Chapter-3
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State Policies in Post-Independence India

Constitutional and Legal Provisions

The Indian Constitutional provides a framework for a social welfare pattern of
development. While civil and political rights are enshrined as Fundamental rights that
are justifiable, social and economic rights like health, education, livelihoods etc. are
provided for as Directive Principles for the State and hence not justifiable. The latter
comes under the domain of planned development, which the State steers through the
Five Years Plans and other development policy initiatives. The Preamble to the
Constitution of India, 1950 establishes India as socialism and welfare state. The basic
framework of socialism is to provide a decent standard of life to the working people
and especially provide security from cradle to grave. Under the scheme of distribution
of legislative powers between Parliament and states, the protection of life and health
have instanced at several entries of seventh schedule. Entry sixth in State List spells
about ‘public health and sanitation’ List third, where Union as well as state is
competent to legislate, envisages social security and social insurance, employment
and unemployment’. Entry twenty four mentions regarding ‘welfare of labour,
including conditions of work, provident funds, and employer’s liability, workmen’s
compensation, invalidity and old age pension and maternity benefits’.¹

India joined the UN on October 30th 1945 and on December 12th 1948 when
the Universal Declaration of Human Rights (UDHR) was proclaimed, India was a
party to this. The UDHR influenced the making of Indian Constitution and played a
key role in shaping the Fundamental Rights and the Directive Principles of State
Policy. As a matter of fact public health is not part of Fundamental Rights but is
included as state’s objective in the Directive Principles of the State Policy.

Fundamental rights guarantees equality which may be extensively interpreted
equality of health as well. Article 14 conferred equal rights and opportunities for men

reads: Public Health and Sanitation: hospital and dispensaries, p. 56
and women in the political, economic and social spheres, Article 15 prohibited discrimination against any on the ground of sex and Article 15 (3) empowered the State to make affirmative discrimination in favour of women and children. The Directive Principles of State, which however are not enforceable, defines the objectives of Indian state to guarantee equal right of physical and mental health to women. Article 39 enjoined upon the State to provide equal means of livelihood and equal pay for equal work and Article 42 directed the State to make Provision for ensuring just and humane conditions of work and also for maternity relief. Article 51A (e) imposed a fundamental duty of every citizen to renounce the practices derogatory to the dignity of women.

Constitutional guarantees and Fundamental Rights to Indian women's:

Article 14: The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.

Article 15 (1): The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex, and place of birth or any of them.

Article 15 (3): Nothing in this article shall prevent the State from making any special provision for women and children.

Article 16 (2): No citizen shall, on grounds only of religion, race, caste, sex, descent, place of birth, residence or any of them, be ineligible for, or discriminated against in respect of, any employment or office under the State.

Article 39 (e): The health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength.

Article 42: The State shall make provision for securing just and humane conditions of work and for maternity relief.²

The state shall, in particular, direct its policy towards securing the health and strength of workers, men and women and the tender age of children are not abused and that the

citizens are not forced by economic necessity to enter avocations unsuited to their age or strength. It is also incumbent upon state to make provision for just and humane conditions of work and maternity relief.³

Third section of the Constitution of India provides fundamental rights to citizens and non-citizens. One of the most important provisions among these are the right to life and personal autonomy. The harmonious construction between directive principles of state policies, which is fundamental in the governance of the country, and fundamental right to dignified life had been aptly summarized by Justice P.N. Bhagwati in Bandhua Mukti Morcha v. Union of India.

This right to live with human dignity enshrined in Article 21 derives its life breath from the Directive Principles of State Policy and particularly clauses (e) and (f) of Article 39 and Article 41 and 42 and at the least, therefore, it must include protection of the health and strength of workers, men and women, and... just and human condition of work and the maternity Benefit Act, 1961- this Act for Mine Workers.

The Fundamental Rights and Article 21 (Right to Life with Dignity) form the basis of Right to Health. Article 21 of the Indian Constitution, a fundamental right reads: “No person shall be deprived of his life or personal liberty except through procedure established by law.” Till the 1970s the courts, by and large, had interpreted ‘life’ literally i.e. right to exist- right not to be killed. In late 1970s, the Supreme Court began to give an expanded meaning to the term ‘life’ appearing in Article 21. Over the years it has come to be accepted that life does not only mean animal existence but the life of a dignified human being with all its concomitant attributes. This would include a healthy environment and effective health care facilities. Today, therefore, the Fundamental Right to Life is seen in a broad context.⁴

The idea of health being Fundamental Right became an important issue at international level. Globally the International Covenant on Economic, Social and Cultural Rights (ICESCR) mandates right to health through Article 9 and 12 of the covenant:

³ Ibid, p. 57
Article 9

The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

   (a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;

   (b) The improvement of all aspects of environmental and industrial hygiene;

   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

   (d) The creation of conditions, which would assure to all medical service and medical attention in the event of sickness.

Also Articles 7 and 11 include health provisions: "The States Parties ... recognize the right of everyone to ... just and favourable conditions of work which ensure ... safe and healthy working conditions; ... the right to ... an adequate standard of living."

India ratified this Covenant on 10th April 1979, and having done that became obligated to take measures to assure health and healthcare (among others) as a right. Article 3 of this Covenant ensures the equality of health right for men and women. Constitution of World Health Organization (WHO) and Universal Declaration of Human Right (Article 15) also emphasized on the equality of health right paving the way for equal opportunity of health to women also. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Articles 10, 12, and 14 is an

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2 Article 3: The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.
important landmark for ensuring security of health for women. These articles provided protection to women against any discrimination of health care ensured access to health care services. Cairo Programme of Action, Principle 8 and Para 8.6 recognized the role of women as primary custodian of family health.

The most important international declaration in the direction of ensuring equality and freedom of reproductive right is Beijing Declaration. Beijing declaration also set out guidelines to establish, improve and expand health services to ensure better physical and mental health of the women with greater accessibility of primary health care services of high quality, including sexual and reproductive health care. 

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6 "States Parties shall ... ensure to [women] ... access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.... States Parties shall ...

eliminate discrimination against women in ... health care ... to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning,...; ensure ... appropriate services in connection with pregnancy.... States Parties shall ... ensure ... that [women in rural areas] ... have access to adequate health care facilities, including information counseling and services in family planning...." 

7 "The explicit recognition ... of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.... We are determined to ... ensure equal access to and equal treatment of women and men in ... health care and enhance women’s sexual and reproductive health as well as Health.” — Beijing Declaration, paras. 17 and 30.

"Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life.... Women's health involves their emotional, social and physical wellbeing and is determined by the social, political and economic context of their lives, as well as by biology.... To attain optimal health ... equality, including the sharing of family responsibilities, development and peace are necessary conditions.” — Beijing Platform for Action, para. 89.

"Strategic objective ... Increase women's access throughout the life cycles to appropriate, affordable and quality health care, information and related services.... Actions to be taken: ... Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation....; Provide more accessible, available and affordable primary health care services of high quality, including sexual and reproductive health care....; Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to health services....; reduce maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015....; make reproductive health care accessible ... to all ... no later than ... 2015....; take specific measures for closing the gender gaps in morbidity and mortality where girls are disadvantaged, while achieving ... by the year 2000, the reduction of mortality rates of infants and children under five .... by one third of the 1990 level....; by the year 2015 an infant mortality rate below 35 per 1,000 live births.... Ensure the
The Constitution makes a forceful appeal to the State through the Directive Principles to work towards assuring these rights through the process of governance but clearly states that any court cannot enforce them. In case of the Directive Principles it is mostly political mileage, which determines which of the principles get addressed through governance. For instance, Article 46 has been implemented with a fair amount of seriousness through the policy of reservations for scheduled caste, tribes and other backward castes/classes because it is the most powerful tool for success in India's electoral politics. But Articles 41, 42 and 47, which deal with social security, maternity benefits and health, respectively, have been addressed only marginally.


The Maternity Benefits Act, 1961, it is alleged to be an extension of the right to health, especially meant for working women in case of confinement, miscarriage, sickness arising out of pregnancy and premature birth of a child. The benefits only provide protection of wages and security of employment, but also provide for medical care. A lot of effort has gone deep into making this medico-legal right at the international and national level. Way back in 1919, the I.L.O. adopted the *Child Birth Convention* which provides for twelve weeks maternity leave for woman employed in industrial and commercial undertaking. Of recent origin is the *Maternity Protection Convention and Recommendation of 1952*. Apart from this, there are some supplementary and incidental instruments. They are *Protocol Night Work (Women) availability of and universal access to safe drinking water and sanitation...* - Beijing Platform for Action, para. 106.

5 Ibid, p. 5
7 Also known as Maternity Protection Convention, 1919 (No. 3) so far 28 states have ratified the convention.
At home, we hear about the maiden effort of N.M. Joshi, who had moved a Bill in 1924. But this was not materialized. Maharashtra pioneered an enactment in 1929 and Central Provinces followed the suit in 1930. The Royal Commission on Labor in 1929 had further accelerated the pace of such legislations and soon other states had also endeavored similar enactments. It took twelve years to the Central Government to enact central legislation styled as Mines Maternity Benefit Act, 1941, followed by Employees’ State Insurance Act, 1948 and Plantation Labour Act, 1951. But these statutes fell short of a uniform pattern of application, which later on culminated in the passing of a comprehensive law in 1961 styled as Maternity Benefit Act. It was made applicable to the whole of India and to factory, mine, plantation and establishment wherein persons are employed for exhibition of equestrian, acrobatic and other performance.

In order to secure good health of woman and child, the Maternity Benefit Act, 1961, Section 2 (1) prohibits the employment of and works by a woman during six weeks immediately following the day of her delivery or her miscarriage. It also provides that a woman on her request will not be employed during one month immediately preceding the period of six weeks before the date of her expected delivery woman does not avail of leave of absence under Section 6 in any work which is by arduous nature or which involves with her pregnancy or the normal development of the fetus or is likely to cause her miscarriage or otherwise to adversely affect her health. To safeguard the wages of female workers the Act further provides that no deduction from the normal and usual daily wages of a woman entitled to maternity benefit under the Act shall be made by reason only of the nature of work assigned to her by virtue of the provisions of Section 4 (3) of the Act.

Section 5 of the Act confers right to payment of maternity benefits on a woman worker. The provisions of this Act every woman shall be entitled to, and her employer shall be liable for, the payment of maternity benefit at the rate of her wages.

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11 Night work (Women) Convention, (Revised), 1948 (No. 89) have received ratification from 62 states.
12 The general conference of I.L.O. in its 77th session held in June, 1990 adopted the protocol.
for the period prescribed under sub-section (3). Such payment shall be made weekly in case of a woman working on the monthly wage basis. Explanation of this sub-section weekly payment of wages means in case of woman working on daily wage basis, such daily wages multiplied by six.

No woman shall be entitled to maternity benefit unless he has worked directly under the employer from whom she claims such benefits for a total one hundred and fifty days during the period of twelve months immediately preceding the date on which the date of delivery or the date of miscarriage. The qualifying period of one hundred and fifty days aforesaid shall not apply to a woman who has immigrated into the state of Assam and was pregnant at the time of immigration.

In total number of days on which a woman worked, she has been laid off under an agreement or as permitted by Standing Orders under the Industrial Employment (Standing Orders) Act, 1946, or under the Industrial Disputes Act, 1947 and she has been on leave with full wages earned in the previous year or on maternity leave or on sick leave, shall be included.

The maximum period for which any woman shall be entitled to maternity benefit shall be twelve weeks, that is to say, four weeks up to and including the day of delivery and eight weeks immediately following the day of delivery. Granted that where a woman dies during this period the maternity shall be payable only for the days up to and including the day of her death.

The period granted under the Act takes care of healthy development of child in the womb and the woman particularly during the pre-natal confinement and post-natal care. A maximum period of twelve weeks which is split up to two periods viz., pre-natal or ante-natal period is limited to the period of proceeding, and the second one, viz., post-natal consists of six weeks immediately following the day of delivery. But the week has not defined in the Act which compounded certain confusion. A question, therefore, arises whether for the computation of maternity benefit for the period of twelve weeks, cover wages for non-working days such as Sundays falling during the period of absence? Prior to the Supreme Court decision in B. Shah v Labor Court (Section 13 (a)), full bench of Kerala High Court in Malyalam Plantation Ltd. v. Inspector of Plantation held that maternity benefit should be calculated with reference
to the working days only. This view, however, did not find the approval of the Supreme Court. The Court referred to various dictionary meanings of the word “week” and observed:

*In the context of sub-section (1) and (3) of Section 5 of the Act, the term “week” has to be taken to signify a cycle of seven days including Sundays. The language in which the aforesaid sub-sections are couched also shows that the legislature intended that computation of maternity benefit is to be made for the entire period of the woman worker’s actual absence, i.e., for all the days, including Sundays, which may be wage less holidays, falling within that period and not only for intermittent periods of six days thereby excluding Sundays falling within that period.*

The Court accordingly held that the computation of maternity benefit has to be made for all the days including Sundays and rest days, which may be wage less holidays comprised in actual period of absence.

The Medical Termination of Pregnancy Act, 1971\(^\text{13}\) was passed to control the population growth and protect the health of pregnant women. This Act bars the application of Indian Penal Code for undertaking termination by registered medical practitioner. It categorically rules that despite anything contained in the Indian Penal Code, a registered medical practitioner shall not be guilty of any offence under that code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act. The grounds for the exercise of such powers are enumerated under *Section 3 (1).* It says that pregnancy may be terminated if the length of the pregnancy does not exceed twelve weeks and not less than two registered medical practitioners are of the opinion, formed in good faith, that the continuance of the pregnancy would involve a risk to the life of the pregnant women or of critical injury to her physical or mental health or leading to a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. It is also mentioned in *Explanation 1* that allegedly if any women pregnant by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant

\(^{13}\) The Medical Termination of Pregnancy Act, 1971 (The Act 34 of 1971), www.indiakanoon.org
women. An another explanatory clause in this Section, it was laid down that where any pregnancy occurs as a result of failure of any device or method used by any married women or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman. In determining whether the continuance of a pregnancy would involve such risk of injury to the health account may be taken of the pregnant woman's actual or reasonably foreseeable environment. In case of pregnancy of a woman minor and lunatic shall be terminated except with the consent in writing of her guardian. To curb the tendencies of frequent termination by quack the Act enunciates that no termination of pregnancy shall be made in accordance with this Act in any place other that a hospital established or maintained by the Government or a place for the time being approved for the purpose of this Act by Government.\textsuperscript{14}

The Pre-natal Diagnostic Techniques Regulation and Prevention of Misuse Act, 1994 was passed to protect the sex ratio and curb the tendency of preference to the boy child. The Act provides for the regulation of the use of pre-natal diagnostic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of the misuse of such techniques for the purpose of pre-natal sex determination leading to female feticide, and for matter connected therewith or incidental thereto. Under this Act no genetic counseling center, genetic laboratory or genetic clinic unless registered under this Act, shall conduct or associate with, or help in conducting activities relating to pre-natal diagnostic techniques. No medical geneticist, gynecologist, registered medical practitioner or any other person shall conduct or cause to be conducted or aid in conducting by himself or through any other person, any pre-natal diagnostic techniques at a place other than a place registered under this Act. No pre-natal diagnostic techniques shall be conducted except for the purposes of detection of any of the following abnormalities like; Chromosomal abnormalities; Genetic metabolic diseases; Haemoglobinopathies; Sex-linked genetic diseases; Congenital anomalies;

\textsuperscript{14} \textit{The Maternity Benefits Act 1995}, The Act was published in Gazette of India on 17/08/1995, No. 29, Part II-S. I ext. p. 1 (No. 42)
and any other abnormalities or disease as may be specified by the Central Supervisory Board.

Another condition for pre-natal dismiss is also underlined under the Act. No pre-natal diagnostic techniques shall be used or conducted unless the person qualified to do so is satisfied that any of the following conditions are fulfilled, namely:

- Age of the pregnant woman is above thirty-five years;
- The pregnant woman has undergone two or more spontaneous abortions or fetal loss;
- The pregnant woman had been exposed to potentially treat organic drugs, radiation, infection or hazardous chemicals;
- The pregnant woman has a family history of mental retardation or physical deformities such as spasticity or any other genetic disease;
- Any other condition as may be specified by the Central Supervisory Board.

No person being a relative or the husband of the pregnant woman shall seek or encourage the conduct of any pre-natal diagnostic techniques on her except for the purpose specified Clinic and person shall conduct or cause to be conducted at its Centers, Laboratory or Clinic pre-natal diagnostic techniques of a fetus. These centers shall not issue or cause to be issued any advertisement in any manner regarding facilities of pre-natal determination of sex available at such center, laboratory or Clinic. Any person who contravenes the provisions shall be punishable with imprisonment for a term which may extend to three years and with fine which may extend to ten thousand rupees. The Act imposes strict liability and reversal of burden of proof. In spite of anything in the Indian Evidence Act, 1872 the court shall presume unless the country with her husband or the relative to undergo pre-natal diagnostic technique and such person shall be liable for abetment of offense under sub-section (3) of Section 23 and shall be punishable for the offenses specified under the section.15

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15 Preamble, "The Prenatal Diagnostic Techniques Regulation and Prevention of Misuse Act, 1994", Section 3 (1, 3), Sec. 4 (2, 3, 4), Sec. 6, Sec. 22 (1&2), Sec. 24. www.indiakanoon.org
State Policies and Planning

At the outset of independence the issue of women's health in India and consequent policy framework of state was a consequence of their social existence. The Indian women had participated actively in large number in the National Movement, but still their lives including their health were under control of the patriarchal social norms. The issues of women's health cropped up during colonial rule, the initiatives taken both by men and women, but were largely controlled by the men. The discourses on women's health revolved around biological reproduction; and successful biological reproduction meant a son by a 'pure' mother. This was the fulfillment of any men's existence and the ideological justification of men's control over women. Similarly, in the History of health service in independent India, the health of women has been perceived by the planners primarily in the context of 'motherhood'.16

The two important documents which later influenced the Five Year Planning and other planning on health are (1) the recommendations of the National Health and Development Committee 194617 and (2) the report of the National Planning Committee, 1948.18 Both the committees expressed their concern and worries about the high rate of mortality as well as morbidity prevailing among mothers and children of our country. The scenario of maternal mortality was miserable. Maternal Mortality Rate (MMR) in certain provinces was as high as 12.9/1000 live birth and fifty percent of the maternal deaths were due to puerperal sepsis and anaemia.19 The Working Group on Population Policy of 1980 considered 'women as the best votaries of family welfare programme' and replaced the view of 'motherhood' by 'womanhood'.

The 1960s and early 1970s also saw the emergence in many parts of the world of a greater awareness of women's issues. The Beijing Declaration made provision that it is the responsibility of the state to provide access to women specific educational information to ensure the health and well-being of the families. The women were also

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18 The National Planning Committee known as Sokhey Committee also
19 Report of the Sub-Committee on National Health (Sokhey Committee) 1948, The National Planning Committee, Bombay, p. 143
guaranteed the equality of health and right of reproduction to control their body and health. The state was also made liable to provide access to health facilities to women. ²⁰

This was also emphasized that the women have the right to enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. ²¹ Para 106 of the Beijing Declaration declared the desired objective to ensure equality of physical and mental health to women. ²²

For any state, the state policies are formulated keeping in mind the social services and the welfare of the state. During colonial rule the public health system was influenced by the social welfare activities and state initiatives of health and hygiene which paved the way for an Indian social system to deliberate on ‘well-being’. It is important about the perception of policies and what policies are proposed

²⁰ Beijing Declaration, Paras 17 and 30, “State Parties shall...ensure to [women] access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning,...state parties shall...eliminate discrimination against women in...health care...to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning,...; ensure...appropriate services in connection with pregnancy... state parties shall...ensure...that [women in rural areas]...have access to adequate health care facilities, including information counseling and services in family planning,...” “The explicit recognition...of the right of all women to control all aspects of their health, in particular their own fertility, is because of their empowerment...we are determined to...ensure equal access and equal treatment of women and men in...health care enhance women’s sexual and reproductive health as well as health.”

²¹ Beijing Platform for Action, Para 89, “...women’s health involves their emotional, social and physical well-beings and is determined by the social political and economic context of their lives, as well as by biology... to attain optimal health...equality, including the sharing of family responsibilities, development and peace are necessary conditions.”

²² Beijing Platform for Action, Para 106, Strategic objective...Increase women’s access throughout the life cycles to appropriate, affordable and quality health care, information and related services.... Actions to be taken: ... Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health; protect and promote the attainment of this right for women and girls and incorporate it in national legislation...; Provide more accessible, available and affordable primary health care services of high quality, including sexual and reproductive health care...; Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to health services...; reduce maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015,... make reproductive health care accessible...to all...no later than...2015...; take specific measures for closing the gender gaps in morbidity and mortality where girls are disadvantaged, while achieving ...by the year 2000, the reduction of mortality rates of infants and children under five ...by one third of the 1990 level...; by the year 2015 an infant mortality rate below 35 per 1,000 live births.... Ensure the availability of and universal access to safe drinking water and sanitation.
to do is an important part of understanding social policy in general sense. A broader horizon of the state would describe it as the means through which governmental power is practiced or the wider orbit of government activity. The formal political institutions of a society are conventionally classified in three categories; legislative, juridical, and administrator. Social policy in practice tends to focus on executive functions, but before moving to strongly in that direction, it is helpful to consider the legislative framework.  

Structured health policy and planning in India is not a post-independence occurrence. In fact, the most comprehensive health policy and plan text ever prepared in India was on the eve of Independence in 1946. This was the ‘Health Survey and Development Committee Report’ popularly referred to as the Bhore Committee. This was the first Committee, which devised a detailed design of a National Health Service in India, which would supply a universal coverage to the entire population free of accusations through a comprehensive state run salaried health service. 

The present scenario of health services marks a clear departure from the prescription of Bhore committee report. The National Health Service that the Bhore Committee had predicted, which would be available to one and all irrespective of their ability to pay got subjected to the market forces in this sector. The enclave pattern of development of the health sector continues even at present—the miserable, the villagers, women and other underprivileged sections of society, in other language, the majority still does not receive access to affordable basic health care of any reliable quality. It was the first initiative, which was worried about all the aspects of health and by some means women health spotted in this committee report. 

From beginning of the first two Five Year Plans the basic structural framework of the public health care delivery system remained unchanged. Urban areas continued to get over three-fourth of the medical care resources, whereas rural areas received "special attention" under the Community Development Program (CDP). History stands in evidence to what this special attention. The CDP was failing

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25 Ibid
even before the Second Five Year Plan began. The government's own evaluation reports confessed this failure. In the remainder of second five year plan and in the commencement of the third five year program, there were nearly 4500 maternity and child welfare centres, each servicing a population varying to 10,000 to 25,000. One third of these centres were situated in the urban regions. As a consequence of improvements in maternity care affected during the first two plans, the maternal mortality rate, which was high as 20 per thousand live births in 1938 was estimated to have come down to 12.4 per thousand live births. There had been a general decrease in the incidence of serious cases of anaemia in areas where antenatal services were comfortably planted and there had been a steady reduction in the infant mortality rate. During the Second Plan, maternity and child welfare services became an integral part of the over-all health services in rural areas. Maternity and Child Welfare Bureaux had been established in most of the states. Installations for the teaching of paediatrics in medical colleges had been extended in late years. Motherhood and child welfare services provided by the primary health centres were supplemented by services provided by welfare extension projects and by voluntary arrangements.\(^{26}\)

At some stage in the Third Plan, it was proposed to link up the maternity and child health services associated with the primary health units with extended facilities in referral and district hospitals. Short courses were to be arranged at these hospitals for personnel engaged in maternity and child health work. Seeing the success of the Employment Guarantee Scheme of Maharashtra the emphasis shifted to rural employment programs like National Rural Employment Program (NRHP), Jawahar Rozgar Yojana and Employment Assurance Scheme. Besides this women’s empowerment became a major development issue in the nineties and schemes like Development of Women and children in rural areas, micro-credit programs etc. were suggested and presently all such schemes were integrated into the Swaranjayanti Gram Swarojgar Yojana. These changing nomenclatures do not necessarily reflect structural changes, but merely repackaging of the same continuum since the CDP days. It has been argued earlier that all the investment in agriculture to date has caused a very modest impact on food output and even today, over four-fifths of the

\(^{26}\) *Second Five Year Plan, 1956-1961*, Planning Commission, Government of India, chpt. XXV, pp. 533-554
population dependent on agriculture lives on the entry of survival. Similarly the impact of the rural development programs has been limited. The purpose of this health organization was "the improvement of environmental hygiene, including planning and security of water supply; proper disposal of human and animal wastes; control of epidemic diseases such as malaria, cholera, smallpox, TB, etc.; preparation of medical assistance along with appropriate preventive measures, and education of the population in hygienic living and in improved nutrition".27

It is clear from the above statement that the objectives of the health organization under CDP of medical care had no priority within the structure of such an organization. In disparity, in the urban area hospitals and dispensaries, which provided mainly curative services, proliferated. So, at the beginning of the third Five year Plan there was only one Primary Health Unit per 140,000 rural populations in addition to one hospital per 320,000 rural populations. In sharp contrast urban areas had one hospital per 36,000 urban populations and one hospital bed per 440 urban residents, rural areas had 1 hospital bed per 7000 rural population.28

To assess the advancement attained in the first 2 plans and to make recommendations for the future path of growth of health services the Mudiali Committee was set up in 1959. The write up of the committee recorded that the disease control programs took in some significant achievements in controlling certain virulent epidemic diseases. Malaria was considered to be under control. Deaths due to malaria, cholera, smallpox, etc. were halved or sharply reduced and the overall morbidity and mortality rates had declined.29 In 1963 the Chadha Committee had recommended the integration of health and family planning services and its delivery through one male and one female multipurpose worker per 10,000 populations.30

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India was the foremost nation in the populace to embrace a policy of reducing population growth through a government sponsored Family Planning Program in 1951. In the first two plans the Family Planning Program was primarily work through voluntary organizations, under the guidance of FPAI. Faced with a rising birth rate and a falling death rate the 3rd plan stated that "the objective of stabilizing the growth of population over a reasonable period must therefore be at the very centre of planned development". It was during this period that the camp approach was tried out and government agencies began to actively participate in pushing population control. This was also the time when family planning became an independent department in the Ministry of health.31

In 1966 the U.N. advisory mission visiting India strongly recommended, "The directorate* should be relieved from other responsibilities such as maternal and child health and nutrition. It is undoubtedly important for family planning to be integrated with Maternal and Child Health in the field, particularly in view of the loop program, but until the family planning campaign has picked up momentum and made real progress in the states the director general concerned should be responsible for family planning only". This recommendation is reinforced by the fear that the program may be otherwise applied in some countries to extend the much needed and neglected MCH services. This was a cardinal change in India's health policy. This policy change, though it had its own inner compulsions, was more so due to the influence of foreign agencies. To endorse this strategy The Special Committee to Review the Staffing Pattern and Financial Provision under Family Planning was appointed. This committee indicated that the camp approach had failed to give the family planning program a mass character and hence the coming in of Intra-uterine Contraceptive Device (IUCD) was a great opportunity. This committee also recommended the introduction of target fixation, payments for motivation and incentives to acceptors.32

In the Fifth Plan the government regretfully acknowledged that despite advances in terms of infant mortality rate going down, life expectancy going up, the

31 Duggal Ravi, 'Evolution of Health Policy in India' 18th April 2001, pp. 1-56 www.cehat.org
* An agency headed by a director usually a subdivision of a major government department.
number of medical institutions, functionaries, beds, health facilities etc., were still inadequate in the rural areas. This indicates that the government acknowledged that the urban health structure had expanded on the monetary value of the rural sectors.\textsuperscript{33}

Major innovations took place with regard to the health policy and method of delivery of health care services. The reformulation of health programs was to consolidate past gains in various areas of wellness such as contagious diseases, medical training and provision of infrastructure in rural areas. This was imagined through the Minimum Need Programme, which would "receive the highest priority and will be the first charge on the development outlays under the health sector. It was an integrated packaged approach to the rural areas. The plan further envisaged that the delivery of health care services would be through a new category of health personnel to be specially trained as multi-purpose health assistants. However, the infrastructure target still remained one PHC per CDP Block.\textsuperscript{34}

The Kartar Singh Committee in 1973 recommended the conversion of workers, including Auxiliary Nurse Midwifery's (ANM), into multi-purpose male and female workers. It's recommended that each pair of such worker should serve a population of 10,000 to 12,000. Hence the multi-purpose worker scheme was set up with the aim to retrain the existing cadre of vertical program workers and the various vertical programs were to be fully incorporated into the principal health care package for rural regions.\textsuperscript{35}

This scheme was adopted on the recommendations of the Shrivastava Committee 1975 which was essentially a committee to look into medical education and support manpower. The committee proposed to rectify the dearth of trained manpower in rural areas. The commission pointed out that "the over-emphasis on provision of health services through professional staff under state control has been counterproductive. The principal recommendations of the committee were to have part-time health personnel selected by the community from within the residential area. They would behave as a liaison between the medical peace works (MPW) at the sub-

\textsuperscript{33} Fifth Five Year Plan, 1974-1979, Planning Commission, Government of India, chpt. VI, p. 234
\textsuperscript{34} Ibid
\textsuperscript{35} Kartar Singh Committee, September 15, 1973, Government of India, Ministry of Health and Family Planning, 1974, New Delhi, pp. 1-77
centres and the residential area. With respect to medical education the committee called for a halt to opening of new medical colleges.\textsuperscript{36}

The Sixth Plan (1980-85) was to a great extent influenced by the Alma Ata Declaration of ‘Health for All’ by 2000 AD (WHO, 1978) and the Indian Council of Social Science Research and Indian Council of Medical Research (ICSSR–ICMR) report (1980). The plan conceded that "there is a serious dissatisfaction with the existing model of medicine and health services with its emphasis on hospitals, specialization and super specialization and highly trained doctors which is availed mostly by the well to do classes. It is also understood that it is this model which is depriving the rural expanses and the hapless people of the benefits of full health and medical services". The plan took a multi-disciplinary approach with a special thrust on the three core sectors of health, training and work. Accordingly, priority was given to the implementation of programs for women under different sectors of agriculture and its allied activities of dairying, poultry, small animal husbandry, handlooms, handicrafts, small-scale industries, etc. Women Employment Program was introduced in 1982 with assistance from the Norwegian Development Agency (NORDA). For the child health the Sixth Five Year Plan reiterated the approach and strategy outlined in the Fifth Plan, and promoted consolidation and expansion of the programs started earlier.\textsuperscript{37}

The plan emphasized the development of a community based health system. The strategies advocated were provision of health services to the rural areas on a priority basis. The training of a large cadre of first level health workers selected from the community and supervised by MPWs and medical officers of the PHCs. No further linear expansion of curative facilities in urban areas; this would be permitted only in exceptional cases dictated by real felt need or priority.\textsuperscript{38}

The plan emphasized that horizontal and vertical linkages had to be established among all the interrelated programs, like water supply, environmental sanitation, hygiene, nutrition, education, family planning and MCH. The objective of

\textsuperscript{36} ibid


\textsuperscript{38} ibid, p. 251-52
achieving a net reproduction rate of 1 in 1995 was reiterated. This plan and the seventh plan too, like the earlier ones make a lot of radical statements and have recommended progressive measures.\footnote{Fifth Five Year Plan, 1974-1979, Planning Commission, Government of India, chpt. VI, p. 368}

During the Seventh Five Year Plan the Planning Commission constituted Steering Groups for different sectors. Two new schemes of Support to Training and Employment (STEP) and Awareness Generation Program for Rural and Poor Women (AGP) were introduced. Three landmark reports, Shram Shakti, the Report of the National Commission on Self-Employed Women and Women in Informal Sector, National Perspective Plan for Women (1988-2000) and SAARC Guidebook on women in Development were prepared during this period. The Department of Women and Child Development was set up in 1985 to serve as the nodal point for women and children within the National Machinery.\footnote{Annual Report 2001-02, Department of Women and Child Development Ministry of Human Resource Development, Government of India, p. 24}

The Eighth Plan (1990-95) adopted the strategy to ensure that benefits of development from different sectors do not bypass women and special programs are implemented to complement the general development programs. Mahila Samridhi Yojana and Indira Mahila Yojana were introduced during this period. The other major development during this plan period were setting up of a National Commission for Women (NCW) and the National Credit Fund for Women known as Rashtriya Mahila Kosh, and the 73\textsuperscript{rd} and 74\textsuperscript{th} Constitutional Amendments wherein one third of seats of rural and urban self governing institutions were reserved for women. The government declared its commitment to the development of ‘every child’, which was manifested in the two National Plan of Action adopted in 1992, one for the Children and the other exclusively for the Girl Child.\footnote{Ibid, p. 25}

The Ninth Plan (1997-2002) established two important alterations in the conceptual scheme for planning for women. First, ‘Empowerment of Women’ became one of the nine primary objectives of the Ninth Plan. The overture of the Plan was to create an enabling environment where women can freely practice their rights both

\footnote{Fifth Five Year Plan, 1974-1979, Planning Commission, Government of India, chpt. VI, p. 368}
\footnote{Annual Report 2001-02, Department of Women and Child Development Ministry of Human Resource Development, Government of India, p. 24}
\footnote{Ibid, p. 25}
inside and outside the household, as equal partners along with manpower. For this purpose a ‘National Policy for Empowerment of women’ was approved in 2001. Secondly, the Ninth Plan attempted convergence of existing services, resources, infrastructure and manpower available in both women-specific and women-related sectors. To this effect, the Plan directed both the Centre and the States to adopt a special strategy of ‘Women’s Component Plan’ through which, not less than 30 per cent of funds/benefits should be earmarked in all the earmarked funds/benefits through an effective mechanism to ensure that the proposed strategy brings forth a holistic approach towards empowering women.

In the Tenth Five Year Plan (2002-07), Planning Commission constituted three Working Groups under the Chairpersonship of Secretary of the Department, namely, (a) Working Group on Empowerment of Women, (b) Working Group on Child Development and (c) Working Group on Improving Nutritional Status of Population with Special Focus on Vulnerable Groups. Joint Secretaries in charge of Women Development (WD), Child Development (CD) and Child Welfare (CW) Bureaus were Conveners of the Groups, which had experts, professionals, activists, and representatives of all concerned Ministries/Departments and some State Governments as Members. Each Group developed its own methodology for consultations and preparation of reports. The reports of the first two Working Group were presented before the Steering Committee of the Planning Commission on Women and Children. The third report was presented to the steering Committee on Nutrition. Both the Committees were chaired by Shri K. Venkatasubramaniam Member, Planning Commission.42

Funding

Since independence, health care has been recognized as an essential social sector investment. It was, therefore, initially envisaged that health services in government institutions will be provided free of cost to all.

42 Ibid, p. 25
Figure 1

Figure 1: Health Expenditure in India (2004) by Source of Financing

Source: National Health Accounts (2009)

The constitution has made health care services largely a responsibility of State governments, but has left enough maneuverability for the centre for a large number of items are listed in the concurrent list. The Centre has been able to expand its sphere to control over the health sector. Hence the central government has played a far more significant role in the health sector than demanded by the Constitution. The health policy and planning framework have been provided by the central government. The growth in health care development of India score is perhaps linked to the declining investments and expenditure in the public health sector in 1990s. In the mid 1980s public health expenditure had peaked because of the large expansion of the rural health infrastructure but after 1986 one witnesses a declining trend in both new investments as well as expenditures as a proportion of the GDP, and as a percent of government’s overall expenditures.\(^{43}\) (see appendix 1, table 5)

During the 1990s, it was recognized that, given the increasing awareness and expectations of the people, and the growing costs of health care, this policy could not continue. The Ninth Plan envisaged that major public health priorities such as

essential primary health care, emergency life saving services, services under the disease control and family welfare programs will be provided free of cost for all. The Ninth Plan advocated that the Centre and the state governments should work out appropriate norms for charges on people above the poverty line for other services and hospitalization and evolve mechanisms for the collection and utilization of funds. The Planning Commission provided additional central assistance to the Kerala government for an experimental model in a district hospital where different segments of the Above Poverty Line population pay for health care and the hospital meets the costs of care of BPL (lowest 20 per cent) population through a system of cross-subsidization. The issue of how much the government sector, private individuals and the country as a whole is spending on health care and which segments of the population are benefiting has been debated widely during the last decade. As there is no National Health Accounting system, there is no information on total government expenditure on health and categories of people who benefit from this expenditure. The WHO has estimated that India, at present, is spending 4.5 per cent of gross domestic product (GDP) on health, of which 0.9 per cent is public expenditure. India ranks thirteenth from the bottom in terms of public spending on health. The Central Statistical Organization (CSO) reported that final government expenditure on health (which does not include expenditure on family welfare) for 1998-99 is Rs. 10,588 crore, accounting for 0.6 per cent of GDP. For the same year the plan and non-plan expenditure of 26 States and the Central Ministry of Health and Family Welfare alone comes to Rs. 16,771 crore or 0.95 per cent of the GDP. The Railways Defense and the Department of Post and Telegraph have created health care infrastructure and spend substantial sums on the health care of their employees and their families. Employees State Insurance Scheme (ESIS) spend large amounts of government funds on health care. The expenditure of PRIs and other local bodies on health is never accounted for as health expenditure nor is the reimbursement of health care costs by different departments at the Centre, in the States and PSUs taken into account while computing public expenditure on health. It is imperative that a system of National Health Accounting, reflecting total government expenditure on health is established. This will enable periodic review and appropriate policy decisions regarding the modalities for ensuring optimal utilization of the current government investment in the health sector and also future investments to meet public health needs.
The gender budgeting initiative in India started in July, 2000 when a workshop on ‘Engendering National Budgets in the South Asia Region’ was held in New Delhi in Collaboration with the UNIFEM, in which Government representatives, UN agencies, media, NGOs, research institutions, civil society and members of the Planning Commission in the South Asia region participated. Noted gender auditing professional Professor Diane Elson made a presentation and shared her experiences on gender budgeting through an interactive session. National Institute of Public Finance and Policy (NIPF&P) was commissioned to study Gender-Related Economic Policy Issues, which included gender segregation of the contribution of women in the economy, assessment of impact of Government Budget on women, the role women can play in improving the institutional framework for the delivery of public services and the policy alternatives for building a gender sensitive national budgeting process.\footnote{Op. cit. Annual Report of 2001-02, p. 151}

NIPF&P submitted its first Interim Report in January, 2001 on the ‘Status of Women in India and their Role in Economic’, which provided input for annual Economic Survey 2000-01. The survey, for the first time ever, incorporated a section on Gender Inequality in the Chapter on Social Sector. The second report of NIPF&P, submitted in August, 2001, made a ‘Post Budget Assessment of the Union Budget 2001-02’. The Report categorized public expenditure in three main types. First those specifically targeted to women and girls, second pro-women allocations which are the composite expenditure of schemes with the women’s component, and third mainstream public expenditure that have gender differential impacts.\footnote{Ibid} This decline must have adversely affected the allocation of fund to the health by various ministries as started above the Railways, Defense and department of Post and Telegraphy have created their separate health care facilities in general and for the health of women and girls.\footnote{Ibid}

In the success of the Family Welfare and MCH programmes, the most important single factor is the active participation and involvement of the people, non-Governmental organizations and community organizations. The role of Mahila
Mandals, Youth Clubs and Village Health Committees is of paramount importance.\textsuperscript{47} The outlays for the family welfare programme are being stepped up to Rs. 3,256 crores. Details are given in appendix 1 table 6 and 7.

The report of this Group will give a fair idea about health and family welfare sector. This is shown in the table 9 Investment on the health and family welfare:

**Table 9: Pattern of Investment on Health and Family Welfare (Rs. Crores)\textsuperscript{48}**

<table>
<thead>
<tr>
<th>Period</th>
<th>Total Plan Investment</th>
<th>Health</th>
<th>%</th>
<th>Family Welfare</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Plan (Actuals) (1951-56)</td>
<td>1,960.00</td>
<td>65.20</td>
<td>3.33</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>Second Plan (Actuals) (1956-61)</td>
<td>4,672.00</td>
<td>140.80</td>
<td>3.01</td>
<td>5.00</td>
<td>0.11</td>
</tr>
<tr>
<td>Third Plan (Actuals) (1961-66)</td>
<td>8,576.50</td>
<td>225.90</td>
<td>2.63</td>
<td>24.90</td>
<td>0.29</td>
</tr>
<tr>
<td>Annual Plan (Actuals) (1966-69)</td>
<td>6,625.40</td>
<td>140.20</td>
<td>2.12</td>
<td>70.40</td>
<td>1.06</td>
</tr>
<tr>
<td>Fourth Plan (Actuals) (1969-74)</td>
<td>15,778.80</td>
<td>335.50</td>
<td>2.13</td>
<td>278.00</td>
<td>1.76</td>
</tr>
<tr>
<td>Fifth Plan (Actuals) (1974-79)</td>
<td>39,426.20</td>
<td>760.80</td>
<td>1.93</td>
<td>491.80</td>
<td>1.25</td>
</tr>
<tr>
<td>Annual Plan (Actuals) (1979-80)</td>
<td>11,650.00</td>
<td>268.20</td>
<td>2.30</td>
<td>116.20</td>
<td>1.00</td>
</tr>
<tr>
<td>Sixth Plan (Actuals) (1980-85)</td>
<td>1,09,291.70</td>
<td>2025.20</td>
<td>1.85</td>
<td>1387.00</td>
<td>1.27</td>
</tr>
<tr>
<td>Seventh Plan (Actuals) (1985-90)</td>
<td>2,18,792.60</td>
<td>3,688.60</td>
<td>1.69</td>
<td>3,120.80</td>
<td>1.43</td>
</tr>
<tr>
<td>Annual Plan (Actuals) (1990-91, 91-92)</td>
<td>1,23,120.50</td>
<td>1,965.60</td>
<td>1.60</td>
<td>1,805.50</td>
<td>1.47</td>
</tr>
<tr>
<td>Eighth Plan (Actuals) (1992-97)</td>
<td>4,85,457.20</td>
<td>8,137.60</td>
<td>1.68</td>
<td>5,972.80</td>
<td>1.23</td>
</tr>
<tr>
<td>Ninth Plan (outlay) (1997-2002)</td>
<td>8,59,200.00</td>
<td><em>19,374.11</em></td>
<td>2.25</td>
<td>15,120.20</td>
<td>1.76</td>
</tr>
<tr>
<td>Tenth Plan (outlay) 2002-2007</td>
<td>18903968.25</td>
<td>2176734.30</td>
<td>3.68</td>
<td>725048.73</td>
<td>1.23</td>
</tr>
<tr>
<td>Eleventh Plan (outlay) 2007-2012</td>
<td>136147.00</td>
<td>-</td>
<td>13043.01</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

*Note* i) *: includes outlay of Rs. 266.35 crores for the department of ISM&H.

\textsuperscript{47} Seventh Five Year Plan, Vol. 2, 1985-90

\textsuperscript{48} Duggal Ravi, ‘Evolution of Health Policy in India’ 18\textsuperscript{th} April 2001, www.cehat.org, see Source: Indian Planning Experience – A Statistical profile, Planning Commission, Government of India, New Delhi, 1998


Public spending on health accounts for around 1 per cent of the GDP. This ratio is among the lowest in the world, although in recent years the share of public spending has been steadily increasing. An important issue in public spending on health relates to the distribution between the Central and state sectors: With the launch of the National Rural Health Program (NRHM), the level of public spending on health has risen nearly 2.6 times between 2004-05 and 2009-10. The share of the Central Government in the total health expenditure (including grants-in-aid to states through the treasury and society routes) increased from 32.1 per cent in 2004-05 to 38.4 per cent in 2007-08. However, there has been a change in the composition between the treasury and society routes in so far as the Central grants to states are concerned. The share of Central grants through state health societies increased from 5.1 per cent in 2004-05 to 16.1 per cent in 2007-08. On the other hand, the share of Central grants to states through treasury rate declined from 14.9 per cent in 2004-05 to 8.5 per cent in 2007-08.  

Looking at the significance of public health expenditure in achieving better health outcomes and reducing catastrophic health expenditure, the Central and state government in India have been increasing their expenditure on health, especially since 2005-06, due to the focus on health with the launch of NRHM. The Union Health Budget increased from Rs. 5,255 crores in 2000-01 to Rs. 8,086 crores in 2004-05 and to Rs. 21,680 crores in 2009-10 while that of States for 2009-10 was Rs. 43,848 crores.  

Looking at the different category of states, the overall growth rate for High Focus states was 16.5 per cent, for High Focus-North East states it was 17.2 per cent, and for Non-high focus states it was 10.8 per cent (compound annually). It clearly comes out that all three categories of states show higher growth rates in the post-NRHM period as compared to the overall growth rate in the pre-NRHM period.  

It has been observed and recommended that India should reiterate its commitment to achieving a target of increasing public spending on health to 3 per cent of the GDP by the National Commission on Macroeconomics and Health.

\footnote{Ibid, pp. 57-127}
\footnote{Ibid}
endorsed by the NRHM and the Working Group on Health Care Financing including Health Insurance for the 11th Five-Year Plan and reiterated in the Eleventh Five-Year Plan document (2007–12) as well.\textsuperscript{53} (see appendix 1, table 8)

To achieve this level of funding, the following critical issues need to be addressed. More attention needs to be paid to Centre–State financial flows. Under the NRHM, the Central and state governments are expected to share additional health expenditures in the ratio of 85:15. Beyond 2012, the state governments are expected to absorb a higher burden, with the ratio changing to 75:25. As per the estimates made in the note prepared by the Ministry of Health & Family Welfare for the XIII Finance Commission, the additional funding needed for this increase in states share is Rs. 15,710 crores for the period 2012-15. This arrangement, however, needs to be carefully examined on a state-by-state basis, mainly with due consideration to the state’s fiscal ability. This also calls for working out appropriate incentive systems to ensure that states are rewarded financially for better utilization of public funds and also for recording improved health outcomes. Governments should move away from uniform norms of financing based on population size, geographical area, and unit of operation (such as PHC or sub-center) towards differential funding based on services delivered, disease burdens, remoteness and difficulty of access.

This outlay constitutes among others, Rs. 17840.00 crore under NRHM, Rs. 2356.00 crore for the benefit of the schemes/projects in the North Eastern Region (NER) and Sikkim and Rs 5720.00 crore for Health. The allocation under NRHM, aims at providing universal access to equitable, affordable and quality health care that is accountable as well as responsive to the needs of the people. A provision of Rs. 1616.57 crore has been earmarked for the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) Scheme, which is aimed at strengthening the tertiary sector. Further, development of human resources in the health sector through the building up of necessary institutional structures is targeted.

The Eleventh Five Year Plan had targeted for increasing the public spending on health to at least 2 percent of GDP by the end of the Plan. However, total public health expenditure as a percent of gross domestic product currently stands at around

\textsuperscript{53} Ibid
0.9 percent. To achieve the target set in the Eleventh Five Year Plan continued effort is called for. Factors essential for achieving this target include among others, greater resource mobilization and reengineering of the resource flows. The Government is committed to providing high quality cost effective health care and delivery especially to the vulnerable sections of society.

**Public Welfare Schemes**

Every year, near about 585,000 women die and many more stumble upon serious problems in childbirth.\(^{54}\) Furthermore, around 120 million women have unwanted pregnancies and 20 million have unsafe abortions. Maternal deaths affect hundreds of thousands of families and communities; several million children are left motherless each year, and an estimated one million young children die soon after the deaths of their mothers. Addition to maternal morbidity to mortality, World Bank’s assessment of the global burden of disease estimated that 18 percent of the disease burden of women aged 15-49 was due to maternal causes, making these the leading cause of ill-health.\(^{55}\) The large part of these problems occurs in low-income countries, where poverty increases sickness and reduces access to care. They also occur within a context of gender-based economic, political and cultural discrimination and neglect of women’s rights to equal status and equitable access to services.\(^{56}\)

Women’s health has remained an important issue of discussion at National and International level, and time to time various schemes and programmes are recommended. The Indian government also formulated different programmes and schemes to ensure better health facilities for women.

During the Seventh Plan a significant step was taken in direction to identify/promote the ‘Beneficiary Oriented Schemes’ in various development sector which extended direct benefits to women.\(^{57}\)

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The National Rural Health Mission (NRHM) was launched on 12th April 2005, throughout the country, with an objective to reduce the Maternal Mortality Rate, the Infant Mortality Rate and the Total Fertility Rate. The Service Guarantees provided under this scheme, which are to be made available by 2010. These are: (1) Early registration of pregnancy before 12th week of pregnancy, (2) Minimum of 4 antenatal checkups first, when pregnancy is suspected, second - around 26 weeks of pregnancy, third - around 32 weeks, fourth around 36 weeks, (3) Associated services like general examination such as weight, BP, anaemia, abdominal examination, height and breast examination, Injection Tetanus Toxoid, treatment of anaemia, etc. (as per the Guidelines for Antenatal care and Skilled Attendance at Birth by ANMs and LHV), (4) Minimum laboratory investigations like hemoglobin, urine albumen and sugar, (5) Identification of high-risk pregnancies and appropriate and prompt referral Counseling.\textsuperscript{58}

The Mission aims to achieve the goals of the National Health Policy and National Population Policy through improved access to Primary Health Services. It aims to reduce the Infant Mortality rate to 28/1000 live births, reduce Maternal Mortality Ratio to 100/100000 live births by 2012, reduce Total Fertility Rate to 2.1 by 2012 and reduce the mortality due to communicable diseases.

NRHM has emerged as a major financing and health sector reform strategy to strengthen State Health Systems. Most prominent features of NRHM are involvement of communities in planning and monitoring, provision of untied grants to the health facilities and the communities annually, placing a trained female health activist in each village for 1000 population known as Accredited Social Health Activist (ASHA) to act as a link between the public health system and the community and bottom-up planning. It stresses on infrastructure strengthening and providing Human Resources both, medically skilled/ technical and managerial at all levels. The Mission attempts to integrate vertical Health & Family Welfare Programmes and their budget and bring them on one horizontal platform.\textsuperscript{59}

\textsuperscript{58} Ibid
\textsuperscript{59} Annual Report to the People on the Health, December 2011, Government of India, Ministry of Health and Family Welfare, p. 4
The Janani Suraksha Yojana (JSY) is an ambitious scheme launched for safe motherhood intervention under the National Rural Health Mission (NRHM) implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. This was launched on 12th April 2005. It is a 100% centrally sponsored scheme and integrates cash schemes with delivery and post-delivery care. The JSY identifies the Accredited Social Health Activist (ASHA) as an effective link between the Government and the poor pregnant women. The health activist usually works under an Auxiliary Nurse Midwife (ANM) and their work is expected to be supervised by a Medical Officer (MO). 60

The Ministry of Health and Family Welfare Government of India, through UNFPA, commissioned a concurrent assessment of the scheme in large states, namely, Bihar, Madhya Pradesh, Rajasthan, Orissa and Uttar Pradesh which constitute 39 per cent of the total population of the country. The success of the scheme has been assessed by the increase in institutional deliveries, particularly among families belonging to low-income categories. 61

The study obtained information on programme and financial management of the JSY scheme from the state and district level nodal officers. It enquired about the estimation procedure of JSY beneficiaries for meeting demands for services and infrastructure for institutional deliveries; accreditation of private hospitals as per the guidelines; community mobilization activities to generate demand for institutional deliveries; management of resources and disbursement of incentives to the beneficiaries. The nodal officers mentioned that the number of beneficiaries of the scheme for a year is estimated considering the birth rate, the total population and trends of institutional deliveries seen in the previous years. The estimates are made for each sub-centre and collated at the next higher levels by the appropriate authorities. 62

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61 Ibid
62 Ibid
Regarding accreditation of the private institution under the scheme, it was found that this was not followed aggressively in Bihar due to issues of corruption, unnecessary and lack of infrastructure to monitor the activities of the private sector. The Madhya Pradesh government decided to involve private institution, however only a few private hospitals/nursing homes could be accredited on the basis of the guidelines provided by the Government of India and these institutions were mainly concentrated in urban areas. In Orissa, only one out of five districts had an accredited private nursing home. This was under process in Rajasthan where various schemes have been proposed which are linked with the JSY plan like 'Yashoda', started under the NIPI, in which mothers belonging to BPL families are given the facility of taking full care of their newborn for 48 hours. In five districts of Uttar Pradesh out of the six selected for this study, private institution have been identified and provided accreditations as per rule. There are various schemes proposed at the state level which are linked with the JSY plan like 'Saubhagyavati Yojana' under which mothers belonging to Below Poverty Line (BPL) families can deliver at the private institutions free of cost.\textsuperscript{63}

A new intervention viz. Janani- Shishu Suraksha Karyakarm (JSSK) aimed to provide free and cashless health care services to pregnant women including normal deliveries, caesarean operations and sick new born (up to 30 days after birth) in Government health institutions, in both rural and urban areas, was approved in may 2011.\textsuperscript{64}

For the first time, an Annual Health Survey (AHS) was launched in 2010. The AHS generate indicators such as Crude Birth Rate (CBR), Crude Death Rate (CDR), Infant Mortality Rate (IMR), Total Fertility Rate (TFR), Maternal Mortality Ratio (MMR), and Sex Ratio at Birth & host of other indicators on family planning practices, maternal & child care and changes therein on a year to year basis at appropriate level of aggregations. The survey was conducted by the Office of Registrar General, under the overall guidance of Ministry of Health and Family Welfare, in all the 284 districts in eight Empowered Action Group States (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Odisha, and

\textsuperscript{63} Ibid
\textsuperscript{64} Op. cit. Annual Report to the People on Health, 2011, p. 6
Rajasthan) and Assam. The survey results of the first round of the AHS have since become available for key indicators and are posted on the website of the Register General of India.\textsuperscript{65}

The state of Madhya Pradesh launched a scheme called Janani Express Scheme in which private transport operators made vehicles available on a 24x7 basis. The family members of a pregnant woman could make a telephone call to get the transport to take her for delivery; the payment to the vehicle was made from the JSY funds. The state and district nodal officers reported that this scheme was very popular. The responses of the Medical Officers (MO) of the Community Health Centre / Primary Health Centre (CHCs/PHCs) were different; only 38 per cent MOs reported that the Janani Express Scheme had been implemented in their work area and it appears that the scheme was getting expanded at the time of this study.\textsuperscript{66}

In Bihar and Uttar Pradesh, the state and districts did not make any effort to organize transport facilities for women. But it was reported that since the scheme had set aside Rs. 200 for transporting women, this information was disseminated to the ASHAs, women and community members. All the districts in Rajasthan have their own methods in providing transport facilities to pregnant women. The most common was the use of '108 ambulance service', which is under the Emergency Management and Research Institute (EMRI) model, for the transportation of pregnant women. More ambulances are functional at the PHC/CHC level to facilitate the transportation of pregnant women. In Orissa, only two nodal officers used their own innovative methods in providing transport facilities to pregnant women.\textsuperscript{67}

Both utilized the Janani Express for transportation of pregnant women. Major efforts for publicity of the JSY have been made in all the states through newspaper advertisements, hoardings, posters, pamphlets and leaflets through which messages on the incentive money to the beneficiaries and other benefits of institutional deliveries are publicized. Monitoring the scheme has been done at two levels. Firstly, all the service units are expected to submit their monthly reports. These reports are consolidated by the PHCs and sent to the CHC/district. The second level of

\textsuperscript{65} Ibid
\textsuperscript{66} Ibid
\textsuperscript{67} Ibid
monitoring is undertaken during field visits wherein not only monthly reports are discussed but actual field implementation of JSY is assessed. These monitoring visits also help locate the problem areas in implementation and discuss possible corrective measures. A payment scale also maintained from the side of JSY for ASHA’s and mother, which involve deliveries in to institutional deliveries. How paid scale of cash payment to assistance for institutional delivery is given below:

Table 10: Scale of Cash Assistance for Institutional Delivery

<table>
<thead>
<tr>
<th>Category</th>
<th>Rural Area</th>
<th>Total</th>
<th>Urban Area</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mother’s Package</td>
<td>ASHA’s Package</td>
<td>Rs.</td>
<td>Mother’s Package</td>
</tr>
<tr>
<td>Low-Performing States</td>
<td>1,400</td>
<td>600</td>
<td>2,000</td>
<td>1,000</td>
</tr>
<tr>
<td>North East States (except Assam) &amp; rural areas of tribal districts of other states</td>
<td>700</td>
<td>600</td>
<td>1300</td>
<td>600</td>
</tr>
<tr>
<td>Other</td>
<td>700</td>
<td>Nil</td>
<td>700</td>
<td>600</td>
</tr>
</tbody>
</table>

The awareness levels among the mothers on the two other important aspects of JSY viz. knowledge about opening of institutions for 24 hours for delivery and accreditation of private hospitals under this scheme was also obtained. More than three-fourths of the mothers (75-80 per cent) in Bihar, M.P., Orissa and Rajasthan knew that the centers are open round the clock for delivery services, while this knowledge was relatively low in U.P. at 61 per cent. On the other hand, the knowledge among mothers about the accreditation of private hospitals for institutional delivery and getting benefits under the JSY scheme was relatively high at 66 per cent in UP, while only 6-11 per cent of the mothers in MP, Orissa and Rajasthan knew about. In Bihar around 25 per cent of the mothers knew about this.

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68 Ibid
The extent of success of the JSY programme can be judged by the proportion of all the deliveries conducted in the government health facility or in the private hospitals accredited under the scheme. As far as institutional deliveries among the mothers who had delivered during the year 2008 are concerned, the state of Madhya Pradesh and Orissa recorded the highest levels (73 per cent) of institutional delivery. Among these institutional deliveries, those conducted in government centres and in accredited private hospital were found to be 68 per cent in M.P. and 67 per cent in Orissa. Thus the direct beneficiary of the JSY scheme was to the tune of 67-68 per cent in these two states.

In Rajasthan the proportion of institutional deliveries was reported to be 59 per cent during 2008, while 52 per cent of them were JSY beneficiaries. This was
followed by Bihar and Uttar Pradesh, where the total number of institutional deliveries during the same period was 49 and 48 per cent respectively. In terms of JSY beneficiaries delivering either in a government institution or in accredited private hospitals, 41 per cent in Bihar and 37 per cent in Uttar Pradesh were the beneficiaries of the scheme. Majority of the deliveries were conducted in PHCs in the state of Bihar (70 per cent), Madhya Pradesh (42 per cent) and Orissa (58 per cent). In Uttar Pradesh and Rajasthan around 44-47 per cent of the deliveries were reported in CHCs while these two states also witnessed deliveries taking place in the PHCs to the tune of 29 and 37 per cent respectively.

![Percent of Institutional Deliveries and JSY Beneficiaries in Selected States, 2008](image)

**Figure 4**

![Trend in Institutional Deliveries in Rural Areas Of Selected States, 1998-2008](image)

**Figure 5**

Table 11, also provides information about the advice received by the respondents regarding institutional deliveries. In Orissa around 91 per cent of the
mothers were given advice by the ASHAs for institutional deliveries, followed by Uttar Pradesh (84 per cent), Bihar (74 per cent) and Rajasthan (64 per cent). In Madhya Pradesh, the ASHAs were found giving such advice to only 36 per cent of the mothers, and most of them in this state were advised by their relatives and AWWs. Around 83 to 86 per cent of those mothers who had delivered in institution, had identified the institution in the states of Bihar, MP and Rajasthan, while in Orissa and UP, around 69 per cent of them had done so in advance.

Table 11: Per Cent Distribution of Mothers by Place of Delivery, JSY Beneficiaries and Reasons for Non-Institutional Delivery Selected States, 2008

<table>
<thead>
<tr>
<th>Particular</th>
<th>Bihar</th>
<th>M.P.</th>
<th>Orissa</th>
<th>Rajasthan</th>
<th>U.P.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>50.9</td>
<td>27.2</td>
<td>27.2</td>
<td>40.9</td>
<td>52.5</td>
</tr>
<tr>
<td>Institutional</td>
<td>49.1</td>
<td>72.8</td>
<td>72.8</td>
<td>59.1</td>
<td>47.5</td>
</tr>
<tr>
<td>-Government Facility</td>
<td>40.8</td>
<td>67.8</td>
<td>66.2</td>
<td>50.8</td>
<td>34.6</td>
</tr>
<tr>
<td>-Accredited Private Facility</td>
<td>0.5</td>
<td>0.2</td>
<td>0.9</td>
<td>1.2</td>
<td>2.4</td>
</tr>
<tr>
<td>-Other Private Facility</td>
<td>7.8</td>
<td>4.8</td>
<td>5.7</td>
<td>7.2</td>
<td>10.5</td>
</tr>
<tr>
<td>Per cent of JSY beneficiary</td>
<td>41.3</td>
<td>68.0</td>
<td>67.1</td>
<td>52.0</td>
<td>37.0</td>
</tr>
<tr>
<td>Type of Institution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>491</td>
<td>813</td>
<td>795</td>
<td>609</td>
<td>415</td>
</tr>
<tr>
<td>Sub-centres</td>
<td>--</td>
<td>0.1</td>
<td>--</td>
<td>11.3</td>
<td>4.0</td>
</tr>
<tr>
<td>PHCs</td>
<td>69.9</td>
<td>41.6</td>
<td>58.0</td>
<td>29.1</td>
<td>37.0</td>
</tr>
<tr>
<td>CHCs</td>
<td>2.2</td>
<td>29.8</td>
<td>18.0</td>
<td>46.8</td>
<td>44.0</td>
</tr>
<tr>
<td>Hospital/Medical College</td>
<td>25.9</td>
<td>19.3</td>
<td>13.2</td>
<td>10.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Sub-divisional Hospital</td>
<td>1.2</td>
<td>9.1</td>
<td>9.4</td>
<td>2.6</td>
<td>5.0</td>
</tr>
<tr>
<td>Whether somebody contacted/advised during pregnancy for institutional delivery</td>
<td>54.2</td>
<td>81.9</td>
<td>87.5</td>
<td>73.9</td>
<td>57.0</td>
</tr>
<tr>
<td>N</td>
<td>652</td>
<td>983</td>
<td>1051</td>
<td>886</td>
<td>678</td>
</tr>
<tr>
<td>Person who contacted/advised for institutional delivery*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relatives</td>
<td>58.4</td>
<td>62.3</td>
<td>28.9</td>
<td>42.8</td>
<td>12.8</td>
</tr>
<tr>
<td>Friends/neighbor</td>
<td>24.5</td>
<td>12.6</td>
<td>15.7</td>
<td>20.2</td>
<td>12.5</td>
</tr>
<tr>
<td>AWW</td>
<td>8.1</td>
<td>43.2</td>
<td>6.9</td>
<td>17.5</td>
<td>10.3</td>
</tr>
<tr>
<td>ASHA</td>
<td>74.1</td>
<td>36.1</td>
<td>91.9</td>
<td>63.8</td>
<td>84.4</td>
</tr>
<tr>
<td>Other (doctor, dai, ANM etc.)</td>
<td>5.7</td>
<td>14.8</td>
<td>20.6</td>
<td>5.0</td>
<td>23.4</td>
</tr>
<tr>
<td>N</td>
<td>497</td>
<td>815</td>
<td>806</td>
<td>623</td>
<td>444</td>
</tr>
<tr>
<td>Identification of delivery in advance</td>
<td>86.3</td>
<td>83.4</td>
<td>68.0</td>
<td>82.5</td>
<td>68.6</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>N</td>
<td>612</td>
<td>328</td>
<td>327</td>
<td>490</td>
<td>629</td>
</tr>
<tr>
<td>Reason for non-institutional delivery*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home is convenient</td>
<td>31.1</td>
<td>7.3</td>
<td>25.7</td>
<td>64.7</td>
<td>53.7</td>
</tr>
<tr>
<td>No need since pregnancy was normal</td>
<td>16.8</td>
<td>11.3</td>
<td>25.4</td>
<td>56.3</td>
<td>48.2</td>
</tr>
<tr>
<td>Cost of the institutional delivery</td>
<td>15.0</td>
<td>2.4</td>
<td>14.1</td>
<td>5.1</td>
<td>2.5</td>
</tr>
<tr>
<td>No nearby institution for 24x7 delivery</td>
<td>1.8</td>
<td>2.7</td>
<td>21.1</td>
<td>4.1</td>
<td>1.9</td>
</tr>
<tr>
<td>Delivery institution is far off</td>
<td>30.1</td>
<td>13.4</td>
<td>26.3</td>
<td>3.3</td>
<td>6.7</td>
</tr>
<tr>
<td>Nobody is there to take care of family during my delivery outside home</td>
<td>9.8</td>
<td>3.4</td>
<td>13.8</td>
<td>4.1</td>
<td>7.2</td>
</tr>
<tr>
<td>Nobody to take me to hospital for delivery</td>
<td>25.2</td>
<td>14.9</td>
<td>15.3</td>
<td>11.4</td>
<td>8.7</td>
</tr>
<tr>
<td>Untimely delivery</td>
<td>25.7</td>
<td>61.9</td>
<td>13.5</td>
<td>14.1</td>
<td>9.5</td>
</tr>
<tr>
<td>Any other reason</td>
<td>1.8</td>
<td>0.0</td>
<td>7.0</td>
<td>3.9</td>
<td>6.8</td>
</tr>
</tbody>
</table>

*Multiple Responses

1- JSY beneficiaries are those who have either delivered in government hospital or in private accredited hospitals

The objectives of the Integrated Child Development Services (ICDS) Scheme, which was launched in 1975, are:

1. to improve the nutritional and health status of children in the age-group 0-6 years;

2. to lay the foundation for proper psychological, physical and social development of the child;

3. to reduce the incidence of mortality, morbidity, malnutrition and school dropout;

4. to achieve effective co-ordination of policy and implementation amongst the various departments, to promote child development; and to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.
The package of services provided under the ICDS includes supplementary nutrition, immunization, health check-up, referral services, pre-school non-formal education and nutrition & health education.⁶⁹

The National Maternity Benefit Scheme (NMBS) introduced in 2001, basically talks of providing cash assistance of Rs.500 to pregnant women. In order to clear the confusion that the cash assistance under the NMBS is independent of the cash assistance under the JSY, the Supreme Court on 20th November 2007 passed an order in the People’s Union for Civil Liberties (PUCL) Case directing that all the State governments and Union Territories (UTs) shall continue to implement the NMBS and ensure that all BPL pregnant women get cash assistance 8-12 weeks prior to the delivery.⁷⁰

Targeted public Distribution system (TPDS) is focus on the poor, under the TPDS, States are required to formulate and implement foolproof arrangements for identification of the poor for delivery of food grains and for its distribution in a transparent and accountable manner at the FPS level. A national Sample Survey Exercise points towards the fact that about 5% of the total population in the country sleeps without two square meals a day. This section of the population can be called “hungry”, in order to make TPDS more focused and targeted towards this category of population, The Government of India launched the scheme called Anna Yojana” with effect from 25 Dec. 2000. The above schemes was implemented in Tamil Nadu with effect from 1 Nov. 2001 in urban areas and with effect from 1 Dec. 2001 in rural areas and the collectors are over all in charge for the implementation of this scheme in the Districts. The objective of the scheme is to ensure food security to the poorest of the poor. Originally at the time of introduction of “AAY” scheme, each beneficiary was given 25 kg per month at the rate of Rs.3/- per kg. This has been increased to 35 kg of rice per card per month at the rate of Rs.2/- per kg through fair price shops from November 2006 onwards. The Government of Tamil Nadu launched the 1kg rice at

⁶⁹ From the case study of Laxmi Mandal vs Deen Dayal Harinagar Hospital, in the High Court of Delhi of New Delhi, W.P. (C) 8853/2008


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Re.1 scheme on the birth centenary of Perarignar Anna on 15.9.2008. The States are required to bear the distribution cost, including margin to dealers and retailers as well as the transportation cost. Thus the entire food subsidy is being passed on to the consumers under the scheme. The AAY Scheme has been expanded in 2003-2004 by adding another 50 lakh BPL households headed by widows or terminally ill persons or disabled persons or persons aged 60 years or more with no assured means of subsistence or societal support. With this increase, 1.5 crore (i.e. 23% BPL) families have been covered under the AAY.71

As announced in the Union Budget 2004-05, AAY has been future expanded by another 50 lakh BPL families by including, inter alia, all households at the risk of hunger. Orders to this effect have been issued on 3Aug 2004. Few guidelines specify the following criteria; in the rural areas, getting income of the family minimum 15,000 per annum, landless agriculture labourers, small and marginal farmer, self-employed rural artisans and old age pensioners and destitute widows, physically handicapped persons etc. Criteria for urban areas are, families getting an income up to 15,000 per year, generally people living in slums and daily wager like rickshaw pullers, porters, fruit and flower sellers on pavement, domestic servants, construction workers and other similarly placed.72

On 2nd May 2003, the Supreme Court directed the Government of India to place on AAY category the Aged, infirm, disabled, destitute men and women, pregnant and lactating women, destitute women; widows and other single women with no regular support; old persons (aged 60 or above) with no regular support and no assured means of subsistence; households with a disabled adult and assured means of subsistence; households where due to old age, lack of physical or mental fitness,


72 Ibid
social customs, need to care for a disabled, or other reasons, no adult member is available to engage in gainful employment outside the house; primitive tribes."73

Rashtriya Mahila Kosh (RMK) has established its credential as a premier micro-credit agency of the country with its focus of women and their empowerment through credit support or micro-finance, as an instrument of socio-economic change and development and also to make the women self-reliant and economically independent. To expand its credit services, RMK also ventured to develop an institutional base at the grass-root levels through Self-Help Groups (SHG). In this process, it also started developing linkages with the existing Women’s Groups of Integrated Women’s Empowerment Project (IWEP) known as Swyamsiddha and Swaranjayanti Gram Swarozgar Yojana (SGSY). The RMK had sanctioned Rs.103.47 crore to 861 organizations since its inception to 31.3.2001. It had disbursed Rs.76.55 crore for the benefit of approximately 4.07 lakh women. Efforts are being made to strengthen the Corpus of RMK, the only National credit institution catering to the credit needs of women in the Informal Sector.74

As per the guidelines issued during the year 2000-01 for utilization of funds, 15 per cent of the total Pradhan Mantri Gramodaya Yojana (PMGY) outlay was earmarked for health sector, 40 per cent of the funds provided to the states were to be utilized for strengthening the existing infrastructure in the 20 per cent districts identified on the basis of high IMR and Crude Birth Rate and 50 per cent of the were to be utilized for strengthening, repair and maintenance of infrastructure in the Sub-Centres /PHCs /CHCs; provision of facilities like water supply, toilet etc. and waste management at PHC/CHC and below district level hospital. In view of the poor utilization of funds by the states in that year, the proportion of funds for health in the current financial year (2001-02) has been reduced to 10 per cent of total PMGY funds. However, the states wanting to utilize more than this allocated percentage for health can make use of the unremarked 35 per cent of the allocations under PMGY. In the current year the guidelines for utilization of funds under the health sector have

73 Ibid
74 Annual Report 2001-02, Planning Commission Government of India, New Delhi, p. 17
been modified. It has been decided to earmark 2 per cent of the funds under PMGY for health sector for ISM&H drugs.\textsuperscript{75}

Under the nutrition component of PMGY, the states utilized the earmarked outlay of 15 per cent of the total PMGY funds and hence the earmarking continues to be 15 per cent of the total PMGY outlay during 2001-02 also. The funds under PMGY are to be used for providing take home food supplements to children in the age group 6 months to 6 years. However, in many states the PMGY funds are not treated as additionally to the earmarked nutrition outlay for nutrition component of ICDS; they tend to use it as a substitute. From the PMGY funds, an additional honorarium to the Anganwadi Workers and Helpers were agreed upon on the condition that they will undertake weighing of all children so that children with under-nutrition could be identified and provided with supplementary nutrition. Even one year after initiation of the programme, only about 20\% of all children in the community are being weighed. Thus universal screening, identification of undernourished children and focused intervention in those with severe under-nutrition has not been operationalized. Planning Commission and the Department of Women & Child Development have repeatedly taken up the matter with the State Governments ensuring hundred per cent weighment of children by the Anganwadi workers, identify severely under-nourished children and target them for supplementary nutrition under PMGY.\textsuperscript{76}

Insurance schemes for improvement in health status are vital for the enhancement of human capabilities. Illness is an important source of deterioration to human health. The health insurance situation in India can be understood by some schemes. Micro Health Insurance schemes (MHIs) are based on not-for-profit principal and targeted to the underprivileged sections of the society. The Private Health Insurance schemes (PHIs) often called Private Voluntary Health Insurance schemes (PVHIs), are the schemes offered by insurance companies in the open market in which enrolment into the scheme is not determined by legislation. In India, the public and private sector companies provide the PHI (voluntary). The General Insurance Corporation (GIC), which comprises of four insurance companies namely NIC, NIAC, OIC and UIC, is the largest public sector organization of providing the

\textsuperscript{75} Ibid
\textsuperscript{76} Ibid
PHI in India. The various policies introduced by the GICs are Mediclaim Policy (group and individual), Jan Arogya Bima, Personal Accident Policy, Nagarik Suraksha Policy and Overseas Mediclaim Policies. Among these policies, the Mediclaim Policy is relatively popular. After the establishment of Insurance Regulatory and Development Authority (IRDA 1999), many private corporate also have entered the Health Insurance market. The Bajaj Allianz, Royal Sundaram, ICICI Lombard, Cholamandalam, Tata and Reliance are the prominent private insurance companies. An important peculiarity of these corporations is the tie-up with some health care provider having super specialty facilities.77

At 1997, the central government has introduced a National Social Assistance Programme (NSAP) for the poor and the elderly. It has three components: 1- National Old Age Pension Scheme (NOAPS); 2- National Family Benefit Scheme (NFBS); and 3- National Maternity Benefit Scheme (NMBS).78

There are also a range of NGOs and self-help groups that operate their own health insurance schemes. Probably the most famous of them all is the Self-Employed Women’s Association (SEWA). For members of the group, it charges an annual premium of INR 30 for a maximum of INR 1,200 per year for hospitalization. There is also a fixed deposit option. The actual healthcare scheme is run (on a group basis) by the government-owned insurer New India Assurance. There are a number of plans along the line of SEWA.79

In addition to increasing the resource allocation for the health sector the Central Government is also playing a critical role in facilitating access to health care delivery channels, public and private, through subsidized health insurance schemes like the Rashtriya Swasthaya Bima Yojana (RSBY) for providing a basic healthcare to poor and marginal workers. The RSBY is being extended to cover MGNREGA

79 Ibid
beneficiaries and beedi workers. In 2011-12 it is proposed to extend the coverage to the unorganized sector workers in hazardous mining and associated industries like slate and slate pencil, dolomite, mica and asbestos etc.

These government schemes however have paved the way for larger population of India to access health benefits particularly to the rural population. For women these schemes proved to be a great relief and quite beneficial, however, with limited success as has been argued by experts. In one of the judgment in the case of Laxmi Mandal vs Deen Dayal Harinagar Hospital, High Court of Delhi\textsuperscript{80} the observation of the court highlights the problems of different interrelated governmental schemes especially due to the lack of coordination and cooperation between central and state government. In the final judgment Court highlighted the following shortcomings in the implementation of the schemes and issued relevant directions.

(i) There is no assurance of portability of the schemes across the states. In the present case, Shanti Devi travelled from Bihar to Haryana and then to Delhi. In Haryana she was clearly unable to access the public health services. At Delhi she had to once again show that she had a BPL card, and on being unable to do so, she was denied access to medical facilities. For the migrant workers this can pose a serious problem. Instructions will have to be issued to ensure that if a person is declared BPL in any state of the country and is availing of the public health services in any part of the country, such person should be assured of continued availability of such access to public health care services wherever such person moves.

(ii) There is confusion on whether the cash assistance under the NMBS scheme is independent of the cash assistance under the JSY scheme, despite the Supreme Court making this unambiguously clear by its order of 20th November 2007 in the case of PUCL v. Union of India. Further it appears that benefit under the NMBS is being denied to women who have had more than two live births and to women who are under 19 years of age, although the Supreme Court order dated 20th November 2007 makes it clear that such benefits should be made available irrespective of the number of live births or the age of the mother. The necessary

\textsuperscript{80} In the High Court of Delhi, New Delhi WP(C) 8853/2008.
clarification requires to be immediately issued by the Central Government to all the State Governments in this regard so that pregnant women across the country are not denied cash assistance.

(iii) There is an overlap of the schemes. The ICDS is administered by the Department of Women and Child Development of the State, the NRHM by the Ministry of Health at the centre and JSY by the Health Ministries of the States. There must be an identified place which the women can approach to be given the benefits under the various schemes. In other words, a pregnant W.P.(C) Nos. 8853 of 2008 & 10700 of 2009 page 47 of 51 woman or a lactating mother should not have to run to several places to get benefits under the schemes.

(iv) The system of administering the IWC under the ICDS requires to be overhauled. AWCs even in Delhi appear to operate from single rooms which are inadequate for the number of children who have to be served at the AWC. AWCs are seen to be in a deplorable condition. There is nothing in the form of any label/board to indicate their presence. They also do not appear to have the necessary equipment to carry out the necessary tests. In the rural set up, it should be possible to have a monthly camp held at an identified place where the pregnant women and young children can undergo health check-up.

(v) The system of referral to private health institutions has to be improved. Safe and prompt transportation of pregnant women from their places of residence to public health institutions or private hospitals and vice-versa needs to be ensured. The critical days and hours prior to the expected date and time of delivery can be a matter of life or death for a pregnant woman. If adequate ambulance services are not available at that stage, many a life will be needlessly lost. The two cases here show the Court orders were required at various times even to remove the baby for critical care from one hospital to another. Even in places like Delhi, the ambulance and transport services require to be augmented and improved significantly.

(vi) The NFBS envisages the payment of sum of Rs. 10,000/- in the event of death of the primary bread winner. It is also necessary to recognize a woman in the family who is a home maker as a "bread winner" for this purpose. In the event of
a maternal death, the family should get the cash benefit under the NFBS. It should be ensured that this is made available to her legal heirs as per their legal entitlement. Necessary instructions clarifying this position will have to be issued by the Central W.P.(C) Nos. 8853 of 2008 & 10700 of 2009 page 48 of 51 Government to the State Governments.

(vii) The statistics furnished by the State Governments on the performance of the JSY show the number of institutional deliveries but do not indicate what percentage of the total number of deliveries in the State they constitute. Only when such information is available and provided under the schemes, the categorization of States as HPS and LPS is possible. The Central Government must insist on this kind of information for meaningful assessment of the working of the schemes.

(viii) On the working of the AAY, it appears that the benefits are not reaching to the pregnant women, particularly those who migrate from one State to another. This problem will require urgent attention at the hands of the Central Government, the State Governments and the UTs. There is also a problem of portability of the AAY benefit. Unless the poor woman is assured of the AAY benefits notwithstanding having to travel from one State to another, the scheme cannot be said to be effective.

(ix) The present cases afford an opportunity to the Central Government, the State Governments and the UTs, particularly the State of Haryana and the GNCTD, to put in place corrective measures.

Thus, we find that the Constitution of India however acknowledges the Right to Health in Article 21 (Right to Life with Dignity) and equality of right to health to women through Article 15 (3). The Directive Principles of State (Article 41, 42 and 47) also envisage for the Right to Health and Article 42 speaks about maternity relief to women. Theoretically these provisions of the Indian Constitution if seen in the light of International covenant and guidelines substantially ensure Right to Physical and Mental health to women. Nevertheless there are numerous practical difficulties in the way to ensure Right to Physical and Mental health to women in order to achieve the goal of gender equality.
This is also important to keep in mind that the financial benefits provided in these schemes are meager keeping in mind the high cost of treatment and current inflationary trends. However it has been argued that even this meager amount is a great relief for the person concerned. Moreover it is also important to note here that by extending financial support and preliminary institutional support the state itself is outsourcing its responsibility to develop a of Public Health System.