

Working Paper 2014-18

## **India's Fragmented Social Protection System**

*Three Rights Are in Place; Two Are Still Missing*

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prepared for the UNRISD project on  
Towards Universal Social Security in Emerging  
Economies: Process, Institutions and Actors

December 2014



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# Acronyms

<b>ANM</b>	Auxiliary Nurse Midwife
<b>ASER</b>	Annual Status of Education Report
<b>AYUSH</b>	Ayurveda, Yoga, Unani, Siddha, and Homeopathy
<b>BCG</b>	Bacille de Calmette et Guérin (vaccination injection)
<b>BPL</b>	Below the poverty line
<b>CMP</b>	Common Minimum Programme
<b>CSO</b>	Civil Society Organization
<b>DLHS</b>	District Level Household & Facility Survey
<b>EAG</b>	Empowered Action Group
<b>EGS</b>	Employment Guarantee Scheme
<b>FYP</b>	Five-year Plan
<b>HDR</b>	Human Development Report
<b>HLEG</b>	High-Level Expert Group
<b>ICDS</b>	Integrated Child Development Services
<b>IHDR</b>	India Human Development Report
<b>IMR</b>	Infant Mortality Rate
<b>INR</b>	Indian Rupee
<b>JSY</b>	Janani Suraksha Yojana
<b>LHV</b>	Lady Health Worker
<b>MCIA</b>	Medical Council of India Act
<b>MDG</b>	Millennium Development Goal
<b>MGNREGS</b>	Mahatma Gandhi National Rural Employment Guarantee Scheme
<b>MMR</b>	Maternal Mortality Ratio
<b>NAC</b>	National Advisory Council
<b>NCEUS</b>	National Commission on Enterprises in the Unorganized Sector
<b>NFHS</b>	National Family Health Survey
<b>NFSA</b>	National Food Security Act
<b>NILERD</b>	National Institute of Labour Economics Research and Development
<b>NREGA</b>	National Rural Employment Guarantee Act
<b>NRHM</b>	National Rural Health Mission
<b>NSSO</b>	National Statistical Survey Organization
<b>PDS</b>	Public Distribution System
<b>PHC</b>	Primary Health Centres
<b>PIL</b>	Public Interest Litigation
<b>RCH</b>	Reproductive and Child Health
<b>RMA</b>	Rural Medical Assistants
<b>RTE</b>	Right to Education
<b>SRS</b>	Sample Registration System
<b>SSA</b>	Sarva Shiksha Abhiyan (The Education for All Movement)
<b>SI</b>	Social insurance
<b>TFR</b>	Total fertility rate
<b>TPDS</b>	Targeted PDS
<b>UDHR</b>	Universal Declaration of Human Rights
<b>U5MR</b>	Under Five Mortality Rate
<b>UHC</b>	Universal Health Coverage
<b>UNDP</b>	United Nations Development Programme
<b>UNICEF</b>	United Nations Children's Fund
<b>UPA</b>	United Progressive Alliance
<b>USD</b>	US Dollars

## Summary

In India, 22 per cent of the population lives below the poverty line and 93 per cent is employed informally, despite the fact that India is the second fastest-growing economy after China. Nevertheless, in a positive trend, India's welfare system has increasingly moved towards a rights-based approach, as opposed to treating India's citizens as mere recipients of state-provided benefits. This paper discusses the key role of civil society mobilization and political support that has led to the implementation of the principles of the Right to Work (albeit mostly in rural areas), the Right to Education and the Right to Food in India.

On the other hand, both India's social insurance system and its public health system remain limited in coverage and fragmented in character. As large numbers of Indians remain vulnerable to poverty on account of health expenditures, it is imperative that all have access to universal preventive and public health services, and that, among those who work in the unorganized sector, at least the poor have full social insurance coverage (old age pensions, death and disability insurance, maternity benefits). Furthermore, in the absence of publicly provided health care, such insurance should give this segment of the population access to a preventive and basic curative health care package.

Our paper touches only briefly upon the issue of social insurance because achieving this is a medium-term goal which the Indian welfare state must work towards within current fiscal constraints. We focus primarily on the performance and the weaknesses of the health system. We find that the government's flagship health insurance scheme for the poor, the Rashtriya Swasthya Bima Yojana, is ineffective in providing financial risk protection with respect to health care, has inadequate coverage, and does not cover out-of-hospital consultations. We argue on behalf of universal health coverage in India and suggest the following areas for immediate policy intervention in the health sector: First: All doctors should be required to serve in rural areas regardless of whether this is required for a post graduate degree. Second: There is a strong case for introducing a three-year course for rural practice in all states. Third: More regular staff and paramedics are needed to manage services and as front-end providers of services. Fourth: the essential drug procurement system needs to be revamped. Fifth: the safe sanitation programme must become more effective if the nutrition and health status of citizens is to improve.

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# I. Introduction

*The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international cooperation based on free consent.*

—International Covenant on Economic, Social and Cultural Rights (1966)

Although India has become the world's second fastest growing economy after China, 269 million Indians (or 22 per cent of the population) live at, or below, the poverty line.<sup>1</sup> While, for the past decade, the absolute number of poor has been declining for the first time in India's history, the proportion of the population suffering capability deprivation is still very high. This is reflected in the fact that one third of adults suffer from malnutrition, more than two out of five children under 5 are malnourished, 310 million people (26 per cent of the population) are illiterate and for the poor, life expectancy at birth, although higher than in the past, remains at around 65 years.

In addition, India remains an outlier among emerging market economies in terms of the very large number of workers employed in the unorganized sector (93 per cent). Given this high figure,<sup>2</sup> coupled with the very large number of poor persons in the country, one would expect that there would be comprehensive social insurance, as well as universal health care coverage, for these hundreds of millions of unorganized sector workers. However, the social insurance and public health systems currently available to Indians are limited in coverage and fragmented in character. We will address these issues in this paper.

Despite such weaknesses, it must be noted that India's welfare system has increasingly moved towards a rights-based approach, as opposed to treating citizens as mere beneficiaries of state-provided welfare. This development is relatively recent, dating to the beginning of the new millennium. The first achievement reflecting the new trend was the passage in 2005 of the Right to Information Act, which made access to documents and information from Government of India ministries at every level accessible to ordinary citizens. Under the act, citizens are empowered to demand from the government whatever written information and necessary supporting documents they wish as long as the information sought does not undermine state security. This was followed in early 2006 with the passage of the National Rural Employment Guarantee Act (NREGA), which gives every rural household the right to demand up to 100 days of employment in public works activities. Although participation in public works had been part of the government repertoire of welfare programmes for the last four decades, NREGA marked the first time the national Parliament made the right to work a legal entitlement in rural areas.

The next major achievement in this rights-based approach to welfare was the passage by the national Parliament in 2009 of the Right to Education Act. This gives all children ages 6-14 the right to eight years of compulsory elementary schooling. The Act laid down a schedule of norms to be realized in every government school throughout the

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<sup>1</sup> This poverty line is quite close to the international poverty line of \$ 1.25 per person per day.

<sup>2</sup> The corresponding share in Brazil is 45 percent; in most South-East Asian countries it usually does not exceed 75 percent.

country within three years of its becoming effective on 1 April 2010. The norms establish standards for such things as infrastructure, teacher-pupil ratio and so on.

The next major rights achievement focused on the Right to Food, in 2013. The National Food Security Act, enacted by the Indian Parliament on 12 September 2013, brings under one umbrella several existing and new entitlements aimed at providing food security for all Indians. The Act extends access to cereals (wheat, rice and millets) for 67 per cent of the country's population through the public distribution system. It increases coverage of subsidized grains through the public distribution system from a quarter of the total population to 75 per cent of the rural population and 50 per cent of the urban population. The concept of the right to food derives from the larger human right to an adequate standard of living, announced in the Universal Declaration of Human Rights of 1948. Article 25 (1) of the Universal Declaration asserts that "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, and housing." Several other international instruments recognize the right to food as part of the right to an adequate standard of living with a focus on the need to be free from hunger (Dev, 2003). Indian legislation establishing the Right to Work (in rural areas), the Right to Education and the Right to Food are major achievements supporting an entitlement-based approach to public welfare.

However, in a country where 22 per cent of the population lives at or below a poverty line of USD 1.25 per person per day and where 93 per cent of the work force is in unorganized employment, much more remains to be done. It is imperative that all persons have access to universal preventive and public health services, and that at least the poor among those who work in the unorganized sector have full, comprehensive social insurance coverage (old age pensions, death and disability insurance, maternity benefits). If directly provided public health care is unavailable, these individuals will also require insurance that will give them access to preventive and basic curative health care services. In this paper, we only briefly touch on the issue of social insurance, since developing it is a medium-term goal subject to significant fiscal constraints. However, we do focus on the health system and its weaknesses in the context of the Right to Health.

This paper is organized as follows: Section II explains how three of the five fundamental rights—work, education, food, social insurance, health—have been realized in India, even if incompletely in some cases. Section III presents the country's health outcome indicators and Section IV covers the health sector overview for India. Section V makes a case for universal health coverage and Section VI offers conclusions.

## II. The Right to Employment, the Right to Education and the Right to Food

*"The measure of a country's greatness should be based on how well it cares for its most vulnerable populations."*

—Mahatma Gandhi

The concept of human rights encompasses the idea that all people have a right to social institutions that protect them from abuse and deprivation. At the same time, human development is a process of enhancing human "capabilities," choices and opportunities so that each person can lead a life of respect and value (Sen, 2005).



Human rights and human development are inter-related. For example, education produces a variety of indirect benefits, including improvements in health, a slowdown in population growth, a strengthening of democracy and good governance—all of which are dimensions of “human development” and human security. Moreover, the factors that make public education a welfare-enhancing public good also support equal dignity and autonomy for individuals (Alston and Bhuta, 2005). Furthermore, analysing economic and material rights in terms of “capabilities” will reveal a rationale for spending greater amounts of money on the disadvantaged and for creating special programmes to assist their transition to full capability (Nussbaum, 1997).

Rights or entitlements by their very definition impose claims on other people or institutions to help or collaborate in ensuring access to these rights or entitlements (HDR, 2000). The effective implementation of rights often requires institutional reforms<sup>3</sup> as well as the participation and accountability of “duty bearers.” The state has the pre-eminent role to ensure that human rights are realized.

Civil Society Organizations (CSOs) have an especially important role to play in securing rights. They often mobilize ground-level groups in contributing to the process of formulating and passing rights legislation. CSOs also form alliances with bureaucratic entities involved in implementing rights-oriented reforms. CSOs can play a valuable role in knowledge sharing and training as well as helping to monitor the implementation of legislation. Once rights legislation is in place, CSOs can build capacity both within the government and with citizens (Puddephat, 2009).

Article 21 of the Indian Constitution guarantees citizens a fundamental right to life and personal liberty. Article 47 makes it a primary duty of the state to raise the standard of living, including the standard of nutrition, of its people and to improve public health. In addition, the provision of social protection is enshrined in Articles 38. Article 41 provides for the right to work, education and limited public assistance. Articles 42 and 43 cover just and humane working conditions, maternity relief, a living wage, etc.

In the context of these constitutional requirements, political support and mobilization of civil society groups have resulted in a focus on universalization and entitlements in education, employment and food. Before we discuss the important role of civil society in securing the constitutionally mandated rights in these areas, a brief overview of the evolution of the legal context and of political support for these rights will be useful.

An important legal development was the decision of the Supreme Court of India<sup>4</sup> in the early 1980s to waive traditional processes of standing and pleadings in order to permit concerned citizens, public interest advocates and non-government organizations to petition it on behalf of individuals or communities suffering violations of constitutionally-protected rights (Alston and Bhuta, 2005). As a result, the court has entertained applications for constitutional protection on behalf of a wide range of traditionally powerless persons, including bonded labourers, rickshaw drivers, pavement dwellers, inmates of mental infirmaries and workhouses, and victims of environmental

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<sup>3</sup> Institutions can be defined as humanly devised constraints which structure incentives in human exchange, whether political, social or economic (North, 1990).

<sup>4</sup> The Supreme Court acts as the country's highest appellate court. It takes appeals primarily involving verdicts of the High Courts as well as those of other Indian courts and tribunals. The Supreme Court has extensive original jurisdiction with respect to the enforcement of fundamental rights. It is also the court that adjudicates disputes between various governments in the country. In its role as an advisory court, the Supreme Court hears matters which, under the Indian Constitution, may specifically be referred to it by the President of India. The Supreme Court also has the power to independently take cognizance of matters it believes requires its attention.

damage. In conducting these cases, the Court has created its own fact-finding commissions to investigate alleged violations and dramatically expanded its remedial powers to include the supervision of government institutions and the mitigation of the effects of systematic injustice. Through its Public Interest Litigation (PIL) jurisdiction, the Court has come to act as a “combination of constitutional ombudsman and inquisitorial examining magistrate,” vested with the responsibility to do justice to poor litigants before it by aggressively searching out the facts and the law and by taking responsibility for fully implementing its decisions. PIL provides a model for courts struggling to balance the transformative aspect of law against the law’s natural tendency to favour those rich enough to invoke it (Alston and Bhuta, 2005).

In addition, the Indian Government, through the National Advisory Council (NAC),<sup>5</sup> created in 2004, has supported the principle that the state has a key role to play in providing minimum levels of employment, education and food as basic entitlements for every needy citizen in the country. The NAC was established as an interface with civil society to provide inputs in the formulation of government policy and to support the government in its legislative activities relating to rights.<sup>6</sup> Based on recent recommendations, the NAC also seeks to provide for citizen engagement in the legislative process.<sup>7</sup> This is especially important since in the past, apart from voting in elections, there have been few opportunities or mechanisms for citizens to participate in the making of laws in India’s parliamentary democracy. In recent years, this deficiency has brought citizens out onto the streets in multiple campaigns, not just in protest, but also advocating change and demanding solutions. This, in turn, has led to the demand for, and widespread energetic debate about, various legislative options. (Gupta and Dey, 2013).

The NAC is currently headed by Sonia Gandhi, Chairperson of the United Progressive Alliance (UPA). Support for Mrs. Gandhi, the civil society movement and the important role played by key social activists resulted in the enactment in 2005 of the National Rural Employment Guarantee Act, which went into effect in February 2006. The NAC has also played a key role in providing impetus to the government’s flagship programmes in rural health, nutrition, education, infrastructure and urban renewal.

Following is a review of some recent landmark social legislation: the right to employment, the right to education and the right to food.

### ***The right to employment***

In India, a major focus of planning for rural development has been the productive absorption of the underemployed and surplus labour by providing direct supplementary wage employment to the rural poor through public works (Second Administrative Reforms Commission, 2006). Over more than five decades, the Government of India has

<sup>5</sup> The National Advisory Council (NAC) was created in 2004 by the Prime Minister, Manmohan Singh, during the tenure of the first United Progressive Alliance (UPA) government (2004-2009), to implement the National Common Minimum Programme (CMP). The NAC continued to exist throughout the second UPA government (2009-2014) to advise the Prime Minister of India.

<sup>6</sup> The NAC has made recommendations to the government in six categories: (i) food security and human development, (ii) empowerment of scheduled castes and scheduled tribes, (iii) empowerment of women, (iv) empowerment of other vulnerable groups, (v) enhancement of efficiency, transparency and accountability, and (vi) promotion of sustainable development.

<sup>7</sup> Recently, the NAC created a working group on Transparency, Accountability and Governance which, among other things, has been working to formulate a framework for citizens’ participation in the pre-legislative process. The group’s draft recommendations include the following. First: Proactive disclosure in two stages of pertinent issues relating to specific prospective legislation. Second: Consultations with stakeholders and experts. Third: Incorporation of useful suggestions from stakeholders and experts into draft legislation. As a part of the legislative process, public comments should be summarised along with the responses of the concerned department/ministry and submitted to the cabinet along with the draft legislation. Were these recommendations implemented, it would make the consultative process mandatory and fundamentally inclusive (Gupta and Dey, 2013).

initiated a number of wage employment programmes starting with the Rural Manpower Programme in 1960 and the Employment Guarantee Scheme (EGS) launched in Maharashtra in the early 1970s. The EGS guaranteed employment to persons above 18 years of age who are willing to do unskilled manual work on a piece-rate basis.

The National Rural Employment Guarantee Act (NREGA) of 2005 represents a paradigm shift in the government's employment policy. A national "employment guarantee act" has been a long-standing demand of the Right to Food campaign and of the labour movement in India. The NREGA establishes employment as a right that people can expect, demand and have enforced.<sup>8</sup> Under the Act, any adult willing to do casual labour at the minimum wage is entitled to employment on local public works within 15 days of applying, with a limit of 100 days per household per year.

MGNREGS (the Mahatma Gandhi National Rural Employment Guarantee Scheme) was launched in 200 of the country's poorest districts during 2006-07 and was later extended to another 130 districts. The new employment law was then implemented in all of India's 600-odd non-urban districts during 2008-09. MGNREGS seeks to increase the income of the poor by providing employment and, as a result, help create durable assets which, in turn, will provide much-needed productive infrastructure for poverty alleviation on a sustained basis. It has also been suggested that MGNREGS will prompt workers' organizations to link the new employment guarantee with social security schemes, and that greater bargaining power will help rural workers obtain other social and economic rights (Dreze and Khera, 2009).

It is said that the challenges to successful implementation of MGNREGA centre on five factors: the focus on universalization and entitlements; funding by the national government and execution by state governments; the remoteness of local governments from those they serve; dysfunctional administrative and institutional arrangements, and problems in the backward areas (Second Administrative Reforms Commission, 2006). Furthermore, the circumstances that shape people's perceptions of their rights, as well as their ability to enforce them, demand close attention (Dreze, 2004).

As a result of the MGNREGA, rural open market wages<sup>9</sup> have risen, in part because wages guaranteed under the programme were initially higher than prevailing rural market wages. For the first time in the history of independent India, the MGNREGA has given landless labourers an alternative to working on a landlord's farm (Mehrotra, 2008). Landless labourers have always had the right to migrate to urban or other rural areas for work, but MGNREGA has made non-agricultural work available locally.

It has been recommended that the impact of an employment guarantee act like MGNREGA should be evaluated on more than traditional indicators such as income and consumption expenditures (Dasgupta, 2013). The capability approach is also used to evaluate the impact of MGNREGA, and has revealed a significant expansion in the capability set of the individuals interviewed (Dasgupta, 2013).

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<sup>8</sup> NREGA was later re-named the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA).

<sup>9</sup> The scheme, in which half of the beneficiaries are women, reaches roughly every fifth household in India's rural areas. In 2012-13, it provided employment to more than 48 million households, generating more than 213 crore\* person days of employment at a total expenditure of more than INR 39,000 crore. The average wage rate per day doubled to INR 128 in 2012-13 from INR 65 in 2006-07. Source: <http://www.thehindu.com/news/national/nw-150-workdays-for-tribals-under-mgnrega/article5736740.ece> (\*1 crore= 100 million).

## ***The right to education***

The Right to Education (RTE) in India was first recognized as a fundamental right by the country's Supreme Court in *Mohini Jain vs. Union of India* (1992) 3 SCC 666. Strong civil society demand for this right was responsible for its enshrinement into law in 2009. In its judgement, the court declared that: “‘Right to life’ is the compendious expression for all those rights which the courts must enforce because they are basic to the dignified enjoyment of life. It extends to the full range of conduct which the individual is free to pursue. The right to education flows directly from right to life. The right to life under Article 21 and the dignity of an individual cannot be assured unless it is accompanied by the right to education. The State Government is under an obligation to endeavour to provide educational facility at all levels to its citizens.”<sup>10</sup>

In December 2002, the Indian Parliament passed the 86<sup>th</sup> Amendment to the Indian Constitution. It mandated the provision of free and compulsory education by inserting Article 21A in the Constitution's Fundamental Rights section, declaring: “The State shall provide free and compulsory education to all children of the age of 6-14 years in such a manner as the State may, by law, determine.” Article 21A in the Fundamental Rights section replaced Article 45 in the Directive Principles of State Policy,<sup>11</sup> specifying that: “The State shall endeavour to provide early childhood care and education for all children until they complete the age of 14 years.” However, the mechanism to bring Article 21A into force was never applied, which, it is suggested, gave rise to the need for the Right to Education bill (Mehrotra, 2012).

In contrast to the supportive role of the National Advisory Council for citizens' entitlements, there has been opposition from certain segments of the bureaucracy. In the case of the Right to Education (RTE), several arguments opposing it were presented by those within government (Mehrotra, 2012). Opponents in the central government contended that a scarcity of resources has *not* been an obstacle for some Indian states in providing free and compulsory education. This position, however, discounted the large number of out-of-school children in many states and the vast number of illiterates in India who are geographically concentrated in very poor, high-population northern and the eastern states. Second, it was argued that the Central Government should not assume responsibility for an ever-expanding list of key social areas such as law and order, health and education, which, according to the Indian Constitution, are chiefly the responsibility of state governments. It was also suggested that if the concentration of such activities at the national level continued, state governments would persist with their lopsided support of populist rather than priority programmes (Mehrotra, 2012). Nevertheless, the RTE Act was passed with strong civil society support.

In the period following the passage of the education Amendment to the Constitution, a participatory process of inviting comments from members of the public, motivated by a strong demand from civil society, yielded several different drafts of the education bill. Finally, in 2008, the Union Cabinet stamped its seal of approval on the bill. The Right of Children to Free and Compulsory Education Act or Right to Education Act (RTE) was passed by the Indian Parliament on 4 August, 2009 and came into force on 1 April, 2010. India had become one of 135 countries to make education a fundamental right of every child.

<sup>10</sup> Cited in [http://www.azimpremjifoundation.org/Right\\_to\\_Education](http://www.azimpremjifoundation.org/Right_to_Education). Accessed in August 2013.

<sup>11</sup> The Directive Principles of State Policy are guidelines for the use of the central and state governments of India contained in Part IV of the Constitution of India. Although the Principles are not enforceable by any court, they are considered fundamental for the governance of the country and make it the duty of the State to apply them in making laws to establish a just society.

The Education Act guarantees free and compulsory education to all children in the 6-14 year age group. It requires a pupil-teacher ratio of 30 for every school at the primary level and a pupil-teacher ratio of 35 for every school at the upper primary level, and it provides for improvements in school infrastructure (IHDR, 2011). Under the RTE, there are no direct school fees or indirect costs for uniforms, textbooks, meals, transportation, etc., to be borne by pupils or parents in order to obtain an elementary education. The law requires the government to provide schooling free-of-cost until a child's elementary education is completed (UNICEF).<sup>12</sup>

Sarva Shiksha Abhiyan (SSA) is the Government of India's flagship programme for the universalization of elementary education across the country in a timely manner. Although it pre-dated the RTE Act, the SSA has been focussed on achieving RTE's goals since the latter was passed. SSA seeks to address the needs of 192 million children in 1.1 million communities across India and is working in partnership with state governments to cover the entire country. Specifically, the programme works to open new schools in communities which do not have them and to strengthen existing schools by providing additional classrooms, toilets, drinking water, maintenance grants and other school improvement grants.

The impact of RTE has been mixed. An 2012 Annual Status of Education Report (ASER Pratham, 2012) surveyed 567 rural districts, 16,166 villages, 331,881 households and 5,96,846 children, and found that India is very close to achieving universal enrolment for children in the 6-14 age group. The enrolment levels for children in this group have been 96 per cent or more for the last four years. However, although the pupil-teacher ratio has shown improvement in rural areas, learning levels have started dropping in many states since RTE came into effect. This suggests that RTE may have led to a relaxation of the quality of classroom teaching since it requires that all exams and assessments be scrapped and that no child be kept back. ASER (Pratham, 2012) recommends that the teaching and learning of basic foundational skills should be the main agenda for primary education in India.

### ***The right to food***

In India, the Right to Food Campaign was mounted by an informal network of organizations and individuals acting on the belief that everyone has a fundamental right to be free from hunger. They worked for the realization of the Right to Food concept through state guarantees of livelihood-security entitlements such as the right to work, land reform and social security. The campaign began with a petition submitted to the Supreme Court in April 2001 by the People's Union for Civil Liberties, Rajasthan. It called for the immediate distribution of the country's huge food stocks to protect people from hunger and starvation.<sup>13</sup> This was followed by a larger public campaign for the right to food which resulted in the appointment of two Commissioners on the Right to Food<sup>14</sup> by the Supreme Court of India.

<sup>12</sup> [http://www.unicef.org/india/education\\_6144.htm](http://www.unicef.org/india/education_6144.htm), accessed in August 2013.

<sup>13</sup> The prevalence of "hunger amidst plenty" in India took a new turn in mid-2001 as the country's food stocks reached unprecedented levels while hunger intensified in drought-affected areas and elsewhere. This situation prompted the People's Union for Civil Liberties (Rajasthan) to approach the Supreme Court with a writ petition on the "right to food." Initially, the case was brought against the Government of India, the Food Corporation of India, and six state governments on the basis of inadequate drought relief. Subsequently, the case was extended to the larger issue of chronic hunger, with all states and union territories named as respondents. Source: <http://www.righttofoodcampaign.in/legal-action/-right-to-food-case>

<sup>14</sup> The two Commissioners, Dr. N.C. Saxena and Mr. Harsh Mander, both retired civil servants (who also served on the National Advisory Council), are still tasked with monitoring the RTF, and reporting to the Supreme Court.

As a result of civil society mobilization and political support, India's national Cabinet recently approved the National Food Security Act (NFSA). It provides for a guaranteed allotment of subsidised food grains from the Public Distribution System (PDS), maternity benefits for all pregnant women and nutritious meals for children through local *Anganwadis*, or primary schools. Every eligible household is entitled to 5 kg of food grains per person per month at a price of INR 3, 2 and 1 per kg for rice, wheat and millet, respectively. It is projected that NFSA will serve 75 per cent of the rural and 50 per cent of the urban population. National coverage ratios are expected to be adjusted for each state based on a fairness principle so that coverage is higher in the poorer states (EPW, 2013).

Prior to the enactment of the Food Security Act, it was argued that although necessary, passing the bill would not in itself be sufficient for reducing hunger in India (Saxena, 2012). For the bill to have a significant impact on hunger, improvements in the governance, productivity and accountability of government machinery related to the growing and distribution of food would be essential. Presently, major food-related programmes, such as the PDS and the Integrated Child Development Services (ICDS) are plagued by corruption, leakages, errors in selection, procedural delays, poor allocations and little accountability. Moreover, these entities often discriminate against and exclude those who need them most (Saxena, 2012; Mander, 2012).

Among the arguments against the passage of the Food Security Act was the huge magnitude of the planned subsidy (Bhalla, 2013). In this context, it is noteworthy that until 1992, the PDS was targeted to operate everywhere in the country and was available to all consumers. The Indian Government revamped the PDS in 1992, limiting its coverage primarily to drought-prone, tribal, hilly and remote areas. In 1997, the PDS was again restructured, becoming the Targeted PDS (TPDS) aimed at people living below the poverty line in all parts of the country. The Targeted PDS is inefficient and inequitable, with massive leakages, diversions from warehouses and in-transit losses to fair-price shops. These problems have led to demands by the Right to Food campaign for universalization of food programmes.

In addition, the Right to Food Campaign is demanding a comprehensive "Food Entitlements Act," going well beyond the limited promise in the UPA manifesto of 25 kg of grain at INR 3 per kg for households below the poverty line. Essential provisions of the proposed "Food Entitlements Act" include: a universal PDS (providing at least 50 kg of grain per family with 5.25 kg of legumes and 2.8 kg of edible oils); special food entitlements for destitute households (including an expanded *Antyodaya* programme for the very poorest); consolidation of all entitlements created by recent Supreme Court orders (e.g., cooked mid-day meals in primary schools and universalisation of ICDS); support for effective breastfeeding (including maternity entitlements and crèches); safeguards against the invasion of corporate interests in food policy; and the elimination of all social discrimination in food-related matters. Finally, the campaign is demanding that the Act includes strong accountability and provisions to redress grievances, mandatory penalties for any violation of the Act and compensation for those whose entitlements have been improperly denied.

### **III. The Two Missing Rights: Social Insurance and Health**

While three basic rights have been clearly articulated and legally realized in India (if not yet fully implemented), two are still missing: social insurance and health.

It is generally recognized that social security consists of two distinct categories of support for workers: social assistance and social insurance (Mehrotra, 2014, forthcoming). Social assistance (i.e., assistance in kind or cash) should be provided to those unable to work (e.g., the old and indigent, the disabled, poor widows, etc.) or those who are unable to earn enough from work to guarantee a basic income or consumption level. Social insurance should be provided to those able to work but who have little access to the safety nets normally available in the organized sector such as old age pensions, maternity benefits, death and disability benefits, and, especially, health care coverage. So far, the Indian state hasn't been very successful in providing social insurance (Mehrotra, 2014, forthcoming).

The availability of, and access to, social security programmes remain fragmentary in India. Government sponsored and administered programmes dominate the provision of pension and health insurance in the country. However, what social security coverage is available is concentrated in the upper levels of the country's income distribution. In fact, legally mandated social security schemes have failed to reach the vast majority of India's population. One reason for this is the vast size of the country's unorganized workforce (World Bank, 2011). While it is estimated that 93 per cent of the Indian labour force is in the unorganized sector (Mehrotra, 2014, forthcoming), less than 1 per cent of workers in this sector have any formal pension coverage through public schemes (while in the organized labour sector, there is 95 per cent pension coverage). Unorganized sector coverage for personal accident insurance through commercial schemes is only 1.2 per cent. For private health insurance, it is 0.5 per cent and for life insurance, 23 per cent (O'Keefe, 2005 cited in Mehrotra, 2014, forthcoming).

In the formal sector, some major social security schemes include the Employees' State Insurance Scheme and the Employees' Provident Fund Organization. In the unorganized sector, initiatives include welfare funds administered centrally as well as through state-level schemes. There is also a defined contribution model activated by the Pension Fund Regulatory Development Authority, the "micro-pension" product of the Union Trust of India, and programmes offered by the Life Insurance Corporation.

We contend that an effective social insurance (SI) programme must have three components: an old age pension, death and disability benefits (or life insurance), and maternity benefits—the internationally recognized requirements by the ILO of a minimum SI programme. In addition, we vigorously support national health insurance for those working in the unorganized sector (NCEUS, 2008, cited in Mehrotra, 2014, forthcoming).

In the next section, we will focus on the right to health.

## ***The right to health***

### ***Health outcome indicators***

It goes without saying that health is an important facet of human development and well-being. Health inputs, as well as health outcomes, have important implications for nutritional and learning outcomes, and of course for quality of life. Ensuring universal coverage of health services is an important component of universalizing social protection. Compared to other United Nations Millennium Development Goals (MDGs) spanning a range of human development factors, health and health care indicators have been the slowest to approach MDG targets. This has been true in India as well as in

other regions. An assessment of health outcomes, process and input indicators reveals that despite the work of India's National Rural Health Mission (NRHM),<sup>15</sup> progress has been slow. Table 1 shows the progress of monitorable targets for health indicators and the targets for India's 12<sup>th</sup> Five Year Health Plan.

**Table 1: Recent Health Indicator Monitoring Data**

S. No.	Eleventh Plan Monitorable Target (2007-2012)	Baseline Level	Recent Status	Twelfth Plan Target (2012-2017)
1.	Reducing Maternal Mortality Ratio (MMR) to 100 per 100,000 live births	254 (SRS, 2004-06)	212 (SRS, 2007-09)	100
2.	Reducing Infant Mortality Rate (IMR) to 28 per 1,000 live births	57 (SRS, 2006)	44 (SRS, 2011)	25
3.	Reducing Total Mortality Rate (TMR) to 2.1	2.8 (SRS, 2006)	2.5 (SRS, 2010)	2.1
4.	Reducing malnutrition among children of 0-3 age group to half its level	40.4% (NFHS, 2005-06)	No recent data available	20%
5.	Reducing anemia among women and girls by 50%	55.3% (NFHS, 2005-06)	No recent data available	28%
6.	Raising the sex ratio for the 0-6 age group to 935	927 (Census, 2011)	914	950

Source: Planning Commission (2013)

The MDG goal of eradicating extreme poverty and hunger required halving the proportion of those suffering from hunger between 1990 and 2015. The estimate of underweight children (an indicator of food insecurity) in India has shown almost no reduction in the past decade. While the proportion of 0-3 year-old underweight children was 53.5 per cent in 1990, it was estimated to be 47 per cent in 1998-99 according to the 2<sup>nd</sup> National Family Health Survey (NFHS) and 46 per cent in 2005-06 as per NFHS 3 (the latest available estimates). The MDG goal, however, requires that the proportion of underweight children be reduced to 27 per cent by 2015.

The MDGs call for a two-thirds reduction in the Under Five Mortality Rate (U5MR) between 1990 and 2015 and a reduction in the Infant Mortality Rate (IMR) to 26.7 per 1,000 live births by the same year. There has indeed been progress in reducing child mortality rates in the past two decades, although much remains to be achieved. The number of deaths per 1,000 live births before a child attains age one stood at 80 in 1990 and fell to 68 in 2000. However, the pace of decline slowed down in the next decade when the IMR fell by only 24 points to reach 44 per 1,000 live births in 2011. Thus, the IMR needs to decline by another 17 points in order to reach the MDG target by 2015, which is unlikely to occur.

In India, large inter-state differences in IMRs are worrisome. While the country's national IMR average in 2011 was 44 per 1,000 live births, the lowest was in Kerala (12) followed by Tamil Nadu (22) and Maharashtra (25). The relatively poorer states recorded much higher IMRs than the national average: Assam (55), Madhya Pradesh (59), Odisha (57), Rajasthan (52), and Uttar Pradesh (57).

India's Under Five Mortality Rate (U5MR) stood at 125 deaths per 1,000 live births in 1990. The MDG target called for a reduction in the U5MR to 42 per 1,000 live births by

<sup>15</sup> The National Rural Health Mission (NRHM) was launched by the Indian Prime Minister in 2005 to provide accessible, affordable and quality health care to the rural population, especially vulnerable groups.



2015. In India, nationally, U5MR dropped to 85 per 1,000 live births in 2000 and according to the Sample Registration System (SRS - Registrar General of India), it declined further to 55 in 2011. Given the rapid pace of decline—an average of almost 3 per 1,000 live births in 11 successive years, it is likely that the MDG target of 42 per 1,000 will be achieved by 2015. However, in the poorer states of Assam (78), Madhya Pradesh (77), Odisha (72) and Uttar Pradesh (73), reaching the MDG target will be a difficult task. The high levels of child mortality in these states reflect the inadequacy of public health institutions as well as a lack of entitlements supporting healthy living.

They also reflect gaps in child immunization practices. According to National Family Health Survey 3, 44 per cent of Indian children received all recommended vaccinations<sup>16</sup> in 2005-06. This figure was lower in rural areas generally —39 per cent— and even lower in Assam and Madhya Pradesh (32 per cent), Bihar (31 per cent), Jharkhand (30 per cent), Rajasthan (22 per cent) and Uttar Pradesh (21 per cent). In 2007-08, the District Level Household & Facility Survey (DLHS) estimated that 54 per cent of all Indian children received all necessary vaccinations, although, as earlier, in Madhya Pradesh and Uttar Pradesh, only about one-third or fewer received these vaccinations.

The health and nutritional status of the child is critically dependent on the mother's health and the care taken during pregnancy and delivery. The Maternal Mortality Ratio (MMR), which reflects the number of women of reproductive age dying per 100,000 live births due to causes related to maternity, is a crucial indicator of the effectiveness of the Reproductive and Child Health (RCH) programme. The MMR also reflects the effectiveness of the health care system in general. In India, maternal mortality was as high as 437 per 100,000 live births in 1990-91. The MDGs called for the MMR to be reduced to 109 by 2015 and the 11<sup>th</sup> Health Plan's ambitious target was an MMR of 100 per 100,000 live births by that date. In fact, the MMR declined dramatically, to 301 per 100,000 live births in 2001-03, and declined another 89 points to reach 212 per 100,000 in 2007-09. Assuming this rate of decline is maintained, i.e., a decrease of around 15 maternal deaths per 100,000 annually, it will take eight years to achieve the MDG target.

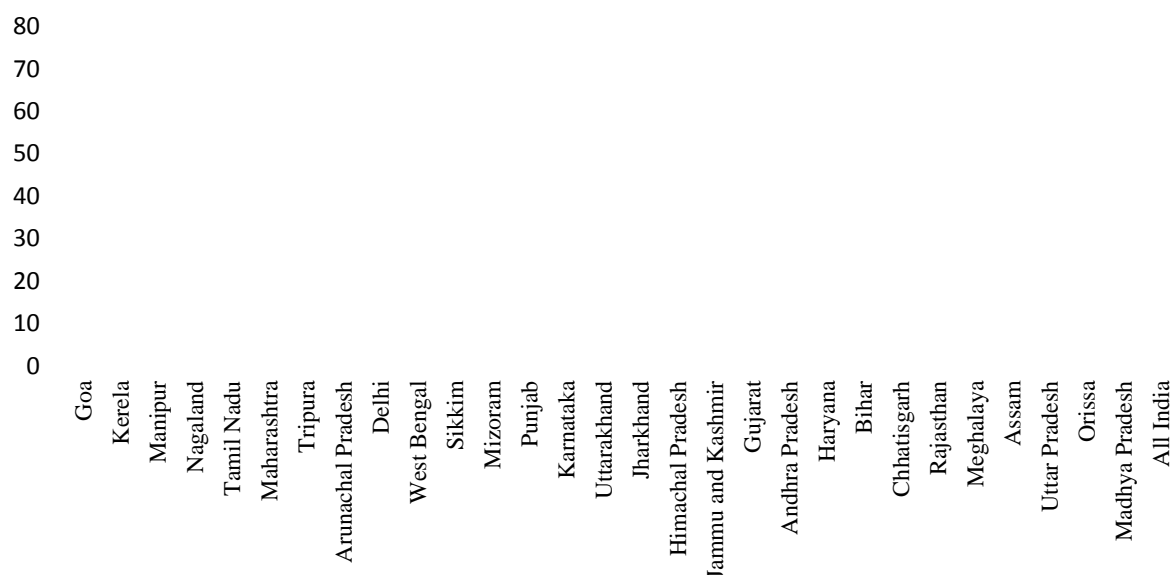
At the state level, Kerala (81), Tamil Nadu (97) and Maharashtra (104) achieved the MDG target of 109 per 100,000 live births in 2007-09. However, a major drag on reducing MMR occurs in the Empowered Action Group (EAG) states where the average MMR was 308 in 2007-09. The EAG states include Assam (381), Bihar (305), Jharkhand (278), Madhya Pradesh (310), Chhattisgarh (275), Odisha (277), Rajasthan (331), Uttar Pradesh (345) and Uttarakhand (188). The high maternity and child mortality figures in these poor states reflect deficiencies in antenatal care, skilled birth attendance and emergency obstetrical care (Planning Commission, 2013).

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<sup>16</sup> One BCG injection to protect against tuberculosis, three doses each of DPT (diphtheria, pertussis, tetanus) and polio vaccines, and one measles vaccine.

**Figure 1: Infant Mortality, Under Five Mortality and Total Fertility Rates in India 2000-2011**

Source: World Development Indicators

**Figure 2: Infant Mortality Rates by State in India 2009**

Source: Registrar General of India

Across India, high maternal mortality rates are attributable to the large number of non-institutional deliveries. The place of delivery generally correlates with maternal health status and is an indicator of demand for public health institutions. Persistent high rates of child and maternal mortality in a given locale suggest that the public health system there has been ineffective in promoting reproductive and child health programmes and healthy practices such as breastfeeding, oral rehydration and preventive care as well as care-seeking behaviours (Planning Commission, 2013). Indian women suffer from lack of access to health care services during pregnancy. According to the National Family Health Survey 3, estimates for 2005-06, only 52 per cent women had three or more antenatal care check-ups.

In those same years, NFHS 3 data shows that in India as a whole, an average of only 39 per cent of deliveries took place in a health care institution. In rural areas, this figure

was only 29 per cent. But there have been recent improvements. District Level Health Survey (DLHS) data shows that in 2007-08, 47 per cent of pregnant women aged 15-49 gave birth in an institution. The Sample Registration System estimates for 2011, however, show that there has been a sharp rise in institutional deliveries, which can be attributed to the work of the National Rural Health Mission (NRHM) and the *Janani Suraksha Yojana* (JSY).<sup>17</sup> The percentage distribution of births by type of medical attention at delivery shows that about 28 per cent of deliveries were overseen by untrained persons. Government and private hospitals accounted for 45 and 21 per cent of deliveries respectively, with the remaining 6 per cent being accounted for by qualified professionals such as nurses or Auxiliary Nurse Midwives.

### *Health sector overview*

Health outcomes data indicates significant gaps in India's health system.. The policy vision of the five-year plans has focused on achieving good health and health care for all citizens, and especially for the marginalized sectors of Indian society. However, improving the health of the population requires investments in health infrastructure and human resources (IHDR, 2011). Expenditures (public and private) on health have been abysmally low in India, hovering around 4 per cent of GDP. By comparison, in Brazil and South Africa, health expenditures account for over 8 per cent of GDP. In China, it is 5.2 per cent, but public expenditures for health account for 56 per cent of that country's total health expenditures, compared to 31 per cent in India. The high proportion of private expenditures for health in India reflects the high level out-of-pocket expenditures (86 per cent of total private expenditure) on health that households incur. High out-of-pocket health expenditures often push members of the poorer sections of society below the poverty line.

However, there is recent evidence of improvement. During the 11<sup>th</sup> Five Year Plan, health expenditures by the Central Government increased by 2.5 times compared with those of the 10<sup>th</sup> Plan, while those of state governments increased by 2.14 times. By the final year of the 11<sup>th</sup> Plan (2011-12), combined public expenditure for health reached 1.04 per cent of GDP. When spending on drinking water and sanitation, the Integrated Child Development Scheme and Mid-Day Meals are included, total public expenditure on health reached 1.97 per cent of GDP in the 11<sup>th</sup> Plan. During the 12<sup>th</sup> Plan (2012-2017), it is expected to rise to 2.5 per cent of GDP.

As noted, low public expenditure on health is manifested in gaps in health infrastructure, both physical and in human resources. The quality of health infrastructure affects the quality of health care delivery, which in turn affects health outcomes. Despite the National Rural Health Mission and increases in public expenditure for health, there has been little increase in the number of Health Sub-Centres (from 142,655 in 2004 to 148,124 in 2011), Primary Health Centres (23,109 in 2004 to 23,887 in 2011) and Community Health Centres (3,222 in 2004 to 4,809 in 2011).<sup>18</sup> India has only nine hospital beds per 10,000 persons, compared to 36 hospital beds per 10,000 persons in China. India's lack of adequate health infrastructure is seen in the fact that the average number of people served per government hospital is 98,970. This figure is as high as 451,325 in Bihar, 229,118 in Uttar Pradesh, 194,863 in Assam, 178,243 in Andhra Pradesh, 159,721 in Haryana, 155,470 in Madhya Pradesh,

<sup>17</sup> Janani Suraksha Yojana (JSY) is a Safe Motherhood intervention of the National Rural Health Mission (NRHM). Its objective is to reduce maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. The scheme is being implemented in all states and Union Territories (UTs), with a special focus on States with high maternal and neonatal mortality rates.

<sup>18</sup> National Health Profiles, 2005 and 2011

and 139,676 in West Bengal. The average number of people served per government hospital bed is 1,512, but it is over 5,000 in Bihar and Jharkhand and over 3,500 in Uttar Pradesh and Assam.

The availability of skilled human resources—physicians, nurses, medical assistants, technicians, support personnel, administrators and more—is also an important prerequisite for effective health delivery. A major shortcoming of India’s public health system has been the failure to provide adequate human resources, including declines in the numbers of male and female health assistances and male health workers (see Table 2).

The number of allopathic doctors with recognized medical qualifications (as defined by the Medical Council of India Act, or MCIA) and registered with state medical councils increased from 656,111 in 2005 to 921,877 in 2011—a gain of 40 per cent. There has also been a decline in the average number of people served by government allopathic doctors from 15,980 in 2005 to 12,005 in 2011. However, despite the overall 40 per cent increase in the number of doctors, the number serving in Primary Health Centres (PHCs) in rural areas has only increased 20 per cent in the past seven years. It is noteworthy, however, that there was an almost 50 per cent increase in female health workers or Auxiliary Nurse Midwives (ANMs) between 2005 and 2011 (table 2).

**Table 2: Government health human resources in rural areas in India, 2005 and 2011**

Year	No. of Doctors at PHCs	Total no. of Specialists at CHCs	Health Assistants		Health Workers	
			Male	Female (LHV)	Male	Female/ANM
2005	21,974	3,953	20,086	19,773	60,756	138,906
2011	26,329	6,935	15,622	15,908	52,215	207,868

Source: National Health Profiles 2005 and 2011

In 2008, the Indian government launched its flagship health insurance scheme for the poor, The Rashtriya Swasthya Bima Yojana (RSBY), or National Health Insurance Programme.<sup>19</sup> The programme combines technology with incentives to insurance carriers to provide in-patient insurance coverage up to an annual sum of INR 30,000 for eligible enrolled households. The RSBY is implemented through insurance companies with premiums subsidized by Union and State governments to the extent of 75 per cent and 25 per cent respectively.

In his 2013 Independence Day’s speech, India’s Prime Minister declared that the RSBY presently covers about 3.5 crore or 35 million families. Assuming that there are 5 members per household, this means that approximately 175 million people, or

<sup>19</sup> For people living below the poverty line, an illness not only represents a permanent threat to a family’s earning capacity, but in many cases it can result in the family falling into a debt trap. Poor families often ignore the need for medical treatment because of a lack of resources, fearing wage loss, or they wait so long that treatment will not be effective. Even if the family decides to get care, doing so is apt to consume their savings, forcing them to sell their assets and property or cut other important spending for food, children’s education and the like. Alternatively, to meet health care costs, the family may take on huge debts. Ignoring treatment may lead to unnecessary suffering and even death, while selling property or assuming debt may end a family’s hope of ever escaping poverty. Such tragic outcomes can be avoided through a health insurance programme in which the risk of a major health shock is shared many households by pooling them together. A well-designed and effectively implemented health insurance programme can both increase access to health care and even improve its quality over time. The RSBY gives participating BPL households freedom of choice between public and private hospitals, making them clients potentially worth attracting on account of the significant revenues that hospitals stand to earn through the scheme. The coverage extends to five members of the family, which includes the head of household, spouse and up to three dependents. Beneficiaries need pay only INR 30 as a registration fee. Central and State Governments pay the premiums to the insurers selected by the State Governments on the basis of competitive bidding. The budgetary allocation for RSBY was INR 264.51 crore in 2009-10, INR 445.89 crore in 2010-11, and INR 279.94 crore in 2011-12. (Source: <http://www.rsby.gov.in/>)

approximately 17 per cent of the households in the country, are covered by the RSBY. This is very low coverage given that 50-60 per cent of the country's population lives in, or is vulnerable to, poverty. Further, as the RSBY doesn't cover consultations out of hospital or medications, its capacity to reduce out-of-pocket expenditures for health care remains low.

Nationally representative data indicates that 3.5 per cent of India's population falls below the poverty line and 5 per cent of its households experience catastrophic health care costs (Shahrawat and Rao, 2012). Predictably, the poverty-deepening impact of out-of-pocket health payments is greatest for those already below the poverty line. Medicines account for the main share (72 per cent) of total out-of-pocket health care payments. This rises to 82 per cent for medicines prescribed during outpatient care, compared with 42 per cent for inpatient care. Other data shows that removing out-of-pocket payments for inpatient care would lead to a negligible fall in the poverty head count ratio and poverty gap. Moreover, if out-of-pocket payments for either medicines and/or outpatient care are removed, then only 0.5 per cent of people treated for medical problems would fall into poverty due to spending on health. Thus, on this basis, insurance schemes that cover only hospital expenses, like those currently being rolled out nationally in India, will fail to adequately protect the poor against impoverishment due to health spending. Benefit coverage which includes medicines and outpatient care for the poor and near-poor (i.e., those just above the poverty line) is necessary in order to provide significant protection from impoverishment (Shahrawat and Rao, 2012).

Another study finds that the impact of RSBY on financial risk protection in India's health care system is questionable (Selvaraj and Karan, 2012). An examination of the poorer households covered by the RSBY in intervention districts (Rajiv Aarogyasri in Andhra Pradesh, and Tamil Nadu Health Insurance schemes) revealed that they experienced a rise in real per capita health care expenditures, particularly with hospitalisation. There are clear indications that RSBY and other state government-based subsidized health care programmes failed to provide beneficiaries with the expected financial risk protection. Such findings support arguments favouring universal health coverage for all Indians and a move away from the current piecemeal, fragmented approaches to a thrust for free primary health care (Selvaraj and Karan, 2012).

## **IV. Towards Universal Health Coverage**

In India, inequalities in the availability of health care due to socio-economic status, geography and gender persist. The fact that three-quarters of health spending is private contributes to these inequalities. Furthermore, health expenditures push around 39 million Indians into poverty each year. Thus, India's health care system is faced with the challenge of responding to the needs of the most disadvantaged members of Indian society (Balarajan, et al., 2011).

Although there is an active civil society demand for universal health care, an historical momentum supporting a Right to Health is missing. The civil society movements for the Rights to Education and Work are much older and were largely responsible for these rights being enacted into law. Although health has long been a state subject in the Indian Constitution, state governments generally failed to give policy-level attention to the health system. In particular, health promotion and improving public health have been neglected. However, even after health became a subject concurrent with other Rights issues, neglect of it continued into the 1990s. Starting in 1991, economic reforms were

marked by liberalization and deregulation and a dismantling of the “licence-quota raj” which previously had so hobbled the economy. For the health sector, this meant reforms favouring the introduction of user (i.e., patient) charges in public hospitals along with private sector development and the growth of private care. During this period, there was a decline in publicly-funded health training institutions and staff positions in the public health system remained vacant. Uttar Pradesh, for example, didn’t have a single health training institution until a decade ago. Also, public health issues such as safe sanitation were recognized as important only in the last decade. In fact, as recently as 2011, 69 per cent of all households in rural India did not have a toilet. However, attitudes about health needs changed after economic growth picked up in 2003-04, leading to the launch of the National Rural Health Mission (NRHM) in 2005-06. These developments set the stage for a demand for universal health care in India.

We, and others, argue in behalf of universal health care in India in the belief that access to appropriate, adequate, and affordable health care is a legitimate entitlement of every Indian citizen (Reddy et al., 2011). It is proposed that an Integrated National Health Care System be established in which all providers, i.e., public and private sectors and allopathic systems of medicine, are integrated. Such a system would ensure the provision of good-quality health services to all the people of India, reduce the financial burden of health care on individuals, and empower people to take care of their health and to hold the health care system accountable (Reddy et al., 2011).

The national 12<sup>th</sup> Five Year Plan for health seeks to work towards the establishment of Universal Health Coverage in the country, ensuring access for each individual to a defined essential range of medicines and treatment at an affordable price. These benefits should be entirely free for a large percentage of Indian’s population.

In October 2010, a High-Level Expert Group (HLEG) on Universal Health Coverage (UHC) was established by the Planning Commission of India under the chairmanship of Professor K. Srinath Reddy. The Group’s mandate was the development of a framework for providing easily accessible and affordable health care to all Indians. In its report, the HLEG concluded that it is possible for India, even with the limited financial resources available to it, to devise an effective architecture of health financing and financial protection for individuals which will make it possible to offer Universal Health Care to every citizen.

The HLEG defined Universal Health Care as a programme, “Ensuring equitable access for all Indian citizens in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, health services of assured quality (promotive, preventive, curative and rehabilitative) as well as services addressing 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.” (12<sup>th</sup> FYP). The HLEG also made the following recommendations:

1. Health Financing and Financial Protection: Government should increase public expenditure on health from the current level of 1.2 per cent of GDP to at least 2.5 per cent by the end of the 12<sup>th</sup> FYP, and to at least 3 per cent of GDP by 2022.
2. Access to Medicines, Vaccines and Technology: Price controls and price regulation, especially on essential drugs, should be enforced. The Essential Drugs List should be revised and expanded, and rational use of drugs ensured.

3. Human Resources for Health: Institutes of Family Welfare should be strengthened and Regional Faculty Development Centres should be selectively developed to enhance the availability of adequately trained faculty and to encourage faculty-sharing across institutions.
4. Health Service Norms: A National Health Package should be developed that offers, as part of the entitlement of every citizen, essential health services at different levels of the health care delivery system.
5. Management and Institutional Reforms: All-India and State-level Public Health Service Cadres and a specialized State-level Health Systems Management Cadre should be introduced in order to give greater attention to Public Health and also to strengthen the management of the UHC system.
6. Community Participation and Citizen Engagement: Existing Village Health Committees should be transformed into participatory health councils.
7. Gender and Health: There is a need to improve access to health services for women and girls (going beyond just maternal and child health) and for other vulnerable groups.

The HLEG recommendations are broad-ranging and are not prioritized. We believe that in planning for Universal Health Care, India needs to focus on five key areas, given the scarcity of physical, financial and especially human resources in the area of health.

**First:** All doctors should be required to serve in rural areas regardless of the requirements for obtaining a postgraduate degree.<sup>20</sup> Several Indian states, including Assam, Arunachal Pradesh, Chhattisgarh, Gujarat, Kerala, Manipur, Meghalaya, Nagaland, Orissa, Tamil Nadu and West Bengal, have made it compulsory for all medical graduates to serve in rural areas (Gupta et al., 2010). We believe that this policy should be extended to all states, especially in light of the very large public subsidy provided for the education of doctors. In this connection, Sri Lanka's experience with compulsory rural posting of doctors is instructive.

In Sri Lanka, an important pre-1930s reform facilitated the extension of medical practice to rural areas. By allowing doctors to have dual practices, the government enticed them to work at less-than-market wages in their rural practices, while increasing their incomes in their second, alternating private practices. In 1970-77, when private practice was abolished, the number of government doctors in rural areas actually declined. The Health Ministry responded by rotating all junior doctors—on a regular, compulsory basis—posting many of them to rural areas. This policy has been enforced by firing doctors who refuse to comply, a significant disincentive because junior doctors can't obtain specialist training outside of the public sector. The expansion in coverage has enabled Sri Lanka to reap the benefits of advances in medical technology and has substantially reduced mortality in all areas of the country in every population group (Rannan-Eliya and Sikurajapathy, 2008).

**Second:** There is a strong case for the introduction of a three-year course for rural practice in all states in line with the experience of Rural Medical Assistants (RMA) in the state of Chhattisgarh.

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<sup>20</sup> Linking postgraduate programmes to rural service appears to be a powerful incentive for attracting doctors to rural posts. There is a strong desire for specialization among doctors after they receive their basic medical degrees. Coupled with the small number of postgraduate seats available compared with the number of medical graduates, this results in intense competition for admission to postgraduate programmes. In Uttarakhand and Andhra Pradesh, it has been found that the prospect of obtaining a postgraduate degree is a strong incentive for medical students/graduates to take on rural posts (Rao et al., 2011, as cited in Rao and Ramani, 2011).

In many Indian states AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homeopathy) physicians are posted at Primary Health Centres in order to mainstream the various Indian systems of medicine. Often they are the sole clinicians present and practice both allopathic and their own system of medicine. Clinicians with three years training in allopathic medicine operate in two states. In the state of Chhattisgarh, Registered Medical Assistants are posted at Primary Health Centres and in Assam, Rural Health Practitioners are posted at sub-centres. In a recent initiative, the national Health Ministry issued a proposal to introduce a three-year clinician course, the Bachelors of Rural Health Care. Its graduates would be posted at rural sub-centres (Rao and Ramani, 2011).

A study of non-physician clinicians in the State of Chhattisgarh found that physicians and clinicians with a shorter duration of clinical training such as RMAs were equally competent in managing medical conditions commonly seen in primary care settings (Rao et al., 2010). Similar levels of competence among physicians and RMAs have been observed in other countries. AYUSH doctors were found to be less competent than physicians and RMAs in managing infectious, chronic and maternal health conditions and for nearly all patient classifications, from infants to adult men. (Rao and Ramani, 2011). However, patients and community members served by Medical Officers, AYUSH doctors and RMAs were equally satisfied with the care they received. Importantly, the presence of an RMA or AYUSH doctor as the primary clinician at Primary Health Centres—but no physician—did not reduce usage of the facility by local residents (Rao et al., 2010).

**Third:** More regular staff and paramedics are needed for managing services and as front-end health care providers. The nurse-to-doctor ratio in India (1.5:1 instead of the desirable 3:1) is poor compared to that of other countries (Reddy, 2012). This is because nurses' training institutions have been allowed to wither even though they are urgently needed in dozens of states.

The availability of competent and committed health workers requires attention to both the numbers and the quality of personnel. New medical and nursing colleges are needed: priority should be given to locating such institutions in states which currently have the fewest of them and, preferably, they should have linkages with district hospitals. The training of health professionals has to emphasize health-system connectivity, problem-solving skills, team function and partnership with the community (Reddy, 2012).

**Fourth:** The drug procurement system needs to be revamped. Essential drugs should be available at affordable prices in the public health system. To strengthen the logistical management of health care, TN Medical Services Corporation was established in January 1995. It is the apex body for purchase and distribution of generic essential drugs for government medical centres.

**Fifth:** Adequate sanitation is critical for improved health. Nearly 60 per cent of the estimated 626 million persons in the world who defecate in the open are in India. This is more than double the number of the next 18 countries where open defecation is prevalent combined (WHO, 2012, cited in Mehrotra and Ghosh, 2014, forthcoming). National Statistical Survey Organization (NSSO) data shows that in 2002, approximately 60 per cent of the population of India did not have any type of toilet facility. By 2009, with a drop to 49 per cent, this figure had improved somewhat but still had a long way to go (IHDR, 2011). Economic loss in India due to a lack of sanitation may be as much INR 2.4 trillion per year— approximately 6.4 per cent of



India's GDP in 2006 (World Bank, 2010, cited in Mehrotra and Ghosh, 2014, forthcoming). These costs are associated with death, disease, accessing and treating water, and losses in education, productivity, time and tourism.

Improved sanitation has a direct, positive impact on health which, in turn, results in improvements in many other areas. First, improving sanitation and reducing or eliminating disease arising from poor sanitation directly impacts the safety of the food and water people consume, which then leads to better health and healthier living conditions. Malnutrition accounts for half of all child deaths and poor sanitation is a major causative factor. Using District Health Surveys and Census data, an econometric evaluation which assessed the impact on health of India's Total Sanitation Campaign 2001-2011 (Spears, 2012, cited in Mehrotra and Ghosh 2014, forthcoming), found that the Sanitation Campaign resulted in reduced infant mortality, on average, by four deaths per 1,000 and resulted in improved height/age ratios of 0.2.<sup>21</sup> This finding has been corroborated elsewhere by international comparisons of sanitation coverage and height, using 140 Demographic and Health Surveys. Second, improved sanitation facilities in schools (i.e., secure toilets) increase the enrolment rates of girls. In fact, the effects of improved sanitation go well beyond enrolment, and extend to actual learning and better cognitive skills (Mehrotra and Ghosh 2014, forthcoming).

## V. Concluding Comments

In this paper, we have discussed the key role of civil society mobilization and political support through the National Advisory Council (NAC) in India, resulting in a focus on universalisation and fundamental human entitlements with respect to the rights to work, education and food. However, two other acknowledged rights, social security and health, are available only to a very limited share of the population. Our paper is concerned primarily with the right to health. We have found that, in comparison with other Millennium Development Goals spanning a range of human development issues, progress in the area of health been the slowest to approach the MDG targets. In India, the health system remains poor in coverage; public expenditure on health remains low and people remain vulnerable to poverty on account of health expenditures. Further, we have also found that the government's flagship health insurance scheme for the poor, the RSBY, remains ineffective in terms of providing financial risk protection relating to health care costs; has inadequate coverage and doesn't cover out-of-hospital consultations or medications. Last but not least, we argue for universal health coverage in India and we suggest several areas for immediate policy intervention in the health sector. First: All doctors should be required to serve in rural areas. Second: There is a strong case for the introduction of a three-year course for rural practice in all states. Third: More regular staff and paramedics are needed to manage services and as front-end providers of services. Fourth: The essential drug procurement system needs to be revamped. Fifth: Sanitation is important for nutrition and improvements in health status.

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<sup>21</sup> The height-for-age index is an indicator of linear growth retardation and cumulative growth deficits. Children whose height-for-age Z-score is below minus two standard deviations (-2 SD) from the median of the reference population are considered short for their age (stunted) and are chronically malnourished.

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