

The Fragmented Social Protection System in India: Five Key Rights but two missing

Santosh Mehrotra, Neha Kumra and Ankita Gandhi



Institute of Applied Manpower Research
Planning Commission, Government of India

© Institute of Applied Manpower Research, 2014

First Edition published in 2014

ISBN: 978-93-83133-38-3

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, without the prior permission in writing of IAMR.

City Office: 53, Lodhi Estate, New Delhi -110 003, India

Campus: Sector A-7 Narela Institutional Area, Delhi-110 040, India

The Fragmented Social Protection System in India: Five Key Rights but two missing

Paper submitted to United Nations Research Institute for Social Development (UNRISD) for 'Towards Universal Social Security in Emerging Economies' project, June 2014

Santosh Mehrotra, Neha Kumra and Ankita Gandhi

**Institute of Applied Manpower Research
Planning Commission, Government of India**

About the Authors

Dr. Santosh Mehrotra is Director-General, Institute of Applied Manpower Research, Planning Commission (in the rank of Secretary, Government of India).

He holds an MA in Economics from the New School for Social Research, New School University, New York (1981) and Ph.D in Economics from Cambridge (1985).

Dr. Mehrotra has over 30 years of experience of working in academia and public systems. Of this 30-year period, over 10 have been in the Indian public system, including seven years directly in the Government of India (Planning Commission), and over five years in academia in government-funded research institutions and university (Jawaharlal Nehru University, New Delhi, where he was Associate Professor from 1988-1991).

From 1991 to 2006, he spent 15 years with two UN agencies—UNICEF and UNDP. He was chief economist of UNDP's global Human Development Report (2002-05), New York. He also led the research programme on developing countries at UNICEF's global research institute, the Innocenti Research Centre, Florence, Italy (1999-2002).

In September 2006 he joined as head, Rural Development Division, Planning Commission, when he was also Economic Adviser, Social Sectors. He was then head, Development Policy Division, Planning Commission (till August 2009). During this period he was an author of several chapters in India's 11th Five Year Plan (2007-2012), and most recently of several chapters in the 12th Five Year Plan (including the one on Skill Development and on Employment). He led the team that wrote the second national Human Development Report (Oxford University Press, 2011).

He was also a Parkin Visiting Professor at the Centre for International Development in the Faculty of Social Sciences, Bath University, UK (2010-13).

Neha Kumra is Assistant Director with the Institute of Applied Manpower Research. She is working on issues of Human Development, Vocational Education and Training & Skills. She holds an MSc in Economics for Development from the University of Oxford and a PG Diploma in Public Management from the University of London.

Ankita Gandhi is an economist working on issues of Human Development, Employment and Skills. She is currently engaged with UNDP and working on G20 issues in the Department of Economic Affairs, Ministry of Finance. She is also pursuing a Ph.D. in Economics at Jawaharlal Nehru University, New Delhi.

Contents

Abstract

I.	Introduction	1
II.	Right to Employment, Right to Education and Right to Food	3
III.	Health Outcome Indicators	11
IV.	Health Sector Overview	15
V.	Towards Universal Health Coverage	17
VI.	Concluding Remarks	21
	Bibliography	23

The Fragmented Social Protection System in India: Five Key Rights but two missing

Santosh Mehrotra, Neha Kumra and Ankita Gandhi

Abstract

In India, 22% of the population lives below the poverty line and 93% of the population is employed informally. This is despite India being the second fastest large growing economy after China. India's welfare system, in this context, has increasingly moved towards a rights-based approach, as opposed to treating India's citizens as mere beneficiaries of state provided welfare. This paper discusses the key role of civil society mobilization and political support that led to the implementation of the Right to Work (albeit in rural areas), the Right to Education and the Right to Food in India. However, it argues that both social insurance system and the public health system remain limited in coverage and fragmented in character. As large numbers remain vulnerable to poverty on account of health expenditures it is imperative that all persons have access to universal preventive and public health services, and at least the poor among those who work in the unorganized sector have full coverage to social insurance (old age pension, death and disability insurance, maternity benefits), and in the absence of publicly provided health care such insurance that might give them access to a preventive and basic curative care package. This paper touches briefly upon the issue of social insurance, because this is a relatively medium term goal that the Indian welfare state will need to work towards under the current fiscal constraints. Instead, this paper focuses on the performance of the health system and its weaknesses. It finds that the government's flagship health insurance scheme for the poor, the Rashtriya Swasthya Bima Yojana, remains ineffective in terms of providing financial risk protection in India's health care, has inadequate coverage, and doesn't cover the consultations out of hospitalization. This paper argues for universal health coverage in India and suggests areas for immediate policy intervention in the health sector. These are as follows. First, all doctors should be required to serve in rural areas regardless of it being a requirement for a post graduate seat. Second, there is a strong case for introduction of the three years course for rural practice in all states in line with the experience with Rural Medical Assistants in a few states. Third, more regular staff or paramedics are needed for managing services and as front end providers of services. Fourth, the essential drug procurement system needs to be revamped. Fifth, the safe sanitation program must become more effective if the nutrition and health status of citizens is to improve.

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)

India has 269 million persons (or 22 per cent of its population) living below its poverty line.¹ Despite India having become the second fastest large growing economy, after China, after

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

2000s the incidence of income (or consumption) poverty is still very large. Although the absolute number of poor has been declining for the first time in India's history since 2004-05, the proportion of population that suffers from capability deprivation is still high. This is demonstrated by the fact that one-third of adults suffered from malnutrition, over two out of five children under 5 are malnourished, 310 million persons (or 26 per cent of the population) are illiterate and life expectancy at birth, although having risen, remains around 65 years (2011).

In addition, India remains an outlier among emerging marketing economies in terms of the share of workers who have informal employment (93 per cent). Given this high share² and the very large number of poor in the country one would expect that there would be provision for social insurance for such a large number of unorganized sector workers, in addition to universal coverage of preventive and even public health care. However, both a social insurance system and the public health system are limited in coverage and fragmented in character, and we will address these issues in this paper.

However, it must be said that India's welfare system has increasingly moved towards a rights-based approach, as opposed to treating India's citizens as mere beneficiaries of state-provided welfare. This development is relatively recent, and dates back to the beginning of the new millennium. The first achievement was the passing of the Right to Information Act 2005, which made access to documents and information from Government of India ministries at every level of government accessible to the ordinary citizens. The citizen was empowered to demand written information and such supporting documents as necessary from the government, wished as long as the information she sought did not undermine state security. This was followed in early 2006 with the passing of the National Rural Employment Guarantee Act (NREGA), 2006 which gave to every rural household the right to demand up to 100 days of work in public works. Although public works had been part of the government repertoire of welfare programs for the last four decades, it was for the first time in 2006 that an Act of national Parliament made the right to work in rural areas a legal entitlement.

The next major achievement in this rights-based approach to welfare was the passing of the Right to Education Act, 2009 by the national parliament. This gave all children in ages 6-14 the right to eight years of compulsory elementary schooling. The Act laid down a schedule of norms which were to be achieved in every government school throughout the country within three years of the Act being activated on 1st April 2010, in regard to infrastructure, teacher-pupil ratio and so on.

The next major achievement came in regard to the Right to Food in 2013. The right to food derives from the larger human right to an adequate standard of living given in the Universal Declaration of Human Rights (UDHR) 1948. Article 25 (1) of the UDHR 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

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

instruments recognize the right to food as part of the right to an adequate standard of living with focus on the need to be free from hunger (Dev, 2003). The National Food Security Act, 2013 enacted by the Indian Parliament on September 12, 2013 brings under one umbrella several existing and new entitlements aimed at providing food security and extends access to cereals (wheat, rice and millets) for 67 per cent of the total population through the public distribution system. It increases coverage to subsidized grains through the public distribution system from a quarter of the population to 75 per cent of the rural population and 50 per cent of the urban population in India. The implementation of the Right to Work (albeit in rural areas), the Right to Education and the Right to Food are major achievements towards an entitlement-based approach.

However, in a country where 22 per cent of the population lives below an absolute poverty line no higher than a \$1.25 per person per day and where 93 per cent of the workforce is in informal employment, it is imperative that all persons have access to universal preventive and public health services, and at least the poor among those who work in the unorganized sector have full coverage to social insurance (old age pension, death and disability insurance, maternity benefits), and in the absence of publicly provided health care, such insurance that might give them access to a preventive and basic curative care package. This paper will only briefly touch upon the issue of social insurance, only because this is a relatively medium term goal that the Indian welfare state will need to work towards under the current fiscal constraints. This paper however focuses its attention upon the health system and its weaknesses, i.e. on the Right to Health.

This paper is organized as follows. Section 2 discusses the reasons why three of the five fundamental rights – to work, education, food, social insurance, health – have been realised in India, even though inadequately. Section 3 presents the health outcome indicators for India and Section 4 presents the health sector overview for India. Section 5 makes a case for universal health coverage in India and Section 6 concludes.

II. Right to Employment, Right to Education and 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

While human rights encompasses the idea that all people have claims to social arrangements that protect them from the worst abuses and deprivations, human development is a process of enhancing ‘capabilities’ or human 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 instance, in the case of education, it is argued that the provision of education produces a variety of beneficial externalities such as improvements in health, slowdown in population growth, strengthening of democracy and good governance – all of which are dimensions of ‘human development’ and human security. Moreover, the externalities that make the public provision of education welfare-enhancing as a public good also correspond with achievement of equal dignity and

autonomy (Alston and Bhuta, 2005). Conversely, analysing economic and material rights in terms of ‘capabilities’ can help us arrive at a rationale for spending unequal amounts of money on the disadvantaged or creating special programs to assist their transition to full capability (Nussbaum, 1997).

Rights or entitlements by their very definition impose claim on other people or institutions to help or collaborate in ensuring access to some freedom (HDR, 2000). As such, the effective implementation of rights often requires institutional reforms³ as well as accountability of ‘duty bearers’. The state has the pre-eminent role as a duty-bearer to ensure that human rights are realised.

Civil Society Organizations (CSOs) have an especially important role to play in securing rights. They often mobilize ground level groups to contribute to the process of formulation and passing of rights legislation and also form alliances with sections of bureaucracy interested in implementing reforms. They can play a valuable role in knowledge sharing and training, and help monitor the implementation of legislation. Once the legislation is in place, they can build capacity both within the government and with citizens for its use (Puddephat, 2009).

In India, Article 21 of the Constitution guarantees a fundamental right to life and personal liberty and Article 47 of the Constitution makes it one of the primary duties of the State to raise the standard of nutrition and the standard of living of its people and to improve public health. In addition, provision of social protection is enshrined in Articles 38 (securing a social order for the promotion of welfare of the people), 39 (certain principles of policy), 41 (right to work, education and public assistance in certain cases), 42 (just and human conditions of work and maternity relief) and 43 (living wage etc.) of the Constitution as a part of the Directive Principles of State Policy.

In this context, civil society mobilization and political support have resulted in a focus on universalisation and entitlements in respect of education, employment and food. Before we discuss the important role of civil society in securing these rights, we present a brief overview of evolution of the legal context and political support for these rights.

In the legal context, an important development has been the decision of the Supreme Court of India,⁴ in the early 1980s, to waive off traditional doctrines of standing and pleadings 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 consequence, 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

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

⁴The Supreme Court acts as the highest appellate court which takes up appeals primarily against the verdicts of the High Courts and other courts and Tribunals of India. It has extensive original jurisdiction in regard to enforcement of fundamental rights. It also acts as the court to hear disputes between various governments in the country. As an advisory court, Supreme Court hears matters which may specifically be referred to it by the President of India under the Constitution of India. Supreme Court also has the power to take cognisance of matters on its own.

infirmaries and workhouses, and victims of environmental 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 supervision of government institutions and mitigation of the effects of systematic injustice. By way of development of its 'Public Interest Litigation' (PIL) jurisdiction, the Supreme Court of India has come to act as a 'combination of constitutional ombudsman and inquisitorial examining magistrate, vested with responsibility to do justice to the poor litigant 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' (as quoted in Alston and Bhuta, 2005).

Furthermore, in recent times, the Government of India (GOI), through the National Advisory Council (NAC),⁵ created in 2004, provided support to the idea that state has a key role to play in provision of minimum levels of employment, education and food as basic entitlements to every needy citizen in the country. The NAC was set up as an interface with civil society to provide inputs in the formulation of policy by the Government and to provide support to the Government in its legislative business.⁶ In a recent set of recommendations, the NAC seeks to provide the space for citizen engagement in its legislative business.⁷ This becomes especially important in the context of their being little space for citizens' participation in the making of laws in India's parliamentary democracy. In recent years, this lack of space has brought citizens out onto the streets in multiple campaigns, not just in protest, but also suggesting change and demanding solutions. This, in turn, has led to the demand for legislations, where different aspects of legislations have been widely and energetically debated (Gupta and Dey, 2013).

The NAC was set up in 2004 and is currently headed by Sonia Gandhi, Chairperson of the United Progressive Alliance (UPA). Mrs. Gandhi's support, the civil society movement, and the important role played by the key social activists have resulted in the enactment of the National Rural Employment Guarantee Act in 2005, which became effective 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.

⁵National Advisory Council (NAC) was set on 4 June, 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, or CMP. The NAC is an advisory body set up to advice the Prime Minister of India. The NAC continued to exist over the period of the second UPA government (2009-2014).

⁶The 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.

⁷In recent times, the NAC has constituted a working group of its members on Transparency, Accountability and Governance which, inter alia, has been working towards formulating a framework for citizens' participation in the pre-legislative process as an important pre-requisite for transparency, accountability and responsiveness in governance. The draft recommendations of the Working Group on Pre-Legislative Process are the following. First, proactive disclosure is suggested in two stages. Second, consultations are suggested. Third, incorporation of feedback is suggested. Public comments should be summarised along with responses of the concerned department/ ministry and submitted to the cabinet along with the draft legislation. It is argued that if these recommendations were to be implemented, it would make the consultative process mandatory, and fundamentally inclusive (Gupta and Dey, 2013).

We discuss below some landmark legislations in recent times – right to employment, right to education and right to food.

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 provision of direct supplementary wage employment to the rural poor through public works (Second Administrative Reforms Commission, 2006). As a result, Government of India has taken up a number of wage employment programmes starting with the Rural Manpower Programme in 1960. The Employment Guarantee Scheme (EGS) started in Maharashtra in the early 1970s which guaranteed employment to persons above 18 years of age who are willing to do unskilled manual work on a piece rate basis.

However, the National Rural Employment Guarantee Act (NREGA) represents a paradigm shift. 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 enacted in 2005 makes employment a right, something that people can expect, demand and enforce.⁸ Under this Act, any adult willing to do casual labour at the minimum wage is entitled to employment on local public works within 15 days, subject to a limit of 100 days per household per year.

Under the MGNREGA, an employment scheme called Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) was launched in 200 poorest districts during the period 2006-07 and was extended to another 130 districts during the period 2007-08. MGNREGS was implemented in all the 600-odd non-urban districts in the country since the period 2008-09. MGNREGS seeks to enhance the income of poor by providing employment and through the process of employment helps create durable assets which would provide the much-needed productive infrastructure for poverty alleviation on a sustained basis. Moreover, it is suggested that the worker's organizations would lead to linking the employment guarantee with social security schemes, and the greater bargaining power would also help rural workers in the realization of other social and economic rights (Dreze and Khera, 2009).

It is argued that the challenges for successful implementation of MGNREGA stem from five factors: the focus on universalisation and entitlements, the funding by the union government and execution by the state governments, the centrality of local governments, administrative and institutional arrangements, and the problems in the backward areas (Second Administrative Reforms Commission, 2006). Furthermore, close attention needs to be paid to the circumstances that shape people's perceptions of their rights as well as their ability to enforce them (Dreze, 2004).

⁸NREGA was later re-named as Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA).

It is worth mentioning that as a result of the MGNREGA, the rural open market wages⁹ have risen partly as wages provided under the programme were higher than the prevailing rural market wages. For the first time in the history of independent India, the MGNREGA has given the landless labourers an alternative to working on the landlord's farm (Mehrotra, 2008). The landless labourers had always had the right to migrate to urban or other rural areas for work, but MGNREGA made work available locally.

It is however suggested that the impact of an employment guarantee act like MGNREGA should be evaluated on terms broader than traditional evaluative indicators like income and consumption expenditure (Dasgupta, 2013). In contrast, for assessing the impact on traditional evaluative indicators, the capability approach is used to evaluate the impact of MGNREGA and it is found that there is a significant expansion in the capability set of the individuals interviewed (Dasgupta, 2013).

Right to Education

The Right to Education (RTE) first recognized as a fundamental right by the Supreme Court of India in the judgement of Mohini Jain vs. Union of India (1992) 3 SCC 666. A strong civil society demand for the Right to Education was responsible for its enactment. It was observed in this judgement 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 make endeavour to provide educational facility at all levels to its citizens."¹⁰

In December 2002, the Indian Parliament passed the 86th Amendment to the Indian Constitution which mandated the provision of free and compulsory education by inserting Article 21A in the Fundamental Rights: "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 replaced Article 45 in the Directive Principles of State Policy¹¹: "the State shall endeavour to provide early childhood care and education for all children until they complete the age of 14 years". But the 86th Constitutional Amendment 2002 stipulated that "it shall come into force from such date as the central government may by notification in the official gazette, appoint". As this notification was

⁹The scheme, in which half of the beneficiaries are women, roughly reaches every fifth household in the rural areas. In 2012-13, it provided employment to more than 4.8 crore households generating more than 213 crore person days of employment at a total expenditure of more than 39,000 crore. The average wage rate per day has gone up to Rs 128 in 2012-13 from Rs 65 in 2006-07.

Source: <http://www.thehindu.com/news/national/now-150-workdays-for-tribals-under-mgnrega/article5736740.ece>

¹⁰Cited in http://www.azimpremjifoundation.org/Right_to_Education. Accessed in August 2013.

¹¹The Directive Principles of State Policy are guidelines to the central and state governments of India. These provisions, contained in Part IV of the Constitution of India, are not enforceable by any court, but the principles laid down therein are considered fundamental in the governance of the country, making it the duty of the State to apply these principles in making laws to establish a just society in the country.

never issued, the 86th Constitutional Amendment did not come into force. This, it is suggested, gave rise to the need for the Right to Education bill (Mehrotra, 2012).

In contrast to the supportive role of NAC for citizens' entitlements, there has been opposition to the same by certain sections of the bureaucracy. In the case of Right to Education, two sets of arguments were presented by those opposing it within government (Mehrotra, 2012). First, it was suggested by the opponents in the central government that resources have not been an obstacle for some Indian states to provide free and compulsory education. This argument, however, overlooked the large backlog of out-of-school children in many states and the vast number of illiterates in India geographically concentrated in very poor, northern and the eastern states, with a large population. Second, it was argued that the Central Government should not take over the responsibility for an ever expanding list of key subjects such as law and order, health and education, which are mainly part of the State governments' responsibility, according to the Indian Constitution. It was also suggested that if the Centre were to go on doing this, State governments would go on with their lopsided prioritizing of populist, not priority programmes (Mehrotra, 2012). Nevertheless, the RTE was enacted given strong civil society support.

In the period following the 86th Constitutional Amendment, a participatory process of inviting comments from members of the public, motivated by a strong civil society demand, yielded several different drafts of the 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 4th August, 2009 and came into force on 1st April, 2010. This makes India one of the 135 countries to make education a fundamental right of every child.

The RTE guarantees free and compulsory education to all children in the age group 6-14 years, stipulates 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 has provisions for improvements in school infrastructure (IHDR, 2011). There is no direct (school fees) or indirect cost (uniforms, textbooks, mid-day meals, transportation) to be borne by the child or the parents to obtain elementary education. The government will provide schooling free-of-cost until a child's elementary education is completed (UNICEF)¹².

Sarva Shiksha Abhiyan (SSA) is Government of India's flagship programme for achievement of universalisation of elementary education in a time bound manner. Although the SSA predated the RTE Act, the SSA has been focussed on achieving the goals of RTE since the Act was passed. SSA aims to address the needs of 192 million children in 1.1 million habitations and is being implemented in partnership with state governments to cover the entire country. Specifically, the programme seeks to open new schools in those habitations which do not have schooling facilities and strengthen existing school infrastructure through the provision of additional classrooms, toilets, drinking water, maintenance grant and school improvement grants.

¹²http://www.unicef.org/india/education_6144.htm, Accessed in August 2013.

However, impact of the RTE remains questionable. 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. The enrolment levels for children in the 6-14 years age group have been 96% or more for the last four years. However, though the pupil-teacher ratio shows improvement in rural areas, the learning levels have started dropping in many states since RTE came into effect. It finds that RTE may have led to relaxation of classroom teaching as all exams and assessments are scrapped and no child is to be kept back. ASER (Pratham, 2012) suggests that teaching-learning of basic foundational skills should be the main agenda for primary education in India.

Right to Food

In India, the Right to Food Campaign is an informal network of organizations and individuals campaigning for the realization of the right to food, through state guarantee of entitlements relating to livelihood security such as the right to work, land reform and social security, with the belief that everyone has a fundamental right to be free from hunger. The campaign began with a writ petition submitted to the Supreme Court in April 2001 by People's Union for Civil Liberties, Rajasthan. The petition demanded that the country's huge food stocks be used without delay to protect people from hunger and starvation.¹³ This was followed by a larger public campaign for the right to food. This resulted in the Supreme Court of India appointing a body to monitor the right: the Commissioners on the Right to Food.¹⁴

As a result of civil society mobilization and political support, the Cabinet of the GOI recently approved the National Food Security Act (NFSA). The entitlements under the NFSA include an assured quota of subsidised foodgrains 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 will be entitled to 5 kg of foodgrains per person per month at the rate of Rs. 3, 2 and 1 per kg for rice, wheat and millets, respectively. The NFSA aims to cover 75% and 50% of the rural and urban populations respectively. The national coverage ratios are expected to be adjusted state-wise based on a fairness principle so that the coverage is higher in the poorer states (EPW, 2013).

Prior to enactment of the NFSA, it has been argued that passing the bill is only a necessary and not sufficient condition for reducing hunger in India (Saxena, 2012). It has been argued that for the bill to have an impact on hunger in India there needs to be improvement in the governance, productivity and accountability of government machinery. Presently, major food related programmes, such as the PDS and Integrated Child Development Services (ICDS) are

¹³The 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 (FCI), and six state governments, in the specific context of inadequate drought relief. Subsequently, the case was extended to the larger issue of chronic hunger, with all states and union territories as respondents.

Source: <http://www.righttofoodcampaign.in/legal-action/-right-to-food-case>

¹⁴The 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.

plagued by corruption, leakages, errors in selection, procedural delays, poor allocations and little accountability. Moreover, they discriminate against and exclude those who need them the most (Saxena, 2012; Mander, 2012). Other arguments against the bill included that the magnitude of the subsidy is estimated to be huge and is imprudent (Bhalla, 2013).

In this context, it is notable that until 1992, the PDS had universal targeting, being available to all consumers. Government of India introduced a revamped PDS in 1992 in limited areas, primarily drought prone, tribal and hilly, and remotely located. This has been substituted in 1997 by the Targeted PDS (TPDS), specifically aimed at Below Poverty Line (BPL) people in all parts of the country. The targeted PDS is inefficient and inequitable, with massive leakages and diversions from warehouses in transit to fair price shop. This has led to demand for universalization by the Right to Food campaign.

Furthermore, 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 Rs.3 per kg for BPL households. Essential provisions of the proposed “Food Entitlements Act” include: a universal Public Distribution System (providing at least 50 kg of grain per family with 5.25 kg of pulses and 2.8 kg of edible oils); special food entitlements for destitute households (including an expanded Antyodaya programme); 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 elimination of all social discrimination in food-related matters. Finally, the campaign is demanding that the Act must include strong accountability and grievance redressal provisions, including mandatory penalties for any violation of the Act and compensation for those whose entitlements have been denied.

The Two Missing Rights – Social Insurance and Health

While three rights have been achieved in India, there are two that are still missing: social insurance and health.

It is argued that social security consists of two categories of support to workers: first, social assistance, and second, 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, disabled, poor widows) or those who are unable to earn enough from work to guarantee a basic income or consumption level, and social insurance to those able to work but who have little access to a safety net that is normally available in the organized sector: old age pension, maternity benefit, and death and disability benefit, as also health coverage. It is argued that the Indian state hasn’t so far succeeded in providing social insurance very well (Mehrotra, 2014, forthcoming).

Social security interventions remain fragmentary in India. Government sponsored and administered programmes dominate pension and health insurance provision in India. However, in distributional terms, social security coverage is concentrated in the upper part of

the income distribution. Moreover, the mandated schemes have failed to reach the vast majority of the population. One of the reasons for the low coverage of social security in India has been the extent of informality of the workforce (World Bank, 2011). It is estimated that 93% of the Indian labour force is in the unorganized sector (Mehrotra, 2014, forthcoming). However, less than 1% of workers in the unorganized sector have any formal pension coverage through public schemes (while in the organized sector that share is 95%). The coverage through commercial schemes is only 1.2% for personal accident insurance, 0.5% for private health insurance, and 23% for life insurance (O’Keefe, 2005 cited in Mehrotra, 2014, forthcoming).

In the formal sector, some of the 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, a defined contribution model activated by the Pension Fund Regulatory Development Authority, the ‘micro-pension’ product of the Union Trust of India, and programs offered by the Life Insurance Corporation.

We argue that a social insurance programme has to have three components: old age pension, death and disability benefit (or life insurance), and maternity benefit – the internationally recognized requirements by the ILO of a minimum SI programme. In addition, we argue for a national health insurance for those in the unorganized sector (NCEUS, 2008, cited in Mehrotra, 2014, forthcoming).

In the rest of this chapter, we shall focus on the right to health.

III. Health Outcome Indicators

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. Ensuring universal coverage of health services is an important component of universalizing social protection. Compared to other Millennium Development Goals (MDGs) spanning a range of human development dimensions, indicators in terms of health have been the slowest to achieve MDG targets. In line with the MDG targets, the 11th Five Year Plan set for itself monitorable targets to be achieved during the 11th Plan period. An assessment of health outcome, process and input indicators reveals that despite the National Rural Health Mission (NRHM),¹⁵ progress in terms of these indicators has been slow to be able to achieve the MDGs. Table 1 shows the progress of monitorable targets for health indicators and the targets for the 12th Five Year Plan.

¹⁵The National Rural Health Mission (NRHM) was launched by the Indian Prime Minister on 12th April, 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. NRHM seeks to provide equitable, affordable and quality health care to the rural population, especially the vulnerable groups.

Table 1: Eleventh Plan Monitorable Targets and Twelfth Plan Targets

S. No.	Eleventh Plan Monitorable Target	Baseline Level	Recent Status	12th Plan Target
1.	Reducing Maternal Mortality Ratio (MMR) to 100 per 100000 live births	254 (SRS, 2004-06)	212 (SRS, 2007-09)	100
2.	Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births	57 (SRS, 2006)	44 (SRS, 2011)	25
3.	Reducing Total Mortality Rate (TFR) to 2.1	2.8 (SRS, 2006)	2.5 (SRS, 2010)	2.1
4.	Reducing malnutrition among children of age group 0-3 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 age group 0-6 to 935	927 (Census, 2011)	914	950

Source: Planning Commission (2013)

The development goal to eradicate 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) has shown almost no improvement 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 2nd National Family Health Survey (NFHS) and 46 per cent in 2005-06 as per NFHS 3. These are the latest available estimates for underweight children. The MDG, however, requires this proportion to be reduced to 27 per cent by 2015.

Reduction of child mortality required reducing by two-thirds the Under Five Mortality Rate (U5MR) between 1990 and 2015, and reducing Infant Mortality Rate (IMR) to 26.7 per 1,000 live births by 2015. There has indeed been progress in reducing child mortality rates in the past two decades albeit much remains to be achieved. The number of deaths per 1,000 live births before a child attains age one, IMR stood at 80 per 1,000 live births in 1990 and fell to 68 in 2000. However, the pace of decline slowed down in the next decade when IMR fell by only 24 points to reach 44 per 1,000 live births in 2011. IMR needs to decline by another 17 points in these four years to be able to reach the MDG target by 2015.

However, the inter-state differences in IMR are more worrisome. While the national 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 an IMR much higher than the national average – Assam (55), Madhya Pradesh (59), Odisha (57), Rajasthan (52), and Uttar Pradesh (57).

The Under Five Mortality Rate (U5MR) or the probability of a child surviving his/her fifth birthday stood at 125 per 1,000 live births in 1990. The MDG target was to reduce U5MR to 42 per 1,000 live births by 2015. It dropped to 85 per 1,000 live births in 2000 and according

to Sample Registration System (Registrar General of India), it further declined to 55 in 2011. Given this pace of decline, almost 3 per 1,000 decline in 11 years, the MDG target can be achieved in the next four years. However, for the poorer states of Assam (78), Madhya Pradesh (77), Odisha (72) and Uttar Pradesh (73) achieving MDG targets seem to a difficult task. Such high levels of child mortality rates in these states reflect the inefficiency of the public health institutions as well as lack of entitlements for healthy living. These also reflect gaps in child immunization practices. As per NFHS 3, 44 per cent children received all vaccinations¹⁶ in 2005-06. This proportion was lower in rural areas where it was 39 per cent, and even lower for rural areas of Assam and Madhya Pradesh (32%), Bihar (31%), Jharkhand (30%), Rajasthan (22%) and Uttar Pradesh (21%). In 2007-08, as per District Level Household & Facility Survey (DLHS) estimates 54 per cent of all children received all vaccinations. However, in Madhya Pradesh and Uttar Pradesh, only about one-third and fewer children respectively received all vaccinations.

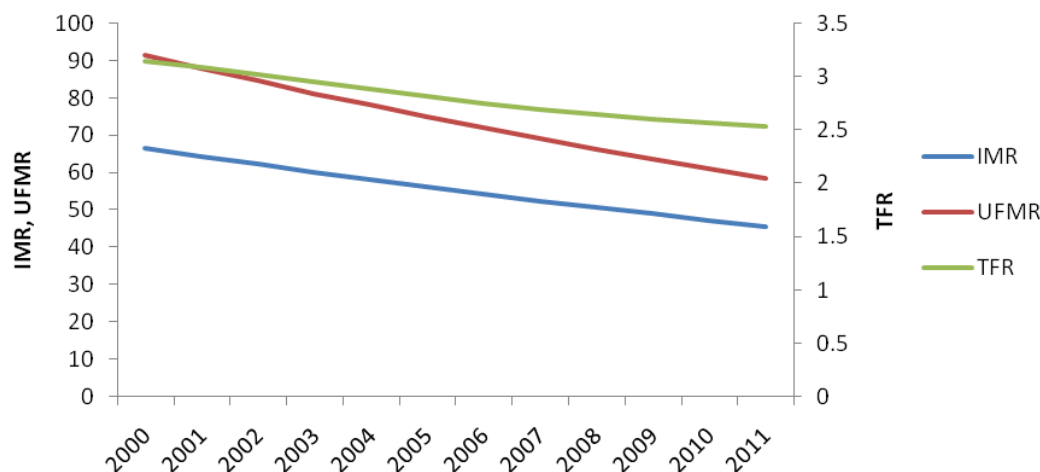
The health and nutritional status of the child is critically dependent on mother's health and care taken during pregnancy and delivery. Maternal mortality ratio (MMR) which measures the number of women of reproductive age dying per 100,000 live births due to maternal causes is a crucial indicator of the efficiency of the reproductive and child health (RCH) programme. It also indicates the effectiveness of the health care system. MMR was as high as 437 per 100,000 live births in 1990-91 and was targeted under the MDGs to be reduced to 109 by 2015 and the 11th Plan ambitious target was MMR of 100 per 100,000 live births. MMR declined dramatically to 301 per 100,000 live births in 2001-03 and declined by 89 points to reach 212 per 100,000 in 2007-09. Given this pace of decline, i.e. decrease of around 15 per 100,000 every year; it will be possible to achieve the MDG target only in the next 8 years.

At the state level, it is seen that Kerala (81), Tamil Nadu (97) and Maharashtra (104) have realized the MDG target of 109 per 100,000 live births in 2007-09. However, the major drag on MMR is the Empowered Action Group (EAG) states¹⁷ where the average MMR was 308 in 2007-09. The EAG states are Assam (381), Bihar (305), Jharkhand (278), Madhya Pradesh (310), Chhattisgarh (275), Odisha (277), Rajasthan (331), Uttar Pradesh (345) and Uttarakhand (188). The sub-optimal performance in terms of these indicators (child mortality and MMR) reflect the gaps in ante-natal care, skilled birth attendance and emergency obstetrical care in these relatively poorer states (Planning Commission, 2013).

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

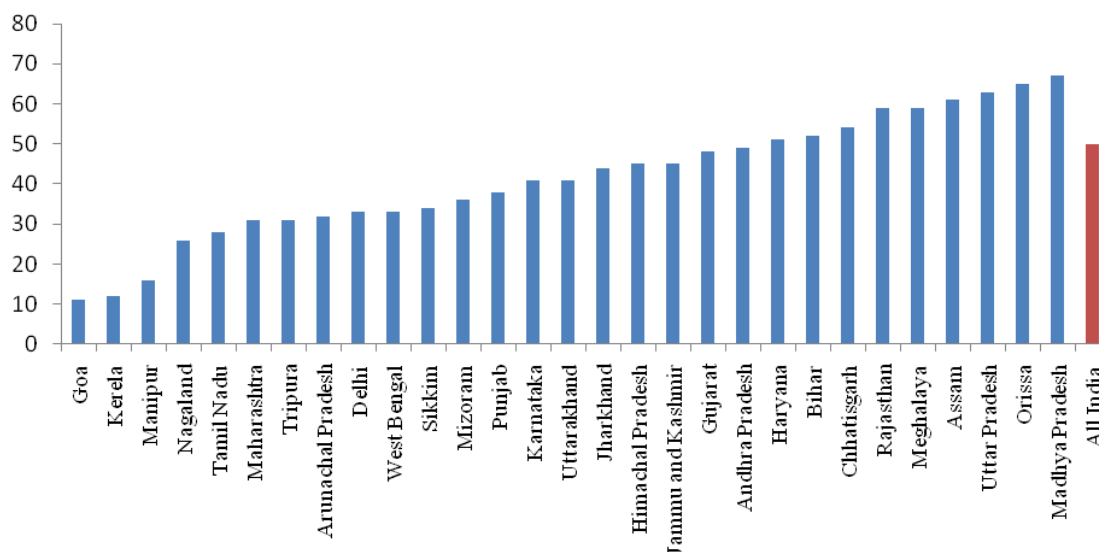
¹⁷The Empowered Action Group (EAG) set up to facilitate preparation of area-specific programmes in eight states, namely, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttaranchal, which have lagged behind in containing population growth to manageable levels, held its first Business Session on June 18, 2001 under the Chairmanship of the Minister for Health and Family Welfare, Dr. C.P. Thakur.

Figure 1: IMR, UFMR and TFR in India



Source: World Development Indicators

Figure 2: State-wise Infant Mortality Rate in India (2009)



Source: RGI as cited in IHDR (2011)

High maternal mortality rates are attributable to the high incidence of non-institutional deliveries. The place of delivery determines maternal health status and is an indicator for assessing the demand for public health institutions. Continued high rates of child and maternal mortality suggest that the public health system has been ineffective in promoting Reproductive and Child Health programmes and healthy practices as breastfeeding, use of Oral Rehydration Salts and preventive and care seeking behaviours (Planning Commission, 2013). Indian women suffer on account of lack of access to healthcare services during pregnancy. As per NFHS 3 estimates for 2005-06, only 52 per cent women had three or more antenatal care check-ups.

In 2005-06, as per NFHS 3 data, on an average only 39 per cent deliveries took place in an institution in the country. In rural areas, it was even lower at 29 per cent. As per the District Level Health Survey (DLHS) data, 47 per cent women aged 15-49 years had institutional delivery in 2007-08. The SRS estimates of 2011 however show that there has been a sharp rise in institutional deliveries, which can be attributed to National Rural Health Mission (NRHM) and the Janani Suraksha Yojana (JSY).¹⁸ The percentage distribution of births by type of medical attention at delivery shows that only about 28 deliveries happened with untrained functionaries or others. Government and private hospitals respectively accounted for 45 and 21 per cent of deliveries, the remainder being accounted for by qualified professionals (like nurse or Auxiliary Nurse Midwife).

IV. Health Sector Overview

The performance on account of health outcomes indicates gaps in the health system of the country. The policy makers' vision for health in the five year plans involves achieving good health especially for the marginalized sections of the society. However, improving the health conditions of the population requires investments in health infrastructure and human resources (IHDR, 2011). The expenditure (public and private) on health has been abysmally low in India, hovering around 4 per cent of GDP. In the case of Brazil and South Africa, health expenditure accounts for over 8 per cent of GDP. In China, the health expenditure to GDP is 5.2 per cent, but the share of public expenditure in total health expenditure is 56 per cent compared to 31 per cent in India. The higher proportion of private expenditure on health results from the high out-of-pocket expenditure (86% of total private expenditure) on health that the private households have to incur. High out-of-pocket expenditure on health, especially by those belonging to the poorer sections of the society often pushes them below the poverty line.

During the 11th Five Year Plan, however, expenditure on health by the Central Government increased by 2.5 times, while that by state governments increased by 2.14 times as compared to in the 10th Plan. By the terminal year (2011-12) of the 11th Plan combined public expenditure on health reached to 1.04 per cent of GDP. When spending on drinking water and sanitation, Integrated Child Development Scheme and Mid-Day Meal are also added and then public expenditure on health comes to be 1.97 per cent of GDP in 11th Plan. During the 12th Plan, it is expected to rise to 2.5 per cent of GDP.

Low public expenditure on health also reflects gaps in health infrastructure both physical as well as human resources. Health infrastructure indicates the quality of healthcare delivery and in turn affects the health outcomes. Despite National Rural Health Mission and increases in public expenditure in health, not much increase has been seen in the number of Sub-Centres (from 1,42,655 in 2004 to 1,48,124 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).¹⁹

¹⁸Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM). It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. The scheme is under implementation in all states and Union Territories (UTs), with a special focus on Low Performing States (LPS).

¹⁹National Health Profiles, 2005 and 2011

Compared to 36 hospital beds per 10,000 persons in China, India has 9 hospital beds per 10,000 persons. The severe shortage of health infrastructure can be determined from the fact that the average population served per government hospital is 98,970. It is as high as 4,51,325 in case of Bihar, 2,29,118 in Uttar Pradesh, 1,94,863 in Assam, 1,78,243 in Andhra Pradesh, 1,59,721 in Haryana, 1,55,470 in Madhya Pradesh, and 1,39,676 in West Bengal. Average population served per government hospital bed is 1512, but is over 5000 in case of Bihar and Jharkhand and over 3500 in Uttar Pradesh and Assam.

Availability of skilled human resources is also an important prerequisite for an effective health service delivery. One of the major shortcomings of our public health system has been the failure to provide adequate human resources in public health system. Number of allopathic doctors possessing recognized medical qualifications (under Medical Council of India Act) and registered with state medical councils increased from 6,56,111 in 2005 to 9,21,877 in 2011 (an increase of 40 per cent). There has also been an improvement in the average population served per government allopathic doctors from 15,980 in 2005 to 12,005 in 2011. However, the increase in doctors in PHCs in rural areas has only been 20 per cent in the past 7 years. But it is noteworthy that there has been an almost 50 per cent increase in female health workers or ANMs between 2005 and 2011 (Table 2).

Table 2: Health Human Resources in rural areas (Government) in India, 2005 and 2011

Year	No. of Doctors at PHCs	Total Specialists at CHCs	Health Assistants		Health Workers	
			Male	Female(LHV)	Male	Female/ANM
2005	21974	3953	20086	19773	60756	138906
2011	26329	6935	15622	15908	52215	207868

Source: National Health Profiles 2005 and 2011

In 2008, the government launched its flagship health insurance scheme for the poor. The Rashtriya Swasthya Bima Yojana (RSBY)²⁰ combines technology with incentives to provide in-patient insurance coverage up to an annual sum of Rs 30,000 for eligible enrolled

²⁰For people living below poverty line, an illness not only represents a permanent threat to their income earning capacity, in many cases it could result in the family falling into a debt trap. When the need to get the treatment arises for poor families they often ignore it because of lack of resources, fearing wage loss, or wait till the last moment when it's too late. Even if they do decide to get the desired health care it consumes their savings, forces them to sell their assets and property or cut other important spending like children's education. Alternatively they have to take on huge debts. Ignoring the treatment may lead to unnecessary suffering and death while selling property or taking debts may end a family's hope of ever escaping poverty. In this context, tragic outcomes can be avoided through a health insurance which shares the risk of a major health shock across many households by pooling them together. A well designed and implemented health insurance may both increase access to healthcare and may even improve its quality over time. The RSBY provides the participating BPL household with freedom of choice between public and private hospitals and makes him a potential client 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 to pay only Rs. 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding. The budgetary allocation for RSBY was 264.51 Rs. crore in 2009-10, 445.89 Rs. crore in 2010-11, and 279.94 Rs. crore in 2011-12. (Source: <http://www.rsby.gov.in/>)

households. The RSBY is implemented through insurance companies with premiums subsidized by Union and State governments to the extent of 75% and 25% respectively.

The Indian Prime Minister in his Independence Day's speech (2013) claimed that the RSBY presently covers about 3.5 crore families, which is 35 million families. If we assume that there are 5 members per household, this gives us a total of approximately 200 million households in the country. Thus, the RSBY covers approximately 17% of the households in the country. This is a very low coverage given that 50-60% of the country's population is vulnerable to poverty. Further, as the RSBY doesn't cover the consultations out of hospitalization, its utility in bringing down out-of-pocket expenditure of households on health remains low.

It is found, using nationally representative data, that 3.5% of the population fall below the poverty line and 5% households suffer catastrophic health expenditures (Shahrawat and Rao, 2012). The poverty deepening impact of Out-of-pocket (OOP) payments was at a maximum in people below the poverty line in comparison with those above it (Rs 10.45 versus Rs 1.50 respectively). Medicines constitute the main share (72%) of total OOP payments. This share reaches 82% for out-patient care, compared with 42% for in-patient care. It is also found that removing OOP payments for in-patient care leads to a negligible fall in the poverty headcount ratio and poverty gap. Moreover, if OOP payments for either medicines or out-patient care are removed, then only 0.5% people fall into poverty due to spending on health. It is argued, on this basis, that insurance schemes which cover only hospital expenses, like those being rolled out nationally in India, will fail to adequately protect the poor against impoverishment due to spending on health. In other words, a broader coverage of benefits, to include medicines and out-patient care for the poor and near-poor (i.e. those just above the poverty line), is necessary to achieve 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 is questionable (Selvaraj and Karan, 2012). An examination of the poorer sections of households in intervention districts of the RSBY, Rajiv Aarogyasri of Andhra Pradesh, and Tamil Nadu Health Insurance schemes, finds that they experienced a rise in real per capita healthcare expenditure, particularly on hospitalisation, and an increase in catastrophic headcount – a conclusive proof that RSBY and other state government-based interventions failed to provide financial risk protection. Thus, an argument is made for a policy to achieve universal health coverage of the population, moving away from the current trend of piecemeal, fragmented approaches, and to provide a thrust to free primary health care (Selvaraj and Karan, 2012).

V. Towards Universal Health Coverage

In India, inequalities in health care by socio-economic status, geography and gender persist and three-quarters of health spending is private. Moreover, health expenditures are responsible for pushing around 39 million Indians into poverty each year. Consequently,

India's health care system is posed with the challenge of responding to the needs of the most disadvantaged members of the Indian society (Balarajan, et al., 2011).

There is an active civil society demand but the historical momentum for the right to health is missing. The civil society movements are much older for the rights to education and work and were largely responsible for their enactment.

A universal health care in India is argued for on the grounds that access to appropriate, adequate, and affordable health care is the legitimate entitlement of every Indian citizen during his or her life (Reddy et al., 2011). It is argued that an Integrated National Health Care System be established in which all providers, i.e. the public and the private sectors and the allopathic systems of medicine, are integrated. It is suggested that the Integrated Health Care System would ensure provision of good-quality health services to all Indian people, reduce the financial burden of health care on individuals, and empower people to take care of their health and hold the health-care system accountable (Reddy et al., 2011).

Moreover, the twelfth five year plan (FYP) of the GoI seeks to work towards the objective of Universal Health Coverage (UHC) in the country and defines the same as the assured access of each individual to a defined essential range of medicines and treatment at an affordable price, which should be entirely free for a large percentage of the population.

In the above context, a High-Level Expert Group (HLEG) on Universal Health Coverage (UHC) was constituted by the Planning Commission of India in October 2010, under the chairmanship of Professor K. Srinath Reddy, with the mandate of developing a framework for providing easily accessible and affordable health care to all Indians. The HLEG submitted its report in the same month, recognizing that it is possible for India, even with the financial resources available to it, to devise an effective architecture of health financing and financial protection that can offer UHC to every citizen.

The HLEG on UHC defined it as: '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, assured quality health services (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' (12th FYP). It also made recommendations under the following heads:

1. Health Financing and Financial Protection: Government should increase public expenditure on health from the current level of 1.2 percent of GDP to at least 2.5 percent by the end of the 12th FYP, and to at least 3 percent 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 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 healthcare 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, girls and other vulnerable genders (going beyond maternal and child health).

The recommendations of the HLEG are broad ranging and lack prioritization. We argue that India needs to focus on five key areas given the scarcity of resources and especially human resources for health.

First, all doctors should be required to serve in rural areas regardless of the requirement for a postgraduate seat.²¹ Several states in India – Assam, Arunachal Pradesh, Chhattisgarh, Gujarat, Kerala, Manipur, Meghalaya, Nagaland, Orissa, Tamil Nadu and West Bengal – have made it compulsory for all the medical graduates to serve in rural areas (Gupta et al., 2010). We argue that this policy should be extended to all states on account of the huge public subsidy on doctors' education, and cite the experience of Sri Lanka with compulsory rural posting of doctors.

In Sri Lanka, an important pre-1930s reform concerning private practice facilitated the coverage of medical practice to rural areas. By allowing dual practice, the government enticed the doctors to work at less than market wages and raise their incomes by simultaneous private practice. In 1970-77, when private practice was abolished, the distribution of government doctors to rural areas suffered. Then the health ministry adopted another policy to improve the availability of medical personnel in rural areas: rotating all junior doctors – on regular basis and compulsorily – 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 enabled Sri Lanka to reap the benefits of advances in medical technology and substantially reduced mortality in all areas and in every population group (Rannan-Eliya and Sikurajapathy, 2008).

Second, there is a strong case for introduction of the three years course for rural practice in all states in line with the experience of Rural Medical Assistants (RMA) in the state of Chhattisgarh.

²¹In the Indian context, it is argued that linking Post Graduate (PG) programmes to rural service appears to be an influential incentive for attracting doctors to rural posts. There is a strong desire for specialization among doctors after their first degree (MBBS), which coupled with few available PG seats compared to the number of medical graduates, makes for intense competition for obtaining admission to PG programmes. It is found from the experience of two Indian states – Uttarakhand and Andhra Pradesh, that the PG incentive is a powerful incentive for medical students/graduates to take on rural posts (Rao et al., 2011, as cited in Rao and Ramani, *Human Resources Technical Paper II*, Public Health Foundation of India, Accessed in August 2013)

In many states of India, AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homeopathy) physicians are posted at Primary Health Centres (PHC) to mainstream the Indian systems of medicine. Often they are the sole clinician present and practice both allopathic and their own system of medicine (Rao and Ramani).²² Clinicians with three years training in allopathic medicine operate in two states. In the state of Chhattisgarh RMAs are posted at PHCs, and in the state of Assam, Rural Health Practitioners are posted at sub-centres. In a recent initiative, the central health ministry proposed to nationally introduce a three year clinician course, the Bachelors of Rural Health Care (BRHC), with the intention of posting these graduates at rural sub-centres (Rao and Ramani).²³

A study on non-physician clinicians in the State of Chhattisgarh found that physicians and clinicians with shorter duration clinical training (i.e. RMAs) were equally competent in managing conditions commonly seen in primary care settings (Rao et al., 2010a). The AYUSH doctors were less competent than physicians and RMAs. This was observed for infectious, chronic and maternal health conditions and for a range of patient types – infants, children and adult men and women. A similar level of clinical competence exhibited by physicians and RMAs is consistent with evidence from other countries on the clinical performance of physicians and clinicians trained for a shorter duration (Rao and Ramani).²⁴ Further, patients and community members served by Medical Officers, AYUSH doctors and RMAs were equally satisfied. Importantly, the presence of an RMA or AYUSH doctor as the primary clinician at the PHC did not reduce its usage by local residents seeking treatment relative to having a physician (Rao et al., 2010).

Third, more regular staff or paramedics are needed for managing services and as front-end providers of services. The nurse to doctor ratio (1.5:1 instead of the desirable 3:1) in India is adverse compared to other countries (Reddy, 2012). This is because we have allowed the nursing training institutions to wither whereas we need them in dozens in states.

The availability of competent and committed health workers requires that attention be paid to both the numbers and the quality of health workers. There is a need to establish new medical and nursing colleges. Also, priority should be given to locate these new colleges in states which have very few of these, and they should preferably have linkages with the 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 essential drug procurement system needs to be revamped. Essential drugs should be available at affordable prices in the public health system. To strengthen logistics

²²Rao K.D. and S. Ramani, What works, where, and how well? Lessons from a comparative assessment of current rural retention strategies for doctors in India, *Human Resources Technical Paper II*, Public Health Foundation of India, Accessed in August 2013.

²³Rao KD and S. Ramani, What works, where, and how well? Lessons from a comparative assessment of current rural retention strategies for doctors in India, *Human Resources Technical Paper II*, Public Health Foundation of India, Accessed in August 2013.

²⁴Rao KD and S. Ramani, What works, where, and how well? Lessons from a comparative assessment of current rural retention strategies for doctors in India, *Human Resources Technical Paper II*, Public Health Foundation of India, Accessed in August 2013.

management system of healthcare, 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, sanitation is important for nutrition and improvement in health status. Nearly 60 percent of the 626 million persons in the world who defecate in the open are in India (i.e. 90 percent of total South Asia). This number is more than double the number of the next 18 countries combined where open defecation is prevalent (WHO, 2012, cited in Mehrotra and Ghosh, 2014, forthcoming). As per National Statistical Survey Organization (NSSO) data, the percentage of population who do not have any type of toilet facility was approximately 60 per cent in 2002 and improved very little by 2009 to 49 percent (IHDR, 2011). The approximate economic loss due to lack of sanitation could be as huge as Rupees 2.4 trillion in a year, which is approximately 6.4 percent 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 impact on health leading to other positive externalities. First, improved sanitation directly impacts nutrition which then results in better health and healthy living conditions. Since malnutrition accounts for half of all child deaths, sanitation also impacts health outcomes. In an econometric evaluation (Spears, 2012, cited in Mehrotra and Ghosh 2014, forthcoming) which assesses the impact of India's Total Sanitation Campaign (TSC) over 2001 to 2011 on health, using large District Health Surveys and Census data, it is found that TSC reduced infant mortality, on average, by 4 deaths per 1,000 and increased height for age (better known as stunting) by 0.2. This evidence is further corroborated by international comparisons of sanitation coverage and height, using 140 Demographic and Health Surveys. Second, improved sanitation in school improves enrolment rates of girls. In particular, the effects of improved sanitation go well beyond enrolment, and extend to actual learning and better cognitive skills (Mehrotra and Ghosh, 2014, forthcoming).

VI. Concluding Remarks

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 entitlements with regards to work (albeit in rural areas), education and food. However, two rights are available to a very limited share of the population: social security and health. For reasons of space the paper focused on health. It is found that in comparison with other Millennium Development Goals (MDGs) spanning a range of human development dimensions, indicators in terms of health have been the slowest to achieve MDG targets. Next, it is found that the health system in India remains poor in coverage, the public expenditure on health remains low, and people remain vulnerable to poverty on account of health expenditures. Further, the paper finds that the government's flagship health insurance scheme for the poor, the RSBY, remains ineffective in terms of providing financial risk protection in India's health care, has inadequate coverage, and doesn't cover the consultations out of hospitalization. Last but not the least, it argues for universal health coverage in India and suggests areas for immediate policy intervention in the health sector. First, all doctors

should be required to serve in rural areas regardless of the requirement for a postgraduate seat. Second, there is a strong case for introduction of the three years course for rural practice in all states in line with the experience of RMAs in the state of Chhattisgarh. Third, more regular staff or paramedics are needed for managing 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 improvement in health status.

Bibliography

Alston Philip and Nehal Bhuta (2005), Human Rights and Public Goods: Education as a fundamental right in India, Center for Human Rights and Global Justice, Working Paper No. 5, *Economic, Social and Cultural Rights Series*, NYU School of Law

Azim Premji Foundation, http://www.azimpremjifoundation.org/Right_to_Education. Accessed in August 2013

Balarajan Yarlani, S. Selvaraj, and S. V. Subramanian (2011), Health Care and Equity in India, *Lancet*, February 5

Bhalla Surjit S (2013), 'Manmonia's FSB: 3% of GDP', *The Financial Express*, July 6

Dev, S. Mahendra (2003), *Right to Food in India*, Centre for Economic and Social Studies, Hyderabad, Working Paper No. 50

Dasgupta Poulomi (2013), Employment Guarantee Schemes and Long -Term Development: A Case Study of the NREGA in India, in Murray Michael J. and Mathew Forstater ed., *Employment Guarantee Schemes*

Dreze, Jean (2004), Democracy and Right to Food, Special Article, *Economic and Political Weekly*, April 24

Dreze Jean and Reetika Khera (2009), The battle for employment guarantee, *Frontline* (Volume 26, Issue 1), 3-16 January [12 January]

Economic and Political Weekly (2013), *Two Steps Forward, One Step Backward*, Editorial, Vol. XLVIII, No. 14

Gupta G, T. Sundararaman and K. Rao, (2010), Human Resources for Health in India: Strategies for increasing the availability of qualified health workers in underserved areas. http://nhsrindia.org/thematic_human_resources_for_health.php. June 2010

Gupta, R and N. Dey (2013), Laws for citizens and by them too, *The Indian Express*, May 20

HDR (2000), *Human Rights and Human Development*, UNDP, Oxford University Press

India Human Development Report (2011), Institute of Applied Manpower Research, Planning Commission, Government of India

Mander, Harsh (2012), Ending Indifference: A Law to Exile Hunger? , *Journal of the National Human Rights Commission*, India, Vol. 11

Mehrotra, Santosh (2008), National Employment Guarantee two years on: where do we go from here, *Economic and Political Weekly*, Perspective, August 2

Mehrotra, Santosh (2014, forthcoming), *Policies to Achieve Inclusive Growth in India, Realizing the demographic dividend*, Cambridge University Press

Mehrotra, Santosh and Deboshree Ghosh (2014, forthcoming), Needed a re-design of the campaign to achieve total sanitation, *Economic and Political Weekly*

- Mehrotra, Santosh (2012), The Cost and Financing of the Right to Education in India: Can we fill the financing gap?, *International Journal of Educational Development*, Volume 32, Issue 1, January, pp. 65-71
- Mehrotra, Santosh, Sharmistha Sinha, Jajati K. Parida, Ankita Gandhi (2014), *Why a jobs turnaround despite slowing growth*, IAMR Occasional Paper No. 1, www.iamrindia.gov.in
- National Commission on Enterprises in the Unorganized Sector (NCEUS) (2008), *Conditions of Work in the Unorganized Sector*, Government of India, New Delhi
- National Food Security Bill (2011), National Advisory Council, http://nac.nic.in/pdf/nfsb_final.pdf
- North, Douglass C. (1990), *Institutions, Institutional Change and Economic Performance*, Cambridge University Press
- Nussbaum, Martha C. (1997), Capabilities and Human Rights, *Fordham Law Review*, Vol. 66, Issue 2
- Planning Commission, Government of India (2013), *Press Note on Poverty Estimates 2011-12*
- Pratham (2012), *Annual Status of Education Report - Rural*, <http://www.asercenter.org/>
- Puddephatt, Andrew (2009), Exploring the role of civil society in the formulation of and adoption of access to information laws: The Cases of Bulgaria, India, Mexico, South Africa and the United Kingdom, Access to Information Working Paper Series, World Bank Institute
- Rannan-Eliya, R. P. and L. Sikurajapathy (2008), Sri Lanka: Good Practice in Expanding Health Care Coverage, in *Good Practices in Health Financing*, World Bank
- Rao, K.D. and S. Ramani, What works, where, and how well? Lessons from a comparative assessment of current rural retention strategies for doctors in India, *Human Resources Technical Paper II*, Public Health Foundation of India, Accessed in August 2013
- Rao, K.; A. Bhatnagar, T. Sundararaman, et al. (2010), Which Doctor for Primary Health Care? An Assessment Of Primary Health Care Providers In Chhattisgarh, India, Public Health Foundation of India, National Health Systems Resource Center, State Health Resource Center, Chhattisgarh
- Reddy, K. Srinath, Vikram Patel, Prabhat Jha, Vinod K. Paul, A. K. Shiva Kumar, Lalit Dandona (2011), Towards achievement of universal health care in India by 2020: a call to action, *Lancet*, 377: 760-68
- Reddy, K Srinath (2012), Universal Health Coverage in India: The time has come, *The National Medical Journal of India*, Vol. 25, No. 2
- Right to Food Campaign India, <http://www.righttofoodindia.org/index.html>
- Saxena, N. C. (2012), Food Security and Hunger in India, *Journal of the National Human Rights Commission*, India, Vol. 11
- Second Administrative Reforms Commission (2006), *Unlocking Human Capital*, Second Report, Government of India

Selvaraj Sakthivel and Anup K. Karan (2012), Why Publicly Financed Health Insurance Schemes are Ineffective in providing Financial Risk Protection, *Economic and Political Weekly*, Vol. XLVII, No. 11

Sen, A.K. (2005), Human Rights and Capabilities, *Journal of Human Development*, Vol. 6, No. 2, July

Shahrawat, Renu and Krishna D. Rao (2012), Insured yet vulnerable: out-of-pocket payments and India's poor, *Health Policy and Planning*, 27: 213-221

Spears, D. (2012), 'Effects of rural sanitation on infant mortality and human capital: evidence from India's Total Sanitation Campaign', *RICE Working Paper*, available at www.riceinstitute.org.

Planning Commission, *Twelfth Five Year Plan (2012-2017)*, Government of India

UNICEF, http://www.unicef.org/india/education_6144.htm, Accessed in August 2013

World Bank (2011), *Social Protection for a Changing India*

About the Institute

The Institute of Applied Manpower Research (IAMR) is the only Institute of its kind. IAMR was established by the Government of India in 1962 and commemorated its Golden Jubilee in 2012. IAMR is an autonomous institution under the Planning Commission, Government of India and is the only think-tank of the Planning Commission. The Director General of the Institute is appointed by the Government of India and holds the rank of Secretary to the Central Government. The primary objectives of the Institute include research, data collection, and education and training in all aspects of human capital planning and human resource development. However, the Institute has come a long way from its original aims, and added many relevant facets to its profile.

For more information about IAMR activities visit our website at <http://iamrindia.gov.in> .

About IAMR Publications

IAMR Research Reports are essential products of IAMR Research Projects. They are usually the outcomes of a long-term research project which consists of the work of IAMR Faculty and the Faculty of other institutions and organizations. These Research Reports carry a report number and the year of publication of the report (e.g. Report No. 1/2012).

IAMR Occasional Papers are research papers by the Faculty members or those who might have made presentations in IAMR Seminar, based on that paper. Occasional Papers are intended to be work-in-progress as a definitive research.

IAMR Policy Briefs are much briefer than both research reports and occasional papers. They are aimed at policy makers who usually would not have gone through the actual research reports or occasional papers.

INSTITUTE OF APPLIED MANPOWER RESEARCH

City Office: 53, Lodhi Estate, New Delhi-110 003

Phone: +91 (0) 11 24697081; 24697082

Fax: +91 (0) 11 2778 3467

Web: <http://iamrindia.gov.in> E-mail: DG.IAMR@nic.in

Campus: Sector A-7, Narela Institutional Area, Delhi-110 040

Phone: + 91 (0) 11 27787215/6/7

Fax: +91(0) 11 27783467

Web: <http://iamrindia.gov.in> E-mail: DG.IAMR@nic.in