CENTRE FOR NEW ECONOMICS STUDIES

CONVERSATIONS IN DEVELOPMENT STUDIES

RIGHT TO HEALTH-CARE IN INDIA: IN THEORIES AND PRAXES

AUTHORS

Anuj Aggarwal
Faculty of Law, Delhi University

Abhay Amal
Ashoka University, Haryana

Anish Lakhanpal and Mrigank Shekhar Mehta
Jindal Global Law School
ABOUT CIDS

CIDS (Conversations in Development Studies) is a peer-reviewed, quarterly research publication produced by the research team of Centre for New Economics Studies, O.P. Jindal Global University. The student-led editorial publication features solicited research commentaries (in the range of 2500-3000 words) from scholars currently working in the cross-sectional aspects of development studies. Each published CIDS Issue, seeks to offer a comprehensive analysis on a specific theme identified within the scope of development scholarship.

The editorial team's vision is to let CIDS organically evolve as a space for cultivating creative ideas for young research scholars (within and outside the University) working dexterously to help us understand and broaden the development discourse through conceptual and methodological insights on contemporary issues.

Any research commentary submission shall feature: a) brief review of the literature on a given research problem; b) the argument made by the author with details on the method used; c) documenting the findings and relevance of them in the larger scope of the literature; and (in some instances) d) present a brief policy action plan for agencies of the state (to address the issue-highlighted in the commentary). There are no pre-identified limitations or restrictions to methodological frameworks used by scholars (writing the commentary). However, the method incorporated in any accepted submission must explain its relevance in context to the nature of the study and the cited literature review.
ABOUT CIDS

CIDS (Conversations in Development Studies) is a peer-reviewed, quarterly research publication produced by the Centre for New Economics Studies, O.P. Jindal Global University. The student-led editorial journal features solicited research commentaries (in the range of 2500-3000 words) from scholars currently working in cross-sectional domains of development studies.

Each published CIDS Issue seeks to offer a comprehensive analysis on a specific theme identified within the scope of development scholarship. The editorial team’s vision is to let CIDS organically evolve as a space for cultivating creative ideas for research scholars (within and outside the University), to broaden the development discourse through conceptual engagement and methodological experimentation on contemporary issues.

Any published research commentary, in general, features: a) brief review of the literature on a given research problem; b) the argument made by the author with details on the method used; c) observed findings and relevance of them in the larger scope of the literature; and (in some instances) d) a brief policy action plan for agencies of the state (to address the issue-highlighted in the commentary).

There are no pre-identified limitations or restrictions to methodological frameworks used by solicited scholars (writing the commentary). However, the method incorporated in any accepted submission must be explained along with its relevance in context to the nature of the study undertaken.
CONTENTS

1. About This Issue .................................................................3

2. Revisiting Right-Based Approach To Healthcare:
   A Comparative Analysis of Insurance And
   Right-Based Model of Healthcare .................................6

3. The Right to Health: A Legislative Nightmare ...........17

4. Psychological-Social Aspects of Widow Rehabilitation:
   A Case Study in Vrindavan .............................................25
About this issue

Right to Health-Care in India: In Theories and Praxes

In the principal focus of development studies, access to basic healthcare shapes the welfare-state. There is an intrinsic and distinctive value attached to health, that is, linked with an individual (or a group’s) capability to exercise an independent agency for higher well-being. Two key references in the development discourse on healthcare situate it in the larger debate of seeing health from the perspective of: legislators (in law and policy), and judiciary (observing a debate around right to healthcare as a fundamental right).

The debate in the policy front lies at two levels; the first being based on budgetary allocation and the second being the implementation by the relevant authorities. There exists a strong policy critique at implementation level which is associated with accessibility, affordability and accountability. Furthermore, most literature states that there is ambiguity in the healthcare policies itself as they state what needs to be done but lacks clarity on illustrating who needs to do what and how it needs to be achieved. Discussions around health financing have also played a major role in determining Universal Healthcare for all. The major conundrum lies here for developing countries- at different stages of development- where healthcare to all needs to be provided at a reasonable cost (via public provisioning system).

In the case of India, where public spending on healthcare is extremely low, healthcare for all becomes a major challenge for policy makers. Most arguments therefore emphasize on a need to substantially raise public spending on health to build capabilities for all citizens. Another interesting aspect of policy discourse- around access to healthcare- addresses concerns around the principle of equity in Healthcare access and service distribution. The aim of which is to reduce the health differences between communities which are situated differently demographically, socially and economically etc.

Progressive realization of health equities tends to reduce inequalities- resulting from differences in Health status. The discourse further crystalizes a debate on legislating for a Right to healthcare. While policy makers introduced various policies and schemes, Constitutional provisions which explicitly mention the Right to Health are mentioned in Directive Principles of State Policy. Therefore,
Policy makers tend to base schemes and (health) policies on what is provided in DPSP’s. There are problems with this.

DPSPs being non-justiciable in nature, invoke a criticism against Courts that refer to multiple case laws in adjudicating matters concerning access to basic healthcare with no law in place. These have recognized the right to health under the ambit of Article 21, wherein the courts have inferred there to be right to life which further includes health facilities (State of Punjab v. Mohinder Singh Chawla). Most discussions around Right to Healthcare thus remain entwined between the policy and legislative perspectives, under a rights-based approach to law as in India. The judiciary has the task of identifying and adjudicating the rights of citizens with respect to Right to Health. At the same time, these debates have brought to light a series of questions. On the legislature and executive’s side, the pertinent question is how to provide and implement a mechanism of universal healthcare in a limited financial budget. Moreover, the question of State’s role in dealing with the private players in the healthcare industry and the increasing role of private healthcare provider vis-à-vis government schemes and policies.

Another question which arises is whether the lack of sanction in the implementation process of the healthcare schemes showcases a poor political will on behalf of these institutions. On the judicial side, the question which arises is to the extent to which the Courts can adjudicate these rights without creating judicial overreach. It is the balance of right which is created against the right which is violated. Some of the research commentaries published in this Issue focus on these concerns.

The first paper titled “Revisiting the Right-Based Approach to Healthcare: A Comparative Analysis of Insurance And Right-Based Model of Healthcare” by Anuj Aggarwal, engages with the current model of healthcare followed by the government. The functioning of the two prevalent models are presented from the perspective of government spending and compared to models followed in other countries. The paper also considers an alternate model that can be followed for healthcare and provides the pragmatic effect of the same.

An absence of a proper right based recognition to healthcare is further discussed in the second paper titled “Right to Health: A Legislative Nightmare” by Abhay Amal. The study indulges in offering a more philosophical perspective behind the importance of recognizing healthcare as a right by further focusing on the lack of provision of universal healthcare in India.

The third study is featured as a special report titled “Psychological-Social Aspects of Widow Rehabilitation: A Case Study in Vrindavan” by Mrigank S. Mehta and Anish
Lakhanpal, providing a more grassroots account of a specific sub-set of the healthcare system, widow rehabilitation. The primary focus of this study is to understand (and associate): mental health and rights of the old age people residing in the town (studied as a case here), the legislative framework present, and the analysis of its implementation. The observed findings from the study further provide recommendations.

The journal is representing the various facets to discussions around a right to healthcare, offering a philosophical basis to it, discussing the current existing framework of healthcare legislation, while providing findings from empirical studies. Through the research commentaries featured in this Issue, the editorial team attempts (and hopes) to initiate a much wider discussion on the healthcare system in India (across states), and the challenges present in ensuring (and safeguarding) citizen’s right to basic healthcare in an affordable, accessible way.
Revisiting Right-Based Approach To Healthcare: A Comparative Analysis of Insurance And Right-Based Model of Healthcare

Anuj Aggarwal

All state governments have an important responsibility of ensuring access to healthcare that allows its population to be productive and contribute to the national economy. However, there exists an array of divergent views on how this access to healthcare can be made possible. These divergent views intersect numerous disciplines like law, economics, and public policy. These debates around the access to healthcare can be at times be strained due to political compulsions for the ruling government and because of the governing political thought of the day, stunting possible solutions. This paper- written as a research commentary- seeks to assess the best possible mechanism of providing an access to affordable and quality healthcare in India by reviewing the literature behind competing and successful model of availing healthcare in other countries. In process, it also seeks to identify and provide possible solutions to various complications and contradictions inflicting the access to healthcare such as increasing cost, lack of infrastructure, reliance on private sector and stunted public health expenditure. The study further provides a broader overview of how the debate has shaped with regards to right to healthcare in India, universal coverage, and how a Universal Basic Income has the potential to address some of the problems in ensuring access.

INTRODUCTION

During the run-up of the 17th Lok Sabha elections, the manifesto of the Congress party promised to enact Right to Health-Care Act, guaranteeing every citizen free access to out-patient-care, medicines, dialogistic tools and hospitalisation. In effect, it sought to provide a Universal Healthcare, presumably through a single-payer system, as against the rejection of insurance based model. In juxtaposition, the ruling BJP-lead government had in the previous year announced the Pradhan Mantri Jan Arogya Yojana or the Ayushman Bharat Yojana (ABY) that aimed to provide a health insurance cover of Rs. 5 lakhs per family per year, seeking to cover 10.74 lakh families irrespective of the family size, which roughly translates to 50 crore citizens. The government

1 Student at Faculty of Law, Delhi University.
plans to expand the cover to primary healthcare by establishing Health and Wellness Centres, but presently it is limited to cost of secondary and tertiary care.

These two conceptions of a right to healthcare and an insurance based ABY for providing healthcare, while sharing a common goal of ensuring an adequate standard of health and well-being of the citizens, provide divergent ideas of realising this ideal. The insurance model stands closer to what United States of America employs with Medicaid, Medicare and Affordable Health Care Act, marks a departure from an absolute right-based approach (Jones and Kantarjian 2015). Whereas, Universal Healthcare is closer to what United Kingdom employs in form of National Health Service (NHS) wherein the government pays for all medical facilities accessed by its citizens as a ‘single payer’ covering all costs related to the expenditure whether sought through private provider or through a public caregiver. (Friebel, Molloy, Leatherman 2018). While both models have their drawbacks, which will briefly be addressed in the commentary, the larger purpose of this commentary is to seek and emulate a model that will theoretically give the best outcomes in the given socio-economic conditions of India. The commentary also seeks to analyse the viability of direct cash transfer granting freedom to people to choose their own preferred healthcare services and their providers especially in primary healthcare sector.

METHODOLOGY

The methodology employed by the author consists of an on-desk secondary analysis of the literature covering comparative healthcare sectors in various jurisdictions including, but not limited to, that of USA, UK and India. The comparative healthcare literature analysed covers debates not only in the domain of public policy, but also economics, law and philosophy.

A CASE FOR SPENDING

The performance of India in certain health indicators such as life expectancy, infant mortality and child malnutrition has been worse if not better than other South Asian Countries. (Joshi 2016). Other countries such as Bangladesh and Sri Lanka have done much better than India albeit with lesser spending due to focus on Preventive Public Health or ‘traditional Public Health’. (Bhagwati, Panagariya 2013) and (Joshi 2016). The case for expenditure for improvement on preventive care through public expenditure is quite strong for two reasons. First, it suffers from the tragedy of commons, wherein the member of the community would often expect their neighbours to expend the cost of sanitation (being a public good), allowing them to simply reap the benefits without incurring the cost. Similar expectations spread across the community gradually lead from little to
no expenditure which results in an overall decline in community sanitation. (Rajagopalan 2017)

Secondly, the cost consideration (for example laying down a sewage system) and certain actions offering little profit motive (such as discouragement from smoking), often do not create enough incentive for the private players to employ their resources. Thus, in the absence of adequate market for private players, the mantle has to be taken up by undertaking public expenditure. However, in practice it has been seen that the government spends less than 10% of the health budget on preventive healthcare. (Joshi 2016). In order to effectively improve public health, the public expenditure needs to go up. The recent stride made by the Government in reducing open defecation from 600 million to about 100 million under the aegis of Swachh Bharat Mission marks a step in a positive direction (Swarup 2019). Emphasis on such projects can enable the government to remarkably reduce its overall healthcare expenditure.

Another factor that influences the public expenditure is the efficient use of the allocated budget. Both Joshi (2016) and Bhagwati-Pangariya (2013) have argued in their works, that the merger of medical and public health services into a single department with a singular cadre have resulted in neglect of public health resulting in less than optimum budget usage. The state of Tamil Nadu which avoided the merger has consequently performed better than other states on health indicators. Thus, a possible step towards efficient expenditure is to have a dedicated service and a cadre for public and preventive healthcare service.

It is pertinent to mention here that one of the criticisms aimed towards a right-based model is that it will turn the focus away from preventive healthcare as the state resources get more focused on creating Healthcare infrastructure once this right is legislatively recognised. It has been argued that most countries including UK, Canada, Thailand and even Brazil were only able to move towards Universal Healthcare once they had adequate infrastructure for sanitation, nutrition and water supply (Rao 2012).

**PRIMARY HEALTH-CARE**

Primary Healthcare generally covers common ailments like cold, cough, fever and minor injuries that afflict all persons throughout the year, occasionally multiple times in a given year, and are not expensive to treat. The present government under the Ayushman Bharat seeks to provide primary healthcare by establishing 1.5 lakh Health and Wellness Centres (HWC) subsuming the previously established Primary Healthcare Centres (PHC) and Sub-centres. It is interesting to note that previously the government had sought to provide primary healthcare through 25,000 PHC and 1,50,000 such sub-centres (Joshi,
Vijay, 2016: 192), yet National Sample Survey Organisation’s (NSSO) 71st round survey reveals that most of the healthcare needs in rural as well as urban areas were met by private sector (72% in rural areas and 79% in urban areas). Studies have shown that Government-run Centres are plagued by doctor & medical professionals absenteeism and lower levels of consultation time given to each patient (Joshi 2016). It is often the case that private clinics and hospitals are able to deliver similar or even better healthcare services despite the lack of recognised degrees due to the abovementioned reasons. Therefore, the ability of the HWC to deliver quality healthcare remains to be seen. A right-based approach thus has its limitations lying beyond the initial infrastructure development.

An alternative approach, therefore, has been advocated by providing direct cash-transfer to the poor and allowing them to choose between private and government healthcare facilities while both compete with each other for patients. The said cost of providing such direct cash transfer is estimated to constitute 0.38% of the GDP (Bhagwati, Panagariya 2013). In order to ensure a robust and comparatively cheaper private infrastructure that can offer real choice to the poor, the government also has to ensure it reduces the cost of attaining quality medical education. For this purpose, it will have to loosen its stranglehold on medical education maintained through Medical Council of India. There have been allegations of corruption in Medical Council of India when it comes granting of licenses to Colleges which ultimately drives up the cost of medical education whilst deteriorating its quality. There have been proposals of reforming the Medical Council of India by replacing it with a National Medical Commission, but it requires more scrutiny before being implemented (Ravi 2017).

**INSURANCE MODEL VIS-A-VIS UNIVERSAL HEALTHCARE**

The dominant model in India has been the Insurance model, which was earlier implemented in the form of Rashtriya Swasthiya Bima Yojana (RSBY) that provided a cover of Rs. 30,000 per family per year. It has now been expanded through Ayushman Bharat as discussed above. In this model, the role of the government is limited to the payment of premium of the applied insurance along with the responsibility of providing medical facilities through its own hospital and clinics free of charge. The cover for medical cost is typically provided by a third party such as insurance companies.

Such a model is different from Universal Healthcare on the primary ground that Universal Healthcare eliminates the requirement of availing a health insurance cover and designates the government to directly provide the cost of healthcare expenditure by an individual as a single payer. Another difference between the two models is that while insurance model covers only the economically-lower
strata of the society, leaving the middle and the upper income groups to opt for private insurance providers, the Universal Healthcare would seek to cover all sections and strata of the society. Thus, while Universal Healthcare entails the government being the third party responsible for the expenditure for all medical facilities availed by an individual as the single payer, the insurance based model requires the government as the sole payer only to pay the premiums while the insurance companies act as the third party payer.

The drawbacks of both the systems coincide when it comes to payment of healthcare by third parties. The involvement of third party paying system especially when it is the government, has received significant attention mainly on contention that it disrupts the supply-demand cycle through the introduction of price controls in order to keep the cost under control, which ultimately leads to shortages, as argued by Sowell (2003).

Sowell (2003) argues that when government is the single payer for the health cost, it seeks to lower its fiscal burden by introduction of price controls, ultimately leading to a myriad of unintended consequences like excessive demand in face of low production incentive leading to either shortages or decline in quality. In India, where government hospitals are free of cost and the government is consistently endeavouring to provide for cheaper healthcare access, in the absence of adequate infrastructure, the problem can be acutely seen in access to medicines and medical devices. For example, the recent imposition of price caps over heart stents lead to deterioration in quality when one of the producers chose to pull the bio-absorbable variant from the market.

Sowell (2003) further discusses that such third party models are often plagued with long-waiting periods due to less availability of beds and doctor-patient time limitations, which is accompanied by expenditure escalations and also translates into a decline in the overall quality of care. This is largely due to the increase in demand as the cost gets reduced by virtue of the fact that someone else other than the patient is paying for it, prompting individuals to seek medical attention even if certain ailments do not require such consultation, or exceeding timeframes under which the ailment can be cured by multiple consultations. This is discernible in the trouble that NHS finds itself surrounded with today.

For example, one in five local hospitals in UK has been consistently failing to meet of their key waiting-time targets, the percentage of providing assistance within 4 hour period in Accidents and Emergency unit was only 77.1% against a target of 95%. Hospitals in UK also face acute shortages of hospital beds with tens of thousands of operations being cancelled between end of 2017 and early 2018. All this while the expenditure on NHS increased roughly 4% a year since its conception and today stands at 10% of UK’s GDP, exceeding the
expectations in comparison to increase in overall national wealth (BMJ 2018:361:k2373). Nevertheless, NHS has been successful in providing access to healthcare to all sections of the society. It has also done well on providing quality healthcare and the public satisfaction with NHS remains high.

Much of the criticism offered by Sowell applies equally to third party payments made by insurance companies and the government. This is visible in the case of United States where even after spending 18% of its GDP on healthcare, US lags far behind other high-income countries on indicators such as infant mortality rate, life expectancy, neo-natal and maternal mortality. Although the cost of healthcare in US has driven up due to some factors unique to its political economy such as cost of pharmaceuticals and administrative cost. This is visible in the case of United States where even after spending 18% of its GDP on healthcare, US lags far behind other high-income countries on indicators such as infant mortality rate, life expectancy, neo-natal and maternal mortality. Although the cost of healthcare in US has driven up due to some factors unique to its political economy such as cost of pharmaceuticals and administrative cost. It can be assumed that such factors would influence healthcare cost in India as well. Thus, between the two models the choice is limited. The advantage of having an insurance based model in India is that it will direct the limited infrastructure to the benefit of the economically-lower sections of the society. It also limits the requirement of government finance on immediate provisioning, which generally requires larger investments on a long-term basis and is presently plagued by low efficiency due to lack of competition& incentive.

**UNIVERSAL BASIC INCOME**

While an Insurance based model is perhaps better suited for a country like India, an alternate approach was hinted in the Economical Survey 2016-17 in form of Universal Basic Income (UBI) which offers a certain amount as a basic income to all adult individuals without any preconditions attached to its disbursement. One of the major benefits of UBI is that it eliminates the misallocation and leakages as it provides direct transfer rather than requirement of access by the beneficiaries, which also reduces the administrative cost of processing the claims of the beneficiaries under a myriad number of schemes.

UBI marks a departure from the paternalistic conception of the state and allows the poor to act as agents rather than subjects of the state and offers greater choice to them in choosing the kind of healthcare they prefer. The transfer of purchasing power also encourages the private sector to compete for access to this consumer base. The fundamental difference between UBI and other models is that the frugality of spending one’s own money limits the demand to only seeking essential medical care, keeping the overall demand under control, thereby limiting the overall cost.

Pilot studies have shown that direct cash transfers resulted in lower incidences of common illnesses, increased spending on medical treatment, better nutrition, reduced general anxiety and it also marked a shift towards private healthcare and
acquiring health insurance. Thus, not only does UBI improves health of its beneficiaries, it also allows marks an increased usage of private infrastructure (showing a preference) and voluntary acquisition of health insurance.

The evidence of voluntarily availing insurance pacifies some of the concerns regarding secondary healthcare cost under UBI as a substitute to the insurance based model. However, another way to look at UBI in comparison to insurance based models like Ayushman Bharat is to acknowledge that while Ayushman Bharat provides a cover for Rs. 5 Lakhs per family per year, for the years where there is no requirement for secondary healthcare for a major illness, there is no net value addition to improving the health of the family. While in case of UBI, the family getting a fixed income per month per individual gets to improve general health, increase average household income and maximize savings for future needs. The saving thereby gained can be used to off-set the cost of future major illness. This obviously depends upon the amount of money transferred as UBI by the government, the cost of which is briefly discussed in the next section.

**COST**

The cost to the exchequer depends upon the objectives UBI seeks to ameliorate. It is difficult to give out an exact figure that will provide for all eventualities. Currently, the government spends roughly 5% of the national GDP over 950-odd schemes that are fraught not just with leakages but also with misallocation. Joshi has estimated that a fiscal space of 10 to 12% of the GDP can be freed if all kinds of subsidies such as ‘non-merit subsidies’, subsidy in terms of food and foregone revenue in addition with savings from privatisation of PSUs is accounted for (Joshi 2016). On the other hand, it is estimated that UBI will measure up to 4.9% of the GDP for providing sustenance wages that covers 75% of the population, a rough equivalent to the cost of present schemes.

This figure would obviously have to go up in order to offer UBI as a substitute to other healthcare models. There have been limited studies to estimate the cost of UBI as a substitute to government facilitated healthcare. While acknowledging the possibility of such a measure, in a recent study for countries like India and Pakistan due the preference for private sector over public health infrastructure, the question was left unanswered. Thus, a better approach would be to not aim for universality in the initial run, instead provide for a targeted basic income and thereafter gradually expand it. At the same time, in order to insulate such from market fluctuations like inflation; it has been suggested to mark it up to a certain share of the GDP.
CONSTRAINTS & CRITICISM

The primary criticism of such a UBI that replaces the existing healthcare measures would be that it seeks to put consumer sovereignty over community welfare. In certain areas, paternalistic measures of the state like risk pooling through insurance can be beneficial for individuals as not everyone is adept in taking the best possible decision for one’s own welfare. This criticism can be met in the light of the overall advantages UBI has the possibility to offer in terms of reduced cost, better access and overall advancement of individual freedom, and whether the result would be a net gain or not. Other difficulties with UBI include the political constraints involved in retraction of other schemes & subsidies and its dependence on increasing financial inclusion by opening of bank accounts.

In order to access and tackle such difficulties, the best way forward, as stated above, would be to gradually implement UBI with the option of opting out of it. This gradualism can be guided by either following the poverty line estimates as target population or through self-identification by putting a small cost over its accusation. For example, requiring identification of oneself by approaching a designated place for seeking claim before it comes into the bank account. At the same time, the government can allow other social security measures to co-exist with UBI for an extended period, and can gradually move towards focusing more on capacity building that offers services like healthcare in a self-funded manner at a competitive rate with the private sector ensuring overall lower cost.

CONCLUSION

There is a strong case for public spending on preventive healthcare which essentially translates into lower expenditure on primary as well as secondary healthcare expenditure. The lack of market for private players means that the government will have to take mantle for expenditure on sanitation, nutrition and awareness campaigns. For primary care, even though the present government expects its HWC to effectively provide healthcare facilities, experience shows that in order for it to be effective the procurement power has to be in the hands of the economically-lower section of the society by providing them with direct-cash transfers and have public healthcare facilities compete with private healthcare providers by charging for treatment. To attract private healthcare providers for primary care, the cost of medical education also has to come down. It requires reform in the way medical education is regulated in India through Medical Council of India. For secondary case, while both models have their flaws, experience with Right to Education Act, which sought to put prohibitive cost on the private sector schools, has shown that right-based approach can be counter-productive. On the other hand, an insurance based model generally
faces cost escalations and can become expensive if not unsustainable in the longer run. In such a scenario, UBI can act as a possible solution. It provides a cushion not just against healthcare cost but also against other accidents of life such as loss of crop and natural disasters. It removes the moral hazard associated with insurance model of availing unnecessary healthcare and also increases the consumer base for private players to provide services in turn increasing competition. Thus, while advancing Ayushman Bharat for secondary care, the government can explore the benefits of UBI as a solution towards India’s healthcare woes.
BIBLIOGRAPHY

Indian National Congress - Manifesto Lok Sabha Election (2019): ‘Congress will deliver’. Available at: https://manifesto.inc.in/pdf/english.pdf (Accessed on 06.06.2019)


‘Ayushman Bharat Yojana’, Ministry of Health and family Welfare, Government of India, New Delhi, Available at: https://www.nhp.gov.in/ayushman-bharat-yojana_pg


Bhagwati, Jagdish, Panagariya, Arvind (2013): ‘India’s Tyrst with Destiny’

Joshi, Vijay (2016): ‘India’s long road- The search for prosperity’

Rajagopal, Shruti (2017), ‘Why we need a right to private property’, Available at: https://www.thinkpragati.com/opinion/1752/need-right-private-property/, (Accessed 06.06.2019)


Press Fromation Bureau, Government of India, New Delhi, (2019), Available at: http://pib.nic.in/newsletter/PrintRelease.aspx?relid=188246


Triggle, Nick and Jeavons, Christine (2018), ‘The Hospital that fail to treat patients on time’, Available at: https://www.bbc.com/news/health-46212058 (Accessed on 08.07.2019)


BMJ 2018:361:k2373)Available at: https://gh.bmj.com/content/bmjgh/3/6/e000944.full.pdf


The Right to Health: A Legislative Nightmare?

Abhay Amal2

The Right to Health (RTH) is an outlier in the political philosophy of rights on several counts. It is not obvious who owes us this right, whether a RTH will ever be economically feasible for even the most successful nations, or whether it can even be considered a just right that can be treated as universal. Regardless, the RTH has grown in popularity, largely due to widespread recognition in international declarations such as the Universal Declaration of Human Rights, the Constitution of the World Health Organization from 1946, etc. Having secured the basic human rights such as the right to life, liberty, and property, the RTH is one in a set of socio-economic rights that activists aim to make a reality. This commentary argues that the flaws of the RTH as envisioned in international agreements, namely its lack of a philosophical foundation, a theory of justice and vagueness are crippling factors that doom the RTH to remaining a mere aspiration, and not a realistically viable policy. As such, it recommends severe compromises in any legislation on the RTH in accordance with the economic limitations of particular states instead of relying on the established tenets of international agreements. It also recommends a conservative approach where policies regarding specific sectors that are affected by a RTH are instituted individually, and over a long time.

INTRODUCTION

The French and American Revolutions ushered in an age of political discourse that often expressed its demands through the language of rights. The rights to free speech, free assembly, privacy, life, liberty, etc., are just some of the rights that are commonly used in any discussion of ‘What we are entitled to’. But what is a right? and why are we entitled to them? Who is responsible for providing these rights to us?

In the 21st century, legislating for a right to health-care has revived a historical debate including (and addressing) these very questions. Traditional discourse on the subject has been dominated by what has been called ‘the liberal consensus’. Theorists of this view are champions of the free market, emphasizing on individual action and government non-interference in economic matters. (Evans 2002) The Right to Health works towards achieving the highest possible standard of physical and mental-wellbeing, adequate housing, food, sanitation, etc., for all citizens. This would require massive redistribution at worst, or a severe legislative compromise at best due to the enormity of the task. While those of ‘the liberal consensus’ do not deny that people need these commodities,

2 Ashoka University, Haryana
they reject the hypothesis that this automatically obligates others to provide these rights to anyone. This is one of many reasons why political theorists have struggled to accommodate socio-economic claims to rights such as the RTH in the pre-existing philosophical framework that undergirds constitutional law.

The recent surge in popularity of the Right to Healthcare (RTH) has resulted in several questions regarding the need for a moral foundation for laws, a feature that proponents of the liberal consensus have praised in systems such as natural rights Having established the foundation for civil and political claims such as the right to life, activists believe that the right to health is the next step in improving life all over the world.

The guiding principle behind legislating a RTH is that every human is entitled to a legitimate chance at achieving the highest aspirations of men and women. The 2014 general election in India saw three parties with three different stances on the implementation of the RTH. The Congress promised a RTH (distinct from healthcare) that included universal healthcare and free education for primary school children. This is the legal rights based approach. The Aam Aadmi Party guaranteed a simple universal healthcare package, whereas the BJP deferred from legal positivists. Their manifesto upholds the value that rights must be justiciable. (Chatterjee 2014) The lack of any theory of justice or a philosophical basis for a RTH has severely hampered its actualization domestically and internationally. This commentary focuses on three key aspects of the debate. Firstly, it explores the general philosophical foundations of rights, and why the nature of RTH as framed in international law hampers the creation of one. Secondly, given the broad mandate of these treaties, it contrasts the scope of a RTH as the framers of these treaties envisioned, and one that might be reasonably accommodative. Thirdly, deriving from the conclusions of the previous sections, it makes some policy recommendations for states to institute an RTH.

THE PHILOSOPHICAL FOUNDATION OF HUMAN RIGHTS

A right can be defined as an entitlement to perform certain actions, to be in certain states, and entitlements that others perform certain actions or be in certain states, and vice versa. (Wenar 2015) All rights are claimed against the state, linking positive law to the economic development of a nation. (Evans 2002) There are two things that rights can be based upon: 1) objective, moral reason, 2) the individual socio-political circumstances of states (legal positivism, legal rights). While legal rights, advanced through positive law, are based on the specific moralities of a society, moral rights are universal principles derived by reason that transcend the idiosyncrasies of particular political cultures. A subset of moral rights, called natural rights, has historically been the dominant way people have perceived the concept of ‘human rights’. (Wenar 2015) The idea of
natural rights goes all the way back to Ancient Greece, when the Stoics theorized of a law grounded in something above the temporal, one that combines reason with the very nature of man. After centuries of dominating discourse on what was then called ‘the rights of man’, natural rights eventually fell out of fashion in the most popular legal and philosophical circles around the early 19th century. Thinkers such as David Hume, Jeremy Bentham, and Edmund Burke excoriated any conception of law based on some abstract ideal of a common human nature. They saw declarations of moral rights as empty claims made to avoid the ardor of legislating these rules into law. For them, universality was an illusion that only exacerbated the inequalities inherent in humans. Bentham summarizes this view succinctly, “right is the child of law: from real laws come real rights, but from imaginary laws, like the laws of nature, come imaginary rights’. (Cranston 1983)

Legal positivists argue that by virtue of their codification into law, the only legitimate rights are legal rights. This grounds their argument into actual legal instruments rather than philosophy. Moral rights are thus only moral ‘claims’ that may or may not be actual legal rights. In common parlance, this means that law is essentially a social construction. (Green 2003) However, the rise of totalitarian regimes concurrent with the popularization of legal positivism points to the central problem with this thesis: it’s morally relativistic nature. It is hard for a lawmaker to deny that recourse to morality is necessary to judge the validity of a law. The absence of a law grounded in something above the temporal institutions and legal systems of states saw the annihilation of hundreds of millions during the twentieth century as Nazism, fascism, and socialism reigned. While some have argued, correctly so, that legal positivism is not necessarily incompatible with natural rights, the right to health is a juncture where it is. The RTH is one of the many claims, like the right to food, free education, freedom from fear and want, etc., that have come to dominate discussions on what qualifies as a human right. This necessitates a strict delineation of codified law based on social factors, and a transcendent moral law. Liberals thus offer a much more limited view of government, which is tasked to protect only the most fundamental rights of a people. These include the right to free expression and belief, the right to own property, the right to assemble, etc. The evolution of democracies since the American Revolution has led to more elaborate frameworks that build upon these same rights that are themselves grounded in some preconception of morality.

One can only discard the idea of moral rights if one is also willing to sacrifice age old ideals such as the universal right to equal treatment before the law, to freedom, to own property, and other inalienable rights. While thinkers like Burke were willing to do so, his argument eventually led him to support the English monarchy over the democratic revolution in France. As Rousseau wrote in the Second Discourse, “it is above all the great antiquity of laws that makes them
sacred and venerable, that men soon come to despise laws which can be changed everyday”. (Rousseau 1984)

This same veneration and sanctity has been bestowed upon the mentioned universal ideals in the Declaration of Independence by the thirteen states of America, stating, “We hold these truths to be self-evident, that all men are created equal, that they are endowed with by their Creator with certain inalienable rights, that among these are life, liberty, and the pursuit of happiness”. (Tobin 2012) The self-evident nature of these rights is the central trait granting these rights their legitimacy. While the right to life is an essential law for the survival of any society, the right to health does not hold the same stature. The reference to a creator is a hallmark of the discourse on natural rights, which has often been thought of as resulting from divine commandment due to its transcendent nature. This is arguably a key reason the idea of natural rights became repugnant in academic circles.

Still, as argued in this section, the ‘idea of morality’ is central to any judgment regarding the validity of a law. Civil and political claims are absolutely essential, economically viable, and represent the basic expectations one can have towards their fellow citizens. However, RTH is what the liberal consensus calls an ‘aspiration’, not borne out of ‘need’, but a misguided notion of freedom that relies on unrestricted access to everything one could possibly need. Here, it is important to clarify that my argument here only emphasizes the need for legislation to be based on and guided by moral precepts that are founded upon some philosophical basis. No such basis can be found for socio-economic rights claims such as the right to health. It does not dispute the logic of legal rights generally, but aims to point out its inconsistencies specifically regarding a RTH.

Public health is often a grossly neglected sector of those undertaken by democratic states, and RTH legislation gives citizens a ‘right’ to demand the approved measures. India, a country comprising 18% of the world’s population, is a prime example of this. The earlier mentioned Congress manifesto blamed a lack of consciousness of rights among the poor for the floundering quality of healthcare in India. (Chatterjee 2014) People who do not know what they should be entitled to cannot demand it. But, instituting it into law will probably not get them adequate healthcare either.

THE CONTENT AND SCOPE FOR A RIGHT TO HEALTH

The World Health Organization estimates that about 1.3 billion people across the world lack access to basic health care, and nearly 2 billion lack access to essential medicines. (Hayden 2012) Factors such as these have catapulted the right to health to the forefront of debate on essential human rights. The positivist
framework is often adopted by proponents of the RTH since, as has been discussed, they can legitimately claim such a right against the state provided it is codified into law. But even then, the law needs to be legislated and defined; yet the scope of any potential right to health can vary drastically.

To understand this better, a distinction is necessary between the discourse on right to health in terms of international law, and in the context of municipal law. RTH supporters have been lent great credence by the inclusion of provisions for a right to health in several international treaties. These include the Universal Declaration of Human Rights (UDHR) in 1948, the International Covenant on Economic, Social and Cultural Rights (ICESC), the 2000 Charter of Fundamental Rights of the European Union, and others. The ICESC defines health as the “right of everyone to enjoy the highest attainable standard for physical and mental well-being”.

The UDHR goes a step further in setting out broader legislative measures that must be included in a right to health bill. This includes food, clothing, housing, medical care, social services, right to security in the event of unemployment, sickness, disability, widowhood, old age, etc. As per Article 25, this applies not just for the well-being of individuals, but also for their families. An interesting feature that both, the UDHR and the ICESC, share is that neither document provides any philosophical justification for these demands. They take it for granted that these needs are essential to the very existence of every human. (Hayden 2012) It is important to differentiate proponents of the right to health from the right to healthcare. Healthcare is an integral part of the right to health, but the RTH itself is much broader in scope. This is simultaneously its biggest strength, and its biggest weakness.

Legislation on civil and political rights such as the right to life and ownership of property is generally restricted by the economic, social, and political arrangements of a given society. This means that laws are legislated based on what can be realistically provided given the economic conditions of specific state at a particular time. Yet proponents of the RTH seek to reverse this formula, thus intensifying the distinction between moral and legal rights. They believe that the legislation of this right is the first step in shifting socio-economic dynamics to accommodate the change in law.

Here, their argument resembles that of Bentham, since only from the law of RTH can the right to it be deduced. For one to have a right to health, there must be a law that grants this right to a body politic. It is through this manoeuvre that RTH legislators dispense with a ‘philosophical foundation’ to human rights altogether, a feature notably absent from key international treaties. The circularity in the argument lies in that any RTH law then becomes an instrument
that is simply justifying itself. It also reduces the penal code from being the ‘law of the land’, to ‘what could be the law of the land despite already being the law of the land’.

It is here that the distinction between international law and municipal law becomes most relevant. RTH proponents almost unanimously cite international law as the basis for a right to health in specific countries since they carry the weight of global opinion. Yet, in this recourse to international law, they betray the very positivist framework that relies on laws being introduced based on particular socio-political factors, and not an overarching international one. The multiplicity of states involved, has ensured that while these nations have in principle agreed upon the inclusion of a right to health, this was done without formal agreement on the specific features of such a law. (Tobin 2012) Some theorists argue that the inclusion of a RTH at all still implies some moral commitment to actualizing the law. But discussions on particular features lead to empty theories that are not economically viable. Still, talks of a positivist framework mean nothing to a lawyer who is only concerned with what the law says. But this leads to laws that can say anything, and not everything can be a universal human right.

RECOMMENDATIONS

Since all rights are claimed against the state, the absence of economic resources would render a RTH redundant. Even Karl Marx refrained from promising a utopia free of suffering, death, loss, failure, breakdown, conflict, or tragedy. Yet, the UDHR and ICESC grant legitimacy to the pursuit of almost all these freedoms. This seems to be influenced by a conception of freedom that considers liberty to simply be an unbridled right to do and achieve anything one desires. Still, philosophers who support the RTH, either try to accommodate it into the moral rights framework, or attempt to draw equivalence between the two by picking flaws in the framework. However, for an effective RTH, this commentary recommends two policies that could aid the cause.

Firstly, and most importantly, severe compromises need to be made in terms of what a RTH bill should include. This cannot be done in international negotiations, and must be made in the confines of state boundaries. As mentioned, RTH academics have distanced the right to health from the right to healthcare, but the right to healthcare is a much more viable end, both economically and philosophically. If legal positivists support the RTH due to their exclusive faith in actual legal instruments based on social facts as opposed to abstract claims, then they must legislate the RTH in the same way. The right to healthcare is an appropriate starting point for a broader right to health. Once basic health services have been secured, governments can attempt to expand the scope of their RTH.
Secondly, depending on the arrived scope of RTH, a conservative approach must be adopted regarding legislating the right into law. Even the ICESC concedes that the RTH can only be developed over time, and that might be an understatement. Thus, governments must look to legislate upon laws based on sector-wise policies, instead of an umbrella RTH that could be majorly disruptive. In his work Theory of Justice, John Rawls wrote, “in a just society, the rights secured by justice are not subject to political bargaining or to the calculus of social interests”. (Wolff 2012) Different countries, if they pursue the goal, will come up with their own versions of a RTH. Most of them will likely be simple healthcare bills that promise some degree of medical coverage to its citizens.

CONCLUSION

The growth of an RTH that spans beyond healthcare will require not only patience, but also a concentrated approach that undertakes particular sectors involved in an RTH. If one’s primary justification for legislating on an RTH is its validation in international law, then these same proponents will likely look in the same place for inspiration. This is why it is crucial to separate the argument against RTH as more than just merely an economic burden. The way we conceptualize an RTH in operation will be central to the way governments seek to actualize is. While the economic aspect certainly needs to be an important regulator for their aspirations, they must also ask themselves why it is exactly that the pursuit of such a goal is noble and desirable at all. This commentary has attempted to emphasize upon the need for such reflection, and to move forward based on the answer to this question.
BIBLIOGRAPHY


Psychological-Social Aspects of Widow Rehabilitation: A Case Study of Vrindavan

Anish Lakhanpal and Mrigank Shekhar Mehta*

India observed a paradigm shift in the care of people with mental distress through the Mental Healthcare Act, 2017. The Act recognizes people living below the poverty line, or who are destitute or homeless and seeks to ensure treatment and care services free of any charge at establishments run or funded by the appropriate Government. In pursuance of the welfare activities and efforts of the State, Swadhar Greb Scheme - launched in 2015 by the Ministry of Women and Child Development strives to extend institutional support to rehabilitate women. In an attempt to cater to the destitute women, primarily widows, the scheme envisages socio-economic and health security. This empirical study is categorized into two aspects. The first, highlights the reservations on the efficient and effective implementation of the Swadhar Greb Scheme. The second, discusses the divergences of non-appointment of counsellors and psychologists in the shelter homes as recognized under the Swadhar Greb Scheme. Additionally, the findings of the study further delve into outlining recommendations and policies to measure the quality of care provided in terms of structure, process and outcome, all taken together. A complete procedural and impact assessment be mapped to measure the outcome of the scheme or intervention done on the distressed residents. We argue that strengthening parallel run schemes in congruence to the objectives of the Mental Healthcare Act, 2017 too, can factor in a significant change to the design of the (existing) policy-implementation structure*.

METHODOLOGY

The following study was undertaken for obtaining a deeper understanding of the socio-economic challenges faced by the widows and to gauge the extent to which the numerous policy recommendations3 pertaining to these issues have been implemented. Process of data collection was primarily by way of personal interviews with the widows as well as the officials of various spaces which are administered specifically to cater to their needs. The spaces inhabited by the widows are either in government shelters, rented premises or any private or public ashram designated for them.

* Students at OP Jindal Global University, Haryana

* We would like to express our sincere gratitude towards the other members of the Legal Aid Clinic, Shivkrit Rai, Annanya Mehan and Poorva Bhatia. Their efforts at rapport formation and data collection played an instrumental role in the realization and fruition of this study.

3 Policy recommendations have been detailed in numerous studies carried out independently most prominent among them the detailed directions given by the Hon'ble Supreme Court.
Requisite visits were conducted by the Jindal Global Law School’s Legal Aid Clinic for a period of five days from 09 December 2018 to 14 December 2018 after getting the required permission from the District Probation/Welfare Officer (DPO) as well as the City Magistrate - Vrindavan, Mathura. Data collected through numerous personal interviews focused on their background, work, widowhood experiences as well as the socio-economic intricacies peculiar to their situation which makes affordability as well as accessibility an extremely cumbersome task for many of them. On the other hand, secondary sources of data were used for developing an understanding of the overall prevailing situation as of now (Report Supreme Court 2017).

The justification for the face to face data collection method came from a number of considerations. There has been an acknowledged need for more data along similar lines as stated in the studies conducted beforehand. Furthermore, in the discourse of poverty and economic vulnerability the dearth of such primary data makes it difficult to conceptualize any nuanced policy solution as acknowledged by the Committee report made under the directions of the Supreme Court. Another factor which justifies the usage of the face to face method is the lower probability for falsification of data and a higher chance of a more accurate screening (Shodhganga 2011).

Studies conducted by the National Commission for Women have concluded that a considerable part of the secondary data which presently exists is susceptible to falsifications so as to portray the situation in a much better light: -

“Anomalies were found at Meera Sehbagini Pagal Baba Ashram and AIWC, Taraash Mandir. In both the places many of the residents did not have pensions or ration cards. At the AIWC run home at Taraash Mandir off the 48 women living there only 13 were receiving pensions. The secondary data analysis shows that while the women in homes are getting the pension and ration, there are other issues such as corruption amongst the home/institution authorities.” (National Commission for Women 2008)

Of the chief contributing factors, corruption amongst the authority officials, wardens as well as the counsellors is a substantial reason for alleged falsification. Upon conducting the personal interviews and establishing rapport, certain differences were found between the narrative produced by the widows and the narrative portrayed by the ashrams mostly related to pension schemes. Lastly, reliance on raw primary data was justified owing to a lack of data on any progress made by the state officials upon receiving the necessary directions from the

4 Hon’ble Supreme Courts general observations, Absence of Data on Widows. ‘Dearth of data renders the widows invisible in the discourse of poverty.'
Supreme Court of India which recommended the creation of channels for a pro-active outreach\(^5\) to the widows.

The hitherto ignored aspect of inaccessibility of mental health services was also to be gauged. Although, the erstwhile mental health legislation provides for special consideration for women protection homes\(^6\), (Ministry of Women and Child Development 2015) the lack of a policy structure and the availability of mental health counsellors in this regard still act as a hindrance for achieving the lofty objective of total affordability and accessibility of healthcare services as envisioned by the policy. Furthermore, provision of data from public officials is to be viewed with suspicion as is evident from the response to the RTI applications filed in this regard.

For the recommended pro-active outreach, idealistic objectives have been delineated by the Supreme Court which involve the creation of a ‘widow cell’ (Supreme Court Report 2017), assistance from para-legal professionals as well as tie-ups with the state legal services authority. However, the progress made on any of the aforementioned recommendations has not been documented till date. Therefore, the aforementioned reasons acted as a justification for the usage of personal face to face interaction and primary data collection. Taking the aforementioned secondary data as a reference point the team discerned numerous anomalies in the projected data whilst gauging the progress made from the time of the making of the aforementioned recommendations.

**OBSERVATIONS AND FINDINGS**

The sample size of the study was not only inclusive of the widows but also the various home/institution functionaries which took responsibility for the upkeep of the institution and widows themselves. Sample size was restricted to the below mentioned institutions:

- **Private Ashrams:**
  - Guild for service (Ma Dham)
  - AIWC, Taraash Mandir
  - Maitri Vidhwa Ashram
  - Chamunda Mandir, Radha Qila, Neepali Ashram

- **Government Ashrams:**

---

\(^5\) Creation of widow cells was recommended as a measure encompassing a whole range of assistance from legal aid to psycho-social intervention.

\(^6\) Mental Healthcare Act 2017, for the first time in India treated mental healthcare as a justiciable right. The law also mandates, under Section 18(4)(d) to rope in community-based rehabilitation establishments which would be essential for widow shelter homes.
The general observations and findings from all the interactions could be condensed as follows:

- Most of the recommendations have not been carried out to their fruition. Various state functionaries including the Mahila Thana confirmed that there is no presence of any Widow Cell and that most of the Supreme Court’s guidelines have been ineffectual.

- Rehabilitative measures were inconsistent. It was found and noted that most of the Swadhar homes and Short Stay Homes did not have clinical psychologists/ counsellors and women with minor/major mental ailments did not receive any required care as formulated by the Swadhar Greh Scheme and ensured by the government.

- Tight control exuded by the institutional functionaries on their mobility places further distress on the widows for whom mobility acts as a significant change in routine and a welcome relief. Although, the functionaries argued altruistically that restrictions on mobility is a necessary evil as many widows do not return for long spells of time and instead start earning money through bhajans/ begging whilst taking advantage of the pension schemes. Although, the same sentiment was not shared by the widows.

- Routes were observed and analyzed by the team for a greater social participation among the widows and to reduce their overall disenfranchisement. Although the ashrams encouraged participation in informal social activity like tailoring, participation in bhajan processions, candle making. However, the tight control on their mobility was still a hurdle.

- On the other hand, there exist avenues for skill development and formalization of their work in the form of manifold vocational training programs however, most of the widows were hesitant to join citing their old age. An overall hesitance was observed even among the younger widows. The team concluded that there was a dire need for an information campaign with respect to such avenues available to them to remove any such hesitance.

- Glaring differences between the narrative of the authorities and the ones portrayed by the widows regarding the overall assistance to be provided in the form of documentation, financial security, skill development as well as professional mental health services. The discrepancies reveal a disconnect as well as a democratic deficit in the rehabilitative measures.
Thus, despite the spirit of the interventions being altruistic, the conditions at most government run homes and Ashrams remain miserable. Therefore, the data aligns with a number of studies conducted prior to this but also adds to it the aspect of mental health counsellors/ clinical psychologists as well as concerns regarding widespread corruption amongst the home/institution functionaries and their own perspective as well.

**RTI (Right to Information) RESPONSES**

To record corroborative findings, information pertaining to divergences and gross violations from the Scheme in shelter homes were identified. Restricting to the theme of the study, it was confirmed by the DPO, Mathura in a letter dated May 1, 2019, numbered 201 as a response to RTI applications that no Counsellor/Psychologist is appointed in any of the recognized shelter homes as of January 2019 despite being mandated by the scheme.

Furthermore, it was acknowledged that under the scheme, shelter homes are sanctioned Rs. 12,000/- and Rs. 4,000/- a month to be expended on fees for availing services of a full-time or part-time Counsellor. Thus, in Vrindavan, Mathura shelter homes are found to be not discharging responsibilities in accordance with the Swadhar Greh rules, violating guidelines framed by the Central scheme. Consequently, in impact-outcome assessment of the scheme, non-appointment of counsellors/psychologists does not help the case of rehabilitation of women in distress, therefore, depleting the objective of the scheme.

**INSTITUTION OF COUNSELLORS- A NECESSITY**

The Swadhar Greh Scheme envisions a supportive institutional framework and formulates and acts in accordance to achieve its objective of ensuring accommodation, maintenance and rehabilitative services to widows rendered homeless due to discord in family ties, violence, mental and sexual abuse, social isolation and other hostilities (Ministry of Women and Child Development 2015). A tenable contention in furtherance of the text of the scheme can be drawn- that is, appointment of qualified counsellors and psychologists within the premises of the shelter homes to meet its objectives:

- Care of widow/women in distress
- Enable them to overcome trauma and regain emotional and mental strength

Text of the scheme expressly vouches for counselling and behavioral trainings as a means to meet the said objectives. Moreover, a counsellor’s role is significant
in determining the social background, identifying the cause of the distress of resident women or new admissions. Therefore, the counsellor plays a consequential role enabling assistance to widows or destitute women to overcome their initial trauma of being displaced and probably other recent misfortunes.

It is plausible to conclusively draw the inference that the mantle of the psychologist or counsellor is invariable, imperative and critical in primary stages of diagnosis and further in rehabilitation of women residents, especially in instances owing to the fact that these women might be subjected to acts of extreme violence, exploitation and abuse (Min 2018). Understanding the aforesaid multidimensional complexities, the scheme provides to empanel a counsellor or psychologist in a recognized shelter home. In addition, a counsellor is expected to satisfy the educational qualification- having a Masters in Social Work/Psychology/Sociology.

AGE AND MENTAL HEALTH

It is a central contention of numerous studies that age in individuals as well as an overall experience of widowhood makes a much more vulnerable and susceptible environment for deteriorating mental health (Trivedi 2017). Among the research studies it is a growing contention that women are the primary consumers of mental health services (Gardner 2007). Additionally, the studies further contend that the aging process introduces a new variable in the analyses which further aggravates the issues of neglect faced primarily by aged individuals and warrants the recognition of specific treatment guidelines specifically for older women who are confronted by such mental health issues (Gardner 2007).

The World Health Organization in its detailed study on Mental Health for Older adults recognized the growing and disturbing trend of mental and neurological disorders increasingly found in aged individuals and their growing vulnerability with the need for professional help the most imminent and a necessity in the later stages of life. (World Health Organization 2017). Furthermore, despite the growing research in the aforementioned areas, the mental health discourse remains inaccessible to the aged lot. The need for counsellors and their professional services is a vital step for rehabilitation for the widows, however the mental health discourse at a macro level, still hasn’t acknowledged the problem in a universal fashion.

---

7 Swadhar Greh Scheme, 2015, Duties of Staff, Counsellors to be adept in Social Work/Psychology/Sociology.
“The uptick in mental health discourse is great in many ways, but it isn’t always good at presenting a multiplicity of experiences. The current face of mental illness is young, white, middle-class, diagnosed with a condition such as depression or anxiety. People of colour, those with more serious diagnoses and the elderly are often not given a look in at all.” (Reynolds 2019)

Therefore, to tackle the stigma, a policy being in place is an insufficient task as the study undertaken suggests a complete disregard for psychological interventions envisioned by the schemes. (Ministry of Women and Child Development 2015)

**LITERATURE REVIEW**

The existing literature along similar lines has not been restricted to Vrindavan but also reflects findings from numerous other states like West Bengal and Orissa. (National Commission for Women 2016). Comparatively, the psychological aspects of widowhood among the numerous international studies are much better researched. Studies depict that an engaged lifestyle is one of the most vital tenets for successful ageing (Adams, Leibbrandt 2011). This usually stems from the researchers relying on original ‘activity’ theory which explains that a participative environment which encourages dabbling in social and leisure activities tends to reduce depressive symptoms among the aged individuals (Adams, Leibbrandt 2011). In the Indian context, the Legal Aid Clinic’s observation in the Vrindavan project brought to notice several activities like sewing, cooking, participating in bhajan ashrams, tailoring, and candle making. While the aforementioned informal social activities were encouraged in almost all widow ashrams, the avenues for formal employment and other vocational programs are still relatively untapped.

The literature also portrays significant divergences between the widowhood experiences in developed and developing countries (in particular the South Asian countries) (Loomba Foundation, Widow Report 2015). The most glaring difference that exists is the divergence between their documentation and the statistical omissions. In developed countries ‘substantial’ (U.N Division for Advancement of Women 2001) statistics exist on their age, number and issues, whereas in developing countries the data leaves much to desired. The overall neglect is therefore, comparatively greater in developing countries as along with the overall experience of widowhood, an amalgamation of various factors like a lack of resources for investigation and a greater stigma attached to widowhood practically renders a widow as ‘socially dead’ and neglected in the discourse on poverty as well as other social evils (U.N Division for Advancement of Women 2001).
The material consequences of spousal death are also borne more by the widows in developing counterparts. Prevalence of premature male deaths make the status of widowhood a ‘personal, economic and social’ status for the women which can further aggravate any psychological strain experienced by them. The same observation as above was re-iterated by the Supreme Court of India Committee Report, made under the directions of the apex court of the country which acknowledged the dearth of data that there is in the analysis of widow issues (Supreme Court Report Judgement 2017). Among various state-specific problems, the aspect of total social and economic vulnerability on account of their disenfranchisement and displacement from their communities are universal issues (Min 2018). Their widespread displacement coupled with the group’s heterogeneous character makes the required documentation an extremely complex task. Furthermore, the lack of a proper documentationendeavour makes for another hurdle for access to reasonable healthcare as well as any psycho-social intervention. (Supreme Court Report Judgement 2017).

Although there exist different social rules and cultural contexts, it is also found that nearly all cultures have to an extent an exertion of control over female agency and govern the women’s lives. Across numerous cultures, widows are still susceptible to patriarchal customs and have to confront discrimination in inheritance rights which again is an aggravating factor in their uphill battle against mental distress (U.N Division for Advancement of Women 2001).

PROBLEMS DISCOVERED

The economic and social participation of widows is staggeringingly low (U.N Division for Advancement of Women 2001). Increasing such participation is a welcome step for social integration and widow rehabilitation and is also a vital goal for curbing any mental trauma experienced as a part of their disenfranchised existence (Min 2018). However, the services are not availed to their fullest potential. Furthermore, in many South Asian countries, the stigma of widowhood is also informed by class and caste biases along with social neglect and health hazards which makes their communities especially susceptible to psychological strain (National Commission for Women 2008).

While around a 60% of women in developing countries are engaged in some form of labour or another, in the context of the widows the figure hangs back at a lowly 20% (U.N Division for Advancement of Women 2001). The widows fall into this gloomy pit of vulnerability owing to a number of reasons. Firstly, in many developing countries like India, they lack the favourable inheritance

---

8 In developing countries, especially in India a widow’s social isolation is at times exacerbated due religious symbolism. The deeply enmeshed patriarchy confers a status on women only through their husband’s identity. Ego, the death of their spouse, renders their identity nugatory.
rights. The male lineage is the primary beneficent of inheritance laws. A lack of social support from any caregiver makes their economic engagement virtually non-existent (India International Centre 2000).

Secondly, there is little governmental support. Although, arguably on paper there are numerous schemes like Swadhar Greh Scheme and vocational training services provided by the government, its implementation has been a harrowing tale steeped in corruption and incompetence (The National Commission for Women 2008). The personnel responsible for the provision for counselling services is not trained sufficiently and trail behind the international standards. Many studies also concluded the deliberate upkeep of faulty and exaggerated data so as to present a rosy picture (India International Centre 2000).

Lastly, apart from the corruption and social realities, there exists a pattern of social and cultural exchanges which engender a general hostility and social stigma (Chandra 2011) towards widowhood in general and tainting their social identity and creating a culture wherein self-reliance, economic independence and freedom from stigma are unattainable goals.

RIGHTS ENFORCEMENT

One of the observations in the study undertaken was that although most widows had heard about the pension schemes and vocational services, only a quarter of them could avail it. There also exists an information asymmetry with respect to the kind of rights and entitlements that these widows could avail and what these entitlements entail. Therefore, informational campaigns and awareness among their communities is a dire need of the hour.

To remove the stigma attached to their identity as a widow, rampant community awareness schemes that hit at such a stigma are also required. Rights enforcement awareness should not only be targeted at widows but the aim should a total societal awareness as the spaces which these widows inhabit also create a toxic culture of stigma and shame (Chandra 2011), (U.N Division for Advancement of Women 2001).

OTHER DOMESTIC STUDIES

Among many other studies, The Committee report under the directions of the Hon’ble Supreme Court highlighted the same deficiencies and also acknowledged a dearth of data which exists with respect to these issues (Supreme Court Report Judgment 2017). In this study, the methodology relied more on secondary data provided by the constituted committee, but also suggested numerous policy recommendations as well as directions which at least on paper looked commendable. The most notable was the creation of numerous outreach
mechanism including the widow cell and state legal services working in tandem to kick start a much-needed consistent rehabilitation mechanism. However as documented by the Legal Aid team, the recommendations are ineffectual as of now and there has been a total disregard of Supreme Court directions.

The study conducted by National Commission for Women utilized a similar methodology of face to face interaction and brought out the glaring anomalies in the official figures (National Commission for Women 2008). The study established among other things the apparent unreliability of any secondary as well as the official figures which as per the study, were misrepresented to portray a better picture. While the study focused on a host of issues and can be counted as the most detailed report regarding the widow vulnerability, the aspect of mental health is still mentioned merely as a passing note and suffers from a lack of concrete policy solutions for the issue of this glaring affordability and accessibility to health care.

POLICY RECOMMENDATIONS

As the rehabilitation scheme of Swadhar Greh was rolled out, over time, it was subjected to scrutiny by National Human Rights Commission and National Commission for Women. From the existing literature, gross violations can be conclusively noted and the same have been identified by the bodies in the status reports genuinely to an extent- whether it be issues of mal-administration, insufficient amount of pocket-moneys to the widows, etc.

CONSONANCE WITH MENTAL HEALTH CARE ACT 2017

Now, to essentially cater to the psychological and mental care, it is imperative for the policymakers to design and govern the scheme aligned with the Mental Healthcare Act, 2017 and provide a 360-degree view of the scheme’s workings and impact generated. In the interim period, prior to formal and regular appointments of Counsellors, the women/widows residing in shelter homes be provided access to clinical psychologists available in Community Health Centres instituted in a District (Sidana 2018). In addition, the government shall ensure formal ties with socially motivated citizens and spirited organizations working in the region enabling accessible and affordable healthcare to the residents.

POTENTIAL CORRUPTION?

 Nonetheless, the collaborations shall not become a channel for public funds to go into private spheres for underutilization or potential corruption. Therefore, essentially it is upon the government to better and strengthen infrastructure and implementation techniques. For enhanced transparency and subsequent
efficiency an ad-hoc nodal officer or a liaison officer shall be appointed who monitors the quality of care and services provided by the recognized shelter homes. The quality of care can be measured in terms of structural efficiencies, procedural measures and impact-outcome assessment, all taken together. Structural measures can be associated with ratio of counsellors/psychologists to patients or potential number of residents in a shelter home. Procedural measures can be attributed to the accessibility and ease in availing services and care of a counsellor/psychologist by the residents. Accessibility comprises a dual requirement in terms of physical accessibility and qualitative care. Thus, the procedural measures must spread awareness with respect to expected services for a particular condition and formalities to be complied with on part of the patients, if any. Lastly, tracing the success map, impact-outcome assessment shall be actively monitored by the bodies.

INTERNATIONAL STANDARDS AND PEDAGOGY

Internationally accepted theories and standards are fairly incorporated in Indian pedagogies (Trivedi 2009), however professional counselling in India, even the conventional ones are still in their nascent stage in the developmental context. While the private counsellors are still on the uptick, the provisional counsellors, the ones provided under public utility programs and schemes particularly like the Swadhar Greh Scheme are still plagued by the problems of incompetence and non-appointment by government officials (National Commission for Women 2008).

Therefore, the training regime for the counsellors enlisted for the kind of program envisioned by the likes of the Swadhar Scheme needs an internationally accepted pedagogy and training so as to tackle the enormity of mental health issues faced by the widows. On this front, the UK’s publicly funded National Health Services, borrow heavily from Professional Standards Authority and other requisite qualifications below which the provisions of services would not be accepted. The role of the Professional Standards Authority is to act as a regulatory body and to supervise the standards of Social and professional healthcare provided across the UK.

“The authority also has a benchmark of ‘standards’ set for all professional caregivers which are not accredited and regulated. Accredited registers are a voluntary scheme where the PSA sets out some standards that are applicable to organizations that deal with occupations that are not statutorily regulated.” (Corker 2013)

The impact-outcome measures shall ideally reflect the qualitative aspects of care provided and whether the desired results are attained or not. Possible tools which can be factored to diversify and strengthen this approach is to incorporate
beneficiary feedback, monthly visits or calls to check on the past patients. Thus, enabling minute insights leading to advanced data studies which further ensure easier, qualitative, affordable accessibility to mental healthcare and health in general.
MINISTRY OF LAW AND JUSTICE, MENTAL HEALTH ACT 2017, GHULAM NABI AZAD, 7TH APRIL 2017, NEW DELHI.

KAPUR, DEVESH AND PRAKIRTI NANGIA (2015) SOCIAL PROTECTION IN INDIA: A WELFARE STATE SANS PUBLIC GOODS?, INDIA REVIEW, 14:1, 73-90

MINISTRY OF WOMEN AND CHILD DEVELOPMENT, 11-03-2015, SWADHAR GREH SCHEME, NEW DELHI.


SHODHGANGA, RESEARCH METHODOLOGY, CHAPTER 2, PP 1-11


GOVERNMENT OF INDIA, MINISTRY OF WOMEN AND CHILD DEVELOPMENT.

"MODIFICATIONS IN THE GUIDELINES OF SWADHAR GREH SCHEME, GOVERNMENT OF INDIA”, NO: SW-57/5/2018-SWADHAR.


MINISTRY OF WOMEN AND CHILD DEVELOPMENT, 11-03-2015, SWADHAR GREH SCHEME, NEW DELHI.


MINISTRY OF WOMEN AND CHILD DEVELOPMENT, 11-03-2015, SWADHAR GREH SCHEME, NEW DELHI.

STATUS REPORT ON WIDOWS IN SWADHAR HOMES IN UTTAR PRADESH, UTTARAKHAND, WEST BENGAL AND ODISHA BY THE NCW IN NOVEMBER, 2016; REPORT NO. 1


CIDS EDITORIAL TEAM

STUDENT EDITORS

AKSHAY GARG
M.A. Public Policy, Jindal School of Government Policy

HARSHITA GUPTA
LLB, Jindal Global Law School

PRITHVIRAJ KHANNA
B.A.LLB, Jindal Global Law School

SHIVKRIT RAI
B.A.LLB, Jindal Global Law School

FACULTY EDITORS AND REVIEWERS

FACULTY EDITOR

DEEPANSHU MOHAN
Associate Professor & Director, Centre for New Economics Studies

PEER-REVIEWERS OF THE JOURNAL

AYONA BHATTACHARJEE
Assistant Professor, International Management Institute, New Delhi.

INDRANIL MUKHOPADHYAY
Associate Professor, Jindal School of Government and Public Policy, O.P. Jindal Global University

LAKNATH JAYASINGHE
Associate Professor, Jindal Global Business School, O.P. Jindal Global University

LOKENDRA KUMAWAT
Visiting Professor of Economics, Statistics, Ashoka University

RAKSHI RATH
Assistant Professor, Jindal School of Liberal Arts and Humanities, O.P. Jindal Global University

SIDHARTH BHASKAR
Assistant Professor, Jindal Global Business School, O.P. Jindal Global University

SUDIP PATRA
Assistant Professor of Management Practice, Jindal Global Business School, O.P. Jindal Global University

SUKUMAR MURLIDHARAN
Associate Professor, Research, Jindal School of Journalism & Communication, O.P. Jindal Global University

VIVEK U. PADVETNAYA
Associate Professor, Jindal School of Government and Public Policy, O.P. Jindal Global University