HEALTH IN INDIA: IS THE NDA GOVERNMENT PRIORITIZING NEEDS CORRECTLY?

KAUSHIKI DAS

Abstract

This paper looks at the health system in India under the NDA government, specifically focusing on health-related schemes, with a close examination of Ayushman Bharat. It additionally looks at how privatization and the health system have become intertwined and the path India is currently taking. It investigates the above by contesting India's funding of healthcare and its prioritization of Ayushman Bharat over other health schemes, much to the country's detriment. It concludes with the opinion that the current emphasis on privatization and Ayushman Bharat, instead of focusing on bettering the provision of primary healthcare, will only further deteriorate the already-failing Indian health system.

Key Words: Ayushman Bharat, Health, Infrastructure, Privatization

1. Introduction

As per William C. Hsiao and his colleagues from the Harvard School of Public Health, health systems can be examined from two perspectives – micro and macro. Overall, they conceptualized health systems vis-à-vis means-and-ends, wherein "a set of relationships in which the structural components (means) and their interactions are associated and connected to the goals the (health) system desires to achieve (ends)." The macro aspect would be the overall health system – its structure and methods of functioning.

They then listed five 'control knobs' which influenced aggregate health outcomes – i) Financing ii) Organization of service delivery iii) Payment systems iv) Government regulations and, v) how governments and private companies affect people's preferences, choices and expectations. This paper looks at health from the macro level, and also engages with some of the 'knobs' Hsiao lists out.

Kaushiki is a M.A. in Development alumni at Azim Premji University. She is deeply interested in research, particularly regarding health and gender. Parallelly, her interests lie in working with program implementation and evaluation. She is currently employed at SoStakes Services Pvt. Limited, Bangalore.

In this paper, I argue that the current path being taken by the government in power will only further worsen the already poor state of India's overall healthcare system. Forcibly pushing the Pradhan Mantri Jan Arogya Yojana (PM-JAY) (i.e., Ayushman Bharat) – an insurance scheme – instead of focusing on the clear need to increase general access to primary health facilities, combined with a drive for further privatization in healthcare, would ultimately widen the unequal access to appropriate healthcare. Jean Dreze (2018) accedes that social insurance schemes like PM-JAY are necessary and have their positives. However, he also argues that merely focusing on medical insurance in India will do no good unless it is accompanied by a substantial increase in public health expenditure and a complete and distinctive overhaul of the primary health infrastructure.

A disclaimer, however, is in order. It cannot be denied that Indian healthcare is a crumbling, inefficient and inequitable structure. It is the product of a string of decisions and oversights made by governments of the past, and the blame cannot be solely laid on the current party in power. For this paper, I am looking at what the current government has done for the health sector. This paper thus attempts to examine how the intersections of the governing party's method of providing welfare in health and increasing privatization have influenced other health measures in the country.

Overview of health in contemporary India

The 2019 Indian general elections saw the BJP-led National Democratic Alliance (NDA) win for a consecutive second term by a landslide, with BJP itself getting 303 seats. Election battlegrounds have always had welfare-related promises (Deshpande, 2017), be it Indira Gandhi's "Gareebi Hatao Andolan" or Narendra Modi's "Sabka Vikas". Another common welfare promise: health.

The ongoing pandemic contributes more to the already mounting evidence towards the crumbling nature of quality healthcare in India, and the major failures on part of the government in focusing on the health welfare promise. That is not to say, however, that evidence did not exist before. Rising income inequality coupled with fast-receding government involvement in health already had the Indian health sector reeling (Taneja, 2020). Problems are further exacerbated by the lack of a well-functioning preventive health care system. (Rao, 2017)

Sunil Amrith (2007), while talking about the historical perspectives of public health in India, claims that Nehru's public health policy was driven not only by the desire to rid the large and growing Indian population of the scourge of epidemics like malaria, but also the desire to create a more centralized state.

Nehru's vision has held partially true when it comes to the realm of health. While health is a state subject, the states are wholly dependent on the Centre for the allocation of resources. This allocation has brought with it a host of troubles, which will be discussed later in the paper.

Currently, at the national level, the BJP has been pushing for its Ayushman Bharat health insurance scheme. However, the state of public health itself is in shambles. For instance, as of 31 March 2019, India had one Primary Health Centre (PHC) per 64,800 people. Furthermore, every PHC doctor has to attend to 37.652 people on average (The Hindu, 2020). Several more such statistics demonstrate the extreme population pressure on public health, which arises from the lack of adequate public health structures.

But, actual remedial measures for public health structures are nearly absent. Simultaneously, one of the main policy-making arms of the NDA government – the NITI-Aayog – has been pushing for privatization (e.g., by drawing up extensive PPP plans) (Pandey, 2020). Even without the emphasis from NITI-Aayog, India's healthcare system is already overwhelmingly dependent on the private sector – private healthcare makes up about 80% of outpatient care and 60% of inpatient care across the country (Gambhir, 2019).

Yamini Aiyar (2019) makes an important point about the overall nature of BJP's brand of welfare vis-à-vis the health sector – the BJP has chosen to focus on health insurance, rather than health. Thus, Ayushman Bharat would be the reply to the question of what has the BJP done for the health sector in India. Sujatha Rao (2018) succinctly points out the problem – it is merely a scaled-up version of already existing (and already failing) health insurance schemes. The issue with India's healthcare is access, be it to public or private hospitals. Rao (2017) also mentions the need for a health system that focuses on prevention through strong primary care. Ayushman Bharat is not a preventive measure; it is entirely curative. The government intends on extending its flagship scheme with the increased involvement of private healthcare facilities. India's health system is already highly privatized and it evidently does not work. So why would privatization work for Ayushman Bharat?

Financing of healthcare in India

India's spending on the health sector has been consistently low. For the financial year 2020, the total expenditure on health by the Centre and states combined was 1.29% of the GDP; the Centre's share in public health expenditure is 25%. The country's aggregate healthcare spending, combining both public and out-of-pocket expenditure is 3.6% of the GDP. This means that out-of-pocket expenditure is higher than public expenditure in the country, with the former being 2.31% of the GDP. India's healthcare spending is also lower than the average for OECD countries – in 2018, the average stood at 8.8% of the GDP (Livemint, 2020). Even worldwide, as per WHO's 2016 Global Health Expenditure Database, India ranked 170th out of 188 countries in domestic general government health expenditure as a percentage of GDP. As late as September 2020, Union Health Minister Harsh Vardhan had emphasized the Modi government's long-term goal of increasing expenditure on public health to 2.5% of the GDP by 2025 (Business Standard, 2020). However, this reiteration seems to be unattainable at the moment. In the September quarter, India's economy shrunk by a massive 7.5%, pushing the country into recession. Going from 1.29% to 2.5% in 4 years, especially considering the COVID-19 pandemic-forced economic slowdown, seems unlikely.

The NDA government, in all fairness, has increased its spending on health. The 2019-20 Budget gave Rs. 64,999 crores to health, which was 23% more than 2018-19's Rs. 52,800 crores. However, the increase in spending is not necessarily driven by a greater commitment to health; it is because expenditure has also risen due to the creation of heavyweight schemes like the PM-JAY. Another point to be remembered is that the GDP has also expanded during the same time, thus keeping the percentage share roughly the same.

The lack of investment in health affects states inequitably. Health is a state subject. Different states rank differently on the NITI Aayog Health Index and one of the main reasons for the backward states being backward is the lack of infrastructure in their states (Rao, 2017). A 2017 NITI Aayog report shows that states which have low income along with low revenue capacity spend significantly lesser on social welfare services like health. Additionally, health disparities among and within states are also tied to the differences in the cost of delivering health services. Thus, pulling back on public expenditure would only deepen the inequities in health between states. Additionally, the low health expenditure on part of the government only bolsters the problem of high out-of-pocket expenditure for individuals, which have both inter and intra- generational consequences.

An important aspect to keep in mind is that for public health spending to be effective, no matter what the amount, it is crucial to look at service delivery. Service delivery and ways to scale it up are other major problem areas for the country.

Health Schemes and Policies in India

a) Ayushman Bharat – At the cost of other schemes?

It would be inaccurate to say that the BJP government does not take healthcare into consideration. In its two terms, it has implemented some heavyweight measures which impacted the health of individuals, like The Swachh Bharat Mission, and the Jan Aushadhi scheme, but neither came under the Health Ministry. The biggest measure taken up by Health Ministry under the government has been, arguably, the Ayushman Bharat Scheme.

The PM-JAY or Ayushman Bharat Scheme intends to provide financial risk protection in healthcare to the poorest and most vulnerable populations of the country. It currently aims to include approximately 40% of India's population across both rural and urban areas. Every identified household would be insured for an annual sum of Rs. 5 lakhs for a variety of ailments requiring secondary and tertiary healthcare. The required treatment in the empanelled private and government hospitals are to be completely cashless (Union Budget, GoI, 2018). The 2018 Annual Budget brought Ayushman Bharat into reality, declaring its dual aim of extending health insurance, whilst simultaneously boosting primary health centres. The 2019 budget saw a huge allocation to the scheme to the tune of Rs. 6400 crores. The same amount was allotted in the 2020 budget as well.

However, there arises a problem at this juncture. The government, in trying to push for Ayushman Bharat (or, the Pradhan Mantri Jan Arogya Yojana) has either failed to increase or reduced resource allocation to other crucial Programs such as the National Mental Health Program, the National Program for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke. As Rao repeatedly says, the focus needs to be on providing primary care for non-communicable diseases, which are also incidentally on the rise due to the changes in lifestyle and the environment.

The idea of government-provided health insurance is not new in India. Previously, the UPA government had rolled out the Rashtriya Swasthya Bima Yojana (RSBY) which held the goal of providing poor families Rs. 30,000 yearly for health treatments. It was implemented via commercial insurance companies and a network of 8697 hospitals. However, upon evaluation, it

has turned out to be an enormous failure. Even after being in existence for approximately 10 years, studies have shown that out of the target of 5.9 crore families, only 3.6 have been covered (Rao, 2018). The average claim rate was about 33%, thereby showing its minimal impact. The reason behind such a negative aftermath was three-fold. First, the coverage provided under the scheme was inadequate. Second, during the course of the scheme, hospital rates went up by approximately 10%; but RSBY did not amend the coverage extended to the patients accordingly. Third, and most importantly, inadequate access to good primary health care put an inordinate amount of pressure on the secondary healthcare provided by RSBY.

With minimal attempts to tackle the problems of access, the NDA govt launched the PM-JAY in an effort to be novel. Rao (aptly) terms the PM-JAY as a "scaled-up version of RSBY". In conjunction with launching PM-JAY, the Government of India started diminishing the existence of the National Health Mission (NHM) – the arm of the health system which does address access to health. The National Rural Health Mission (a subset of the NHM) has been consistently facing challenges with the capacity of healthcare facilities being habitually poor. Figures show that less than 0.3 beds are available per 1000 people in rural areas. Despite this, the funds allotted to the NHM have been decreasing. In the 2019 Budget, the NHM's allocation saw an increase of Rs. 1062 crore from the 2018-19 budget. However, this increase did not cover the prevailing inflation rate, thus effectively negating the increase. Even worse, in the 2020 Budget, the Government of India allocated Rs. 33,400 crores to the NHM, which was 1% less than the previous year. Similarly, funding for communicable diseases has dropped by 27% and funding allocations for reproductive and child health (RCH) have gone from 40% of the health budget to 15%. In contrast, in 2018-19 Ayushman Bharat saw a funding hike of Rs. 4400 crores (Indian Union Budgets 2018 - 2020).

Ayushman Bharat seeks to tackle the problems in primary healthcare by upgrading sub-centres to Health and Wellness Centers (HWCs). But sub-centres currently have poor infrastructure and are heavily understaffed. Former members of the Mission Steering Group (MSG) of the National Health Mission (NHM) – Sarojini Nadimpally, Yogesh Jain and Amar Jesani – opine that for sub-centres to become HWCs, allocation of funds should have been above and beyond the funds allocated to the NHM. Instead, the amount allocated for HWCs in 2019-20 was Rs.1350 crores. Counting the decreases in allocation in other schemes, it might be argued that the Government decided to upgrade HWCs at the expense of other schemes and Programs (The Wire, 2019). Furthermore, if one considers the current state of sub-centres, the amount allocated is not nearly enough to elicit a substantial

enough change. It would either mean that not enough sub-centres were made into quality HWCs, or that a large number of subpar HWCs were created.

Another interesting development has taken place concerning the NHM. In January 2017, some of the public health professional members in the MSG were informed that their tenure was over and no new members were appointed in their place. In 2018 – for the first time in ten years – a full-fledged MSG meeting was held in the presence of only ministers and bureaucrats without any public health professionals (Kurian, 2018). In a field as technical as healthcare and medicine and one that demands professional expertise, this transition is bound to have a significant negative impact. It also begs the question as to why the NDA Government adopted such a path.

While the government perhaps plans to expand the reach of PM-JAY, in its current structure it only applies to 40% of the Indian population. However, health facilities need to be provided not just to poor families, but middle-class families as well. Out-of-pocket expenditures for middle-class families for severe health conditions, often force them into dire financial situations, a point which PM-JAY currently overlooks. Roughly 7% of the Indian population is thrust below the poverty threshold every year due to the high out-of-pocket healthcare expenditure. These figures are reported despite the existence of RSBY, a health insurance scheme.

PM-JAY also only addresses in-patient care. However, most out-of-pocket expenditure (approximately 2/3rd) is for out-patient care. RSBY had the same problem and statistics showed that 25% of patients were spending more than 40% of their income on various out-patient requirements like buying medicines and diagnostic tests before they were even admitted to the hospital. Medicines make up 52% of household health expenditures in India (MoHFW, 2016). PM-JAY is bound to have the same problem.

Another point to be remembered is that the financially weaker section of society prefers to not get hospitalized as this leads to indirect costs like loss in employment days. Therefore, the more pressing need was to address the problems in out-patient care, both in terms of quality and access (Rao, 2018).

b) Pradhan Mantri Bharatiya Janaushadhi Pariyojana (PMBJP)

The PMBJP or the Jan Aushadhi Scheme is not succeeding either. While it does not come under the Health Ministry, it is still important to discuss it. It is a fine example of a scheme that had the potential of effecting massive positive changes, but due to the inefficiency of both the previous and the present governments, has only had a lukewarm impact.

The previous UPA Government had set into motion the Jan Aushadhi Scheme in 2008, to combat the high out-of-pocket expenditure on medicines. It would provide the people with generic medicines at a fraction of the market price of branded medicines. A few definitions are necessary here. As per the FDA, a generic drug is a medication created to be the same as an existing approved brand-name drug in dosage form, safety, strength, route of administration, quality, and performance characteristics. Thus, the only difference between a generic and a branded drug would be the price, with the latter being much more expensive. India, however, has the unique phenomenon where companies sell "branded" generics. Such 'branded' generics are anywhere between 30% and 90% more expensive than their non-branded counterparts. In India, two major problems reveal themselves regarding medications. The first is the aforementioned price difference and resultant high out-of-pocket expenditure on medicines. Second, there is a problem with quality. There have been notable instances of pharmaceutical companies showing a lack of Good Manufacturing Practices and selling inferior quality generics in India. Doctors are forced to depend on the reputation of companies (like Dr Reddy's or Cipla) that have established their commitment to quality over several years. Even if a doctor did recommend a non-branded drug (which they are reluctant to), the absence of legislation to ensure compliance with drug manufacturing and testing guidelines increases the chances of a medicine shop selling a sub-par generic of an unknown company to the unsuspecting patient. (The Wire, 2017) (Roy and Rana, 2018) (Joshi et al., 2019)

The scheme, if implemented successfully, would have contributed immensely towards solving both these problems. Firstly, the cost of medicines would be taken care of. Secondly, by selling through government-sanctioned outlets, companies would ideally be wary of sending adulterated stocks of medicines. However, as is with other health schemes, implementation was highly unsatisfactory.

Under the UPA government., the paucity of allocated resources hindered its effectiveness. The BJP government after coming to power, renamed it and admittedly committed more resources to it. However, more resources did not solve the problems faced by Jan Aushadhi Kendras (JAK). The low availability of JAKs, poor stock of medicines in the stores, problems

in inventory, and the reluctance of doctors to prescribe the non-branded generic drugs continue to persist. Here too, the BJP failed to prioritize access or implement effective regulation, leading to the sub-par performance of the scheme. The scheme, till now, has failed to address the endemic problem of high out-of-pocket expenditure on medicines. Only in 2020, 6 years after the suggestive name-change of the scheme, did the government announce its plan in the Union Budget to create JAKs in all districts of the country.

A huge push for privatization?

India, under the Narasimha Rao government in advisement with Dr Manmohan Singh (the then-Finance minister), took on the task of economic liberalization with the assumption that privatization would happen simultaneously in a big way. It did not. It came in almost 10 years later during the 2002 Budget. President A.P.J Abdul Kalam made a noteworthy opening address in which he remarked that, "It is evident that disinvestment in public sector enterprises is no longer a matter of choice but an imperative... The prolonged fiscal haemorrhage from the majority of these enterprises cannot be sustained any longer." The government still did not term it privatization, it called it "disinvestment".

This policy was applied in a phased manner, and it was done according to what was considered "strategic" sectors – it would retain control over the strategic and "disinvest" in the others. Additionally, the governments in the past have done so gradually. However, health shows a completely different picture. It shows a sector that became overwhelmingly privatized in a relatively short amount of time.

In India, 80% of healthcare is provided by private facilities. According to Rao (2017), India has always had a widespread private sector, particularly in health. Previously, it was fee-for-service. Now it has metastasized to being a wholly and highly commercial system. The private sector consists of small and big private hospitals, small and big nursing homes, a host of solo practitioners as well as unqualified quacks.

The McKinsey Report of 2012 found that in India, "the urban rich access healthcare at a rate that is double that of the rural poor and 50 per cent more than the national average." Private healthcare is scarcely available in rural areas, as the privateers tend to flock to the urban areas in search of richer clients. Rao also points out a change in ownership patterns in private healthcare, wherein corporate entities have gone from owning single hospitals to multinational chains of hospitals. And this environment is mostly unregulated. Rao heavily criticizes the rush on the government's part to partner with these entities to provide healthcare, saying that the government

has failed to note the long-term impact the growth of such entities will have. She proposes that the private sector be reined in if the goals for better health and lower impoverishment are to be ever achieved.

Even in the case of public-private partnerships (PPPs), it is seen that the private sector always gains more in India because the government shoulders a significantly larger proportion of the risk. Rao makes an important point when she says that the private sector gains an edge by its significant lobbying power (e.g., World Bank, IMF), which can provide compelling data and sway political leadership to their advantage to their easy access to such forces (Rao, 2017).

The current government's push for privatization in health has been spearheaded by its top policy-making think-tank, the NITI-Aayog. In 2017, the NITI-Aayog released a 140-page document that contained a framework wherein the central government would allow private hospitals to run particular services within district hospitals on a 30-year lease, particularly in tier 2 and tier 3 cities. This PPP model was proposed with the supposed intention of addressing the problem of health infrastructure in those cities. It would deal with three types of non-communicable diseases – cardiac problems, pulmonary diseases, and cancer care. This proposal was met with huge opposition for several reasons. First, despite health being a state subject, only a few states were consulted before this framework was announced. Second, no members of civil society or academia were consulted either. RTI documents revealed that the NITI-Aayog built the framework in close consultation with the World Bank and was further refined after consultation with representatives from prominent private healthcare companies. Health experts outside the corporate sector were barely consulted. Third, it went against the long-standing demands of health experts to increase government expenditure on health. They pointed out that this was just another way for the government to once again refuse responsibility for its declining health infrastructure. Interestingly, a senior officer within the NITI-Aayog itself had pointed out in one of the drafting meetings that the document focused on inputs to get the private industry interested, rather than focusing on final health outcomes. Unsurprisingly, her concerns were overruled (The Scroll, 2017).

The framework received such a strong pushback that the government had to clarify that it was merely a 'draft.' In 2020, however, the privatization plans gained steam yet again when NITI-Aayog released a 250-page document detailing a "Scheme to link new and/or existing private medical colleges with functional district hospitals through Public-Private Partnership" and drew up a meeting to gather feedback from stakeholders. Post this development, the

government gave further legitimacy to the plan when the Finance Minister, Nirmala Sitharaman, included this plan in the Annual Budget of 2020. These actions go quite far to exhibit the government's keen and perhaps biased interest in extending privatization in health.

With its flagship PM-JAY scheme, it has stuck to this resolve by relying on private players to come forward and participate in the PM-JAY. NITI-Aayog published tenders calling for private firms to establish empanelled hospitals very soon after announcing the scheme. The CEO of the AB-NHPS in an interview said that "once the scheme is running full scale, we believe many new private hospitals will come up to cater to the needs of the patients even in rural parts of the country because they will now be covered under the insurance scheme; the government will pay for their treatment" (Jha 2018). The concept of empanelled hospitals is not new. However, private hospitals have chosen to set up shop almost exclusively in urban and semi-urban areas. The government now intends on providing increased incentives for further incentivization, such as viability gap funding. It, however, has not put forward its plans on how it may seek to regulate these newly created private healthcare centres.

My argument, aligning with a host of health experts, is not that privatization ought to be prevented. Rather, it calls for a closely monitored and regulated private sector, which currently is exceedingly lax. Since the private sector is already the dominant provider of health, a reform of the healthcare sector will not be possible without them. However, since the system has become highly commercialized, the primary concern is that their profit motive will work against that of public interest. Research done on private providers of health in low- and middle-income countries shows that private providers deviate from evidence-based practices more often have poorer patient outcomes, and are more likely to provide unnecessary testing and treatment (Angell, et.al, 2019). India shows similar reports as well. There have been widespread complaints of unethical behaviour on part of private hospitals as well, but they usually get away with a slap-on-the-wrist.

A way to control private behaviour would be to generate competition between public and private players, with both of them acting as checks and balances on each other. Competition within a private monopolistic setup would only benefit the profit-hungry private sector, not the patients. However, the direction in which the government is moving, and if one looks at its privatization plans in other sectors, the government may decide sometime in the future to become an insignificant stakeholder in the healthcare sector, an outcome the country should be heavily wary of.

Infrastructure (or the lack of it)

It is common knowledge by now that Indian rural healthcare is in an exceedingly poor condition, particularly primary health care. A report published by the World Health Organisation in South-East Asian Region in 2018 noted that for every 10,000 persons in the country, there were 9 hospital beds. In contrast, the global average was 30 per 10,000. As per the 2018-19 Economic Survey, 60% of PHC's have 1 doctor, while 5% have 0. Interestingly, Gujarat revealed itself to be the worst performer when it came to PHC's, with more than 90% of its PHC's having only 1 doctor, closely followed by Kerala and Karnataka at 80% and Bihar, Uttar Pradesh and Rajasthan at 70%. More than 1 in 5 PHC's in Chhattisgarh functioned without any doctors whatsoever. Such states (i.e., those with either 1 doctor in most PHC's or 0 doctors) also reported higher rates of infant and maternal mortality in their rural areas. The crisis in the case of primary health centres has a sort of domino effect. Poor infrastructure at the primary level means that early attention to health issues, particularly non-communicable diseases, cannot be given. This, in turn, increases the pressure later on secondary and tertiary health care centres, as well as jeopardising patient outcomes (e.g., higher morbidity rates, creation of long-term side effects of the disease)

The disparity between urban and rural healthcare has been laid bare further in the context of the COVID-19 pandemic. Statistics reveal that despite the existence of the NRHM, rural areas are woefully ill-equipped to deal with the COVID-19 pandemic. In some states, up to 50% of District Hospitals do not have adequate ICU beds, specialists or pollution control board clearance. Additionally, at the PHC level, about 8% do not have clinical staff, 39% do not have lab technicians and 18% of them do not have a pharmacist. This lack of staff perhaps stems from the popular culture of healthcare professionals preferring to gain employment in the urban and/or private healthcare sector. Quantity and quality continue to favour the urban, richer populations. They have the advantage of private hospitals affording quality healthcare. Additionally, 61% of the total number of government hospital beds are in urban areas, although 84% of the 23,582 government hospitals in India are in rural areas as of 2017 (The Hindu, 2020). This last statistic is a clear marker of the inequitable development in the health sector, with private players prioritizing the urban more than the rural.

Will a court-based approach work?

Some argue that the way to ensuring better access to healthcare could perhaps be better legislation. However, that approach holds some major obstacles.

India does not explicitly recognize the right to health barring the provision of health within the directive principles of state policy. First off, it is clearly a positive right, as express action needs to be undertaken to provide it. Rao (2017) correctly ascertains that a justiciable right to health would have policy implementation problems vis-a-vis funds as well as chances of litigation owing to the existence of an already fragmented system.

Secondly, the Indian judiciary has taken cognizance of the question of health as far back as 1997. In Bandhua Mukti Morcha v. Union of India & Ors. (1997), the Supreme Court interpreted the right to health under Article 21, i.e., the Right to Life. In Pashchim Bangal Khet Mazdoor Samity v. State of West Bengal and CESE Ltd. v. Subhash Chandra Bose, and several other judgments, the courts again posited a clear connection between the right to health and Article 21 – the Right to Life (Gopala, 2020). Among more recent developments, a High Level-Group on the health sector, which had been constituted under the 15th Finance Commission, recommended in September 2019 that the right to health be declared a fundamental right (Sirohi, 2020). The High Level-Group's recommendation is perhaps a step in the right direction, where such a declaration would strengthen people's access to healthcare. But it clearly cannot be the main approach because despite the courts making the connection between the rights to health and life for more than a decade, it has failed to dramatically improve the problem of access. It serves as a curative measure, and not as a preventive one.

Concluding note

It is evident that the government in power is pushing its flagship scheme, Ayushman Bharat, at the cost of other schemes. It may be doing so to establish a distinct image of itself to the public, or it may be doing so because it genuinely believes that the insurance scheme will help. However, PM-JAY and any other schemes the government rolls out cannot succeed without infrastructure. The government's insistence on relying solely on the private sector to boost infrastructure will only harm the prospects of its success.

Access to health care needs to factor in various intersectionalities faced by different classes of people. In India, it would mean factoring in caste, class, gender and the rural-urban divide. Right now, as it stands, the health infrastructure in India, private and public combined, heavily favours upper-class, upper-caste, urban populations. The gravity of this drawback is made clear when one notes the statistic that 833.1 million people out of 1210.2 million live in rural areas (Census of India, 2011). Translated to a percentage, close to 70% of the population is based in rural areas but quality health infrastructure is provided to the minority 30% residing in urban areas.

Not focusing on increasing access to healthcare infrastructure has major implications. Other than the obvious problem of the negative impact it creates on the general health outcomes of the country, it harms an individual's right to health. Right to Health and by extension the Right to Life cannot be ensured unless the means of actually providing healthcare can be ensured. While schemes PM-JAY and Jan Aushadhi look at the payments systems (as conceptualized by Hsiao), they do not address the gaping hole in the 'organization of service delivery' knob, which in India's case, would be the access to primary healthcare facilities.

The challenges revealed in the delivery of health are rooted in ensuring access to primary healthcare facilities. Additionally, a balance between public and private suppliers of healthcare, along with the regulation of the large private healthcare sector needs to be achieved. With an ever-increasing population and its resultant pressure on the health system, if a major revamping is not undertaken soon, it would not only result in the malfunctioning of the wheel of healthcare, but also perhaps lead to the wheel breaking entirely.

Works cited and Bibliography

Aiyar, Y. (2019). "Modi Consolidates Power: Leveraging Welfare Politics." *Journal of Democracy,* Vol. 30(4), pp. 78–88.

Amrith, S. (2007). "Political Culture of Health in India: A Historical Perspective." *Economic and Political Weekly,* Vol. 42(2), 2007, pp. 114–121.

Angell B.J., *et al.* (2019). "The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the path to universal health coverage in India: Overcoming the challenges of stewardship and governance." March, 2019, *PLoS Med 16(3):* e1002759. DOI: https://doi.org/10.1371/journal.pmed.1002759

Deshpande, R., *et al.* (2017). "States as laboratories: The politics of social welfare policies in India." *India Review,* Vol. *16*(1), pp. 85-105. DOI: 10.1080/14736489.2017.1279928

Dreze, J. (2018). "Ayushman Bharat Trivialises India's Quest for Universal Health Care." *The Wire,* 24 September, 2018. Available at: https://thewire.in/health/ayushman-bharat-trivialises-indias-quest-for-universal-health-care

Gambhir, R. S., *et al. (*2019). "Out-patient coverage: Private sector insurance in India." *Journal of Family Medicine and Primary Care,* Vol. *8*(3), pp. 788–792. DOI: 10.4103/jfmpc.jfmpc_101_19

Gowda, V. G. and Jena G. (2020). "By Neglecting Public Health, Govts in India Have Abandoned Their Responsibility". *The Wire,* 19 August, 2020. Available at: https://science.thewire.in/health/public-health-neglect-india-coronavirus-government-responsibility/

Gupta, D. (2007). "Citizens versus People: The Politics of Majoritarianism and Marginalization in Democratic India." *Sociology of Religion,* Vol. *68*(1), Oxford University Press, pp. 27–44.

Hsiao, W. (2003). "What is a Health System? Why Should We Care?" Working Paper Series, Boston: Department of Health Policy and Management, HSPH.

Jha, D. N. (2018). "Health Insurance May Require Rs 20,000–30,000 Crore...First Phase Involves Only the Public Hospitals." *Times of India,* 15 August, 2018. Available at: https://timesofindia.indiatimes.com/blogs/toi-edit-page/health-insurance-may-require-rs-20000-30000-crore-first-phase-involves-only-the-public-hospitals/?source=app

Joshi, S. S., Shetty, Y. C., and Karande, S. (2019). "Generic drugs – The Indian scenario." *Journal of Postgraduate Medicine,* Vol. 65(2), 2019, pp. 67–69. https://doi.org/10.4103/jpgm.JPGM_420_18

Kasthuri, A. (2018). "Challenges to Healthcare in India - The Five A's." *Indian Journal of Community Medicine: official publication of Indian Association of Preventive & Social Medicine,* Vol. *43*(3), pp. 141–143. DOI: 10.4103/ijcm.IJCM_194_18

Kumar, R. (2015). "Right to health: Challenges and Opportunities." *Indian Journal of Community Medicine: official publication of Indian Association of Preventive & Social Medicine,* Vol. *40*(4), pp. 218–222. DOI: 10.4103/0970-0218.164379

Kurian, O. C. (2018). "Weakening NHM Mission Steering Group is a mistake India can ill-afford." 27 March, 2018, *Health Express,* The Observer Research Foundation. Available at: https://www.orfonline.org/expert-speak/weakening-nhm-mission-steering-group-is-a-mistake-india-can-ill-afford/

Mehra, P. (2020). "India's economy needs big dose of spending", 8 April, 2020, *Livemint.* Available at: https://www.livemint.com/news/india/india-s-economy-needs-big-dose-of-health-spending-11586365603651.html

Pandey, K. (2020). "Who are those pushing for privatized healthcare?" *Down To Earth Magazine,* 23 March, 2020, Accessed on June 15, 2020. Available at: https://www.downtoearth.org.in/blog/health/covid-19-where-are-those-pushing-for-privatised-healthcare–70651

Provisional Population Totals of Census 2011, Census of India Report, 2011

Ramaswamy, R. (2020). "COVID-19 exposing urban-rural health divide in India", 5 May, 2020, *The Hindu.* Available at: https://www.thehindu.com/thread/reflections/covid-19-exposing-urban-rural-healthcare-disparities-in-india/article31511629.ece

Rao, S. K. (2017). Do We Care? India's *Health System.* New Delhi: Oxford University Press.

Rao, S. K. (2018). "The Government's Previous Health Insurance Schemes Failed. Why Should the New One Work?" *The Wire,* 5 February, 2018. Available at: https://thewire.in/health/the-governments-previous-health-insurance-schemes-have-failed-why-should-the-new-one-work

Rao, M. (2017). "Privatising district hospitals: Health ministry, states, experts had little say in Niti Aayog plan" *The Scroll,* 6 September, 2017. Available at: https://scroll.in/pulse/849632/privatising-district-hospitals-niti-aayog-sidelined-health-ministry-for-world-banks-advice

Ravindran, TK. S. and Philips N. E. (2020). "Towards Universal Health Coverage? Taking stock of two decades of health reforms in India". *The India Forum,* Issue: 3 July, 2020. Available at: https://www.theindiaforum.in/article/towards-universal-health-coverage

Roy, V., and Rana, P. (2018). "Prescribing generics: All in a name". *The Indian Journal of Medical Research,* Vol. *147*(5), 2018, pp. 442–444. https://doi.org/10.4103/ijmr.IJMR_1940_17

Ruger, J.P. (2005). "Democracy and health". *Quarterly Journal of Medicine,* Vol. 98, 2005, Oxford Academic, pp. 299–304. DOI: 10.1093/qjmed/hci042

Sirohi, N. (2020). "Declaring the right to health a fundamental right." *Health Express,* 14 July, 2020. Available at: https://www.orfonline.org/expert-speak/declaring-the-right-to-health-a-fundamental-right/#:~:text=The%20Directive%20Principles%20of%20State,for%20the%20right%20to%20health.&text=In%20September%202019%2C%20a%20High,be%20declared%20a%20fundamental%20right.

Soans, A. (2017). "Quality, Not Price, is the Key Issue When Prescribing Generic Drugs in India" *The Wire*, 1 May, 2017. Available at: https://thewire.in/health/drugs-generics-branded-health

Taneja, A., *et al.* (2020). "Strengthening India's Public Health System Is the Need of the Hour". *The Wire,* 19 September, 2020. Available at: https://thewire.in/health/watch-strengthening-indias-public-health-system-is-the-need-of-the-hour