defined by Marshall, is the capability to claim the entitlements encompassing "*the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilised being according to the standards prevailing in the society*" (Marshall, [1950] 1992: 7, 8; emphasis added). Social citizenship essentially means decommodification of welfare. This is the sketch of development of citizenship in the post-war years in Britain and is specific to that context but the paradigm of the three citizenship rights is still relevant and instructive to our understanding of citizenship development today (Lister 2005).

This scheme, of development of citizenship and corresponding rights, has not been without its criticisms. It has been argued that this scheme is specific to Britain and cannot be equated to other nations; that 'the theory of social citizenship promotes dependency and depoliticises "second class citizenship" and; the New Right has critiqued social citizenship and welfare state as being "(a) inconsistent with the demands of (negative) freedom or (desert-based) justice, (b) economically inefficient, and (c) steps down the road to serfdom" (quoted in Kymlicka and Norman 1994). Marshall's claim that citizenship is a status and social citizenship aspires to promote status equality has been critiqued as leading to hierarchies of status and thus leading

to competition and varying status entitlements as well as the post war citizenship status in a welfare state being 'bureaucratic, paternalistic and exclusionary' (Turner 2001). This problem was envisaged by Marshall when he said that citizenship in itself is a 'legitimate architect of inequality'.

Despite these criticisms, social citizenship and welfare provisioning, have been defended as being mechanisms to combat the vagaries of market and capital; to associate citizenship with welfare provides us with a guide as to how welfare has to be provided and defended. The idea of citizenship will be highly impoverished without social citizenship or welfare; it also promotes social participation and social solidarity by diminishing extreme inequality and vesting citizens with a modicum of wealth (King and Waldron 1988). Citizenship at its core is based on the concept of equality of status and once it is established in one sphere, e.g. civic sphere, it 'spills over to other spheres' but manifesting in different forms. Thus it is a unified concept not a unitary concept (Roche 1987; Lister 2005: 474). To claim that citizenship is a unified concept does not entail that it is a harmonious concept rather it is an essentially contested concept and one right may be connected strongly to others and others might be connected weakly, but for an effective exercise of citizenship one right is dependent on the other rights (Roche 1987; Lister 2005: 477). Lister identifies two tensions inherent in the idea of citizenship, one around the idea that citizenship is unified around the principle of equality of status and another that citizenship contains internal tensions (Lister 2005: 481, 482).

Esping-Andersen (1990) proposes that to insulate the welfare state from the vagaries of market and capital, the welfare provisioning thereby social rights, have to be decommodified. Decommodification may refer to service rendered, or to the status of the person but it essentially means the degree to which distribution is detached from the market mechanism. In other words, 'it is not the mere presence of social right, but the corresponding rules and preconditions that dictate the extent to which welfare programs offer genuine alternatives to the market' (Esping-Anderson, 1990:107). The key principles in social citizenship involve first and foremost the granting of social rights. This entails a decommodification of the status of individual with reference to the market. Second, social citizenship involves social stratification; one's status as a citizen will compete with, or even replace, one's class position. Third, the welfare

state must be understood in terms of the interface between the market, the family, and the state (Esping-Andersen, 1990).

Esping-Andersen hypothesises that “the salient features that explain the crystallization of regime differences are interactive. They involve, first, the pattern of working class political formations and, second, the structuralisation of political coalitions with the historical shifts from a rural economy to a middle class society. The question of political coalition formation is decisive.” Thirdly, “the past reforms have contributed decisively to the institutionalization of class preferences and political behaviour.”

These defences of Marshall, notwithstanding, there have been two major criticisms to which Marshall’s theory of citizenship is prone and open to; first, the feminist critique that Marshall’s version of citizenship ignores the gendered nature of citizenship and provides only a male centric view of citizenship and; second, Marshall’s account of citizenship does not provide for rights of minorities, ethnic or cultural. It is therefore imperative to consider how we can address the claims of minority groups and women to foster equal opportunities and equity. Specifically, how are health rights to be designed and accorded so that the concerns and demands of minorities and women regarding health are addressed and promoted. Can according group rights be a solution or do we need to improvise to other method and means?

Haldun Gulalp has critiqued the provision group rights as being arbitrary and repressive of the individuals of the group. He says it is in an arbitrary manner that the question, ‘who is a minority’ is decided by the elites and; group rights endowed on the community, with rights of autonomy, does not prevent or stop any oppressive practices within the group hierarchy and thus disempowers the individuals of the group. Group rights besides disempowering the individuals also leads to their suppression within the group. The group rights or cultural rights granted in the name of ‘preserving authenticity’ might possibly turn into ‘a license for insular authoritarian cultural practices’(Gulalp 2013: 35-39). This again problematises the conferment of group rights which curtail the individual autonomy.

Gulalp proposes a solution to provide equal opportunity to groups which have hitherto been discriminated. He says we should recognise the social and historical malleability of these “cultural groups” and not fix or freeze identity groups into the political

system to grant those rights. Individuals would be free to form alliances and associations based on a combination of 'an indefinite number of socially significant characteristics such as: ethnicity, gender, race, language, religion, class position, professional status, age, physical ability, sexual orientation, political and philosophical orientation, and so on' (Gulalp 2013: 36-38). This list is an open ended and we can add or remove other significant characteristics. These groups are not to be given priority and significance from top but individuals should be free to choose from any of these identities they feel attached to and should have the freedom of exit, this shall allow for the creation of new identities along with the changing socio-political realities. To illustrate this he gives the example of needs associated with age, as they are fluid and change over time and, thus individual would be free to associate with those groups which she prioritises. Health is a significant need associated with age, the cultural practices, economic affluence and environmental conditions prevailing in a society and thus it is imperative to ask at this point if health rights could be provisioned in the fashion as Gulalp proposes.

The welfare state has been characterised as paternalistic, interventionist (Jayal 1994; 1999) and populist (Gulalp 2013) and welfare has manifested in rhetoric and populist measures only. These populist measures have an inherent inadequacies attendant in their hollow "rights-talk masking strategies of what T.H. Marshall called class abatement" (Jayal, 2013: 16) and thus pose danger to the serious promotion of welfare as Marshall had cautioned that "class abatement does not attack class system but tries to check the nuisance of poverty" (Marshall, [1950] 1992). In the guise of bringing reforms in health sector state has opened the doors to private enterprise and trans-national business entities and capital to invest in the health sector thereby marking the rolling back of state from the provision of welfare. This is a divergence from the scheme envisioned by Marshall, but not completely so, as this portrays the contest between capital and social citizenship. The development and proliferation of civil society organizations in the sway of globalization along with the rise of identity politics has posed a challenge to the welfare state and led to the retrenchment of social welfare rights (Gulalp 2013).

CHAPTER 3

POLITICAL ECONOMY OF HEALTH RIGHTS: CONCEPTION, FORMULATION, DEMAND, AND PROVISION

Health as an aspect of strategic planning and governance policy has not yet fully developed in India. The initial reference to health as an aspect of governance and regulation developed post-independence in feeble ways in the national five year plans. It received very little attention in terms of a crucial area of welfare governance. The first National Health Policy (NHP) was framed in 1983 and second in 2002 and third health policy drafted in 2015 and finalised in 2017. Public Health has been the most neglected aspect of welfare and it receives the least financial support from the Centre as well as the states, as evidenced in the routine government fiscal allocations, be it in the yearly plans or in the five yearly plan allocations. It garners one of the lowest shares of public health expenditure by a state in the world in terms of percentage of total GDP. Health expenditure as public spending was 0.98 percent in 1975 and rose to 1.36 percent in 1986 and fell to 1.28 percent by 1991 and decreased further to 0.9 percent by 2000 (Rao 2017: 17). Coupling this fiscal misallocation is the complete silence on part of the media, the academia as well as the civil society in raising a sustained voice to demand befitting and proportionate allocation of monies, administrative and infrastructural facilities and manpower for the same.

Public health in India has been one of the most neglected aspects of governance (Dreze and Sen 2002, Das Gupta 2005). The idea that the state is to be held responsible for provision of public healthcare has not rooted itself in Indian political culture (Amrith 2007). The historical development of health policy formulation was short-lived and inherently limited and the causes for the same lay in “underlying contradictions in the intellectual culture and institutional forces shaping the Indian state’s commitment to public health” (Amrith 2007: 114). It is also argued that the Report of National Planning Committee of 1948 (Sokhey Committee) was imbued by the notions of “purity-impurity”; of improving the racial stock of the Indian people by selective breeding or eugenics, couched under the neutral terminology of family welfare programme or more specifically family planning programmes (Amrith 2007:

114-20; Hodges 2004: 1159-1163). The well-being of the populace was seen in "instrumental" terms as a means to improving the economic conditions of the nation rather than an end in itself. Ill-health was thus seen as a result of the poverty of the people and the overemphasis on overpopulation manifested the upper-caste anxiety over the over-breeding of the "wrong-sorts" (Amrith 2007: 114-20; Hodges 2004: 1159-1163). Family planning came to capture the imagination of the political class and the planners, so much so that it was made a separate vertical programme in the health ministry and later as a separate department under the ministry in 1966. The over-emphasis on family planning programme is reflected by the fact that during this period and later on the family planning got as much budgetary support as almost equals the entire budget for the public health service in India.

In 1938 a National Planning Committee (NPC) was formed by Indian National Congress and a sub-committee under the chairmanship of Col. S.S. Sokhey was appointed to look into the issues of health policy and health reform and it submitted its report in 1948. This report was "sketchy compared to Bhore Committee Report and it was not well studied and it lacked in detailed analysis of the existing health situation and as well as of the future plans" (Duggal 2001). The NPC on the basis of the report of the sub-committee on health in 1940 resolved to adopt for India a form of health organization that integrated curative and preventive functions administered through a single agency; this integrated organization shall be administered by the state and thus it recommended that promotion and maintenance of public health was the primary responsibility of the state; it resolved that the state should strive to promote the development and availability of essential drugs, scientific tools and technology for health innovation and development of trained manpower for the health sector working on a fulltime and permanent basis (NPC 1948: 224-226).

BHORE COMMITTEE REPORT 1946:

In 1943 in the wake of World War-I, the Imperial Government instituted the *Health Survey and Development Committee* and its Report was published in 1946 in four volumes, popularly known as The Bhore Committee Report after the name of its Chairman Sir Joseph Bhore. It reflected the renewed confidence in science in overcoming the epidemiology and disease, which was the fallout of the development of new medicines and new medical and epidemiological knowledge developed during

the war years. The Bhore Committee was an unlikely mix of people from different backgrounds and was not only comprised of official British civil servants and but had independent medical personnel and people from diverse streams of knowledge and political persuasions and was open to new ideas for an official body. It also received advice from a group of international consultants who toured India in 1944. Bhore Committee Report was sought to widen the scope and definition of the "conception of disease" by including "social, economic and environmental factors" which are equally responsible for the production of diseases. It also established the links between health improvements and economic development by suggesting that "unemployment and poverty produce their adverse effect on health through the operation of such factors as inadequate nutrition, unsatisfactory housing and clothing and lack of proper medical care during periods of illness" (Bhore Committee Report 1946, Vol. I: 7). It sought to provide for a National Health System in India drawing from the comparative experiences in US, UK, Canada, New Zealand and Australia and stated that for a comprehensive health system provision the State has to be primarily responsible in organization as well as regulation of health system (Bhore Committee Report 1946, Vol. I: 21). A central and crucial aspect of the plan for National Health Service under the Bhore Committee Report was the 'Three Million Plan', a national network of district health centres linked to more specialised centres of medical care in larger urban areas (Bhore Committee Report 1946, Vol. II: Chapter 3). The Report was detailed in its analysis and diagnosis of Indian health system and it still remains relevant to measure the policy proposals and developments in health systems and many of the subsequent policies on healthcare and prescriptions for developing health system seem wanting compared to the Bhore Committee Report (Amrith 2007: 116-17).

Bhore Committee endorsed the resolve of the NPC and provided for the setting up of a National Health Service with these objectives. The National Health Service should provide for the medical care in both preventive and curative aspects of the individual promoting positive health; these services should be close to the people it seeks to serve for its maximum utilisation and effectiveness reflecting their medical and epidemiological needs; the health organization should provide for wider cooperation between the health personnel and the people; the health organisation should be

structured in a way to elicit and reflect the views and demands of the auxiliary health staff and should have their representation in it who are the integral part of the whole edifice and on whom the success of the system depends; modern medical practice is a complex web of interdependence and interlinkages of various services and personnel such as diagnosis and treatment, consultant, laboratories and institutional facilities of varied nature together forming "group" practice and these essential services must be provided by the health service in an integrated manner; special provision should be made for the needs of certain section of population such as mothers, children and mentally challenged persons etc.; no individual should be unable to avail of these services for the lack of ability to pay for them and; it emphasized the importance of a clean and healthy environment for health promotion at home, workplace, places of amusement and recreation etc (Bhore Committee Report 1946, Vol. II: 17).

Bhore Committee emphasized the importance of rural health in the light of disparities in rural and urban health services and provided that the district should be the unit for rural health provision. It stated "two requirements of the district health scheme are that the peripheral units of the (health) organization should be brought as close to the people as possible and that the service rendered should be sufficiently comprehensive to satisfy modern standards of health administration" (Bhore Committee Report 1946, Vol. II:22). This scheme of district as a unit of health organization was called the Three Million Plan, representing an average district population and it envisaged a three-tier system in an ascending scale of efficiency from the point of view of staffing and equipment. "At the periphery will be the primary unit, the smallest of these three types. A certain number of these primary units will be brought under a secondary unit, which will perform the dual function of providing a more efficient type of health service at its headquarters and of supervising the work of these primary units. The headquarters of the district will be provided with an organization which will include, within its scope, all the facilities that are necessary for modern medical practice as well as the supervisory staff who will be responsible for the health administration of the district in its various specialized types of service" (Bhore Committee Report 1946, Vol. II: 22).

It provided that this health organization would provide an integrated comprehensive health services in terms of curative, promotive and preventive aspects of public health

for both the rural as well as urban population. This organization shall be based on varying size and differing technical efficiency of the different tiers of the unit providing for both the curative as well as preventive aspects of public health (Bhore Committee Report 1946, Vol. II: 30).

Bhore Committee Report envisioned ambitiously to provide for one hospital bed for every 550 people and one doctor for every 4,600 people at each district level which would form the unit of implementation. This provisioning was curtailed by the conference of provincial ministers held in October 1946 to provide for one health centre for every 40,000 people, 30 beds for every five centres, 200 beds in every district and to provide safe water to 50 percent of the population in next 20 years and 100 percent in 35 years; and adequate sewerage in towns having population of 50,000 within 10 years (Rao 2017: 9).

“The Committee also made special recommendation in the area of environmental hygiene, public health engineering, housing, health education, health services for mothers and children, health services for school children, industrial health service, the population problem, medical education and research and vital statistics” (Duggal 2001). This shows that Bhore committee was a comprehensive and very wide in its analysis and prescriptions for the development of health services in a holistic manner. This Report is followed by many subsequent health policies and health plans under the Five year plans. The most of them re-iterate the recommendations of Bhore Committee Report and suggest piecemeal reforms.

The entire period of 1960s and 1970s was marked by the overemphasis on tackling epidemics most notably Malaria. It was not until 1983 that the state formulated a National Health Policy. The National Malaria Control Programme was launched in 1953 with the help of the Technical Cooperation Mission of USA and the technical advice of the World Health Organization (WHO). With the support from the UNICEF, the WHO, and the Rockefeller Foundation, the BCG vaccination programme was launched to tackle TB alongside vaccination programme for eradicating smallpox. TB and smallpox together were the cause of many deaths and had taken epidemic proportions in the country. India was helped by many international organisations and agencies with their expertise and technical capacity to

cope with the situation and develop domestic capacity. But over time such dependency over international technical assistance led to a “tendency towards adopting a techno-managerial approach to disease control rather than undertaking more difficult but sustainable policy of tackling the causative factors and linking disease with social conditions that produce it-an understanding that continues to elude us to this day” (Rao 2017: 12). This dependency engendered an approach which is bereft of reflection on what is best for us in our context.

More importantly this approach led to neglect of the Bhore Committee Report recommendations towards the laying the foundations of a robust health system. Alongside the emphasis was placed on creating tertiary and speciality hospitals in urban area taking up majority of the resources allocated like the creation of AIIMS etc leading to scant resources left for the development of health care facilities in rural areas. This approach led to taking roots of a fragmented approach towards building of health system, urban areas drawing the larger share of budgets and attention and rural areas and population getting neglected until some calamity or epidemic forces the people in power to pay a lip service in the form of one stop relief measure. The unbalanced and distorted provisioning and greater emphasis on urban areas, may be because of higher publicity of urban affairs due to better media coverage or due to the influence and attention middle class demands and garners, have led to the neglect of the rural health system and population and is brought out in the surveys and reports of the state agencies as well.

The health system developed and showed signs of the malaise of centralized formulation and control via vertical programmes in the immediate steps taken to tackle the serious epidemic of Malaria. The Malaria control programme constituted as a vertical and centralized programme was successful for a brief tenure, because of heavy investment of donor money and imported DDT, but later on the programme showed signs of failure and eventually failed because of the inherent inadequacies in the health policy and the health system to adequately tackle diseases affecting the country. In many ways malaria control programme encapsulated many a fatal flaws attendant to the political culture of public health since independence; national malaria eradication programme took up around 70 percent of the funds for entire

communicable disease control programme and upto 30 percent of the entire health budget of the nation under the second plan.

The flawed approach of viewing health as only “instrumental” in achieving some other end is also reflected in the malaria eradication programme, it was stated that malaria control would enhance agricultural productivity, but in 1970s when malaria eradication programme reached to a reasonably successful levels the nation was witnessing an agrarian crisis and then the emphasis was shifted to population control, which was seen as a more cost effective measure to eradicate poverty and the support for malaria control gradually declined.

In this background most of the states failed to keep up the levels of malaria control similar to previous years but Kerala and Mysore did pretty well to keep malaria under control. These states had the advantage of a political class which was not apathetic to the demands of public health of citizens. Public health was given adequate attention as well as funding and these states had the history of “universal” campaigns of disease control and eradication equally matched by sustained and deeply politicised efforts to build and entrench local institutions. The political culture that developed on public health in India post-independence was clearly evident in the malaria control programme; an approach to health divorced of popular participation and dialogue as well as policy implementation in vertical fashion from a centralised agency or ministry of central government without involving the states in the designing of this implementation strategy (Amrith 2007: 119).

Post-independence the health policy was formulated under the five-year plans and the allocation of funds was also done by the same. This practice had an attendant flaw that this method is devoid of flexibility and did not cater to the differing demands of states with varying epidemiological and fund requirements. Under the first two five year plans urban areas got around three-fourths of the medical care resources and the rural areas got special attention under the Community Development Programme (CDP). CDP did not focus on social sectors and primarily became a policy for agricultural development. This programme underwent numerous changes, mostly in terms of nomenclature and was eventually reduced to rural livelihood programme and healthcare became a non-prioritised aspect under it. To evaluate the progress made

under the first two five year plans Mudaliar Committee was set up in 1959 and was tasked to provide recommendations for future course of health care development programmes.

Mudaliar Committee Report published in 1962 lamented that the fiscal allocations to health sector had consistently decreased through the second and third plans, despite the recommendations of Bhore Committee and Central Council of Health to increase the allocations. Mudaliar Committee also envisaged and recommended for an insurance cover to be devised via income contributions for covering health care costs in a long run. It suggested consolidation of peripheral health centres to provide health care services to a select population rather than select services to all the populace. It emphasized on development of tertiary care, specialization, protection of independence of private practitioners and their involvement in curative and preventive efforts of the state. This committee divorced medical care and public health as two different aspects under the planning (Qadeer 2008: 55-56).

Mudaliar Committee though lamenting that except for the rise in numbers of trained doctors, there was a woeful shortfall in the numbers of auxiliary and other personnel in health sector but ironically recommended development of medical colleges and specialization with enhanced allocations to medical education. This trend was evident in the next two plan periods with growth in medical colleges for training doctors and specialised centres and stagnant numbers of nurses and auxiliary health personnel (Duggal 2001).

The third plan while highlighting the lack of auxiliary staff and personnel only provided a lip service towards promotion of comprehensive public health care and this plan period also witnessed inadequate development of the much needed health personnel and the reason given for this shortfall was inadequacy of resources. The irony was self-evident as this period also witnessed increased outlays for new medical colleges, establishment of preventive and social medicine and psychiatric departments, completion of the All India Institute of Medical Sciences and schemes for upgrading departments in Medical Colleges for post-graduate training and research continued to be high.

Under the Fourth plan family welfare programme came to be prioritized to the extent that the resources allocated to this programme (36 percent) almost equalled the resources allocated to the total health sector including water supply and sanitation (41 percent). This plan period also witnessed the dependence on vertical programmes initiated under the aegis of WHO and foreign experts (Qadeer 2008: 56).

This vertical disease control programme entailed a vast army of special single-purpose health workers leading to overlapping and duplication of work in the same geographical area. In 1963 Chadha Committee recommended the integration of health and family planning services to be delivered by multi-purpose health workers. Under pressure from foreign countries, especially USA, population control was made a priority area to be addressed and it was sought to be tackled in a "camp approach". Later on under the advice of U. N. Advisory Mission 1961, maternity and child health programmes were separated from health and family planning department.

Fourth five-year plan, which began in 1969, was high on the rhetoric of socialistic pattern of development and was formulated in the aftermath of a plan holiday period of three years. The period witnessed the surge in mortalities due to epidemics such as malaria and thus emphasized the expansion of Primary Health Centres (PHCs). This plan also saw prioritising of family planning programme and rising population was seen as the driver of poverty, ill health and "crippling handicap" on development. An incentive based approach to family planning was developed in the backdrop of failure of "camp approach" to bring down the population numbers significantly. It was also recognized that an effective public health programme to curb communicable diseases depends on a multiplicity of factors from environmental, organizational constraints to the social roots of disease epidemiology.

Under the Fifth five year plan attempts were made to make up on these fronts by integration of nutrition, maternal and child health and family welfare services by the introduction of Minimum Needs Programme (MNP). This sought to balance the disparity between the rural and the urban health facilities; developing the referral services by strengthening the district and sub-divisional hospitals; intensification and control of communicable diseases; improvement in quality of education and training of health service personnel. The implementation of this plan was hampered by the

promulgation of emergency (1975-77) and with it severe cuts in allocations to family welfare, maternity and child health and nutrition programmes were made. While almost all the resources were geared towards completion of family planning targets to bring down population levels. This period characterized an undemocratic pursuit of population control policies by the state characterized by force, compulsion and violence.

It was also during this period that the National Population Policy was announced with the stated aim of "direct assault on the problem of population rise as a national commitment". Ironically this stated policy commitment was in direct contradiction to the Indian commitment made at the Bucharest Population Summit that "development is the best contraceptive". The Population policy recommended the states to follow a compulsory sterilization programme through suitable legislation. With this shift also came the distortion of resource outlay to various health programmes as now family planning commanded the largest share of health sector outlay. Also the urban bias in health sector outlay was becoming increasingly evident since this plan period benefitting largely the privileged classes evident from the pattern of social consumption indicators (Duggal 2001). "The assets of the lowest 10 percent of the rural population remained where they were at 0.1 percent while for the lowest 30 percent population it in fact slid down from 2.5 to 2.0 percent. The assets of the top 30 percent moved from 79 percent to 81 percent of the total. Similarly, the share of the poorest 30 percent in consumer expenditure also moved up only by two percent from 13.1 percent in rural areas and not even that in urban areas" (GOI 1981, Qadeer 2008).

It makes for a sad learning that despite high rhetoric and intention of socialistic development the first four decades of planned development health and other aspects of social development were seen in instrumental value as means to certain other end; health development for economic growth; malaria eradication for agricultural productivity. Also it can be seen that there was complete lack of serious and concerted effort at devising or even taking initial small but concrete steps, given the argument of resource constraint, in the direction of making a foundation for developing a robust health system. The centralisation of health policy making and implementation reflected in the vertical programmes shows a clear lack of concerted intent and

endeavour to strengthen the capacity and technical know-how of the states so that the systems of learning and capacity building for future are put in place. Also and crucially we see the neglect of the rural population in terms of scant resources deployed and infrastructure built leading to a fragmented health system leading to the congestion of public and private health facilities in urban areas and lack of even basic primary health care facilities in rural areas.

Rao (2017) states that in the first three decades of planned development, the health system was shaped by three broad approaches. “First, there was the dominant policy focus on controlling infectious diseases and family planning. The programmatic needs of these priorities then influenced the organization of primary health. Second, the focus was on teaching hospitals to produce the required human resources. Third, due to limited resources and weak prioritization, investments required for building a sound foundation of primary care were patchy and grossly inadequate” (Rao 2017: 13).

Fifth five year plan was significant in the respect that it emphasized on the expansion of sanitation and drinking water supply. To look into greater detail of the problem of sanitation and water supply a commission was set up in 1960, the National Water Supply and Sanitation Committee (Simon Committee). This committee pointed out the gross inadequacies of states in maintaining proper and updated data about sanitation and water supply. It stressed that immediate survey and investigation be made to bring up the required information and data about the problem of sanitation and drinking water supply.

The revelation of such a skewed distribution was sought to be corrected in the Sixth five year plan by expanding the Minimum Needs Programme and scaling up the outlay for communicable diseases. Family planning programme was reverted back on the lines of child survival and safe motherhood strategy and direct investments in family planning programme were scaled down. It also provided for doubling the infrastructural network of rural healthcare services. Sixth plan was influenced by the Alma Ata Declaration of Health for All by 2000 A.D. (WHO 1978) and the ICSSR-ICMR Report, 1980. This plan pointed out the lopsided and biased nature of health infrastructure expansion and service provision towards the urban areas. It stated that “there is a serious dissatisfaction with the existing model of medical and health

services with its emphasis on hospitals, specialization and super-specialization and highly trained doctors which is availed of mostly by the well to do classes. It is also realized that it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services" (Draft FYP VI, Vol. III, 1978, 250; quoted in Duggal 2001). This plan sought to correct this imbalance by providing health services for rural areas on a priority basis; training of first level healthcare cadre recruited from the community under the supervision of multi-purpose health workers and medical officers of PHCs; it provided that no linear expansion of health infrastructure in urban areas shall be made unless it is a real felt need and urgent. This plan emphasised the integration of vertical and horizontal linkages of inter-related services and programmes, like water supply, environmental sanitation, hygiene, nutrition, education, family planning and maternity and child health (MCH) programmes. This plan though very high on aspirations and declaration was followed by the old malaise of inadequate action on implementation on ground.

It is instructive to note here that Thailand developed its robust rural primary healthcare that resulted in its outstanding and stellar performance in health outcomes for the whole population, by putting a ten year moratorium on any public spending on urban health care and gearing to develop a robust healthcare infrastructure in rural areas. But such an initiative could not be taken in India despite similar realization mirrored in the sixth plan as discussed above.

It has to be noted that by this time it was generally felt and widely understood that integration of health planning and services is far more complex than was earlier thought as integration of primary, secondary and tertiary levels of services. This understanding came over the years with implementation experiences of vertical, technology-based programmes like National Malaria Eradication, National Leprosy Control, and National Family Welfare Programmes and watching them fail eventually. It was now understood that integration involves a "complex *conceptual exercise* of prioritising problems, recognizing linkages between them and, consequently allocating resources. Once technological choices are made these have to be grouped as clusters that can be delivered through common organisational structures. The second crucial aspect of integration is *organisational*, where common technologies such as iron for ICDS, and RCH or condoms for AIDS and family

planning can be procured and delivered through a unified organisation. Even diverse programmes can share personnel, vehicles, and facilities to make the organisation efficient and cost effective. At the level of service outposts, where grass root workers provide service and receive community feedback, this lesson led to the conversion of single-purpose workers into multipurpose workers (GOI 1973): the logic being it reduced travel time, increased rapport with community, provided information and knowledge to workers, and enhanced their efficiency. The last leg of integration is functional where different levels of services, with appropriate manpower and resource allocation, support and reinforce each other through *referral and monitoring* to enhance the overall output of the service" (Qadeer 2008: 50, Italics in original).

By the end of 1970s it was felt that implementation of health care services via vertical programmes was not leading to the desired results but the lessons were not learnt and "yet, their integration over time into the general health services was partial, confined to the lowest level, or at best to the district organisation and more to camouflage failures than to confront them. The lessons from the past were thus ignored (Qadeer 2008). The failures of communicable disease control and family planning programmes were not simply the result of administrative, organisational, and technical problems, but due to lack of basic services such as education, public distribution system for the provision of rations, housing, electricity, roads and transport, drinking water supplies, and water management" (Qadeer 2008: 60).

In this light, Indian Council of Social Science Research and Indian Council of Medical Research Joint Committee Report (ICSSR-ICMR Report 1980), which came in the immediate aftermath of Alma Ata Declaration, provided for inter-sectoral approach to health-care service, planning and provisioning. It also emphasized the importance of Comprehensive Primary Health Care as had been declared and agreed to by India at Alma Ata.

The inadequate attention given public health care provisioning led to the mushrooming of many different types of medical treatment centres ranging from stand-alone diagnostic clinics, nursing homes and hospital in the urban and semi-urban areas catering to the different sections of society.

The Sixth and Seventh Five Year Plans had a common thread running between them and this was the theme of privatization. This period saw the rising influence of international donor agencies in the health care and medical service provisioning. The goals now aspired in the planning language were not of achieving the proposed targets rather efficiency, reduction of costs and quality and, this was sought to be achieved by increased space and incentives provided to private players in the health care services market. The Seventh Five Year Plan was drafted under liberalising economic influence and it argued for the entry of Non-Governmental Organizations (NGO) and *private sector partnerships* into the health sector. The Eighth Plan provided for privatisation of medical care and of *targeting the underprivileged* for providing Primary Health Care and National Health Programmes. The rationale for this was that the rising middle class could now pay for the medical expenses. But this was a belied expectation as the middle and lower classes of the society had a limited and marginal utilization of the public health services, especially of the in-patient services, as the upper middle class and the rich had a greater utilization of the tertiary and specialized public health care services. It was seen that "the top 20 percent population with high consumption continued to use 49 percent of all in-patient days in the public sector, as against 26.6 percent in the bottom 20 percent with lowest consumption. The 20 percent at the top also monopolised 46.5 percent of free-ward days, as against the bottom 20 percent who could use only 27.8 percent. The upper two quintiles paid 80 percent of the total user fee in the public sector but, this being less than 20 percent of hospital revenue, their monopolisation of subsidies was three times that of the poor" (Mahal 2002).

Also it was observed that the introduction of user fees in public sector hospitals drove the poor out of health coverage. The critical role and significance of the public sector health provisioning for poor is evinced from the fact that, though private health sector commands and caters to the majority of out-patient care, but in situations of serious diseases and cases requiring hospitalization and in-patient care, "those with lowest monthly per capita consumer expenditure (all falling under 40^{th} percentile), have increased the utilisation of public sector hospitals from 48 percent to 60 percent as shown by the 42nd and 52nd rounds of NSS" (GOI 1989; quoted in Qadeer 2008: 64). Also the public sector services are overwhelmingly utilised by the poor for delivery,

pre-natal care and immunisation services with the utilisation rates to the tune of 69, 74 and 94 percent respectively (Peters et al 2002).

In the initial four to five decades after independence the dominant considerations in the health planning and policy were scarcity of resources and lack of technical know-how and skilled health personnel to manage the health burdens afflicting the nation. This argument prefaced the dependency on international agencies and donors agencies for funds and technical expertise reflected in the Malaria eradication and smallpox eradication programmes. Taking assistance of these agencies to address our health problems was a good initiative considering the absence of technical and expert knowledge in the nation but the fallout of these programmes was the designing of our health system on and around the framework of these assisted programmes rather taking a comprehensive view of our health system and designing it on our greatest needs and developing the capacities and skills which were lacking. But such initiatives were abandoned even in the presence of strong and well laid out proposals as the Bhore Committee Report. The health system characterised by vertical programmes for specific diseases with manpower dedicated to that specific purpose led to wastage and neglect of other aspects of health on one hand and centralization of health system on the other. The centre became to hold greater control over money and personnel as well as dictating the rules of the game to the states rather than seeking and evincing demands from states as to their needs and provisioning accordingly.

The second aspect of the development of health system during this period was the inadequate attention paid to the health needs of the rural population and resultant fragmentation of the rural and urban health provision. The initial response in the form of community development programme and later modified into rural livelihood programme paid scant attention to developing a robust health system for rural areas and these areas got stuck with underdeveloped or no health infrastructure in place even after four decades of independence. This skewed development stemmed largely from the argument of inadequacy of funds and resources. But as we shall see later in the next chapter that the new avatar of rural healthcare development the National Rural Health Mission (NRHM) has been reduced to a hospitalised child delivery programme rather than a comprehensive health programme. This new policy has the inherent aspect of selective provisioning via dividing the population into twin

artificial constructs of income. This selective provisioning has brought into this urban and rural divide the class divide as well. Poor provisioning for poor people.

The third aspect of the development of health system during this period which starts to show signs in the later part is the greater emphasis on secondary and tertiary sector of health care system and inadequate attention paid to the primary sector. The primary health sector is crucial and caters to the greater number of population as well as reduces the development of diseases and problems needing secondary and tertiary care. In the absence of inadequate primary health services the burden on secondary and tertiary sector is bound to grow and cost more as services in tertiary sector are technology-intensive and thus costly.

The fourth and last aspect of this period is the growth of private sector healthcare providers of all hues and scale in the country. The private sector in health care has mushroomed in the later part of 1980s and has become tremendously rapid at present in the country especially in the urban areas. These range from small clinics to diagnostic centres to swanky high-tech super speciality hospitals by corporate entities catering to the rich and 'medical tourists' and are mostly offer secondary and tertiary care.

THE POLICY FORMULATION FOR HEALTH IN INDIA: FROM NATIONAL HEALTH POLICY 1983 TO NATIONAL HEALTH POLICY 2017

Health rights in India have been voiced in different forms and have developed via various organizations. This also implies that there has not been a single agency or department involved and dealing with this issue over the years. For the first time health policy and provisioning were conceptualised and formulated by the Report of the Health Survey and Development Committee 1943 (Bhore Committee Report). This report is considered the most comprehensive planning document for health services in India (Murty, Sarin and Jain 2013:71).

The health system in India as well as the health situation of people has changed little over the years. The population is also witnessing a social, economic, demographic and epidemiological transition. This necessitates a health policy which responds to the challenges of the present and future generations. The disparities in the health performance and epidemiological aspects of different states of India call for a health

policy responsive to the different demands of these varying situations of health transition. It would make planning, policy formulation and implementation responsive to the different conditions of health of people of different states, if states are given greater voice and control over planning, formulating and implementing the policies as per their respective needs (Peters, Rao and Fryatt 2003).

POLICY PROCESS AND PRESCRIPTION OF HEALTH PROVISIONING:

India uses the five year planning process to carry out the development process nationally in the prioritised areas of investment and development. "It is through this process that priorities for family planning, 19 centrally sponsored disease control programmes, and the expansion of primary care services to rural areas under the minimum needs programme have been articulated and implemented across the country. Despite the rhetoric to integrate programmes and strengthen local decision-making, the funding system of the plans has reinforced a series of parallel disease control programmes and a separation of health and family welfare programmes. It has also institutionalized a centrally-based rigid approach for planning of personnel and health facilities based on population norms that have little relationship to workload, presence of the private sector or local epidemiological considerations" (Peters, Rao and Fryatt 2003: 253).

In terms of position in the epidemiological transition of a state and capacity of the public sector to provide adequate healthcare, all the states need to strengthen their *oversight of the health system* to bring accountability and quality in the public as well as private health care providers.

Health financing is an area which needs to be developed and institutionalized, especially in states which are in the later stages of health transition, in a way that is suitable and sustainable to particular requirements of the state.

In *public health services* states in early health transition phase need to improve the quality and coverage of programmes for reproductive and child health, malnutrition, tuberculosis, and malaria. In states that are in the middle of the health transition phase the need is to focus on programmes which attend to behavioural health risks, cardiovascular diseases, mental health and injuries response services. HIV/ AIDS is

the common challenge to almost all the states but degrees vary and the respective states need to provide for accordingly.

In the case of provision of *ambulatory care* the challenge facing all the states is similar as the primary health centres catering to outpatient care are sparse and not evenly and adequately dispersed. The choices could be to rope in the private sector as well as to expand the coverage of public primary health centres. This issue can be adequately addressed by collaborating with the private healthcare providers as the private healthcare providers are the largest service providers for outpatient care in India. The issue of *inpatient care* is closely connected to the strategies of health financing. This involves development of a robust insurance system for health care financing and the technicalities involved have to be addressed by keeping in mind the specific economic and health transition situation of the state.

Large urban municipalities pose a health challenge which is sure to grow rapidly as the urbanisation expands and this area needs more attention by the states. The urban health provides a very complex situation as it has mix of poor slum population, migrants as well as wealthier classes who can pay for private costs and involves a host of healthcare providers and different governmental actors involved in the healthcare system. These issues point to the need for "splitting and lumping" of health policies, at the state level the need is to split the healthcare policies to take care of respective health demands of the particular state and at central level lumping of various central health programmes (Peters, Rao and Fryatt 2003: 254-7; italics in original).

DEMAND MAKING FOR HEALTH PROVISIONING:

The provision, expansion and development of social services depend primarily on the state and are influenced by "top-down interventions, bottom up pressures, and some combination of both." State is primarily the initiator of top-down services in form of actions and initiations for such service provision. Top-down interventions are crucial as they are critical to introduction, sustenance and institutionalisation of 'bottom-up' developments. But top down effects to be introduced, sustainable, effective and institutionalised depend a great deal on the political will and responsiveness of the elite and the state. This aspect is severely lacking in India (Gupta, M. and Pushkar 2015: 7; Mehta 2012: 208).

The state apathy can to an extent be stimulated by bottom-up pressures in the form of civil society activism. This tension between top-down interventions and bottom-up activism is an essential and enduring tension of development with respect to provision of public services. The nature of a country's political regime, not just its democratic or authoritarian credentials but also how political power is organised and exercised, that is determining factor in making substantial impact on how this tension plays out, with respect to both the expansion and improvement in social services (Gupta, M. and Pushkar 2015: 8).

It is also claimed that in a democratic polity and society, where democratic values have taken root by its sustained prevalence overtime, there develops a social culture that promotes a greater dispersal of and acceptance for egalitarian ideas, an emergence of cohesive political community or social solidarity endowed with high levels of social capital at national or sub-national levels, which is crucial for different communities and groups to come together and make sustained demands for public service provisions especially in an ethnically diverse society as India. In Indian context the demand for public services such as health and education has been minimal and these services are not seen as prerogative rights of citizenship and not demanded by those deprived of these rights. It has been observed in Indian context that caste and religion play a greater pull in associational life and claims and demand making is on these lines rather on the basis of issues of interests and social welfare aspects (Gupta, M. and Pushkar 2015: 9).

Madhvi Gupta and Pushkar state that such claims making is not done by the people deprived of such rights in India because of the following reasons: "(i) Citizens no longer expect or trust political leaders and public officials to deliver public goods; (ii) They believe that any claims-making efforts on their part at improving social service provision will not be successful; (iii) They have learned to cope with (or adapted to) deficits in public services; when necessary and to the extent possible, they acquire them privately; (iv) Differences within communities, based on ethnicity, class, and gender, diminish the willingness and ability of communities to come together to demand better social services (Gupta M. and Pushkar 2015: 10).

In a survey done in rural Udaipur District of Rajasthan state on health provision, its linkages to wealth of a rural households and the self reported health perception by the people availing of these provisions it was found that public health facilities, primary health centres and sub-centres, were mostly closed during the regular working days due to the absenteeism of the sole primary health worker in the community. “Starting with the public health facility surveys, the weekly absenteeism survey reveals that, on average, 45 percent of medical personnel are absent in subcenters and aid posts, and 36 percent are absent in the (larger) primary health centers and community health center”(Banerjee, Deaton and Duflo 2004: 329). It was also found that the sub-center was closed 56 percent of the regular opening hours and only in 12 percent regular opening hours was the single health personnel was found present. The chronic absenteeism at public health and educational facilities has been documented to be a common affliction of the South-Asian countries (Nazmul Chaudhury and Jeffrey Hammer, 2003; Chaudhury et al., 2003).

Expenditure on health form one of the key expenses for poor rural families and it was found in rural Udaipur that “in the expenditure survey, households report spending 7.3 percent of their budget on health care. Households in the top third of the per capita income distribution spend 11 percent of the budget on health care. Visits to public facilities are generally not free (the households spend on average 110 rupees when they visit a health facility) even though medicines and services are supposed to be free, when they are “available.” Even those who are officially designated as “below the poverty line,” who are entitled to completely free care, end up paying only 40 percent less in public facilities than others” (Banerjee, Deaton, Duflo 2004: 329). Private facilities for health care account for the larger share of time and resources as they take up 57 percent of the visits and 65 percent of the costs (Ibid: 330).

Public health is distinct from medical care and presently there is a lopsided overemphasis on the high-modernist techno-centric curative medical care. Medical care treats individual conditions of disease but public health caters to the prevention of morbidity for the whole population. In India state policies and programmes have largely focussed on providing curative care and personal prophylactic interventions, such as immunisation, while preventive aspects of public health have relatively been neglected consistently. “Public health services are conceptually distinct from medical

services. They have as a key goal reducing a population's exposure to disease - for example through assuring food safety and other health regulations; vector control; monitoring waste disposal and water systems; and health education to improve personal health behaviours and build citizen demand for better public health outcomes" and public health services produce "public goods" of incalculable benefit for facilitating economic growth and poverty reduction" (Das Gupta 2005: 5159).

NATIONAL HEALTH POLICY 1983:

National Health Policy (NHP), 1983 was announced during the sixth plan period and this Policy was in great measure a replica of the ICSSR-ICMR Report. National Health Policy 1983 argued for "universal, comprehensive primary health care services which are relevant to the actual needs and priorities of the community at a cost which people can afford" (MoHFW, 1983: 3-4). The NHP of 1983 was the first formal health policy in the country since independence and it stated the need and objective of its formulation as the need for "an integrated, comprehensive approach towards the future development of medical education, research and health services requires to be established to serve the actual health needs and priorities of the country" (MoHFW 1983: 1). The NHP of 1983 critiqued the over-emphasis on curative aspect of medicine and disproportionate neglect of the preventive, promotive and rehabilitative aspects of health care; argued for a decentralized system of healthcare characterized by low cost, de-professionalisation (involving volunteers and paramedics), and community participation; expansion of private curative sector to reduce the burden on government sector; establishment of nationwide network of epidemiological stations to facilitate the integration of nationwide health interventions; and it sets up targets which are primarily demographic in nature (Duggal 2001).

The period after the National Health Policy of 1983 witnessed a spurt in the expansion of rural health infrastructure with the aim of providing one PHC per 30,000 population and one Sub-centre per 5000 population as it provided in 6^{th} and 7^{th} plan. This target was achieved more or less except for a few states which have lagged behind in this aspect. Despite this expansion in the infrastructural network of PHCs and Sub-centres their utilization remains sub-optimal because of "the poor quality of the facilities, inadequate supplies, insufficient effective person-hours, poor managerial skills of doctors, faulty planning of the mix of health programmes, and lack of proper

monitoring and evaluatory mechanisms. Further, the system being based on health team concept failed to work because of the mismatch of training and the work allocated to health workers, inadequate transport facilities, non-availability of appropriate accommodation for the health team and an unbalanced distribution of work-time for various activities. In fact, many studies have observed that family planning, and more recently immunisation, get a disproportionately large share of the health workers' effective work-time" (Ghosh 1991; Gupta and Gupta 1986).

Decentralization and de-professionalisation as envisaged by the NHP 1983 have taken place to some extent but community participation has been minimal as the health system in place in rural regions have not been functioning properly and have been affected by the problems mentioned above as well as the health policy has been conceived in total dissonance of the needs and expectations of rural population. The NHP 1983 favoured privatization of health services for bringing the burden down on public exchequer and also stated that private sector should have greater role in provision curative medical care and state should play a greater role in preventive, promotive and rehabilitative aspects of health care. The private health sector accounts for over 70% of all primary care treatment sought, and over 40% of all hospital care (NSS-1987; Duggal and Amin 1989; Kannan et.al. 1991; NCAER 1991; NCAER 1992; George et.al. 1992).

National Health Policy of 1983 lacked in providing a comprehensive and real analysis and portrayal of the needs of the majority of the population. It showed an urban and upper class bias and favoured privatization when the majority of the population was not able to pay for medical bills. The catastrophic consequences of hospitalization expenses led many people into debt or to sell their valuable assets or land holdings (UNDP 1997; Bajpai and Goyal 2004). The commitment towards universal healthcare that this health policy evoked at the beginning has been shelved comfortably and the emphasis on gains on account of efficiency via selective primary health care override the issues of severity of health problems, equity and social justice.

The Seventh Five year plan incorporated the recommendation of the NHP 1983 and emphasized for the development of specialities and super-specialities in both the public as well as private sector. This plan also provided for urban health services,

biotechnology, medical electronics, and non-communicable diseases. This plan carried forwards and enhanced the resources for population control programme (FYP VII, 1985, II: 273-287).

Eighth Five year plan was pushed forward by two years in the wake of massive economic crisis in India and this plan also carried forward the template of the plan previously cast. It reiterated the selective health care approach and provided for health for the unprivileged to be achieved by targeting. It provided for privatization and incentivised privatization by providing tax incentives on the condition of maintaining certain minimum standards.

During the Eighth plan a committee to review the health system was set up called the Expert Committee on Public Health Systems. This committee made a thorough reappraisal of the previous plans and policies and stated that the communicable diseases are showing a surge and the need for an effective disease surveillance mechanism is very crucial. It provided that detection-cum-response centres be established at the district level for early detection and swift action for containment of the outbreak of communicable diseases. It also proposed horizontal integration of all vertical programmes at the district level for their effectiveness and allocative efficiency.

The Ninth Five year plan is a contrast to the previous plans in the sense that it provides an assessment of the previous plans and policies and juxtaposes the Bhore Committee Report in present situation. It evaluates the rural health sector infrastructure and recommends that given the lack of doctors and other medical personnel, the PHCs or Sub-centres can be strengthened by offering part time-positions. It also provides for strengthening the referral system. It gives due consideration to the varying health care capabilities of different states and provides that state-specific planning should be done keeping in mind the specific needs and particular capabilities of the states. This plan also laments the lopsided development of urban health infrastructure with mushrooming of secondary and tertiary care units but a desperate lack of primary healthcare facilities. This trend has led to overburdening of secondary and tertiary care units for minor ailments and increased out of pocket expenditure for economically poor as majority of secondary and tertiary

health care facilities are private. This plan recommends opening of primary care units in economically poor areas, as slums in urban settlements.

Ninth plan also reviews the National Health Policy of 1983 in terms of its goals and objectives and calls for reappraisal and reformulation of NHP for a reliable and relevant policy framework not only for an improved healthcare system but also for measuring and monitoring health care delivery system and ascertaining the health situation of the population. It critiques the present poor data collection and management system and calls for district level data collection and database management for relevant planning purposes.

This plan also reviews the population policy and family planning programme and posits maternity and child health services at its core. This plan period also placed greater emphasis on maternity and child health services and National Population Policy was also announced in the mid- 2000s. The population policy again is streamlined at population control rather than population welfare. The major emphasis is on demographic aspects of the population. This plan laments the meagre resource allocation towards health sector and stresses the expansion of resource allocation for improvement in infrastructure, organizational and health outcomes. The continuous harping on the horizontal integration and inter-sectoral approaches in the NHPs and Population Policies has been reduced only to the exercise of documenting the demographic achievements and the advertising of world class healthcare technology by private super-speciality hospitals to earn foreign revenues via health tourism. “This monetary and demographic obsession is the basis for instrumentalising the NRHM into a vehicle for medicalised reproductive health care rather than Comprehensive Primary Health Care. The basic necessities of life available to the rich and taken for granted by them, are no more central to health planning for the poor” (Qadeer 2008: 66).

WORLD DEVELOPMENT REPORT 1993:

The World Development Report 1993 (WDR 1993), titled *Investing in Health*, came as fallout of the global economic reforms accompanied with the structural adjustment policies and was an important factor shaping the future landscape of health reforms worldwide. The report carried forward the World Banks agenda of Selective PHC

instead of the comprehensive PHCs and immunization and family planning were stressed as the dominant programmes to be undertaken via this shift. The approach of Indian planning on health has been termed as 'dualist' manifesting as the "conflict between the promises made and the actions undertaken by the state" as well as the dualism of the state itself witnessed in the apathy to take actions on welfare measures and land reforms or redistributive measures on one hand and active courting of the modernisation of technology in industrial sector as well as refusal to tax the agricultural incomes of large landowners (Qadeer 1994: 27-32).

The WDR 1993 proposed a selective PHC which emphasized on "essential" public health and clinical services and this emphasized on HIV/AIDS control programmes, population control and family planning strategies and Tuberculosis and unsurprisingly the control of communicable diseases fails to find a mention. The sought after mechanism is market, for all illnesses and diseases. The Report proposes cuts in public spending on health care including tertiary care and promotes population control strategies; stresses the shift of curative care to private sector; introduces cost recovery mechanisms in public sector; limits the scope and diversity of services under the public health provisioning to a certain defined "essential" clinical and public health services; and seeks to tackle poverty through structural adjustment policies, education and women's empowerment (Qadeer 1994: 33).

The redefining of the PHC to an "essential" public health and clinical services distorted the concept of comprehensive PHC and the course of future primary health care in three critical aspects: it led to "altered priorities, delinked clinical and public health services, and conscious denial of those welfare inputs which were earlier considered necessary for basic health". Communicable diseases do not form part of this package of "essential" services though these are one of the leading causes of morbidity, malnutrition and mortality in young as well as adults. Maternal and child health programmes are also restricted and immunisation takes the first priority (Qadeer 1994: 34).

The WDR 1993 distorts the definition of public health in a manner that the entire onus for public health is shifted on the individual. This report distorts the concept of public health by removing its rootedness from the specific socio-economic and cultural

contexts and reduces them to certain set of fixed interventionist strategies. The concept of public health encompassing promotive, preventive, curative and rehabilitative services is shelved for this narrower interpretation just to restrict the basket of services the public sector can cater to and the rest of the curative burden is transferred to private sector for profit. This report shifts the emphasis of public health from control of diseases to disease management which is nothing short of dangerous for the public health as it is widely understood that to control an epidemic of communicable disease involves widespread coverage of infective cases with complete treatment rather than just curing of chronic or difficult cases (Qadeer 1994: 33-38). The WDR 1993 thus proposes drastic changes in the direction and content of health service development (Rao, Nayar, Baru and Priya 1995: 1156-1160).

The Ninth and Tenth Plans (GOI 1997, GOI 2002) represent the unfolding of the effects of the nexus between Global Public Private Partnerships (GPPP) of Multi-national Corporations with national, international and private capital. This marks the advent of GPPP driven agenda being marketed by WHO as the 'appropriate' national disease control priorities in Third World (Wheeler 2001). This was marked in the Tenth plan by expansion of unregulated yet subsidized medical market by opening up of public institutions to private investments, the facilitation of Public Private Partnerships (PPPs), and private medical care providers distorted the health care provision by investing and expanding the areas of provision in more paying and profitable aspects of medical care than the services widely and most needed.

The state was now increasingly urged to play the role of facilitator of private sector than a provider of the much needed low cost public health care. Public health services were allowed to deteriorate with a planned neglect. The neglect of the public sector and promotion of private sector has led to the exponential expansion of private medical care providers in primary, secondary and tertiary levels and the relative absence of public sector health providers at secondary and tertiary levels has had the effect of catastrophic indebtedness of the poor for serious hospitalizations and at times the poor not seeking health care services at all because of inability to pay. This period witnessed the privatisation of public sector drug industries and changes in drug policies and changes in the patents regime towards a process as well as product patent regime in consonance with the TRIPS regime. This has led to the escalation of prices

of essential and life-saving drugs and the gradual decimation of generic drugs industry (Qadeer 2008: 65; LOCOST 2004).

This plan also led to the reduction of already narrowed Selective Primary Health Care services to a programme of poorly run Primary Level Care. This plan championed the Public Private Partnership mechanism and also permitted the public sector doctors to pursue private practice. The rural population is provided a minimal and redundant health services under the National Rural Health Mission (NRHM) providing basic services by an Accredited Social Health Activist (ASHA), Auxiliary Nurse Midwife and Anganwadi workers. This approach brings to light the reality of urban biased elitist mind-set as well as the apathy of the policy planners inherent in their imagination that the diseases of the poor rural folks can be treated by less trained health personnel as these are simple diseases requiring minimal investment and care (NRHM 2005).

NATIONAL HEALTH POLICY 2002:

The National Health Policy 2002 was published in this period and on the face of it this policy document seems to be in tune with the commitments made by earlier documents and carrying forward the national goals. This policy document provides for "integration of vertical programmes, strengthening the infrastructure, promotion of public health as a discipline, filling the gap of availability of doctors by introducing short-term training for basic services (revival of the licentiate medical practitioner), decentralisation of health care delivery through Panchayati Raj and autonomous monitoring institutions, setting up a national disease surveillance system as well as a national accounting system, strengthening ethical practices, and regulation of private practice. It also talks of increase in investments, particularly from the centre. This would go up to 25 per cent from the present 20 per cent of the total health expenditure. It would also induce greater investment by the states as well, whose expenditure has gone down from7 per cent to 5 per cent of their budgets" (Qadeer 2002: 12). It provided impetus to the privatization of health and promotion of health tourism as means to earn foreign exchange. This policy calls the earlier commitments as *unrealistic in the present context* and does not provide the causes and the rationale for this shift (Qadeer 2008: 68).

This policy does away with the need for maintaining referral interlinkages between different levels of health care services. This policy not only destroys the concept of Primary Health Care services (PHCs), which were designed with the in-built referral system as the backbone for its success, but also the state commitment of PHCs for the underprivileged. This policy assumes that the private sector can provide the first referral as well as the secondary and tertiary level care. This policy relinquishes the ideas of inter-sectoral planning and the role of social determinants in influencing health of the population evidenced by the silence of this document on the issues of adequacy of availability of food, issues of undernutrition, drinking water supply, sanitation etc. The policy calls for documenting the health statistics, devising the framework for national disease surveillance system, and increasing the quality and efficiency of National Public Health Programmes (NPHP) but falls short of providing a roadmap for the same. It talks of regulating the private sector but neither does it provide for the legislative measures nor the institutional mechanisms for monitoring and regulation.

To provide the basic services in underserved rural areas the policy talks of entrusting the nurses with extra functions and to train them suitably for the same in a short duration. This comes in the backdrop of extreme shortages of nurses and auxiliary staff in the health care system and burdening them with more functions. The purpose is further defeated by the carrying forward of contract basis and part time employment of doctors, paramedical as well as auxiliary staff. This practice shows the non-committal attitude of the state in entrenching the public health service and expanding it by staffing it with permanent committed personnel (Qadeer 2002: 12-13).

PRIVATIZATION OF HEALTH THROUGH PUBLIC ROUTE:

The health policy envisages decentralization by entrusting the local self-governments with the task of implementation of the major health programmes and services. To do this autonomous bodies consisting of social activists, private health professionals, Member of Legislative Assembly (MLA) or Member of Parliament (MP), and government officials, are visualized to help in the implementation of the programme. So it scuttles the autonomy and independence of local self-governments to visualise imaginatively and design creatively to administer and run the health services by making it akin to vertically dictated centralised programme. The state health

departments are tasked with the function of monitoring and providing technical help and are envisaged to maintain a relative distance for allowing flexibility to the local self-governments.

Another aspect of decentralization is evident from the intent to involve civil society but it talks only of the Non–Governmental Organizations (NGOs) and does not look at involving the Gram Sabha and the Ward Committees at rural and urban areas respectively. Also the NGOs are made a blanket homogeneous category in the policy while overlooking the vast diversity amongst the NGOs and it does not provide any method to screen the disingenuous NGOs from scrupulous ones. On the issue of personnel and staff the policy talks of making medical education more practically oriented; training the present personnel for additional responsibility; and training the licentiates to add to the present numbers of practitioners. The policy talks of promoting health tourism keeping in view the comparative advantage the Indian private health service providers have in secondary and tertiary health care sector. The foreign earnings they gain in this service provision is proposed to be deemed as export of services and shall thus be liable to all exemptions and incentives extended to export earnings. Further the policy document talks of levying user fees in public health service delivery institutions despite the evidence to show the deterring impact user fees have on the poor who are unable to pay such fees (Qadeer 2002: 15-16).

The NHP 2002 talks of enhancing the resources allocated to the health programmes but does not look into any details of the present allocation patterns and prescribes any corrections or the reasons to correct the imbalances or inadequacies that are urgently needed for an overhaul and restructuring of the present fiscal allocation mechanism in the health system. This policy though talks of carrying forward the policies enunciated in the NHP 1983 but only pays lip service to the prior commitments (Duggal 2002: 16).

Also the policy though talks of provisioning more medicines and consumables it is completely silent on the issue of provision of essential drugs at reasonable and affordable prices especially with reference to the WHO mandated list of 300 essential drugs. This issue is highly critical at this juncture as this period also marks the shift in Indian patent laws form process patent to TRIPS mandated dual process as well

product patent regime which restricts the development of generic drugs by domestic pharmaceutical companies at cheaper cost. This policy also mentions the proposal to regulate private health service provision and practitioners but does not provide any details for the same (Duggal 2002: 19).

The global economic reforms and imposition of World Bank and IMF-led structural adjustment policies brought along the health sector reforms worldwide. Leading to shrinking role of the State in health provision and their terms mandated to following a restricted individualist approach to health; without recognizing the "the structural factors that govern and contour health or the ecology of disease". These structural adjustment policies dictated following the 'principles of cost-containment' and were restricted by the imperative of 'cost-benefit considerations' which led to 'disjointed interventions', that only focused on the curative part of the disease overlooking the holistic approach towards disease, known as the bio-medical approach in public health. This brought the disease centric vertical programmes worldwide and the NHP 2002 also laments the failure of these vertical programmes (Athreya and Rao 2006: 25).

The Eleventh Plan takes an instrumental view of health and education in considering their advancement as means for achieving a higher economic growth. It also points out the shortage of high quality skilled people needed in knowledge intensive industries but does not propose the expansion of inadequate support staff that is critically needed for proper functioning of the services presently in place. Emphasis is placed on the public financing for these services but not for public provisioning and greater thrust is put on the issues of governance and accountability.

The plan dilutes the commitments the state made Alma Ata towards the comprehensive Primary Health Care as is conspicuous by the absence of any reference to the PHCs. Secondly, this plan ignores the role widespread hunger plays in inducing widespread morbidity and mortality in the population. Finally, the plan is silent on the health rights of women and marginalized communities, Dalits and Adivasis in particular. The plan represents the false belief that high growth rates would automatically translate into better lives of the people ignoring the other crucial

aspects of good health besides higher income such as education, clean environment, sanitation, public investment in public health interventions of preventive care etc.

The plan reposes its faith in righting the wrongs of this state of ill health of public sector by National Rural Health Mission, a centrally sponsored series of projects to strengthen rural health care in some 18 states. The plan resorts to making full the shortfall in doctors by inducting doctors trained in Indian Systems of medicine or AYUSH (Ayurvedic, Unani, Siddha and Homeopathy). It does not talk about the shortfall in the numbers of non-medical staff, supervisory staff, in drugs and supplies, in management skills, support and auxiliary staff and nurses. Issues of women's health have been ignored except for a passing mention about the importance of institutional deliveries. It believes in bringing accountability by introducing user fees, which internationally has been shown to be deleterious to the utilization of health services by the poor. It talks of failure of private insurance in health sector globally but proposes for community based health insurance, which is known to have regressive effects on the poor (Athreya and Rao 2006: 28-32).

In the wake of liberalization of the economy post-1991 the governance ideology that state embraced had three characteristics that limited and questioned the state's ability as an institution to deliver services: "the marginalization of the state, according primacy to markets, and ceding space to Non-Governmental Organizations (NGOs)" (Rao 2017: 15). In 1993, the World Bank accepted to give loans to the health ministry to run national health programmes but on three conditions: "a) the concept of an essential health package as opposed to the grand vision of comprehensive primary care articulated at Alma-Ata, b) confining the role of the government to implementing selective disease control programmes justified on the principles of Disability-Adjusted Life Years (DALYs- a concept no one understood), and c) allowing markets to provide hospital and medical care with government engagement on the basis of public-private partnerships (PPPs)" (Rao 2017: 17). Under a PPP, the government would engage an NGO on a contract to implement the schemes for which it remunerates them. Contracting of NGOs was justified on accounts of improving organizational efficiencies and activities such as sanitation, laundry, diet and the delivery of allied services were outsourced and contracted out to the NGOs and private entities. User fees on the willingness to pay based surveys were introduced in

the hospitals on the argument that these cash strapped hospitals would be therefor be able to mobilise resources to bear with their expenses.

National Sample Survey Organization's household survey (NSSO 60th round) in 2004 showed that failure of the selective health care approach promoted by the World Bank resulting in people not being able to pay for health expenses and thus not availing of health services at all or taking loans at huge interest rates leading them into inter-generational poverty. The survey showed that 20 per cent of people did not avail of medical services in cases where they needed to because of financial constraints. Garg and Karan (2004) found in their analysis of 1999 data that 3.24 per cent of population or 32.45 million people were being pushed below poverty line every year due to catastrophic health expenses and 90 per cent of these were from rural households.

The engagement of non-governmental organisations with government agencies for public service delivery and development initiatives has spurned a hybridization of these agencies in their character and confusion as to their linkages with state as well as private sector donor agencies. The myriad forms and nomenclatures these take abound from simplistic NGOs to GONGOs (Government Organized NGO), and INGOs (International NGOs) etc. These organizations in substituting the state as service providers have tended to de-governmentalize the state and proliferate the nodes of governance outside its formal structures. This shifting of responsibility for developmental work to non-government and quasi-government entities under neoliberal ideologies is rapidly increasing in India but it does not mean that government has shelved the developmental plank. Development is still one of the criteria on which the state bases and derives legitimacy. This trend of engaging the civil society and non-governmental actors in development engagements with the state has also governmentalized many civil society actors and reduced their mandate to specific activities prescribed by the State or the donor agencies. This had the impact of drastically curtailing the scope of the activities and the impact of their actions on the ground as well as enmeshing them in a web of governmental bureaucracy at times placing them at odds with the State as well (Sharma, Aradhana 2006).

The privatization of the health sector rose after the 80s and saw a dramatic increase in the 90s. Nandraj (1994) provides that in 1963-4 the private sector comprised of 61

percent of doctors, 21.5 per cent of beds, and 16 per cent of hospitals. By 1990, private sector expanded to include 58 per cent of hospitals and 29 per cent of beds. In the 1990s the economy was undergoing a balance of payment crisis and the state had little budgetary support for the health sector and it was struggling to build and provide primary health care infrastructure in rural areas as per its commitment to attain the global goal to provide 'Health for All' by 2000. The state had to succumb to IMF imposed conditionalities to cut down on expenditures to reduce the fiscal deficit and the this led ,firstly, to cutting down of already meagre resources allocated to social sectors including health and secondly, to promoting the private sector via fiscal incentives. By 2004 the private sector accounted for three-quarters of out-patient treatment, 60 per cent of inpatient treatments, and three-quarters of specialists and technology (Commission for Macroeconomics and Health 2005).

In this backdrop the emphasis for creation and strengthening of basic primary health care system got some traction. National Rural Health Mission was imagined as a programme to revive the primary health care sector and later National Urban Health Mission was also initiated to cater to urban primary healthcare needs as well as to reduce the patient load form secondary and tertiary level hospitals in urban areas. Both these programmes were clubbed under the nomenclature of National Health Mission.

REPORT OF THE NATIONAL COMMISSION ON MACROECONOMICS AND HEALTH (NCMH) 2005:

The NCMH 2005 report brought out the glaring deficiencies and the dysfunctional state of health in India at the time. It pointed out that India accounts for 16.5% of the global population, we contribute to a fifth of the world's share of diseases: a third of the diarrhoeal diseases, TB, respiratory and other infections and parasitic infestations, and perinatal conditions; a quarter of maternal conditions, a fifth of nutritional deficiencies, diabetes, CVDs, and the second largest number of HIV/AIDS cases after South Africa.

It also pointed out that an estimated 3.3% of India's population is pushed into impoverishment every year because of out- of –pocket health expenditures. The poorest 10% of the population rely on sales of their assets or on borrowings, entailing

inter-generational consequences on the family's ability to access basic goods and affecting their long-term economic prospects.

It highlighted that the reasons for this failure can be attributed to three broad factors: poor governance and the dysfunctional role of the state; lack of a strategic vision; and weak management.

It pointed out the shortfall of doctors in the healthcare delivery system as India has a doctor-population ratio of 59.7 physicians for 100,000 population, worse than most developed countries which have 200 and more for every 100,000 population.

NCMH pointed out that the attempts to protect the poor from income shocks under the Universal Health Insurance Scheme failed for two reasons: one, the risk pool is confined to below poverty line families already at high risk, making it a losing proposition; and two, lack of any institutional mechanisms to implement the scheme.

NATIONAL RURAL HEALTH MISSION (NRHM):

The National Rural Health Mission (NRHM) was started in 2005 as a programme for strengthening the rural health infrastructure. The Mission Document for NRHM in its preamble states the objectives and reasons for the programme to bring out necessary architectural corrections in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children (GoI, NRHM Mission Document 2005-2012).

NRHM was started in 18 states which had poor health indicators or health infrastructure to provide better health services to rural population. The mission seeks to increase the health spending by the government on health care to the tune of 2-3 percent of GDP from the meagre 0.9 percent of GDP at the time it was initiated. “It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare” (GoI, NRHM Mission Document 2005-2012).

Additionally it sought to revitalise the local traditions of medicine and to promote them in an institutional manner in the public health system under the acronym AYUSH. To effectively integrate the health concerns with determinants of health like sanitation and hygiene, nutrition, and safe drinking water through a District Plan for Health. It sought to decentralize the programmes for health to be managed at the district level thus it made district as the nodal point for public health management. It aimed to correct the inter-state as well as inter-district disparities in public health infrastructure especially for the 18 high focus states.

NRHM sought to achieve the above mentioned objectives by involving the Panchayati Raj Institutions (PRIs) by training and enhancing their capacity to own, control and mange public health services. It employed a massive number of female health activists known as Accredited Social Health Activist (ASHA) to promote the household level access to improved health care. To institute a Village Health Committee at the Panchayat level to make health plan for the village. It allocated untied funds to sub-centers to enable them to initiate local planning and action as well it sought to increase the numbers of Multi-Purpose Workers (MPWs). It also provided for integration of vertical programmes at all the levels from national, state, district to block levels as well as to strengthen the capacities for data collection, assessment and review for evidence based planning, monitoring and supervision. It also indicated at promoting Public-Private Partnerships for efficient achievement of public health

goals. It also sought to reorient medical education to support rural health issues including regulation of medical care and medical ethics. It also sought o provide for a effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care (GoI, NRHM Mission Document 2005-2012).

NRHM was a multi-pronged strategy to address the inadequacies of rural health and sought to address them in terms of manpower by the introduction of female Accredited Social Health Activists (ASHAs), who were to be the link between community and the public health system. ASHAs were to be chosen and be responsible to the Panchayat and were an honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for Reproductive and Child Health (RCH), construction of household toilets, and other healthcare delivery programmes. She was to facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, Auxiliary Nurse Midwife (ANM), functionaries of other Departments, and Self Help Group members, under the leadership of the Village Health Committee of the Panchayat. Induction training of ASHA was to be of 23 days in all, spread over 12 months and on the job training would continue throughout the year (GoI, NRHM Mission Document 2005-2012).

Secondly, NRHM sought to strengthen the village Sub-centres by allocating them an untied fund of Rs 10,000 per year for local expenditure in a joint account of Sarpanch and ANM and would be operated by the ANM in consultation with Village Health Committee. It provided for additional MPWs (male) or ANMs where in need; upgrading existing sub-centres or building new ones where the population has increased as per the 2001 population norm.

Thirdly, it aims for strengthening of Primary Health Centres (PHCs) for quality preventive, promotive, curative, supervisory, and outreach services, by providing them with quality essential drugs and equipment; to provide 24 hour service in at least 50 percent of the PHCs by addressing the shortage of doctors by mainstreaming the AYUSH manpower. PHCs must adhere to Standard treatment guidelines and protocols. It provides for intensification of the ongoing communicable disease control

programme; initiate new programmes for controlling non-communicable diseases; to upgrade all the PHC for 24 hour referral service and to make efforts to increase the number of doctors at PHC to two doctors (one female and one male).

Fourthly, it sought to strengthen Community Health Centres (CHCs) for 24 hour first referral care; codification of new Indian Public Health Standards (IPHS); promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management; developing standards of services and costs in hospital care; and providing outlays for creation of new CHCs and provision for their recurring costs of maintenance etc.

Fifthly, it seeks to develop a District Health Plan (DHP) which would form the core of activities proposed around activities like sanitation, water supply, hygiene and nutrition. District Health Plan would be formulated by the amalgamation of field responses from Village Health Plans, state and national priorities for health, water supply, sanitation and nutrition. District becomes the core unit of planning, budgeting and implementation. The Centrally Sponsored Schemes could be rationalised or modified according to the consultation with states. All vertical Health and Family Welfare Programmes at the district and state level would be merged into one common "District Health Mission" at the district level and "State Health Mission" at the state level.

Sixthly, it provides for convergence of sanitation and hygiene activities under the District Health Plan. The District Health Mission would guide activities of sanitation at the district level, and promote joint information, education and communication for public health, sanitation and hygiene through Village Health and Sanitation Committees (VHSC), and household toilets and school sanitation programme. ASHAs would be provided incentives under the mission for promoting sanitation and hygiene measures amongst the community members.

Seventhly, the mission seeks to integrate the National Disease Control Programme for Malaria, TB, Kala Azar, Filaria, Blindness and Iodine Deficiency, and Integrated Disease Surveillance Programme for improved programme delivery. It proposes new initiatives to control non-communicable diseases and provide mobile medical units at district level for improved outreach services.

Eighthly, it proposes to initiate the formulation of regulatory measures for the private sector on the issues of transparency and accountability. It seeks to reform regulatory bodies or create new ones where necessary. It also proposes including private sector representatives at the District Institutional Mechanism for the mission. It also promotes the concept of Public-Private Partnerships in health sector and shall identify partners which shall be need based, thematic and geographic.

Ninthly, it proposes new health financing mechanisms by creating a new task group and to look for avenues of risk pooling for hospital care. A National Expert Group will be constituted to formulate and monitor the standards of services – outpatient, in-patient, laboratory, surgical interventions etc., and to give suitable advice and guidance on protocols and cost comparisons. It proposes creation of a District Health Accounting System, and an Ombudsman to monitor the District Health Fund Management, and take corrective actions. Insurance Regulatory and Development Authority (IRDA) shall be approached to promote Community Based Health Insurance (CBHI) and to evaluate periodically for efficient delivery.

Lastly, it proposes reorienting the health/medical education to cater to the needs of rural population. It proposes improving the referral system from rural PHCs to Secondary and tertiary care units mostly located in urban areas. It proposes creation of new medical and para-medical education institutions in states where they are needed. It provides for constituting a task group to look into the issues of improvement of guidelines and provide the details as well as the creation of Commission for Excellence in Health Care (Medical Grants Commission) akin to University Grants Commission (UGC) and National Institution for Public Health Management etc.

The NRHM was rolled out in 2006 in the 18 high focus states and the performance of NRHM to achieve the stated goals has been mixed. The Comptroller and Auditor General of India (CAG) did a performance audit on implementation of the NRHM during April-December 2008 in the Ministry of Health and Family Welfare, State Health Societies (SHS) of 33 States/UTs, District Health Societies (DHS) of 129

districts and 2369 health centres at block and village levels covering the period from 2005-06 to 2007-08[12].

NRHM was launched in the backdrop of the announcement of Millennium Development Goals (MDGs) and it seeks to improve the health indicators to the requisite levels as provided in the targets under the MDGs. The core of NRHM is to reduce maternal mortality and infant mortality. The structure of NRHM is woven around this goal such as the enrolment of ASHAs to provide ante-natal and post-natal advice and care and to escort expectant mothers to the nearby health center for institutional delivery and the provision of incentives to the ASHA as well as the mother for institutional delivery under the Janani Suraksha Yojana (JSY). The NRHM aims to achieve the MDGs by a three pronged strategy, namely (a) community involvement, (b) decentralisation to Panchayati Raj institutions - Zilla Parishads, and (c) programme management units in each district. The NRHM plan, it has been argued, does not provide any room for lateral or creative thinking on the part of the village members; the Village Health and Sanitation Committee (VHSC) and Rogi Kalyan Samities (RKS) rarely meet due to paucity of time at the disposal of district as well as revenue officials. ASHAs are provided rudimentary training and are rendered incapable of providing any useful advice or help. Also the medicine kits they were provided is rarely supplied with medicines and they also are not paid regularly which acts as a disincentive for their active participation. The central financing to the states and then to districts for NRHM is flawed as there is no accountability and audit by the states as it is considered outside the jurisdiction of their treasury and outside audit by their internal departmental mechanisms and thus is marred with corruption. The Indian health system has become inverse pyramid-like with very little primary health care and ballooning secondary and tertiary level medical care dominated by private sector. In this scenario NRHM, it is claimed, “has however turned out to be an antithesis of primary healthcare - which was supposed to be essential, acceptable, accessible, affordable, participatory and appropriate health- care for all” (Ashtekar 2008: 23-26).

NRHM was initiated to bring bottom-up planning and demand in the health sector and the CAG Report indicts the lack of action on the part of states in completing the

[12]Available at http://www.cag.gov.in/html/reports/civil/2009_8_PA/contents.htm

household and facility surveys and state specific perspective plans. In nine States, district level annual plans were not prepared during 2005-08 and in 24 States/UTs block and village level annual plans had not been prepared at all. The results of the outsourcing of plan preparation had been mixed, with district plans outsourced to private agencies in eight States not being prepared in time. The report emphasises the development of planning capacities in the respective states under the mission for it to be effective.

On the community participation front the mission was failing due to the non-constitution of the various committees envisaged under the mission for its implementation. In nine states Village Health and Sanitation Committees (VHSC) were still to be constituted as well as the Rogi Kalyan Samitis (RKS) were found to be weak in grievance redressal mechanisms, outreach and awareness generation efforts. The states failed to form the committees to involve the local communities to participate in health planning, the funds to be devolved were not allocated neither were the untied funds allocated utilized by the health centres. The aspect relating to involving NGOs in the health planning and identifying or creating a mother NGO to coordinate the NGOs was also not done in most of the states.

The CAG report highlights the failure on the issue of funds convergence by the states. It says that many states had failed to contribute their share of funds to be allocated towards the mission. The majority of the states which formed part of the high focus group where the health development indicators are low and diseases are high were receiving relatively lesser central grants, as high unspent balances of previous years remained, indicating that capacity building needs to be focussed on. Release of funds to the State Societies and consequently to district and block levels required further streamlining to ensure prompt and effective utilisation of funds.

NRHM developed Indian Public Health Standards (IPHS) to put in place standard guidelines for the development of infrastructure and capacity of health delivery system. But the ratio of people to health centres remains low as NRHM proposed to construct one sub-centre for each Gram Panchayat. There is a requirement of 2, 45,655 sub-centres in India and only 56,896 sub-centres are there thereby creating a shortfall of 1, 55,478 sub-centres. At the current norms of population for PHCs and

CHCs, there is a requirement of 11,337 new PHCs and 2933 new CHCs[13]. Basic facilities (proper buildings, hygienic environment, electricity and water supply etc.) were still absent in many existing health centres with many Primary Health Centres (PHCs) and Community Health Centres (CHCs) being unable to provide guaranteed services such as inpatient services, operation theatres, labour rooms, pathological tests, X-ray facilities and emergency care etc. Mobile health units, which were proposed as the means to reach far flung regions where health facilities are absent, have not been made operational in many states despite the allocation of funds for the same by the Centre. The report laments that the work of ASHAs is not being effective because of the absence of health personnel at various levels in the health system and the health system is characterised in many of the states by the inadequacies as well as vacancies in the posts of specialist doctors at CHCs, adequate staff nurses at CHCs/PHCs and Auxiliary Nursing Midwife (ANMs) / Multi-purpose Worker (MPWs) at Sub Centres.

Despite the health ministry setting up the Empowered Procurement Wing (EPW) and the release of a comprehensive procurement manual, in 26 states and Union Territories, no procurement manual had been prepared.

On the field researchers have studied the implementation of NRHM and found that it is beneficial and productive at those regions where there existed no health infrastructure earlier and the rolling out of NRHM and allocation of monies for infrastructural development did bring out change and building up of basic health infrastructure. This study showed that in some districts of Orissa, NRHM did make a slight difference in improving health infrastructure as well as health outcomes but this comes with a condition that the state government has to show a political will to effectively implement the mission as well as allocate the requisite funds and manpower on their part (Patra, Murthy and Rath 2013: 471-480).

In another study of the interaction of the NRHM formulated top-down plan with the ground reality of interaction of various actors in the rural areas. In the present study done in tribal regions of Maharashtra, the author finds that the top-down model of community participation was modified into a “community monitoring plus”

[13] See Report of the Working Group on National Rural Health Mission (NRHM) for the Twelfth Five Year Plan (2012-2017)

arrangement because of the multiple actors staking claims over the control of the village health governance. The author emphasises the role pre-existing social relationships in the particular society play in shaping and defining the success or failure of the mission and in the multiple ways they change the mission's success from the metric defined in the script handed down from the top. In the present study of NRHM in rural Maharashtra the VHSC did not work because it was an entity alien and incompatible to the pre-existing social relationships down on the ground (Donegan, 2011: 47-65).

In a mid-term appraisal of NRHM conducted in 2009 it was found that NRHM has been valuable in certain aspects such as in respect of putting in place an ASHA for every 1000 population; creating greater awareness about ante-natal care, institutional delivery, post-natal care and child immunization; raising institutional deliveries; raising the number of out-patients being provided with healthcare services in the health facilities; provision of un-tied funds at all levels of facilities and providing the much needed flexibility for outreach of services and so on. But the scale of improvements and demands are so large that it is not possible to bring that change in a period of five to six years. The authors highlight seven key areas of attention under the NRHM for it to become more broad-based and effective in catering to the needs of rural health care. These are: "1) a much higher level of public health spending in general and much higher outlays for NRHM in particular; 2) proper recruitment, comprehensive training, effective control and oversight and timely and adequate payments for the ASHAs; 3) an effective and efficient management structure for the health facilities at the village, block and district levels; 4) a well-defined and implementable role of the Panchayat Raj Institutions (PRIs) and a comprehensive and on-going training program for the panchayat members; 5) commensurate physical infrastructure and human resources in the sub-centers and the Primary Health Centers with the growing needs of the regions; 6) scaling up necessary interventions to bring down the infant mortality rate (IMR) (focusing on neo-natal mortality in particular) and maternal mortality rate (MMR); and 7) NRHM to work hand-in-hand with the Aanganwadi workers of the Integrated Child Development Scheme" (Bajpai, Sachs and Dholakia 2009: 123).

A study done in 2011on the developments made under the NRHM found that in terms of progress made in creating infrastructural facilities was short of the targets proposed to be achieved under the mission. The 24 hour PHCs which were proposed under the mission have "increased to 44% (between 2005 and 2010) in their numbers, such PHCs comprise only 36% at the all-India level and 27% in high focus states. The corresponding figures for CHCs are 93% and 88%, respectively. The progress with respect to upgradation is also a matter of concern. About 71% of the CHCs have been selected for upgradation. While facility surveys have been undertaken in 95% of these CHCs, the process of physical upgradation has been started in only 65% of the CHCs and completed in only a third of the CHCs. Another disturbing feature is that about 46% of the SCs are not operating out of government buildings. This figure is slightly higher in high focus states (49%)". It also points out the massive scarcity of diagnostic equipments and medicine stocks. Regarding the allocation of untied funds to sub-centers (SCs), PHCs and CHCs to the tune of Rs 10,000, Rs 25,000 and Rs 50,000 respectively was also not met as only 49 percent of SCs, 36 percent CHCs and 42 percent PHCs received such funds. In terms of manpower as well there is huge deficiency, as the study points out that, 11% of the PHCs do not have a doctor (this is 17% in high focus states). At the CHC level, only 49% of the required specialist posts have been sanctioned so far, and 25% positioned. Less than a third of the required number of staff nurses has been positioned. With regard to the ASHAs the study reports that the ASHA website reveals that 7.49 lakh ASHAs have been selected from 2005-06 to 2009-10. While this is a large number, implying that about 90% of all villages have been covered but majority of them are inadequately trained and there is little transparency in their selection process leading to allegations of nepotism. Though 94% of ASHAs have received the first module training, only 26.6% have received the fifth level of training. Also the training is infrequent and discontinuous and most states do not even reach a minimum of 12 days training per year (against the desirable period of 28 days). On the issue of involvement of Panchayati Raj Institutes (PRIs) in planning the study points out that in 2006-07, about 48% of the districts had prepared district plans, and by 2008-09 this figure rose to 85%. However, 2009-10 witnessed a decline (74%) – which might indicate that the process of decentralisation is running out of steam. Also 75 percent of villages had formed Village Health and Sanitation Committees (VHSC) and 71 percent of PHCs had registered Rogi Kalyan

Samities (RKS). Although 90 percent of districts had constituted District Programme Management Units (DPMUs), towards facilitation of Health Management Information System (HMIS) as a mechanism for effective monitoring and supervision of the Mission activities and evidence based planning, it has been observed that the HMIS is not used adequately to inform planning and responsive corrective action (Husain 2011: 53-60).

NRHM was introduced to cater to the healthcare needs of the vast rural population which comprised of poor as well as illiterate people with inadequate health care facilities. The results of NRHM have been mixed, it has been very crucial in bringing the rural primary health care aspects into the limelight and giving it political as well as institutional precedence, creating a large pool of voluntary community social health workers in the form of ASHAs, though their training and rewards need to be enhanced and strengthened, it infused a much needed increase in basic auxiliary health worker in public health system from the government, it has also led to creation of much needed health infrastructure where none existed before. Apart from these benefits which flow as a direct consequences of effective and successful implementation of the mission there have been certain indirect benefits in terms of the much needed assessment of the public health facilities, inadequacies and preparation of large mass of data and investigations around these issues which promises to serve in improving and strengthening the present scenario.

A study was conducted to assess the quantity and quality of service delivery in rural public health facilities under NRHM in the four states of Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan. Quantity was assessed on the static and dynamic condition of physical infrastructure; by the numbers of paramedical, technician and medical staff employed, as well as figures for attendance and gender breakdown; by the supply, quality and range of drugs; by availability and usage of decentralised untied and maintenance funding of centres; and by actual availability of laboratory, diagnostic and service facilities. Quality was assessed in relation to the condition of the above tangibles, as also supplemented by subjective data on intangibles, such as patient satisfaction, gathered from the exit interviews. It found that quantity indicators, as mentioned above, varied across the states as well as within the states amongst districts. Quality also varied similarly. The author emphasised that the results

can be translated into a ranking of the states as on or the other states performed better than the other but that is counter-productive and defeats the purpose of the survey. The issue that needs to be stressed and focussed is how we can enhance the capability of the personnel manning the health care system and how to improve the quality as well as quantity of the healthcare provision. The crucial role of NRHM has been that it has brought public health issue of rural population in the political agenda (Gill, K 2009).

It becomes amply clear from above discussion of the design and implementation experience of NRHM that it is an inferior health service provisioning to the rural population by engaging a contractual employee in the form of ASHA remunerated in honorarium and is asked to do more with little training and insufficient medical supplies. They are not made permanent employees and are not provided with employment benefits resultantly hampering their morale and dedication to work. Many of the committee reports talk of entrusting them with extra functions as well without suggesting improvements in their employment structure. This again brings out the belief of policymakers that rural health demands can either be fulfilled by minimally trained ASHAs or it signified the apathetic nature of policy makers and elected representatives. The provision of bare minimum health services selectively targeted to the citizens who have been classified as vulnerable and labelled BPL again entrenches the class abatement idea argued by Marshall.

Around this period two issues related to the health system provision were sought to be addressed by the state, namely, the issue relating to the health care needs of the urban poor, especially those living in the large slums bereft of proper primary health facilities, water supply, as well as sanitation. The other issue was the provision of a social insurance for health related expenses incurred by the poor people which most of the times led to catastrophic expenses by borrowing or distress sale of their assets such as land or jewellery. The provision of primary public health facilities to the urban poor was to be addressed by the introduction of National Urban Health Mission (NUHM), which was to become integrated along with NRHM under the single programme of National Health Mission (NHM). Thus, NHM now subsumes under it both the NRHM and NUHM and coordinated by the Health Ministry. The issue of provision of insurance for the poor for expenses incurred on hospitalisation were

sought to be covered by the introduction of Rashtriya Swasthya Bima Yojna (RSBY) under the Ministry of Labour and Employment.

NATIONAL URBAN HEALTH MISSION (NUHM):

National Urban Health Mission (NUHM) was launched in 2013 to cover the urban population to have access to free primary health services. As per Census 2011, population of India has crossed 121 crores with the urban population at 37.7 crores which is 31.16 percent of the total population. Under NRHM there were no norms for provision of primary health care and infrastructure in the urban areas thus limiting its scope. Municipal Corporations, Municipalities, Notified Area Committees and Nagar Panchayats were not units of planning under NRHM. NUHM will be overseen by the Mission Steering Group of NRHM and shall be expanded to act as the apex body for NUHM as well. Urban local bodies shall become a unit of planning with their own approved broad norms for setting up of health facilities. The plan made up by the urban local bodies shall become a part of the District Health Action Plan drawn up for NUHM. The existing structures and mechanisms of governance under NRHM shall be suitably adapted to fulfill the needs of NUHM as well. The metropolitan cities of Mumbai, New Delhi, Chennai, Kolkata, Hyderabad, Bengaluru, and Ahmedabad shall manage NUHM through their Municipal Corporations directly. For planning the local non-governmental organizations shall be actively involved under NUHM. Under NUHM the focus and thrust shall be on public health and provision of quality primary public health facilities that shall cater to their basic health care needs effectively. NUHM shall cover those cities and towns that have a population above 50,000 and all district headquarters shall be covered automatically.

The NUHM shall accord high priority to urban poor population living in listed and unlisted slums. It shall also focus on vulnerable groups in urban settings such as homeless persons, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers, and other temporary migrants. NUHM shall have a public health thrust on sanitation, clean drinking water, vector control, etc. It shall also seek to strengthen the health capacity of urban local bodies. NUHM shall establish synergies with existing social and developmental policies and shall channelize the infrastructure as well as personnel by rationalizing the extant situation. For example it shall depend on ASHAs as well as other personnel from schemes such

as JnNURM, ICDS etc. and shall establish Rogi Kalyan Samitis (RKS) to ensure effective participation of urban local bodies and their capacity building. It shall also have quality monitoring and regular surveillance as well as auditing systems in place and shall follow the existing systems such as IPHS or revise the same for urban areas.

The services under NUHM shall be of universal nature and outreach services shall be done via Female Health Workers (FHW) or ANMs, who shall be headquartered at urban PHCs. NUHM seeks to leverage on participatory mechanisms by involving the community at large as well as engaging volunteers like ASHAs and shall form groups like Mahila Arogya Samiti (MAS) (50-100 households) and Rogi Kal;yan Samitis. It is proposed that MAS shall be provided with a grant of 50,000 per year to conduct awareness programmes as well as sanitation and hygiene activities. The capacity building and orientation programmes shall be undertaken to involve the members of community through MAS. NUHM shall leverage the urban local bodies and shall promote their participation in planning and management of urban health programmes.

NUHM seeks to provide a single point delivery of health services via Urban PHCs and towards this end it shall promote convergence of communicable and non-communicable diseases. The existing Integrated Disease Surveillance Project (IDSP) structures shall be strengthened for improved surveillance. NUHM shall not provide for contractual staff of AYUSH as it is in the NRHM. NUHM shall be designed to cater to the specific urban needs as per the prevalent disease profile, which is constituted of non-communicable diseases in major proportion. The Urban PHC shall be designed to screen, diagnose and refer the cases of chronic diseases to secondary and tertiary level through a system of referral. So it shall also focus on strengthening healthcare facilities at secondary and tertiary levels. The NUHM shall induct additional managerial and financial resources at all levels to strengthen and add skilled manpower and technical support for effective implementation of its objectives (GoI 2013).

RASHTRIYA SWATHYA BIMA YOJANA:

Rashtriya Swasthya Bima Yojana (RSBY) is a health insurance scheme targeted at the people falling Below Poverty Line (BPL) to cover the hospitalisation costs for the year up to the tune of Rs 30,000. It was launched in 2008 by the Government of India,

as a centrally sponsored scheme, whereby the centre incurs the 75 percent of expenses on premiums and the states cover the rest, in case of Jammu and Kashmir and North-Eastern group of states the Centre covers 90 percent of expenses on premiums. It is a scheme which is launched in a Public–Private Partnership format, whereby private as well as public insurance companies are selected to provide insurance via competitive bidding process. The scheme uses innovative technology in registering, provision as well as maintaining database. Smartcards are issued to the enrolled members under the scheme, which has their details as well as biometric information. The state creates a State Nodal Agency (SNA) to overlook the whole process of enrolment and disbursement of smartcards via its agents called Field Key Operators (FKO), who are responsible to state and in collaboration with the insurers and insurer appointed Third Party Administrators (TPAs) they oversee and manage the whole process from enrolling, printing and allotting the smartcards to the members. The smartcards are unique in that they are interoperable throughout India and are not tied to specific hospital or state. The list of hospitals or health centres providing the insured care under RSBY are selected on the basis of screening criteria and then empanelled on the list of RSBY hospitals. This pan-Indian operability of the RSBY smart-cards is very helpful for migrant labourers who have to travel to other states from their home states in for work for major part of the year. The Ministry of Labour and Employment is the nodal ministry rolling out the scheme at the centre, though at state level some states have transferred it to health ministry as well. The enrolment under RSBY has been increasing and it has covered millions of poor people and seems promising in alleviating the misery of catastrophic health expenses for the most poor (Swarup and Jain 2012, La Forgia and Nagpal 2012).

Evaluation of RSBY is complex as well as mixed and is premature as the scheme is in early stage and there is great variance between states as well as districts within states on the aspects of enrolment, issue of smartcards, and utilisation of RSBY as well as rates of hospitalization under the RSBY. In a study done in 7 states to evaluate RSBY on enrolment and utilisation aspects it was found that the rates of enrolment being sluggish as to reach the target of full coverage of all BPL population by 2012; the rates of utilisation measured by hospitalisation are high but skewed as those districts which had higher and better private health care providers under RSBY showed great

hospitalisation rates whereas those districts which did not have sufficient private hospitals and inadequate government facilities showed very low rates of hospitalisation (Narayana 2010: 17-23).

In another study assessing the key performance indicators (KPIs) of RSBY evaluated the scheme on the KPIs of Conversion Ratio, a ratio of number of households enrolled to total number of eligible BPL families per district indicates the depth of reach of the programme; on Hospitalization Ratio which measures the ratio of the number insured to those who claimed insurance at least once and; Total Expense Ratio (TER) which is the ratio of sum of total claims paid out plus cost of smartcards and taxes to total premium collected. The study analysed these KPIs on their rates, factors affecting the rates as well as the present status of the RSBY based on these KPIs. It found that insurance awareness among the illiterate and poor is very low and this reflected in the conversion ratio as well as hospitalisation ratio being low in districts with low literacy and high poverty but it also showed that information and awareness can bring a change as the conversion ratio was higher in the next year in those districts where in first year some people had availed of the services of RSBY as well as had an active Gram Panchayat, indicating a spread of information and awareness amongst the people. Total expense ratio which measures the profitability of providing insurance to the insurers found mixed results that out of 226 districts 47 districts showed a TER higher than 100 percent indicating loss to the insurers. The authors attribute the losses to the insurers because of high hospitalisation rates in the initial years of the scheme. The findings show and emphasise the great variance in the operation of RSBY at the different districts as well as states indicating RSBY is failing at those areas which need it the most (Krishnaswamy and Ruchismita 2011; Hou and Palacios 2010).

In another study that undertook an experimental information and education campaign and household survey in the first year of the RSBY in Delhi found that households that had prior information about the scheme were more likely to enrol and Information, education and communication (IEC) campaigns had marginal effect on enrolment. Insurers did not seem to enrol only healthy households and the survey found that people who had pre-existing disease history were also enrolled by the insurers as per the mandate of RSBY (Das and Leino 2011).

In another study conducted to evaluate the RSBY in early implementation found that there were large discrepancies in the official database of BPL households based on the census 2002 report indicating large inclusion as well as exclusion errors. As the responsibility for the preparation of BPL database was not under the Ministry of Labour and Employment which was overseeing and coordinating RSBY, some minimum criteria was laid down and specifications were laid down before submission of database and making an entry into the RSBY database. This caused some delay in the process of enrolment of new beneficiaries. The study points out that enrolment though crucial is not the end of the RSBY rather it is the provision of cashless healthcare facilities to the poor so it looks at the hospitalization claims. It points out that it is poor who are not benefitting fully from RSBY as hospitalisation claims from rural areas according to 60^{th} round of NSS survey amount to only 2 percent and there is great variance in inter-district as well as inter-state rates of hospitalisation showing low utilisation rates for rural, illiterate and poor districts. The scheme aims to increase utilisation rates as Maternity benefits have been added to the list of procedures included in RSBY basket. The utilisation rates are dependent on the quality of hospitals, the healthcare personnel as well as the quality of service provision; so the author stresses the importance of improving quality to enhance utilisation rates of hospitals both public and private. There are many ways to improve quality an example of Kerala is provided where RSBY has been linked with NRHM to use the demand side approach to provide effective incentives. There have been instances of fraud as well in the implementation of RSBY as was seen in district of Dangs in Gujarat where several private sector hospitals were able to submit false claims for several months before being de-empanelled by the insurer but not before the claims ratio for the district exceeded 200 per cent. This case and several others led to the introduction of processes for de-empanelment as well as a centralized database of such hospitals. There have been instances where the RSBY beneficiary patients had to pay for medicines and incur out of pocket expenses. At many instances the cover of insurance under RSBY is considered insufficient to pay for other procedures in cases where complications might arise. The mandate in with states to cover and expand the amount of coverage and it depends on the respective states to do the same. Rules of RSBY enrolment are also not followed at the time of enrolment as smart cards are not issued at the time of enrolment but at some later point of time which leads to delayed usage

of the scheme and at times enrolled persons do not receive smartcards at all. At places the intermediaries responsible for issuance of cards have asked for monetary payment for issuing the cards (Palacios, R 2010; Hou and Palacios 2010).

The launch of NRHM and RSBY has been claimed to have strengthened the private sector as these programmes, with their PPP mode of implementation, provided the private players a lucrative market for their products. Rao (2017:24) claims "during the years 2007-2014, India witnessed the strange playing out of a zero-sum game. On the one hand, the government, by deliberate policy, injected into the private sector over Rs 200 billion per year (public as well as private out-of-pocket expenditure that was tax-exempted) as premium for health insurance, thus helping it expand and consolidate its market presence in the secondary and tertiary care markets; on the other hand, it invested an equal amount of money under the NRHM for strengthening the public sector delivery system, largely in the primary healthcare segment." As RSBY is largely an insurance protection for secondary and tertiary level hospitalization treatment with mostly private healthcare providers, the states did not strengthen primary health care, promote prevention, and establish a referral system. Government did not take advantage of the supply-side finance and by treating insurance only as demand-side intervention making citizens to choose the services gave rise to spending distortions (Rao 2017).

Hooda (2017) states that there is a shift from public provisioning of comprehensive healthcare services (Supply-side Financing Strategy) to merely ensuring universal access to services through health insurance (Demand-side Financing Strategy)[14]. Hooda concludes that "health insurance has been unsuccessful in protecting households from poverty and impoverishment resulting from out-of-pocket payments, and that insurance in fact subverts the effectiveness of traditional health financing system. Free or low-cost healthcare provisioning by the state remains the best way to enhance the health and well-being of households, provided the inadequacies and

[14] A supply-side financing strategy (SFS) strengthens essential primary, secondary and tertiary healthcare services and is financed through general taxation. It is based on provisioning of universal free or low cost health services to the citizens at the point of delivery. As this financing strategy is premised on supplying the services to the citizens it has the potential to reach the remotest regions if implemented effectively. Whereas a demand-side financing strategy is premised on enabling the health service access from private or public providers by providing financial protection through health insurance of selective or universal nature.

inequalities across districts are addressed, and low-cost medicines and diagnostics are made available to all."

HIGH LEVEL EXPERT GROUP FOR UNIVERSAL HEALTH COVERAGE (HLEG) 2011:

In 2010 the Planning Commission instituted a High Level Expert Group (HLEG) for Universal Health Coverage (UHC) to analyse the Indian healthcare system and to provide a report on provision of universal health coverage to the population. The HLEG suggested very pertinent and detailed report in 2011 and suggested various steps that shall go a long way to transform Indian health system into a universal healthcare system. The HLEG's key recommendations provide for affordable and accessible health care to all keeping in mind the social determinants of health and making reforms in light of the highly diverse and hierarchical nature of Indian society. It recommended that UHC cannot be reduced to only 'insurance' to the population but extends to 'assurance' of health care moving beyond the idea of freedom from illness alone. HLEG places the government in a pivotal role in provision of UHC as a guarantor to ensure its success and sustainability. Thus HLEG links UHC from a pious goal to a right to health as an entitlement.

HLEG provides a definition of UHC as, "**Ensuring equitable access for all Indian citizens**, resident in any part of the country, regardless of income level, social status, gender, caste or religion, **to affordable, accountable, appropriate health services of assured quality** (promotive, preventive, curative and rehabilitative) **as well as public health services addressing the wider determinants of health** delivered to individuals and populations, with **the government being the guarantor and enabler**, although not necessarily the only provider, of health and related services" (GoI, HLEG 2011: 3; emphasis in original). The HLEG proposes that every person shall be entitled to essential primary, secondary and tertiary health care services that shall be guaranteed by the central government. The range of essential health care services shall be offered as a National Health Package (NHP) which shall include all common conditions and high-impact, cost-effective health care interventions for reducing health-related mortality and disability. The NHP services shall be determined by a panel of experts keeping in mind the resource availability and the health needs of the country. The health care services forming the NHP shall be

provided for by public sector as well as contracted-in private facilities as well including the Non-governmental organizations and non-profit organizations.

The HLEG suggested recommendations on six critical areas that it identified as essential to augment the healthcare capacity. These six focus areas are, i) Health financing and financial protection; ii) Health service norms; iii) Human resource for health; iv) Community participation and citizen engagement; v) Access to medicines, vaccines and technology and; vi) Management and institutional reforms.

The HLEG identified three principal objectives of the reforms in health financing and financial protection, namely, a) to ensure adequacy of financial resources for the provision of essential health care to all; b) to provide financial protection and health security against impoverishment for the entire population of the country and; c) to put in place financing mechanisms which are consistent in the long-run with both the improved wellbeing of the population as well as containment of healthcare cost inflation.

Under this head the HLEG recommended the following, i) The Government, both central government and states combined, should increase public expenditure on health from the current level of 1.2 % of GDP to at least 2.5% by the end of 12^{th} plan, and to at least 3% of GDP by 2022; ii) The state should ensure availability of free essential medicines by increasing public spending on procurement; iii) To use general taxation as the principal source of health care financing complemented by additional mandatory deductions for health care from salaried individuals and tax payers, either as a proportion of taxable income or as a proportion of salary; iv) it recommended against levying sector specific taxes for financing; v) It recommended against the levy of user fees for any kind service under the UHC; vi) It proposed introduction of specific purpose transfers to equalise the levels of per capita public spending on health across different states as a way to offset the general impediments to resource mobilisation faced by many states and to ensure that all citizens have an entitlement to the same level of essential health care; vii) It proposed to adopt flexible and differential norms for allocating finances so that states can respond better to the physical, socio-cultural and other differential and diversities across districts; viii) It proposed that the expenditures on primary health care, including general health

information and promotion, curative services at primary level, screening for risk factors at the population level and cost effective treatment, targeted towards specific risk factors, should account for at least 70% of all health care expenditure; ix) It recommended against using insurance companies or any other independent agents to purchase health care services on behalf of the government; x) It proposed that the purchase of all health care services under the UHC system should be undertaken either directly by the Central and state governments through their departments of Health or by quasi-governmental autonomous agencies established for the purpose; xi) It proposed that all government funded insurance schemes should, over time, be integrated with the UHC system. All health insurance cards should, in due course, be replaced by National Health Entitlement Cards. The technical and other capacities developed by the Ministry of Labour for RSBY should be leveraged as the core of UHC operations- and transferred to the Ministry of Health and Family Welfare (GOI, HLEG Report 2011: 8-14).

Under the head of Health Service Norms it provided the following recommendations, i) It proposed to develop a national health package that offers, as part of the entitlement of every citizen, essential health services at different levels of the health care delivery system; ii) to develop effective contracting-in guidelines with adequate checks and balances for the provision of health care by the formal private sector; iii) it proposed to reorient health care provision to focus significantly on primary health care; iv) it emphasised the strengthening of District hospitals; v) to ensure equitable access to functional beds for guaranteeing secondary and tertiary care; vi) to ensure adherence to quality assurance standards in the provision of health care at all levels of service delivery; vii) to ensure equitable access to health facilities in urban areas by rationalizing services and focusing particularly on the health needs of the urban poor (GOI, HLEG Report 2011: 16-18).

Under the head of human resource for health it proposed to, i) ensure adequate numbers of trained health care providers and technical health care workers at different levels by, a) giving primacy to the provision of primary health care, b) increasing human resources of health (HRH) density to achieve WHO norms of at least 23 health workers per 10,000 population (doctors, nurses, and midwives); ii) to enhance the quality of HRH education and training by introducing competency-based, health

system-connected curricula and continuous education; iii) to invest in additional educational institutions to produce and train the requisite health workforce; iv) it proposed to establish District Health Knowledge Institutes (DHKIs) to enhance the quality of health workers' education and training; v) it stressed the strengthening of existing State and Regional Institutes of Family Welfare and selectively developing Regional Faculty Development Centres to enhance the availability of adequately trained faculty and faculty-sharing across institutions; vi) it proposed to establish a dedicated training system for community health workers; vii) it proposed to establish State Health Science Universities; viii) it proposed to establish the National Council for Human Resources in Health (NCHRH) to prescribe, monitor and promote standards of health professional education.

Towards community participation and citizen engagement it proposed, i) to transform existing Village Health Committees (or Health and Sanitation Committees) into participatory health councils to make it more broad based by engaging representatives of civil society organizations; ii) it proposed organising regular health assemblies at district, state and national levels; iii) it suggested enhancing the role of elected representatives as well as Panchayati Raj institutions in rural areas and local bodies in urban areas; iv) it proposed to strengthen the role of civil society and non-governmental organisations; v) to institute a formal grievance redressal mechanism at the block level.

Towards enhancing the access to medicines, vaccines and technology it proposed, i) to enforce price controls and price regulation especially on essential drugs; ii) to revise and expand the National Essential Drugs List (NEDL); iii) to strengthen the public sector to protect the capacity of domestic drug and vaccines industry to meet national needs; iv) to ensure the rational use of drugs in prescription in both public and private sectors by elimination of non-essential and irrational drugs in prescription; v) to set up national and state drug supply logistics corporations; vi) it stressed to protect the safeguards provided by the Indian patents law and the TRIPS Agreement against the country's ability to produce essential drugs; vii) it suggested to empower the Ministry of Health and Family Welfare to strengthen the drug regulatory system.

Towards management and institutional reforms the HLEG suggested, i) the introduction of All India and state level Public Health Service Cadres and a specialized state level Health Systems Management Cadre in order to give greater attention to public health and also strengthen the management of the UHC system; ii) to adopt better human resource practices to improve recruitment, retention motivation and performance; rationalize pay and incentives; and assure career tracks for competency-based professional advancement; iii) to develop a national health information technology network based on uniform standards to ensure inter-operability between all health stakeholders; iv) to ensure strong linkages and synergies between management and regulatory reforms and ensure accountability to patients and communities; v) to establish financing and budgeting systems to streamline fund flow, and towards this end it recommended establishment of the following agencies, 1) National Health Regulatory and Development Authority (NHRDA) to regulate and monitor public and private health care providers, with powers of enforcement and redressal. It shall also look over contracts, accredit health care providers, and develop ethical standards for care delivery, enforce patients' charter of rights, formulate legal and regulatory norms and manage protocols for NHP. To perform all this functions NHRDA shall have three units under it, which shall be looking into the specific objectives and activities, these are, a) The System Support Unit (SSU), which shall be responsible for developing standard treatment guidelines, management protocols, and quality assurance methods for the UHC system; b) The National Health and Medical Facilities Accreditation Unit (NHMFAU), this institution shall be responsible for the mandatory accreditation of all allopathic and AYUSH health care providers in both public and private sectors as well as for all health and medical facilities and; c) The Health System Evaluation Unit (HSEU), which shall monitor and evaluate the performance of both public and private health services at all levels. 2) The second body under NHRDA shall be called National Drug Regulatory Authority (NDRDA) to regulate pharmaceutical and medical devices and provide patients access to safe and cost effective products. 3) The third body under NHRDA shall be called National Health Promotion and Protection Trust (NHPPT) which shall play a catalytic role in facilitating the promotion of better health culture amongst people, health providers and policy makers. Lastly, HLEG

recommended investment in health sciences research and innovation to inform policy, programmes and to develop feasible solutions.

The HLEG sought to provide for universal health coverage for all which took certain aspects seriously for realisation of health as an entitlement of an entrenched right. These aspects encompassed principles such as universality in a real sense covering all within the ambit especially the most vulnerable and discriminated groups; equity in access to services and benefits on the principle of 'horizontal equity' (equal resources for equal needs) as well as equity ensured by special measures to ensure coverage of sections with special needs meaning 'vertical equity' (more resources for additional needs). It also considered empowerment of some sections as well as personnel for promoting health and providing comprehensive care with non-exclusion and non-discrimination. It stressed the issue of financial protection in case of catastrophic health expense by arguing for cashless services meaning the non-payment at the point of provision of service under the scheme. It emphasised the protection of patients' rights, provision of appropriate care and respect of patients' choice. It argued for portability and continuity of care throughout the country under the scheme. It placed public financing at the centre of the scheme whereby substantial funds would come through tax based funds and it shall be a single payer system. Accountability, transparency and participation shall be integral to the scheme. It shall design the scheme in a manner that the specific situation of health transition is kept in mind and structured similarly to cater to the needs that arise from this transition. It shall argue for addressing broader determinants of health and towards that it considers gender as a key determinant of health and shall devise the UHC in a manner to address these concerns.

THE 12TH FIVE YEAR PLAN:

In the backdrop of HLEG report 12th five year plan period followed and the plan proposed to expand the reach of health care and work towards the long term objective of establishing a system of Universal Health Coverage (UHC). It proposed to provide everyone with the essential medicines and healthcare that comprised the package at an affordable price and free of cost to large segment of population. 12th plan proposes expansion of health care coverage to those who are left out of it in both the rural as well as urban areas. It also proposes to expand the reach of public health care

lamenting that public health care has been inadequate and for this reason large population has to rely on private health care system and incur huge expenses on health. 12th plan proposes to substantially increase in both plan and non-plan health sector expenditure by the end of the plan period and clean drinking water and sanitation shall be given priority in resource allocation. It states that financial and managerial systems will be redesigned to ensure more efficient utilisation of resources to achieve better outcomes and states 'more can be done from less for more' for better health outcomes. It states that efforts shall be made to encourage cooperation between the public and private sector towards achieving health goals via contracting in of services for gap filling, and also various forms of effectively regulated and managed PPP, while ensuring that there is no compromise in terms of standards of delivery. It seeks to reform RSBY to enable access to a continuum of comprehensive primary, secondary and tertiary care. It seeks to leverage the platform of RSBY to cover the entire population below poverty line. It proposes to do away with user fees in health provision in keeping with the recommendations of HLEG. It proposes to expand the health sector manpower and set up new medical and nursing schools, etc prioritising setting these up in the hitherto underserved regions. Also massive effort shall be made to recruit and train paramedical and community level health workers. It laments the multiplicity of central sector and centrally sponsored schemes preventing a holistic health-systems-approach, leading to duplication and redundancies, and making coordinated delivery difficult. This also constrains the states to prepare need based plans or deploy their resources in efficient manner. It proposes the way forwards from this multiple top down approach is to strengthen the pillars of health system, so that it can prevent, detect, and manage each of the unique challenges that different parts of the country face. It proposes to prioritise the provision of generic drugs free of cost under the Essential Health Package. It states that effective regulation of medical practice, public health, food and drugs is essential to safeguard the people against risk and unethical practices.

12th plan emphasises that special attention shall be given to health care needs of the marginalised and vulnerable groups. It shall seek to address this issue by taking steps to make access to services easier for these groups by bringing down the barriers to access by creating health infrastructure, improving connectivity and by making the

service delivery cashless. It also proposes to bring in special services for people with special needs to be provided by skilled and trained professionals. It proposes to monitor and make concurrent impact evaluations by collecting disaggregated information on disadvantaged segments of the population. It proposes mandatory representation of marginalised and vulnerable groups in the community level fora such as Rogi Kalyan Samiti (RKS) and Village Health Sanitation and Nutrition Committee (VHSNC). It proposes to have 50 percent representation of women in the VHSNC. It asks for training of health workers to the special needs differently-abled or people with special needs.

The 12th plan on social sector and health specifically draws from the recommendations of HLEG and seeks to carry forward and achieve the targets set out by the HLEG Report. It prioritises Universal Health Coverage as the goal to be achieved in two to three plan periods and take steps to achieve the same.

HLEG report was not accepted and implemented as there was miscommunication and mistrust between the Health Ministry on the one hand and Public Health Foundation of India (PHFI), the body writing the HLEG report and the Planning Commission on the other. Many of the members of HLEG Report were also members of Planning Commission. Health Ministry's objection to the HLEG report was centred on para 3.1.10 of HLEG Report. This section of the HLEG report "proposed for outsourcing of block or district health systems as singular package to corporate agencies. These agencies were to lead what was called an integrated network, but what in effect was placing public facilities under different ownership, and shifting the role of government from provider to a purchaser" (Rao 2017: 361).

Ministry had objected to two of the recommendations proposed by Planning Commission drawing from the HLEG Report. The first was, the recommendation of HLEG "to have government purchase care from managed care organizations (providers) constituted as integrated networks as delivery nodes operating within a geographical area to provide a continuum of services-primary, secondary, and tertiary- to the registered population. Payment to these networks was to be on per capita basis" (Rao 2017: 360). This was reminiscent of the US model of managed care and was to be implemented over a period of two to three plans.

The second recommendation the ministry had objected to was one whereby HLEG proposed that the grants to the states supplied directly to them by passing the central health ministry under the additional assistance route. This was suggested to incentivise the states to purchase these services and bring in the desired reforms.

These two recommendations were the bone of contention between the Ministry and Planning Commission and Planning Commission included both these in the final draft despite reservations put forth by the health ministry. This ensued many a parleys between the two organisations and intervened by National Advisory Committee as well, where these recommendations were objected to by the ministry and thus NAC came up with its own plan which was almost the same as HLEG. All this led to bitterness between the two departments and Planning Commission delayed and stalled the provision of required budgetary support for the first two plan years (Rao 2017: 358-67).

The above discussion of the HLEG and the subsequent developments point to the general picture of workings of policy making with policymaking outsourced to private organisations or quasi-private organisations and the mistrust and miscommunication that the prevails between health ministry and these organizations. The HLEG and Planning Commission showed scant regard for taking the ministry into confidence which was responsible for implementing the policy and no deliberations between them ever take place to reconcile their differences.

Also substantively, the proposals of HLEG regarding this networked provision via these private agencies reducing the state to purchase health services from these agencies would have pushed the commodification of health in big way, which is already underway in the economy.

The National Health Accounts (NHA) in 2013-14 provided the Total Health Expenditure (THE), which is the sum total of Current Health Expenditure (CHE) and Capital Expenditure (CE), estimates to be at Rs 4,53,106 crore, this equates to 4.02% of the country's Gross Domestic Product (GDP) and Rs 3,638 per capita. The current health expenditure is estimated at Rs 4, 21,194 crores (93% of THE) and the capital expenditure1 is estimated at Rs 31,912 crores (7% of THE). The estimated total

government health expenditure in FY 2013-14 is Rs 1, 29,778 crores which is 1.15% of GDP (NHA 2013-14).

The Total Health Expenditure (THE) comprises of capital expenditure and Current Health Expenditure (CHE) in both public and private sectors providing healthcare in India.

Capital expenditure includes expenditure on construction of buildings and infrastructure, research and development, education and training in medical/ paramedical/ allied sciences, etc.)

Current Health Expenditure (CHE) is the expenditure incurred by the specific entity in the current fiscal year.

Out-of-pocket expenditure (OOPE) is the amount spent by the individuals privately themselves on health expenses in the particular fiscal year.

Table 1: Comparative indicators from NHA 2004-05 and NHA 2013-14

S. N	Indicators	NHA 2004-05	NHA 2013-14
1	GDP (Rs Crores)	3149412	11272764
2	THE as % of GDP	4.2	4.0
3	CHE as % of THE	98.9	93
4	Total Govt. Health Expenditure as % of THE	22.5	28.6
5	Household Health Expenditure as % of THE	71.7	67.7
6	OOPE as % of THE	69.4	64.2
7	Firms as % of THE	5.7	2.4
8	Social Health Insurance (including govt. based voluntary insurance and reimbursement of govt. employees) Exp as % of THE	4.2	6.0

9	Private Health Insurance as a % of THE	1.6	3.4

Source: NHA 2013-14 (NHATS) (NHSRC) MoHFW.

NATIONAL HEALTH POLICY 2017:

During this period the Draft National Health Policy 2015 was placed in the public domain for comments, suggestions and feedback by the Ministry of Health and Family Welfare, Government of India and has been finalised and put forth as the National Health Policy 2017. The policy proposes raising public health expenditure to 2.5 % of the GDP. It also notes that 40% of this would need to come from Central expenditures. This expanded investment at per capita level translates to a fourfold increase in public per capita health expenditure over five years. The major source of revenue generation for public health expenditure shall be general taxation and it also talks of creating a health tax akin to the education cess. It highlights that the majority of allocated resources, to the tune of 50 percent, to public health sector goes into the human resources for health such as expenses related to salaries and running costs of medical and other colleges and training institutes. It moots higher investments to balance this iniquitous distribution of allocated resources. It proposes to utilise and leverage the opportunity of directing revenues generated by way of Corporate Social Responsibility (CSR), though modest compared to the needs, in strategic manner for well-focused programmes, communities or geographies with special levels of vulnerability which require special attention. The draft NHP 2015 seeks to address the promotive as well as preventive aspects of health influenced by the wider social and environmental determinants of health and for that it mandates the Ministry of Health & Family Welfare to provide a roadmap for a series of coordinated policy initiatives and practical actions, to be implemented across all sectors. It also highlights the wider ramifications of loss of health of population on the reflected in the negative impacts on workforce participation, economic growth, and societal sense of well-being and achievement. It states that apart from this instrumental vision of health, promotion of health and wellbeing are worthy goods own their own to be achieved for health and happiness of the population. It states that individual actions can go a long way in determining the health and wellbeing of a person but it is influenced by the economic

and social environment in which the individual resides so it is imperative to bring a transformation in the larger social and economic environment to bring a transformative change in health outcomes. It emphasizes the influence of wider social, economic and environmental determinants of health and prevention agenda that addresses them requires cross-sectoral, multilevel interventions that involve sectors such as food and nutrition, education, safe drinking water and sanitation, housing, employment, industrial and occupational safety, welfare including social protection, family and community services, tribal affairs and communications. It stresses that the state should apart from making policies and goals, the Government has an obligation to build community support and capacity to enjoy good health, particularly among those who are most vulnerable and have the least capacity to make choices and changes in their lifestyle or living conditions that might improve and protect their health: the very young, the marginalized or socially excluded, the poor, the vulnerable to violence, the old, and the disabled. Towards this the policy asks the government to strengthen the Village Health Sanitation and Nutrition Committee and the other local government entities in both the rural as well as urban areas. To address the socio-economic determinants of health the policy identifies seven priority areas for coordinated action by the government. First, it proposes strengthening of the Swachh Bharat Abhiyan to bring reduction in water and vector borne diseases and declines in improperly managed solid waste; second, to promote balanced and healthy diets by strengthening meal programme in Anganwadi and schools to bring down malnutrition, and improved food safety; third, to address the growing tobacco, alcohol and substance abuse by strengthening the Nasha Mukti Abhiyan; fourth, it seeks to bring down the preventable deaths on account of accidents and injuries by focusing on road and rail safety measures; fifth, it stresses to bring down the gender violence manifesting from sex determination, to sexual violence would be addressed through a combination of legal measures, implementation and enforcement of such laws, timely and sensitive health sector responses, and working with young men; sixth, it seeks to promote safe and healthy work environment and address issues relating to occupational safety as well; lastly, it seeks to address the indoor as well as outdoor pollution by taking various measures to bring down decreases in respiratory and other pollution borne diseases.

The policy seeks to expand the prevailing preventive and promotive health programmes of immunization and ante-natal care, school health programmes and some limited health education and health communication efforts to include other aspects such as early detection and response to early childhood development delays and disability, adolescent and sexual health education, behaviour change with respect to tobacco and alcohol use, screening, counselling for primary prevention and secondary prevention for common chronic illness-both communicable and non-communicable. Amongst these issues the draft NHP 2015 prioritises health of children for much greater emphasis, investment and action by incorporating health education as part of the curriculum, by promoting hygiene and safe health practices within the school environs and by acting as a site of primary health care. It stresses that the school noon programme as well as food supplementation programmes at the Anganwadi shall be leveraged to achieve accelerated declines in child malnutrition. It calls for greater scrutiny and monitoring by the city health officers and district medical and health officers of the certain occupations which are inherently hazardous to health to see if they are complying with the mandated occupational safety norms to promote preventive aspects of health.

The NHP 2017 stresses that to achieve the goals enunciated it is crucial to move away from the highly selective primary care approaches to a strengthened comprehensive primary care approach, strengthening and transformation of the ASHA programme from some sort of stop-gap arrangement to a way of organizing health care and finally it requires a much wider involvement of communities and multiple stakeholders. It emphasizes the role of ASHAs in disease prevention and health promotion and seeks to expand the role of ASHAs to undertake primary prevention for non-communicable diseases, in palliative care and community mental health, through health promotion activities, working with care givers and the Village Health Sanitation and Nutrition Committees, which would include representatives of local government.

The NHP 2017 also talks of bringing a ‘Social Movement for Health’ by wider involvement of stakeholders including elected local governments, local communities and community based organisations like self-help groups, students of schools and colleges, non-government organizations, professional organizations, and corporate social responsibility mechanisms.

To address the social determinants of health and to bring an assessment of improvements in these, the NHP 2017 proposes developing capacities and processes for 'Health Impact Assessment' of existing and emerging policies of key non-health departments, directly or indirectly impacting health, and establishing systems that seek concurrence of Department of Health in new policies of key non-health sectors. To achieve this it envisages convergence with sectors such as nutrition, education, water and sanitation, agriculture, housing, labour etc. across each stage of the planning cycle, and inter-departmental convergence, for synergistic improvement of health status.

The policy also recommends the setting up of seven 'Task Forces' for formulation of a detailed 'Preventive and Promotive Care Strategy in each of the seven priority areas for preventive and promotive action outlined above, and to set the indicators and the targets and mechanisms for achievement in each of these areas.

NHP 2017 stresses on expanding the Primary Health Care from the hitherto Selective Primary Health Care to a Comprehensive Primary Health Care to mean primary care for all of reproductive and child health, communicable diseases and non-communicable diseases through appropriate health communication, technologies and care provision. The health facilities shall provide the larger package of comprehensive primary health care and shall be called health and wellness centres. Most elements of primary care would be designed such that a nurse or paramedical with suitable training should be able to provide the necessary care. The policy proposes to strengthen the referral system from primary to secondary and tertiary care and proposes enhanced use of information and communication technology tools.

The policy seeks to expand the capacity of secondary health sector and create new secondary care units such that 1000 beds are available for a population of one million, which is evenly distributed throughout the country. The secondary care units primarily serve as referral units so they should be evenly spread across the region and efficient emergency transport systems have to be created. It also proposes purchasing care from private hospitals to close critical gaps in public provisioning of services.

The NHP 2017 also talks of strategic purchasing by which it refers to the Government acting as a single payer-purchasing care from public hospitals and private providers as

part of a strategic plan for district health systems development. This is proposed as a measure to improving efficiencies of use of funds - when actual services delivered can be much skewed across facilities and where there are complex local needs of equity and marginalization. The draft health policy states that strategic purchasing is also an opportunity to provide stewardship to the private sector- where purchase by the State would indicate where and what services have critical gaps and encourage growth of the sector in such areas. It also proposes to fill the much needed gap in secondary sector of skilled and specialists by devising a scheme to develop such skill sets across public and private hospitals.

It proposes that a change in orientation of viewing public health system has to be brought in policy formulation rather than seeing public hospitals as social enterprises that ideally must recover the costs of their functioning, to re-imagining them as part of a tax financed single payer health care system in which, what public hospitals deliver is not free care, but rather pre-paid care (like in commercial insurance) and which is cost efficient in addressing health care needs of the population.

The fallout of viewing public health care as not free care but pre-paid care is that quality of care would become an imperative - and all public facilities must have periodic measurements and certification for level of quality and must be financed and incentivized to meet and retain quality standards. The policy stresses on improving the quality of health care provision and provides that every health care facility is measured and scored for quality, and certified and incentivized when it achieves a certain minimum score.

It also stresses the expansion of blood banks and provision of safe blood as an important component of improved service delivery.

Regarding the urban health care provision the policy stresses on expansion and improvement of urban primary health care system. It proposes strengthening of NUHM and corresponding increase in resource allocation for it. It provides that the special focus of the urban health policy shall be urban poor and the target population covered under NUHM. It also proposes improvements in urban environment which has a direct bearing on the urban health outcomes and emphasizes measures of reduction of air pollution, better solid waste management, water quality, occupational

safety, road safety, housing, vector control, and reduction of violence and urban stress.

In tertiary care sector the policy states that tertiary care has expanded in recent years but it has been skewed towards private health care sector and is expensive. It proposes that public tertiary care facilities be expanded by creating more speciality units like the AIIMS and training institutes for speciality and super-speciality courses.

The policy also proposes that to ensure quality of Medical Education, a common entrance exam on the pattern of NEET for UG entrance at all India level needs to be enforced. A Licentiate Exam will be introduced for all medical graduates with a regular renewal at periodic intervals with CME credits accrued.

The policy proposes that improvements in the public health sector's efficiency can be brought by changing and streamlining the mechanisms of resource allocation and payment system to the public health facilities. It proposes setting up of a robust National Health Accounts System to enable this. It provides that fixed normative allocations that are independent of volume and pattern of services delivered and do not factor in quality of services rendered are inefficient. The policy therefore calls for major reforms in public financing even for public facilities where a significant part of the funds- especially most of those related to operational costs would be in the form of reimbursements for care provision and on a per capita basis for primary care. Fixed costs, which include items like infrastructure development and maintenance, the non-incentive cost of the human resources i.e salaries, much of administrative costs would however continue to flow on a budget basis.

It also provides that allocations would be made on the basis of differential financial ability, developmental needs and high priority districts to ensure horizontal equity through targeting specific population sub-groups, geographical areas, and health care services and gender related issues. A risk equalisation formula based on health care needs could be developed. A higher unit cost or some form of financial incentive payable on quarterly or annual basis could be given for facilities providing a measured and certified quality of care. Also considering targeted increase in allocation of public expenditure for curative care, high cost non-communicable

diseases, chronic diseases would receive attention in addition to current focus on reproductive, maternal and child health programmes.

It also proposes enhancing the regulatory framework for health sector and laments that the Clinical Establishments Act 2010 cannot be operationalized fully because of the non-cooperation of many states in its implementation and the non-committal nature of Indian Medical Association. The policy calls for a major reform and strengthening of Medical Council and other bodies and their accountability. It also emphasizes the Government's own accountability in professional education, in ensuring that the process leads to providing professionals who correspond to national needs. One has to build an approach to governance such that there is a balance between autonomy that professional councils require and the good governance, accountability, effectiveness and responsiveness to national priorities and needs.

It also provides that the Drugs and Cosmetics Act would be amended to incorporate chapters on medical devices-which are essential to unleash innovation and the entrepreneurial spirit for manufacture of medical device in India. Strengthening testing and surveillance capacities in Center and States, a national data bank of all regulatory actions, and e-governance tools would strengthen and speed up regulatory processes. Building capacities in line with international practices in our regulatory personnel and institutions would have the highest priority.

The policy laments the fact that India is the pharmacy of the developing world; but about half of its population does not have access to essential lifesaving medicines and the situation is worse when it comes to medical devices and in-vitro diagnostics. It proposes that pricing for drugs shall continue to be regulated for an increasing range of essential drugs via notifications released by National Pharmaceutical Pricing Authority (NPPA) under National Essential List of Medicines (NELM). Both the list and the cap on prices shall be periodically revised. Timely revision of NELM along with appropriate price control mechanisms for generic drugs shall remain a key strategy for decreasing costs of care for all those patients seeking care in the private sector.

It provides for active use of tools of ICT for greater and efficient resolution of health care needs at the national level. It proposes that the integrated health information

system will be based on key principles and strategies like (a) adoption of National Electronic Health Record Standards (announced by the Ministry in 2013) and Metadata and Data Standards; (b) federated architecture to roll-out and link systems at State level and national level; (c) progressive use of "Aadhaar" (Unique ID) for identification (in case UID is not available, then other ID would be created as per the standards notified by the Ministry) and issue of a unique Health Card to every citizen; (d) creation of health information exchange platform and national health information network; (e) use of existing/planned national and state level IT infrastructures such as the National Optical Fiber Network, Meghraj (cloud), (f) smartphones or tablets for capturing real-time data; and (h) setting-up of dedicated governance structures.

It also proposes that in knowledge based sector like health, where advances happen daily it is important to invest at least 5 % of all health expenditure on health research. The establishment of a Department of Health Research (DHR) in the Ministry of Health & Family Welfare was in recognition of the key role that health research would play for the nation. It proposes to strengthen the health research by promoting the research institutes and providing them incentives and requires resources.

Regarding making health a justiciable right the draft national health policy proposes the following formulation- "the Center shall enact, after due discussion and on the request of three or more States (using the same legal clause as used for the Clinical Establishments Bill) a National Health Rights Act, which will ensure health as a fundamental right, whose denial will be justiciable. States would voluntarily opt to adopt this by a resolution of their Legislative Assembly. States which have achieved a per-capita public health expenditure rate of over Rs 3800 per capita (at current prices) should be in a position to deliver on this- and though many States are some distance away- there are states which are approaching or have even reached this target."

The draft NHP 2015 the precursor the NHP 2017 has been criticized for not bringing anything new or radical to the policy on health and copying the policy prescriptions of the 12th Five Year Plan and from the report of the HLEG on Universal Health Coverage. The NITI Aayog (formerly the Planning Commission) is reported to have been against increase in investment in health and against improvements in the public health sector. The idea of free medicines and diagnostics did not go very well with

the NITI Aayog. It favoured private sector and for an insurance-based health services model whereby people would pay or contribute in a sickness fund to avail of the health services. Many have claimed that the NITI Aayog is not serious about health and has not been doing serious thinking to provide universal health care. On top of this the Centre drastically cut the finance flow to the health sector as has been evident by the Fourteenth Finance Commission's fund allocation to the sector. These reductions in the 12th plan allocations hampered the rolling out of the UHC (Duggal 2016: 12).

In this period from 1983 to 2017 we see certain characteristics of development of health policy which is predominated by one major concern: privatisation. The overall emphasis and direction of reforms and other steps taken in the name of decentralization, increasing efficiency by engaging NGOs or by bringing health insurance, privatization of health is the underlying theme.

First, privatisation began in terms of establishment and proliferation of myriad hues of clinics, diagnostic centres, and later as corporate hospitals. These were wholly private entities and worked and competed alongside the public healthcare system. The private health players mushroomed in the urban areas as it was easier and profitable to do business as the public facilities were underfunded and understaffed and finding it difficult to cater to the rising healthcare needs of the population. The argument put forth to incentivise the private sector to enter the market via tax benefits was that they were efficient and would reduce the excess burden on public facilities and also help in improving the health profile of the citizens.

Second shift comes in the form of engaging of NGOs in the provision of health services as partners of government. This shift also derives its legitimacy from the argument of inefficiency of the public sector to properly cater to the health demands of the citizens. The other debilitating feature of this development was the depoliticisation of provisioning of basic services to the citizens. These NGO took up various forms as hybrid organisations and were partly government organizations as well as part non-government and it created confusion as to who is responsible in cases of non-provision. This marked the gradual shrinking of state from provider to facilitator of basic services.

Third shift occurs via processes of decentralisation and in the name of giving ground level organisations more fiscal space and powers to formulate and implement the policies as per their demands. But what has been happening is outsourcing of these functions again to the myriad non-governmental organizations of these functions. The state is increasingly becoming enabler by facilitating the supply of basic goods via private entities.

Fourth shift is witnessed in the form of privatisation of gains and making the expenditure public. This is exemplified in the type of insurance mechanisms espoused by various states and the centre. The Yeshaswini Health Insurance scheme in Karnataka, the Rajiv Arogyasri in Andhra Pradesh and the RSBY at the national Level have all been structured in this fashion. The state or the governments pay the premiums to the private insurance providers as well as the private empanelled hospitals where the citizens who are eligible go for health services. This has allowed the private players to consolidate their hold in the health insurance market.

Finally there are instances of leasing of government health facilities to private players for 30 years or more to be run for profit, already some instances of this happening as in the Bhuj district hospital, Sikkim Manipal Hospital etc.[15] and would have happened in big way had the proposal of HLEG been implemented which makes the state a purchaser of health services provided by integrated networks of private players for the whole block or district.

All the health provision policies brought out by the state be it NRHM or RSBY have a selective and targeted approach of provisioning of services. This has a tendency of relegating the implementation of these schemes into insignificance as they cater to the least politically vocal segments of the population who also tend to be the poorest economically. The politically vocal and economically self-sufficient segments of the population do not derive their services from these schemes and thus do not have a stake or say in the proper functioning of these policies. But it has been found that rising OOP on account of medicine bills or hospitalisation bills have equally affected all segments of population rich and the poor alike though the affects are catastrophic for the poor only. Only comprehensive health provisioning by the state at very low

[15] For details see Rao (2017).

costs or free provisioning can be the solution to meet the health challenges of the citizens and this necessitates larger funding and systematic and regulatory overhaul of the system (Hooda 2013).

CHAPTER 4

DILEMMAS OF LITIGATING HEALTH RIGHTS

Indian Constitution provides for socio-economic guarantees to the citizens under the Directive Principles of State Policy (DPSP). The Constitution declares these guarantees to be non-justiciable under Article 37 of the Constitution and thereby does not allow for appropriate judicial remedy in cases of their non-realization or violation either under Article 32 to approach the Supreme Court or under Article 226 to seek remedy from the High Courts. But Article 37 also provides that 'the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the state to apply these principles in making laws'. Therefore the courts read that DPSP should 'conform and run subsidiary' to the fundamental rights[16]. It was in the landmark judgment of *Keshavananda Bharati v State of Kerala*[17] that the court recognized the fundamentality of DPSP in the governance of the country at par with the fundamental rights of the individual. The court brought out the complementary relation between the fundamental rights and the directive principles. It emphasized the harmonious interpretation of the fundamental rights with DPSP to create a 'just social order'[18]. This view of complementarity between the fundamental rights and DPSP and 'neither being superior to the other' has now become the established rule of interpretation.[19]

The social rights are mostly given recognition by the court by giving an expansive reading to the fundamental right to life and liberty as provided under Article 21. The initial attitude of the court in interpreting Article was legalistic and literal as was exemplified in the *A. K. Gopalan v State of Madras*[20] judgment where the court refrained from looking into the fairness or reasonableness of a law if it was enacted in a valid manner. This narrow reading of Article 21 was changed and expanded to

[16] State of Madras v. Champakam Dorairajan (1951) SCR 525
[17] (1973) 4 SCC 225
[18] Mathew J. in Keshavananda Case para 1707 at p. 879
[19] See State of Kerala v N. M. Thomas
[20] (1950) SCR 88

'substantive due process' culminating in the *Maneka Gandhi v Union of India*.[21] In this case the petitioner challenged the refusal by the Government to grant her a passport resulting in the curtailment of her liberty to travel abroad. The petitioner challenged the Passport Act, 1967 whereby the passport of petitioner was impounded. The petitioner submitted that the impugned Act provided no procedure for the same and even if some procedure could be deduced it was unreasonable and arbitrary and therefore in violation of right to life and liberty under Article21. The Court explained the scope and content of the right to life and liberty by asking the question that whether the provision of mere procedure is enough or that procedure should comply with certain requirements. The court answered that the procedure should not be 'arbitrary, unfair or unreasonable'. This led to expansive interpretation of right to life and liberty encompassing various aspects of life. The court gave an expansive and comprehensive exposition of this right in *Francis Coralie Mullin v The Administrator*[22] judgment, the court stated that:

The right to life includes the right to live with human dignity and all that goes with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter and facilities for reading, writing and expressing oneself in diverse forms, freely moving about and mixing and commingling with fellow human beings. The magnitude and components of this right would depend upon the extent of economic development of the country, but it must, in any view of the matter, include the bare necessities of life and also the right to carry on such functions and activities as constitute the bare minimum expression of the human self.

During this time, in the aftermath of emergency period, the court devised the Public Interest Litigation (PIL), an entirely 'judge-led and judge-dominated movement'.[23]PIL also became the preferred means to give effect to social rights and contributed to the development of social rights jurisprudence in India. At the core of PIL leading to social rights litigation was the relaxation of rigours of standing and

[21] (1978) 1SCC 248. This case was heard in 1978 in the backdrop of the emergency period, which was marked by gross violations of basic liberties and political rights via draconian laws such as Maintenance of Internal Security Act (MISA). See also G. Austen, Working of a Democratic Constitution: The Indian Experience (New Delhi: Oxford University Press 2000).

[22] (1981) 2 SCR 516

[23] Baxi, Upendra (1985) Taking Suffering Seriously: Social Action Litigation in the Supreme Court of India, Third World Legal Studies: Vol 4, Article 6.

procedure that allowed many public spirited people and groups to bring forth the plight of the socially and economically disabled before the court.[24] Apart from this relaxation of the norms of standing and procedure PIL introduced many other aspects which allowed the court to have a closer surveillance of its orders such as the appointment of amicus curiae to assist the incognizant litigants, appoint independent expert commissioners to go to the field for fact-finding and submit their reports and to supervise the implementation of its orders. The nature of litigation in PIL is non-adversarial and the court provides the remedy depending upon the context of the case and facts. The court rulings have a declaratory part and a mandatory part: in a declaratory order the court pronounces the desirability of state action without pronouncing consequential rulings imposing the state to take steps immediately but it acts to highlight the binding nature of state commitment to such instances under Articles 141[25] and 144[26] of the Constitution[27]. Mandatory part of the order stipulates a time bound compliance from the state and executive to take certain steps.[28]The court gave periodic orders for time bound step-wise compliance via the mechanism of 'continuing mandamus', a procedural compliance technique which the court has often used by keeping the case on docket and giving new orders gradually over time after taking into cognizance the implementation of earlier orders.

The changes in PIL regarding relaxation of strict procedural requirements with respect to standing and pleading were clearly exposited in the *S. P. Gupta v Union of India*[29]judgment. The case involved a number challenges to the state action directed at

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[24] See A. Desai and Muralidhar, Public Interest Litigation: Potential and Problems, in B. N. Kirpal et al. (ed.), Supreme But Not Infallible: Essays in Honour of the Supreme Court of India (New Delhi: Oxford University Press, 2000), pp. 159-192.

[25] It provides that 'the law declared by Supreme Court shall be binding on all courts within the territory of India'.

[26] It provides that 'all authorities, civil and judicial, shall in the territory of India shall act in aid of Supreme Court'.

[27] An example of declaratory order can be gleaned from the judgment in Unnikrishnan J. P v. State of Andhra Pradesh (1993) 1 SCC 645, where the court pronounced that Right to education of a child is part of Article 21 and flows from it and the state has to make provisions to provide basic education for every child up to fourteen years of age. The government made education a basic fundamental right nine years later via an amendment to the Constitution and provided for it in Article 21-A.

[28] An instance of such order can be found in the judgment in CEHAT v Union of India (2001) 7 SCALE 477 and (2001) 8 SCALE 325, whereby the court ordered the governments to strictly comply to the provisions of the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994. This Act seeks to check and penalize the sex-selective female foeticide in India.

[29] AIR 1982 SC 149

judiciary. Two key issues were as follows: first, the law minister sought to implement a policy which mandated and put a restriction on number of judges who could be posted at a court who hailed from that particular region or state. The minister sent letters to the respective chief ministers of the states to take the consent of judges to take postings outside of their states. This move was sought to be done to keep away the parochial interests from entering and getting entrenched in the courts by bringing in judges from outside the state. Second, the tenure of postings of judges was sought to be curtailed to shorter periods of time. These directives were challenged as being unconstitutional attacks on the independence of judiciary. On the second issue the petitioners, Bombay Bar Association and Law Society, sought issuance of mandamus to make the tenure of judges permanent.

The *locus standi* of the petitioners was challenged by the Union of India as they had suffered no direct injury and did not have a stand to challenge the policy. The court made a distinction in the rules of standing that have taken place in the private law to that of public law. Under private law a claim to redress could be brought by a person who has suffered the injury but in the modern times, the court said, changes have come about in this traditional understanding of requirement of standing. Thus, this rule has been put under strain and tension in modern times and exceptions have been carved out into this principle. Bhagwati J., then promulgated a broad statement of principle deriving from these exceptions[30]:

It may therefore now be taken as well established that where a legal wrong or legal injury is caused to a person or to a determinate class of persons by reasons of violation of any constitutional or legal right or any burden is imposed in contravention of any constitutional or legal provision or without authority of law or any such legal wrong or legal injury or illegal burden is threatened and such a person or determinate class of persons is by reason of poverty, helplessness or disability or socially or economically disadvantaged position unable to approach the court for relief, any member of the public can maintain an action for an appropriate direction, order or writ….

[30] Ibid at 188

This broad enunciation of principle of standing is significant in two aspects. First, it provides for very broad grounds for standing for a surrogate to initiate action at the court. Second, this principle encompasses a very wide range of situations under which action could be initiated.[31]

The reasoning for broadening and relaxation of the requirements of standing were justified by the court on twin grounds. First, as mentioned above that the court made a distinction between the traditional private law requirements of restrictive standing and the change demanded in the newer public law for a wider norm of standing. Second, the requirements of standing were liberalised as the purpose of law itself was undergoing change. The law was being used now to foster social justice with newer rights being created and novel duties placed on the state as well. Individual rights were supplemented by social rights as former would be meaningless today in absence of the latter. The social rights were to be found in the Directive Principles of State Policy.

The court had the opportunity to give concrete form to the above principle and build upon it in the case of *Bandhua Mukti Morcha v Union of India*.[32] The case involved a petition by an organisation which was working towards ending the practice of bonded labour, a social practice under which a person remained as a bonded worker to another to pay the monetary debt which he or she had taken. The bonded labourers were meted out harsh working conditions and laboured in conditions which took a toll on their health and life and the debt was usually never written off. Forced labour was made illegal and unconstitutional under Article 23[33] and the Bonded Labour System (Abolition) Act, 1970. The act and the constitutional provision were flouted regularly and this system of labour was still in practice.

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[31] See Craig P. P. and S. L. Deshpande, Rights, autonomy and process: Public Interest Litigation in India, 9 Oxford J. Legal Stud. 356, 373 (1989), pp. 360-61.

[32] AIR 1984 SC 802

[33] Article 23 of the Constitution: Prohibition of traffic in human beings and forced labour – (1) Traffic in human beings and beggar and other similar forms of forced labour are prohibited and any contravention of this provision shall be an offence punishable in accordance with law; (2) Nothing in this article shall prevent the State from imposing compulsory service for public purpose, and in imposing such service the State shall not make any discrimination on grounds only of religion, race, caste, or class or any of them.

The challenge to the standing of the petitioners under Article 32, as they having no fundamental rights theirs being violated, was not entertained by the court, but the reasoning marshalled to reject this challenge this time was different from the *S. P. Gupta case*. Bhagwati J., provided an interesting reasoning, conceiving of the chapter on fundamental rights under part III of the Constitution as being unitary rather than discrete individual rights standing on their own in separation. Bhagwati J., based the rejection on article 21 rather than on article 23, and reads article 21as protecting human dignity, and the ability to live free from exploitation. After construing article 21 in this wider scope, he then reads article 21 in conjunction with the Directive Principles of State Policy, specifically article 39, 41 and 42.[34]The right to live with human dignity derived its essence from the articles 39, 41 and 42 and thus article 21 included the protection of health of workers, education facilities and humane conditions of work. On the issue of non-enforceability of provisions of DPSPs, Bhagwati J., states that the State has made various legal statutes and Acts to enforce the provisions of DPSPs and thus central government was bound to enforce these laws and, *a fortiori*, the states as well to secure workers a life of basic human dignity. These obligations the court said were constitutional obligations flowing from article 32.

Again, the issue related to standing was construed broadly and it was stated that anyone, who is acting *bona fide*, could bring in a petition for those who by reason of poverty, disability or socially disadvantaged position could not bring their grievances relating to violations of fundamental or social rights for relief under article 32.

Another innovation which the court employed in this case relates to the modification of adversarial form of litigation practised in regular litigations. The court appointed two lawyers and later an academic to do field study of the quarries and surrounding areas, the report submitted by them was challenged by the defendants as inadmissible

[34] Article 39 provides for certain principles of policy to be followed by the State to secure, inter alia, citizens, men and women equally, have adequate means of livelihood; ownership and control of material resources of community are so distributed to serve common good; equal pay for equal work for men and women; workers, men, women, and children are not put into avocations abusive to their health, age or strength. Article 41 obligates the state to provide, within its economic capacity and development, for right to work, to education, to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of unserved want. Article 42 provides that State shall make provision for securing just and humane conditions of work and maternity relief.

as evidence as it was *ex-parte* statement and had not been cross-examined. Bhagwati J., provided a 'teleological reasoning' to justify the admissibility of the report. First, he stated that article 32 has to be read purposively not formalistically and the purposive construction has to be done keeping in mind the Preamble, the fundamental rights chapter and the directive principles and reading them together. Second, article 32 provides for moving Supreme Court for violation of fundamental rights by any 'appropriate' proceeding. Bhagwati J., stated that the appropriateness of procedure was not to be gathered from the 'form' of proceedings but by its 'purpose'. In our country rife with rampant 'poverty, illiteracy, deprivation and exploitation' insistence on 'appropriate form' would take the justice out of reach of the common man. Third, the powers of court to issue directions, order or writ under article 32 have to be understood in the light of preceding point and thus have to be construed widely for enforcing fundamental rights. Fourth, it was stated that the adversarial form of litigation would be fruitless in these proceedings as the opposing parties were placed in such disproportionate positions of powers. Fifth, the bonded labourers, who were the real petitioners in this case, obviously could not furnish the relevant materials before the court so the report furnished by the commissioners would be treated as admissible evidence. It could not be objected as inadmissible on the grounds that it has not been obtained via cross examination as that would be unsuitable in the present case. The court said the defendant wold be given the opportunity to produce affidavit evidence against the report, and the judges would consider the two in balance.[35]

Thus, the PIL is justified in resorting to these modified rules and blurring the division between fundamental rights and DPSPs on substantive as well as procedural grounds. On one hand, the link between part III and part IV of the Constitution is established by reading in the provisions of part IV in the provisions of part III. Article 21 securing life and liberty construed broadly to mandate protection of human dignity. It is the provisions of DPSP which provide the minimum content of socio-economic security for securing human dignity. On the other hand, the court forges a procedural link between part III and part IV of the Constitution. Article 32 that provides for moving the court is read expansively to allow the poor and vulnerable to court and secure their rights. The provisions of part IV provide the justification for according standing to a

[35] Ibid note 14 at pp. 364-65

member of public with bona fide interest. It also provides the basis for modification of normal adversarial proceedings.[36]

The court in India sought to redress the social and economic disability by reading the provisions of DPSP in the fundamental rights by giving an expansive reading to the right to life as provided in Article 21. By making social and economic rights as facets of right to life the court has been able to instruct the state to take steps to provide to the citizens the basic minimum core of these social rights not asking them to provide these rights to the fullest. The incapacity of the court to mandate the state to provide these rights unequivocally stems from the categorical and ostensible exposition of socio-economic rights in the DPSP as un-enforceable policies fundamental for the governance of the country. The DPSP are cast as duties upon the state rather than rights of the citizens therefore the failure of state or the executive to take any action does not carry the contingency of judicial remedy for state action for a concrete action towards provisioning of social rights.

The arguments raised for non-enforcement of social rights traditionally have been grounded on these three accounts: separation of powers, expense, and ineffectiveness. The separation of powers argument raises the bogey of encroachment of legislative and executive domains by the judiciary. The argument went on the lines that as the socio-economic rights are not rights per se but interests which are not specifically well-defined and thus do not entail corresponding duties, which are intrinsically a concomitant of rights only. As it was difficult to pin-point a particular duty bearer in case of breach of socio-economic interests they do not fit in the category of rights. Legislatures could develop programmatic plans to further these interests but judiciary could not develop jurisprudence around these interests on the lines of rights as these interests lacked a correlative duties. Concomitant to this argument was the other that was put forward that as these socio-economic interests entailed great discretion and flexibility to enforce them which the legislature only had and as the judiciary lacked such discretion so they do are not fit to be entertained by the courts.[37]

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[36] Ibid note 14 at p. 365-66

[37] See for detailed exposition of these arguments Tushnet, Mark (2008) Weak Courts Strong Rights: Judicial Review and Social Welfare Rights in Comparative Constitutional Law.

The argument on the grounds of expense stated that the enforcement of socio-economic rights entailed vast costs and judicial enforceability would make such expenses contingent upon the rulings of the court and would destabilise the economic planning of the governments. This was challenged by bringing to notice that civil and political rights enforcement also entailed costs and expenses and a programmatic planning for realising social rights wold bring economic shocks to minimum. For example, securing the right to vote to citizens also entailed huge expenses on the part of the state as well and needed mobilization of many people to conduct polls. Thus socio-economic rights were no different than civil or political rights on grounds of expenses. State needed to put in place vast institutions and individuals to secure the vast array of civil and political rights and incurred huge expenses as well for example the institutions of police and courts are in place to secure civil and political rights but they do entail expenses on huge scale to provide and protect civil and political rights. Another aspect related to the costs is that the costs related to the protection and promotion of civil and political rights diffused, distributed and thus invisible in the government budget, whereas the costs attached to securing socio-economic rights are generally consolidated expenses and are visible in government budgets. The courts devised a method of qualifying the orders, for implementation of socio-economic rights, with the stipulation that they do so within the available resources. Thus this argument of socio-economic rights demanding larger expenses on scrutiny seems to be wanting in substance.[38]

On the grounds of ineffectiveness the courts devised creative remedies, such as continuing mandamus etc., which allowed the courts to see to the effective enforcement of these orders. Also the experience with civil and political rights enforcement has shown that not all remedies pronounced by courts are effective, some remedies are more effective than others as was found to be the case with the implementation of socio-economic rights implementation.

LITIGATION OF HEALTH RIGHTS:

Health is not a fundamental right under the Constitution but it has been construed as to be so by the judiciary. The following cases are not exhaustive but are indicative of

[38] See Stephen Holmes and Cass Sunstein (1999), The Cost of Rights: Why Liberty depends on Taxes.

the shifts in the understanding of health as a right and the interplay of judicial construction of making it a right from an unenforceable directive policy provision to fundamental right and then to a consumer commodity to be relegated to be demanded at less empowered consumer forums. This illustrative discussion also is instructive to see how the scope of health as a right was limited to only certain privileged group of persons, those formally recognized as employees or workmen in the state employment. It is also instructive of how the court entertains a claim to right to health and on what conditions.

In *C.E.S.C Ltd and ors. v Subhash Chandra Bose and ors.*[39], the issue was the interpretation of the word 'supervision' and 'employee' as provided in the Employee State Insurance Act, 1948 (ESIC Act). The Calcutta Electricity Supply Corporation (India) Ltd. (C.E.S.C.) engaged the defendants on contract to provide works related to excavation, conversion of overhead electric lines and laying of underground electric cables under public roads, as well as repair and maintenance of the above works. Regional Director of Employees State Insurance Corporation (ESIC) informed C.E.S.C that the workers employed by the defendant contractors fall within the purview of the meaning of employees and thus would be under the ambit of the provisions of ESIC Act and the employers are liable to pay premiums towards the insurance of the employees. This was challenged by CESC on the grounds that they were not the employers of the workers and were not liable to pay the demanded sum of money. Thus the appeal to the court. The minority judgment of Ramaswamy, J construes the E.S.I.C. Act purposively and states that the purpose of the Act is social security of the workers and thus it needs to be interpreted expansively than the Contract Act defining the word 'agent'. Ramaswamy, J states that "…in the light of socio-economic justice assured in our Constitution, right to health is fundamental human right of workmen."[40]But lacking a legislation providing the same there can be no right to health. At this instance a minority voice is raised by judiciary to carve a right to health for employees in state agencies but it is negated and dismissed.

In the next case the right to health is explicitly recognised but it is only available to those who are in a position to claim it and majority of the citizens who are not

[39] AIR 1992 SC 573
[40] Ibid.

formally employed are automatically kept out of it without even a thought given to their plight.

In *State of Punjab and others v Mohinder Singh Chawla, etc.*[41] the contention was whether the state government was liable to reimburse the expenses towards room rent payable by the employee while undergoing a medical treatment at a hospital approved by the state government for such treatments outside the state. The defendant was reimbursed the medical costs but was denied the expenses incurred towards hospital room rent while staying there as inpatient for medical treatment. The Court clearly stated that "it is now settled law that right to health is integral to righto life". It also directed the state government to pay the expenses incurred by the defendant.

Thus, we see that from the two cases above the shift in position of the construction of the right to health by the court. It is to be noted that these cases are raising the issue of a workmen or employee of the state to have the state take care of health care of the employee. So it is still a restrictive understanding of right of health only to those who are by virtue of their service or contractual engagements with the state are allowed to claim and seek redress for their healthcare provisioning.

In *Pt. Parmanand Katara v Union of India and ors*,[42] the issue of undue delay caused in treating the victims of accidents brought to the hospital because of designation of certain hospitals as fit to deal with medico-legal cases and the delays caused due to formalities of police in such cases was brought before the Court. Court directed the specific authorities in the government health administration and police administration that in such cases provision of emergency treatment was the prime and foremost necessity and other formalities can be completed after the immediate medical assistance has been provided to the victims. The court stated that it was the obligation of the State to safeguard the life of the citizens. It also stated that the duty of doctor was to provide immediate medical assistance in cases medical emergencies.

In *Paschim Banga Khet Mazdoor Samity and others v State of West Bengal and another*, [43]the victim fell off a train and incurred serious injuries in head and brain

[41] (1997) 2 SCC 83
[42] AIR 1989 SC 2039
[43] (1996) 4 SCC 37

haemorrhage. The victim was taken to the nearest primary health centre and after first-aid, the medical officer referred him to be taken to a hospital that is equipped to handle this serious injury. The victim was taken from one hospital to another and was not admitted to all of those, around seven hospital in total, throughout the night on account of want of bed or want of facilities to treat the severe condition of the patient. It was only on the next day that he was admitted to a private medical hospital and was administered treatment. The present petition is challenging the denial of medical service by the various government hospitals to the victim as amounting to denial of his right to life and liberty. The court prima facie accepted that the denial of provision of medical treatment to person in emergency amounted to the denial of life and liberty and provided pecuniary damages to the victim.

The interesting aspect of this case that the court goes on to give directions to the state government to bring an overhaul of the medical and health facilities to prevent recurrence of such incidents. This is despite the fact that the state government had constituted a committee to look into the incident and provide recommendations to prevent such incidents and to fix the blame on the erring medical officers in the respective hospitals who denied the patient admission because of lack of beds or facilities to treat his condition. The court goes on to expand the directions to all the other states in India though they were not parties to the said case. The government of India was made a party to the case and thus the court also issued the same directions to the centre as well. The directions issued by the court range from upgrading primary health centres to provide necessary immediate care to stabilise the victim; upgrading the block and district level hospitals to address such cases in future; facilities for specialist treatment to be made available at district and sub-division level hospitals; to create centralised communication system at the state level among hospitals to attend to situations of emergency and want of medical facilities such as beds or specialized treatment equipments; proper arrangement of ambulance facilities for immediately transporting patients in emergency situations from lower level hospitals to the referral hospitals; and to make sure that health facilities and health providers are made available in certain times of the year when owing to festivals or some such occasion the chances of such incidents rise sharply.

The court made reference to the fact that state had to incur expenses to provide for these facilities but it had to be kept in mind that the safety and security of life is the foremost duty of state. The court in this instance went beyond its traditional ambit and provided directives regarding the functions needed to be taken to prevent such occurrences.

In *Indian Medical Association v V. P. Shantha and ors.*,[44] the issue was whether a medical practitioner providing medical services would fall within the ambit of the definition of 'service' as provided in Section 2(1) (o) of the Consumer Protection Act, 1986. Court makes a distinction between medical practitioners and nursing homes providing services for free to all; on payment of fees by all and; those practitioners and nursing homes providing free services to some and payments from the rest. The court held that the first category would not fall within the ambit of the definition of service under the section 2(1) (o) and the latter two types would fall under the ambit of the section. It also provides that the government facilities providing free services to all, with a token amount for registration, shall not be falling within the ambit of the section and thus would not be considered service under the provision. This decision upheld the decision of National Commissions of Consumer Court in the cases of *M/s Cosmopolital Hospitals and anr. v. Smt. Vasantha P. Nair*[45] and *Dr. Sr. Louie v. Kannolil Pathumma*.[46]

In this case the court relegates the claims of health to consumer forums and commodifies the citizenship rights. The argument for the same is furnished that it has been done in consonance of U N General Assembly's Consumer Protection Resolution No. 39/248. The pecuniary damages which the consumer forums are eligible to give the court in itself was fit to give those in normal situations as has been seen in *Pashchim Banga Khet Mazadoor case.* The negative impact of this decision is that the claims of violations of rights are reduced to consumer commodities to be bargained at the consumer forums.

[44] (1995) 6 SCCC 651
[45] (1992) 1 CPJ 302
[46] (1992) 1 CPJ 30

In *Voluntary Health Association of Punjab v Union of India*[47] the Supreme Court was moved by writ petition for provisioning of free and equitable provision of antiretroviral (ARV) to persons living with AIDS. The court issued notices to the National AIDS Control Organisation (NACO) as well as to states. The government formulated a new policy in 2003 to give free ARVs to people in six high incidence states.[48]

In *Common Cause v Union of India and others*[49]the Supreme Court gave directions to the Centre and the State governments to constitute state and national councils of blood transfusion in the wake of rampant malpractice and commercialization of blood banks. The concerns raised related to the inadequate and ill-equipped manpower, inadequate screening and storage facilities, nexus of profiteering form blood donations by commercial donors. The apprehensions were raised that the blood being provided by the commercial blood banks was of inferior quality as they did not screen the donors for infections for AIDS or Hepatitis etc. The court gave directions to Centre to formulate an appropriate legislation in this regard as well. In pursuance of this order the councils were established by 2004 and a national blood policy was formulated in 2000. But the situation has not changed to a great degree still there are instances of commercialization and malpractices brought into light. This draws attention to the inadequacy of court intervention.[50]

IMPACT OF LITIGATION OF HEALTH RIGHTS:

The analysis of the impact of such interventions by the court in health rights has been termed as 'temporary solutions to complex problems' and judicial pronouncements have tended to be declaratory emphasizing the 'strength of rights rather than remedies'.[51] It has also been termed as *ad hoc* approach of judicial activism, as the DPSP that are the fount of socio-economic guarantees in India are non-enforceable and liberal judicial construction has allowed it to be implemented. But there is no consistency in the application of this rule of interpretation. A great deal depends on

[47] Writ Petition 311 of 2003

[48] See S Shankar and P Mehta, 'Courts and Socioeconomic Rights in India' in V Gauri and D Brink (eds), Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World (CUP 2008) 146, 161.

[49] AIR 1996 SC 929

[50] See Ibid n. 33 at 162

[51] See Ibid. n. 33 at 178-79

the attitude and ideology of the judge. Also it is claimed that the court resorts to rhetoric of stating the importance of rights such as the centrality of the right to life or others but does not engage in critical framing of a theory of judicial review for entrenching socio-economic rights evident by 'lack of principle in judicial reasoning'.[52]Shankar and Mehta[53] after reviewing the adjudication of health and education rights in Indian High Courts and Supreme Court posit that judges take up a case for adjudication of social right if one of the three conditions exist: '(a) no law on the issue[54] (judgments in 1980's and 1990s transforming social rights into justiciable rights); (b) the legal framework exists but is not implemented[55] (judgments on municipal failures to provide potable water); or (c) legal framework inadequate to meet new challenges[56] (judgments on intellectual property and rights and drug policies).' The authors conclude that "our evidence shows that court's role in health and education policies was indirect and minimal at best, focussing more on (b) and less on (a) and (c)."

The court intervention in cases of governmental failures has resorted to two types of remedies: 1) the court directs the state agency or ministry to report from time to time on the progress on the directive issued; 2) in this type the court itself overtakes the supervision of the progress of implementation of its orders. This has been characterised as weak form of remedies by Tushnet (2004). Weak form of remedies are those where the court provides a flexible approach by not specifying a time limit and keeps the case on board by giving interim orders or continuing mandamus and supervise the progress. The weak remedies allow the incremental implementation of directives or its orders. This is apposite for social rights implementation as it is in the nature of social rights that they have a longer gestation period. This method employs

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[52] Pillay, Anashri (2014) Revisiting the Indian Experience of Economic and Social Rights Adjudication: The Need for a Principled Approach to Judicial Activism and Restraint, ICLQ vol 63, April 2014 pp 385-408.

[53] See note 33 at p. 177

[54] This has been termed by Baxi as "state of lawlessness" in Baxi, Upendra (1985) "Taking Su□ering Seriously: Social Action Litigation in the Supreme Court of India," Third World Legal Studies: Vol. 4, Article 6.

[55] Madhav Khosla terms this as 'conditional social rights' see M Khosla, 'Making Social Rights Conditional: Lessons from India' (2010) 8(4) ICON 739.

[56] This was seen in the *Common cause case* cited above at note 34, whereby the court considers blood as a drug under the Drugs and Cosmetics Act 1940 and the technical nature of issue prompts the judiciary to constitute a committee to undertake formulation of policies.

taking of views of experts on the issues which are complex and technical and thus usually committees are constituted to provide the requisite suggestions. This was the case in the *Common Cause case* regarding regulation of blood banks. The court in the case had set up a committee to look into the issues and suggest recommendations for the same.

But weak forms of remedies have their weaknesses as well. As these tend to take time many a times the governments do not enforce the recommendations of the committees citing the usual resource deficiency reason. Also weak form remedies entail constant supervision of the directives or the programmes devised to implement policies as has been evident from the implementation process of right to food campaigns. Thus it becomes crucial for the success of such remedies that civil society, NGOs and other voluntary citizen organizations are kept involved to supervise and check the implementation process. As Charles Epp (1998) stated that India had all the requisite conditions for the blossoming of a rights revolution but lacking the support structures for legal mobilization the rights revolution could not take off successfully in India. He included “rights-advocacy organizations, willing and able lawyers, financial aid of various types, and in some countries, governmental rights enforcement agencies” as forming the support structures for legal mobilization (Epp 1998: 19).

CHAPTER 5

CONCLUSION

Social citizenship, as posited by T.H. Marshall, provides for a provision of social and economic rights by the state to the citizens contemporaneous with the level of social and economic standards prevailing in the society. It does not make a demand on the State for providing all rights but some basic rights which go on to make the quality of lives of people richer and better. The provision of social rights, which encompass the rights categorized as socio-economic rights, such as right to education for children, right to healthy life and right to maternity relief etc. make the substance of civil and political rights richer. They enable the citizen to exercise their rights more fully and enjoyable. The demand of social citizenship with respect to provision of rights is universality and equality of provision to all.

The attendant consequences that flow from such provisioning is that it enhances the social compact, enhances the stakes of citizens in maintenance of such provisioning and instills the values of respect for rights of others. The scheme of social rights seeks to provide full exercise of rights in society and seeks to balance the influences of the market on rights. Marshall also states that citizenship as a concept has itself become a 'legitimate architect of inequality'. Citizenship creates inherent hierarchies in the rights it seeks to secure. The political and civil rights compete and tend to create a hierarchy in itself. Social citizenship tends to mitigate this phenomenon.

Social citizenship also is crucial to ward off the tendencies of State that tend to seek to provide nominal welfare without meaning to change the economic hardships of the indigent. Marshall terms these as strategies of 'class abatement'. To be meaningful Marshall contends that rights have to be meaningful rather than specific to poor only as these shall not bring any effectual change in the deprivations of the poor. Social welfare policies are meaningful if they seek to shrink both the ends of income distribution scale that is if it seeks to curb both extreme riches as well as extreme economic inequalities. Second if they promote the integrative aspect of society. And third if they seek to provide social rights such as education and health universally.

Marshall defines social citizenship as "*the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society*" (Marshall, [1950] 1992: 7, 8; emphasis added).

Marshall's characterization of social citizenship is relevant for Indian society as social citizenship framework provides the relevant tenets for curbing the divisive social and economic processes in India. India is traditionally a hierarchical and fragmented society based on norms of caste, class and ethnicity.

Health of citizens is sought to be secured by the provisions of Directive Principles and it is not provided in the fundamental rights. The state has sought to secure the health of people via policies. The state makes provisioning via five year plans and it is overseen by the Health Ministry. The healthcare system in India is divided into three-tier structure: first, at the base are primary health centers at village level; above them at the block level are the Community Health Centers and above them are District Hospitals. The Primary Healthcare Centers are for basic health provisioning, Block level healthcare centers provide secondary care and District healthcare centers provide tertiary care.

Alongside these state run healthcare facilities are the private healthcare providers of all hues ranging from stand-alone clinics, diagnostic centers to super-specialty hospitals run by corporates providing specialized tertiary care. The health system in India is largely privatized and health spending is also privatized as the major expenses on health are borne by the private individuals out of their own pocket. Private healthcare expenses account to the tune of 67 percent of all the expenditure incurred in India by healthcare users. This is one of the highest in the world and reflects the inadequate role played by the state in investing in healthcare. The amount of investment the State incurs in providing health as percentage of Gross Domestic Product comes around 1.2 percent.

The flow of resources and funds for health provision in India is from the Centre to the States. The rationale for this is that Centre has more resources mobilization capabilities and to see that states invest sufficient amount of money for healthcare. Poorer states have less resources and poor infrastructure and institutional capacity to

invest money in the healthcare sector. This leads to these states not being able to avail the next tranche of allocated money. This leads to lower investment and utilization of the funds allocated to the states. Thus there needs to be equalization of per capita spending via specific purpose transfers to poorer states.

The health policies have developed via committees constituted from time to time by the Government. The Health Survey and Development Committee (Bhore Committee) Report, 1946 was significant in its proposals but it was not enforced fully by the states citing lack of resources.

Afterwards the health policies have been published in 1983, 2002 and 2017. The health policies propose the framework for developing and steering the healthcare system but they have not been given due importance and attention by the successive governments.

The health sector is governed by the Centre as well as by the State governments. The Centre has many vertical programmes for health provision but they are disease specific and not comprehensive as they are run in mission mode. States provide for the salary of manpower in these schemes. The prominent health schemes in place right now are the National Rural Health Mission (NRHM) which seeks to revamp the primary healthcare facilities and provisioning. The results of NRHM are mixed as the mandate has been reduced in implementation to just ensuring reproductive health and it now caters mostly to institutional deliveries. This has happened in the wake of pressure to reduce the high incidence of infant mortality.

Towards reduction of the high out of pocket individual expenses the Rashtriya Swasthya Bima Yojana (RSBY) has been launched. This scheme provides nominal insurance cover of Rs. 30000 to people Below Poverty Line (BPL) for the stated health conditions at certain empaneled hospitals. The insurance premium is paid by the government and insurers are mostly private players. The empaneled hospitals also have majority of private hospitals. The alarming trend characterizing Indian healthcare system is the growth and expansion of the private healthcare sector post-liberalization of Indian economy in mid 80s and aggressively post-90s.

The picture of healthcare system in India is one of fragmented nature of planning and provisioning with the Centre as well as States providing for healthcare and making policies for similar aspects of health. The rural areas have severe lack of health facilities, manpower and provisioning. Urban areas now overpopulated with private health care providers.

The Constitution provides principles for just and equal society in the Directive Principles of State Policy. But the provisions of this part are made non-enforceable in Court. But the Constitution provides that the provisions of Directive Principles shall be fundamental for the governance of the nation and the State is duty bound to employ them while formulating policies.

Health of citizens is sought to be secured by the provisions of Directive Principles and thus claims to provisioning of healthcare are not enforceable in a court of law. The courts have creatively sought to enforce these by reading the right to health in Article 21 of the Constitution providing for right to life and liberty.

The courts have used the Public Interest Litigation (PIL) to widen and relax the rigours of standing and pleading to entertain the claims on social rights. This has been criticized on grounds of breach of separation of powers, inefficiency of such proceedings and expense grounds.

The employment of weak form remedies in PIL engages committees, expert bodies and commissioners to investigate the ground status of the claim. The social rights litigation have long gestation period and require the constant support and mobilization of other agencies such as strategic lawyers and civil society and NGOs etc. Unless such a support structure exists and is committed to the case for long term the chances of realization social rights remain bleak.

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