Vol. XLII No. 4 October-December, 2023

COMMON CAUSE

www.commoncause.in

POLICY-ORIENTED JOURNAL SINCE 1982

RIGHT TO HEALTH

IS IT HIGH TIME THE CONSTITUTIONAL GUARANTEE OF THE RIGHT TO LIFE AND LIBERTY UNDER ARTICLE 21 COVERED HEALTH AS A FUNDAMENTAL RIGHT?

Price: Free distribution to members Regn No. 39331/1982

Common Cause is in the vanguard of India's anti-corruption movement and the fight for stronger public institutions since the 1980s. We make democratic interventions through PILs and bold initiatives. Our landmark PILs include those for the cancellation of 2G licenses and captive coal block allocations, against the criminalisation of politics, for Internet freedom and patients' right to die with dignity. Please visit commoncause.in for more information on our mission and objectives. We also run special programmes on police reforms and cleaner elections.

Common Cause runs mainly on donations and contributions from well-wishers. Your support enables us to research and pursue more ideas for a better India.

Now you can donate using our new payment gateway.

You may also deposit directly into our bank account (details are given below) and send us an email at commoncauseindia@gmail.com, providing information such as donor's name, address and PAN number for issuance of the donation receipt.

Name: Common Cause
Bank: IndusInd Bank
Branch: Vasant Kunj, New Delhi
S.B. Account No.: 100054373678
IFSC Code: INDB0000161
Address: Common Cause,
Common Cause House, 5, Institutional Area,
Nelson Mandela Marg, Vasant Kunj, New Delhi - 11 00 70
(Phone numbers: 011 26131313 and 45152796)

Designed at GENESIS genesisadvt@hotmail.com 9810033682

A VITAL LAW WHOSE TIME HAS COME

Right to Health Naturally Flows Out of Article 21

Indian Constitution is a mystery box that holds new surprises for every new generation. It comes to our rescue every time we need direction to move forward, never mind occasional reverses! It has an infinite ability to respond to emerging situations through fresh interpretations or court verdicts. And that is why it is a living document.

We, the people of India, owe our new and evolving citizenship rights – such as the rights to food, information, privacy, or sexual orientation – to the transformative power of the Constitution. It has shown us time and again that the scope of expanding fundamental rights is indeed unlimited. And that is why we believe it is time that the right to health was specifically included in the Right to Life. By the right to health, we essentially mean the right to healthcare covering services of hospitals, medicines, and medical professionals. Healthcare is a means to an end culminating in the overall happiness and well-being of all.

We pin our hopes on the Right to Life under Article 21 because it is settled today that 'life' implies meaningful and dignified life and all that goes along with it. It is this Article that gave the hawkers and pavement dwellers of Mumbai the right to livelihoods with the assurance that they could not be removed arbitrarily (Olga Tellis, 1985). More recently, it gave us the right to privacy (Puttaswamy, 2017) and disallowed criminalisation of sexual acts between consenting adults (Navtej S Johar, 2018).

In a Common Cause PIL, Article 21 gave us the patients' right to die with dignity through a Living Will or Advance Medical Directive in 2018. The Apex Court noted that keeping a person alive through artificial means can be a mere extension of a cruel and meaningless life. In yet another case, the Court held that a convict shall not be deprived of his life or liberty even while in prison except through lawful procedures (Sunil Batra, 1978).

The above examples establish that a substantive and truly purposeful right to health can flow from the expanded scope of Article 21 just as it happened with the Right to Food in the last decade. The National Food Security Act (NFSA) came into existence only in 2013 after the landmark court verdict in PUCL Vs Union of India (2001) praying for the enforcement of food security and the famine code given starvation deaths in parts of India. It dawns on us today that it should have come even earlier because starvation existed in India despite the Right to Life.

Unfortunately, the right to health, where it stands today, is an illusion despite the Apex Court validating it through words and India being a signatory to many global covenants and declarations. It is still a mirage, perhaps, because the Court has stopped short of declaring it a fundamental right with specific directions to the executive as it did with the right to food. Indian Parliament also failed to bring legislation as was done in the case of the Right to Education through a Constitutional Amendment in 2002, followed by legislation in 2009.

We, at Common Cause, believe that it is only a matter of time before the Constitution shows us the direction once again. We hope that the Apex Court will rise to the occasion if the better sense continues to evade our political class. It must also be admitted, in all fairness, that successive governments have launched well-intentioned healthcare schemes in the past, but these will never be as effective as a Constitutional guarantee. We have discussed some of these issues in more detail in the following pages of your journal. Do let us know what you think. As always, your comments and suggestions are welcome at commoncauseindia@gmail.com.

With best wishes for a happy and meaningful 2024,

Vipul Mudgal
Editor

DOES RIGHT TO LIFE INCLUDE HEALTH AND WELL BEING?

A Crucial Indicator of a Nation's Progress

Swapna Jha*

Though the Constitution of India does not expressly recognise the right to health as a fundamental right it has several provisions that deal with the health of the public at large. A silver lining, however, comes from the Supreme Court of India, which has established, through judicial interpretation, that the right to health is indeed a fundamental right under Article 21 which guarantees right to life and personal liberty. The apex court has repeatedly observed that under Article 21, "life" means a life with human dignity and not mere survival or animal existence.

In the case of Paschim Banga Khet Mazoor Samity v. State of West Bengal (1996) 4 SCC 37, the scope of Article 21 was further widened, as the court held that it is the responsibility of the Government to provide adequate medical aid to every person and to strive for the welfare of the public at large.

The right to health encompasses various factors crucial for a good quality of life, extending beyond mere survival. It involves access to healthcare, sanitation, nutrition, and overall well-being. In modern society, the pursuit of a better quality of life is intricately tied to maintaining and improving health.

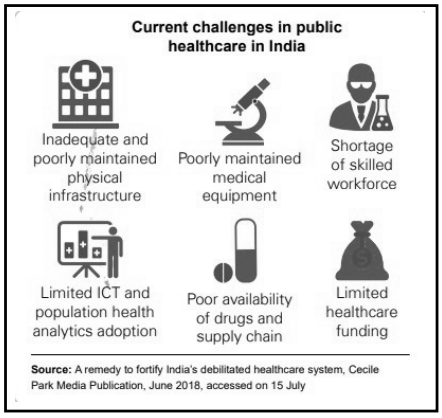
However, the right to health is still an illusion for most of the country's marginalised population. As per data released by the Health Ministry, under the National Health Profile, on June 19, 2018, there is one government allopathic doctor per 11,082 population, one government hospital bed per 1,844 population and one state-run hospital for 55,591 population.

The WHO Constitution and the Universal Declaration of Human Rights in the forties were the first international instruments to endorse health as a fundamental right of every human being. The right to the highest attainable standard of physical and mental health was subsequently incorporated into the International Covenant on Economic, Social and Cultural Rights (1966). In international human rights law, the right to health is an inclusive right, extending beyond healthcare to the underlying determinants of health, such as access to potable water, sanitation, adequate food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

> ***"The right to health encompasses various factors crucial for a good quality of life, extending beyond mere survival. It involves access to healthcare, sanitation, nutrition, and overall well-being."***

The normative scope and content of the right to health (i.e., the standard for the human right to health) comprise four interrelated elements which require that public health and healthcare facilities, goods, services and programmers, in addition to the underlying determinants of health, be Available, Accessible, Acceptable and of a reasonable Quality. The right to health for all people means that everyone should have access to the health services they need, when and where they need them, without suffering financial hardship. It also imposes obligations of immediate effect on states including the guarantee of non-discrimination, and the obligation to take deliberate, concrete and targeted steps towards realising the right

* *Swapna Jha is a Senior Legal Consultant at Common Cause.*



Source: KPMG Report, 2019 Ayushman Bharat - A big leap towards Universal Health Coverage in India

to health for all.[1] No one should get sick and die just because they are poor, or because they cannot access the health services they need.[2]

Defining Health

There is no proper legal definition of health. The most widely accepted definition is given by the WHO, which defines 'health' as *'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'*

Health is a crucial factor in national development. Unfortunately, healthcare is one of the most neglected aspects of development in India. According to a study by the World Bank, 50% of the economic growth differentials between developing and developed nations are attributed to poor health and low life expectancy. The healthier the citizens of a country, the more effective the workforce; the better the health of their children, the fewer births, and hence the fewer dependents. Ensuring the health and well-being of all is essential to poverty eradication efforts and achieving sustainable development, contributing to economic growth and prosperous communities.[3]

It is also a key indicator of a country's progress: a nation with a healthy population is more likely to experience sustained growth. Good health is also essential for the stability of entire regions, as pandemics, which transcend borders, can have severe social and economic impacts on families and communities, and can put increased pressure on health systems.

Although global health has improved significantly in recent decades, this benefit has not been shared evenly within and among nations. Several hundred million people across the globe continue to go without basic health services, especially in rural areas and in the most impoverished communities. More than six million children die each year and nearly 300,000 women die in pregnancy or childbirth, many from preventable causes.[4]

Government Policies and Efforts

Public spending on health as a percentage of GDP is an indicator of the priority accorded to health in the planning process of any nation. Policy documents like the approach paper to the 12th Five Year Plan (2012 to 2017), the High-Level Expert Group for Universal health coverage, the program implementation framework of the NRHM and the report of the National Commission on Macroeconomics and Health have all endorsed the need to raise the level of public spending on health in India from around 1% to 2-3% of GDP.

In India public expenditure on health is incurred by three tiers of the government, the central government, the state government and the local bodies. The central government spends directly on health and also provides grants in aid to state governments who, in addition to spending out of the grants in aid received from the center, incur health expenditure directly out of the resources available with them. Their health expenditure also includes transfers to rural and urban local bodies for health spending while the local bodies too incur health expenditure from the resources available with them. The sum total of health expenditure by each of these three tiers of government provides an estimate of public spending on health in India. In 2009- 2010 and 2010 -2011 public expenditure on health in India was around 1.1% of GDP and in the financial year 2023 it is estimated to be 2.1%.

The increased spending has resulted in an important

initiative by the government. National Health Mission (NHM) is Government's largest public health programme, which aims rather ambitiously to achieve universal access to quality healthcare. It consists of two sub-missions, the National Rural Health Mission (NRHM); and the National Urban Health Mission (NUHM). While public health services in India have improved slowly over the years they are nowhere near the minimum norms prescribed by WHO. This applies to things like government hospital beds per thousand people and population wise number of allopathic doctors. The situation varies from state to state with some states being vastly ahead of others. Same is the story of the primary and community health centres, Accredited Social Health Activists (Asha), doctors and nursing staff.

However, it must be noted that the successive government initiatives have resulted in reducing the country's average death rate. In 2020, communicable diseases accounted for 12,271 deaths in India, which was 10 per cent lower than the corresponding figure for the previous year. Acute respiratory infections and pneumonia accounted for the majority of deaths in 2020. Vector-borne diseases accounted for 4 per cent of total communicable diseases related deaths in 2020. This figure stood at 8 per cent in 2019[5]. The figures show some improvement but the outcomes in India are nowhere close to the international standards.

India's Progress on Sustainable Development Goals

The WHO's Sustainable Development Goal (SDG) number 3 is "good health and wellbeing for all at all ages". There has been some progress on improving global health in recent years. For example, 146 out of 200 countries or areas have already met or are on track to meet the SDG target on under-5 mortality. Effective HIV treatment has cut global AIDS-related deaths by 52 per cent since 2010 and at least one neglected tropical disease has been eliminated in 47 countries. However, insufficient progress has been made in other and more fundamental areas, such as on reducing maternal mortality rate (MMR) and expanding universal health coverage. Globally, approximately 800 women died every day from pregnancy or childbirth in 2020. As many as 381 million people were pushed or further pushed into extreme poverty in 2019 due to very high out-of-pocket expenditure on health.[6]

> ***While India is way behind in achieving Universal Health Coverage, the government has been trying to intervene through nationwide schemes like the Ayushman Bharat and Pradhan Mantri Jan Arogya Yojana (PMJAY) launched in 2018.***

While India is way behind in achieving Universal Health Coverage, the government has been trying to intervene through nationwide schemes like the Ayushman Bharat and Pradhan Mantri Jan Arogya Yojana (PMJAY) launched in 2018. It aimed to empanel more healthcare providers, especially in small towns, towards the aim of having 1.5 lakh Health and Wellness Centers and covering at least 50 crores beneficiaries from 10 crores financially vulnerable families under Rs. 5 lakh per family, per year coverage in secondary and tertiary care hospitalisation, by 2022. With an aim to bring low-cost treatment close to people's homes while targeting non-communicable diseases, maternal and child health as well as to provide essential drugs and diagnostic services at affordable prices, the government regulations are paving the way for better infrastructure and health facilities throughout the country.

Launched on September 23, 2018, PMJAY has been designed to provide financial risk protection against catastrophic health expenditure that

impoverishes an estimated 6 crores people every year. The number of individual beneficiaries verified under PMJAY stands at more than 21.90 crores. Over 26,031 hospitals have been empaneled under the scheme till date. This has facilitated over 4.07 hospitalisations as on January 5, 2023, saving beneficiaries over Rs. 47,055 crores in out-of-pocket medical expenditure. It is estimated that PMJAY has contributed in curtailing out-of-pocket expenditure to the tune of 1.5 to 2 times the actual expenditure recorded under the scheme.

Another important initiative, the National Digital Health Mission (NDHM) is being rolled out to create an integrated nationwide database of health services and providers. The mission aims to create a management mechanism to process digital health data and facilitate its seamless exchange; develop registries of public and private facilities, health service providers, laboratories and pharmacies; and to support clinical decision-making as well as offer services like telemedicine.

The NDHM has the potential to make the health system more evidence-based, transparent and efficient. This will immensely help the government in its efforts to prioritise policies and programs that resonate with the targets set in SDGs.[7]

> ***"In many countries, some if not most physicians work simultaneously for the public sector and in private practice. This means the public sector ends up subsidizing unofficial private practice."***

Findings of the World Health Reports

The WHO carried out the first-ever analysis of the world's health systems in "The World Health Report 2000 – Health systems: Improving performance"[8]. The main message from this report, according to WHO Director-General Dr Gro Harlem Brundtland, "… is that the health and well-being of people around the world depend critically on the performance of the health systems that serve them. Yet there is wide variation in performance, even among countries with similar levels of income and health expenditure. It is essential for decision-makers to understand the underlying reasons so that system performance, and hence the health of populations, can be improved."

Some of the noteworthy findings of the World Health Report are:

Many health ministries' focus on the public sector and often disregard the frequently much larger private sector healthcare.

In many countries, some if not most physicians work simultaneously for the public sector and in private practice. This means the public sector ends up subsidizing unofficial private practice.

Many governments fail to prevent a "black market" in health, where widespread corruption, bribery, "moonlighting" and other illegal practices flourish. The black markets, which themselves are caused by malfunctioning health systems, and low income of health workers, further undermine those systems.

Many health ministries fail to enforce regulations that they themselves have created or are supposed to implement in the public interest.

While private health expenses in industrial countries now average only some 25 percent because of universal health coverage (except in the United States, where it is 56%), in India, families typically pay 80 percent of their health care costs as "out-of- pocket" expenses when they receive health care.[9]

India is ranked fifth from the bottom in terms of public spending on health globally and

155th out of 167 countries on hospital bed availability. It has one of the highest out-of-pocket spending levels on health in the world. Out-of-pocket spending as a proportion of total health spending is a leading cause of impoverishment in India. The hospital industry accounts for 80% of India's total healthcare market; it is expected to be valued at USD 132 billion by 2023. Despite its huge role, regulation of the private sector is weak.[10] It is time we start following best practices from across the world, allocate a higher percentage of our GDP towards healthcare and ensure a better public delivery system to achieve the SDG goal of universal healthcare within a reasonable time frame.

Endnotes

1 WHO. (2023, October 30). Human Rights. who.int. Retrieved October 31, 2023, from https://bit.ly/3RFgSw0

2 WHO. (2023, October 30). Conflict and crisis reveal the tip of the iceberg the world's vulnerable face in accessing their right to health. WHO. Retrieved October 31, 2023, from https://bit.ly/3H2m4Fb

3 Collins, F. S. (2023, December 13). Growing importance of health in the economy. The World Economic Forum. Retrieved November 1, 2023, from http://weforum.org

4 Government of Canada. (2023, October 30). Health and Development. Government of Canada. Retrieved November 3, 2023, from https://bit.ly/3TJw1yR

5 National-Health-Mission-2023-24.pdf (cprindia.org)

6 https://unstats.un.org/sdgs/report/2023/The-Sustainable-Development-Goals-Report-2023.pdf

7 National Health Authority (NHA). National Digital Health Mission. NITI Aayog. Retrieved November 12, 2023, from https://bit.ly/47eOmah

8 Ministry of Health and Family Welfare (mohfw.gov.in)

9 WHO. (2023, October 30). World Health Organisation Assesses the World's Health Systems. WHO News. Retrieved November 10, 2023, from https://bit.ly/47ioDxu

10 Taneja, A., & Sarkar, A. (2023, June 26). FIRST, DO NO HARM - Examining the impact of the IFC's support to private healthcare in India. Oxfam International. Retrieved October 31, 2023, from https://bit.ly/3vlv6dW

TOWARDS UNIVERSAL HEALTHCARE:

Lessons from India's Homegrown Success Stories

Udit Singh* and Noor Ameena**

The Right to health is a basic human right which was first recognised in the WHO Constitution (1946): "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"[1].

The National Health Profile 2022 clarifies that healthcare is not simply medical care; it is allied with a cultural understanding of ill health and well-being, the extent of socioeconomic inequalities, the reach of health services and the quality and costs of care along with present bio-medical understanding about health and illness[2].

Right to Health and the Indian Constitution

The right to health is not expressly provided as a right under the Constitution. However, the Supreme Court of India repeatedly stated that the right to health is an inherent right[3] within the meaning of the right to life under Article 21. Article 47 of the Constitution bestows upon the State the duty to raise the level of nutrition and the standard of living and to improve public health which has been placed under the State list of the seventh schedule of the Constitution.

And that is why the states exercise major control over health-related finance, organisation, and management. Although the Constitution has made healthcare services largely a responsibility of the state governments, it has left enough leeway for the Union Government as several allied items (for e.g. population control and family planning) are listed in the concurrent list[4]. The Union Government exerts control over the states in areas of health policy and planning by tying health financing through Central Schemes.

Public Health In India

Public health is defined as "the science and the art of preventing disease…through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease…."[5]. It means assuring conditions in which the population can be healthy. It is the organised application of resources to achieve health to enable socially and economically productive life[6].

Healthcare services include

i) population-wide preventive services like sanitation, drinking water, and epidemic control;

ii) clinical preventive services like screening and vaccination; and

iii) clinical curative services. The first and second together constitute public health services[7].

The health policies in India delineated from a holistic public health approach by an array of policy decisions since the 1950s - public health resources were targeted to single-issue programmes like malaria/ polio eradication programmes, public health engineering services including water supply and sanitation were delinked from Health Department, and amalgamation of public health and medical services eventually resulting in cowing of public health services by medical services[8].

* *Udit Singh is a Legal Consultant at Common Cause.*

** *Noor Ameena is a Doctoral Fellow at NALSAR University of Law, Hyderabad.*

> ***The inadequacies of the public health system were thoroughly exposed during the advent of the recent COVID-19 pandemic.***

There is sufficient evidence in the existing literature on the subject to show that investing in public health services leads to better health outcomes[9]. This also makes economic sense, making it a sound economic practice for low-income countries to sustain investment in public health, thereby preventing the possible outbreak of diseases[10]. The inadequacies of the public health system were thoroughly exposed during the advent of the recent COVID-19 pandemic.

India's Own Best Practices

It is well-known that health outcomes vary significantly in different states of India. Kerala and Tamil Nadu (TN) emerged as the top performers in the overall health performance in the Annual Health Index released by NITI Aayog for 2019-20[11] jointly prepared with the Union Health Ministry and the World Bank. Titled as "The Healthy States, Progressive India" the nationwide survey-based report has ranked Kerala and Tamil Nadu as the best-performing State in the health indicators while Uttar Pradesh remained at the bottom despite showing some incremental progress. The States' ranking was done on multiple indicators such as neonatal mortality rate, under-five mortality rate, sex ratio at birth, maternal mortality ratio, modern contraception prevalence rate, full immunisation coverage, antenatal care, identification and cure of TB, among many others.

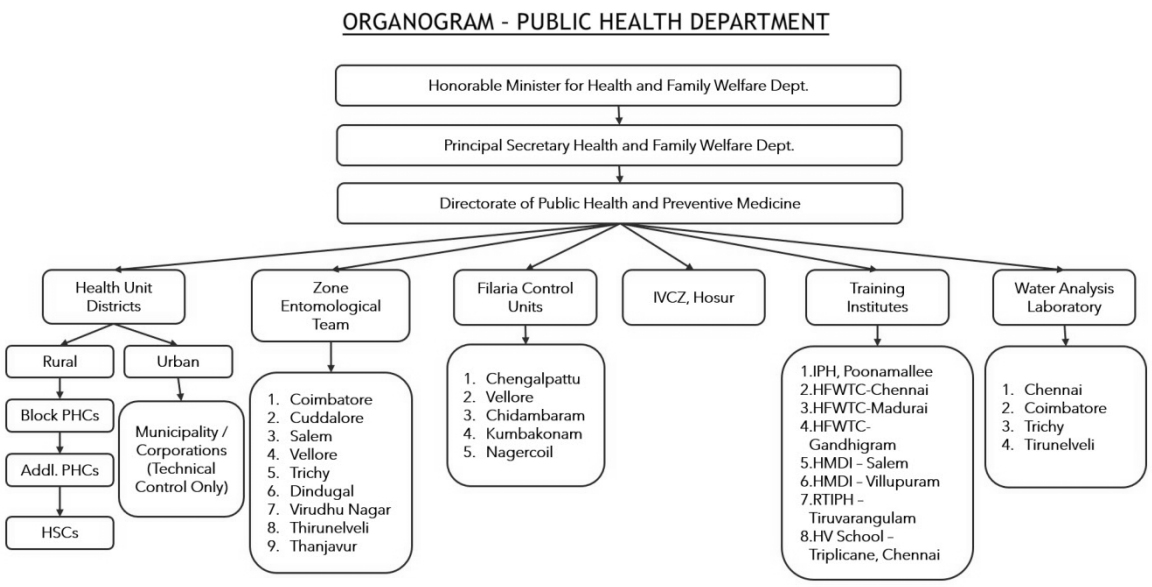
We are discussing in this article India's own success stories in terms of the delivery of health services to show what is working well right here despite all odds and what isn't. Things boil down, it seems, eventually to a combination of good policies, effective implementation and good governance. The development models of Kerala and TN are characterized by investment in the social determinants of health, including education, sanitation, food, and clean water, and better achievements in the health sector are a natural consequence. With a dedicated public health infrastructure and community-oriented development, these states have lessons for the rest of the country.

Public Health Governance in Tamil Nadu

TN's approach towards public health governance is unique with a functional public health infrastructure distinct from medical care. The health governance in TN is executed through three axles - The Directorate of Medical Education, the Directorate of Medical Services, and the Directorate of Public Health and Preventive Medicine. The State's Department of Public Health and Preventive Medicine was established in the erstwhile Madras province as early as in 1923, while the TN Public Health Service acquired statutory status in 1939 with the enactment of the Madras Public Health Act, in 1939. Post-independence, TN continued to be governed by the same and retained the separate public health infrastructure, despite the subsequent shift in the Union Government policies to merge the public health and medical services. Hence, TN became the first and only state with a legal framework for public health until recently. Rajasthan enacted a law on the right to healthcare in 2022, and Kerala passed a public health legislation in 2023.

The TN public health department is instrumental in the early achievements in immunisation coverage, high couple protection rate and institutional deliveries, and eradication of epidemics way ahead of the rest of the country. The very fact that TN survived two major disasters, a tsunami in 2004 and the floods in 2015 without being followed by a major epidemic outbreak, and how these were effectively managed in the times of crisis indicates the strength of the

Department of Public Health, Government of Tamil Nadu.



Note: PHC- Public Health Centre, HSC- Health Sub Centre, IVCZ - Institute of Vector Control & Zoonosis

Source: https://www.tndphpm.com/#/organogram

system.

In the wake of the National Health Policy 2017 proposal to create a Public Health Management Cadre in all states, the Tamil Nadu experience is worth studying. Tamil Nadu Public Health Service is an elaborate system with a cadre of non-practicing doctors supported by dedicated cadres for Entomologists, Public Health Nurses, Statisticians, Health Inspectors, Village Health Nurses, and administrative cadres. Medical graduates who choose public health as their specialty forego their private practice and become part of TN Public Health Services after acquiring the necessary qualifications. Once in service, they are posted as Municipal/City Health Officers, Assistant Professors in Medical Colleges, Principals of Training Colleges, etc. Upon promotion to Deputy Director, they are posted as District Health Officers in charge of National Health Programs, Primary Healthcare, and Environmental Hygiene promotion, including drinking water and sanitation, prevention and control of infectious diseases, prevention and control of non-communicable diseases, implementation of Tamil Nadu Public Health Act 1939, COPTA, Birth and Death Registration, etc. They are promoted as Joint or Additional Directors with state-level responsibilities and deputed to National Missions like NHS, ICDS, TANSACS, TNHSP, or UN Agencies[12].

> ***By absorbing existing maternity assistants and training new entrants as village health nurses, TN created a women force for penetrating rural healthcare.***

During the 1980s, the TN deployed thousands of village health workers across the state under the Central Scheme of Multi-purpose Health Workers. Innovating on the Scheme, all the village health workers

deployed by the state were women; by absorbing existing maternity assistants and training new entrants as village health nurses, TN created a women force for penetrating rural healthcare. This period also saw dedicated efforts to expand the primary healthcare facilities by collating resources from the Centre and the State, philanthropists, industrialists, and the community, often by contributions in kind (land, labour, etc.). In 1996, 24-hour primary healthcare was introduced to provide out-patient services in the evening and emergency and obstetric care to women. Together, these contributed to the early success of immunisation drives and the reduction of infant and maternal mortality rates. Another innovative measure was the setting up of Tamil Nadu Medical Services Corporation in 1995 as an autonomous body to purchase and distribute drugs to public hospitals and primary health centres, thereby ensuring the availability of essential medicines by eliminating middlemen and promoting generic drugs. This service was further expanded to provide lab-testing facilities, such as ultrasound scanning, etc., within the primary health centres. The TN model, coupled with a good public health infrastructure and penetration of primary healthcare in the 1980s, came to be lauded as a model of good health at low cost[13], indicating its achievements in the health sector at relatively lesser per-capita spending on the health sector.

TN is also known for its higher doctor-patient ratio in the country. It has more than 900 super-specialty doctors in the government sector[14]. The unique policies developed by the state in medical admission have led to the continuous supply of doctors to the government without urban-rural differentials. The TN Government reserves 50 percent of postgraduate and super-specialty seats for government doctors. To avail of this reservation, one must have served at least three years in a government facility. The government also mandates a superannuation bond to these candidates to serve the government hospitals till retirement. This ensures the continuous supply of doctors in government health facilities including super-specialists.

Community-led Healthcare Model of Kerala

The Kerala model of the public health delivery system shows that collaborative governance by coproduction between government and civil society can improve health services, efficiency, equity, and better health outcomes[15]. Kerala's unique development model with higher human development indices at a lesser per capita income level is internationally recognised[16]. The achievements

> ***Strengthening local self-governments and grassroots networks is something the rest of the country can emulate from Kerala.***

of Kerala in the public health sector are partly attributed to historical events, including the public health and disease control interventions in the Princely State of Travancore[17], which was expanded to the erstwhile provinces of Cochin and Malabar. The continued investments of successive governments in Kerala in health and education, and decentralised and community-oriented development practices sustained the momentum of public health interventions.

The 73rd and 74th Constitutional Amendments brought in the introduction of Panchayati Raj institutions in governance, Kerala treated it as an opportunity rather than a challenge. Between 1996 and 2001, a People's Campaign for Decentralised Planning, at the instance of the government, was a radical attempt at decentralisation aimed to deepen the democratic participation of the public by devolving 40 percent of the funds to local self-governments and empowering them to plan

their development accordingly[18]. This has led to improvements in public health and healthcare services by creating latrines, safe drinking water facilities, and improvements in PHCs and taluka hospitals catering to local requirements.

The episodes of the Nipah outbreak in 2018, 2019, and 2023 and the state response during the COVID-19 pandemic reflect how decentralised development and community participation contribute to combatting health emergencies. The strong public health infrastructure built through decentralised governance has contributed to social behaviour conducive to preventing communicable diseases, improved healthcare-seeking behaviour, and state-wide disease surveillance. The state was quick to respond by creating protocols for contract tracing containment strategies through quarantine and social surveillance, and people's trust and cooperation were augmented by accurate information dissemination, community mobilisation, and

> ***It includes home-based services, institutionalised services outside hospitals, and hospital-based services.***

Logo of Kudumbashree Community Network - "Together, Forward"

Source: https://www.kudumbashree.org/

decentralised enforcement mechanisms of social protocols.

Kerala's strong grassroots-level network of women's self-help groups (locally termed "kudumbashree"[19]), Anganwadi workers (outreach workers from the Integrated Child Development Service Scheme), and Accredited Social Health Activists (ASHAs) (group of women recruited through the National Health Mission) formed the axle of epidemic control by conducting door-to-door symptom surveys. This ensured the quarantine of suspect cases, provided psychosocial support and care of the elderly and palliative care patients. They were instrumental in establishing the 'community kitchen', which, along with the public distribution system, ensured an uninterrupted food supply to quarantined people, the destitute, and migrant labourers[20]. The role of community health workers in the pandemic is not an isolated event but the result of an effective, coordinated grassroots system in place. In an evaluation of ASHA among the states in India, Kerala stood at the top, with 85 percent of the potential users reporting that they have availed the services of ASHA workers (Lowest being 50% in Andhra Pradesh), and 97 percent of the ASHA workers reported making household visits (lowest being 57% in Jharkhand).[21] Strengthening local self-governments (LSGs) and grassroots networks is something the rest of the country can emulate from Kerala.

Pain and Palliative Care Program in Kerala is a community-led initiative supported by the Government. What began as a community-run neighbourhood network, through local donations in Kerala today constitutes 2/3rd of the palliative services in India. It includes home-based services, institutionalised services outside hospitals, and hospital-based services. The NRHM has also integrated community-based palliative care with the Government of Kerala through the Arogyakeralam Palliative Care Project[22], implemented with the support of LSGs – an example of integrating community services into central schemes. The continued supply of volunteers is ensured by innovative programs to extend this network to educational institutions like Our Responsibility to Children and Students in Palliative Care[23]. This movement has transformed a purely medical model of care into a socially responsible model

with the active involvement of democratic institutions and people's participation.

The newly launched AARDRAM Mission and Haritha Kerala Mission are set to rejuvenate primary health centres and improve environmental health.

The Way Forward

At a time when we discuss universal healthcare and right to health for all, it is important to shift our focus towards a holistic approach – a public health-based universal healthcare. What has worked for improving healthcare in Kerala and TN is a combination of creating a designated public health cadre, streamlining public health education, training adequate public health professionals, incentivising the frontline health workers, greater decentralisation and community participation. It is important to note through the Kerala and TN success stories that good public health is a long-term goal in which the community's participation is as crucial as good public health governance by the State.

Endnotes

1 World Medical Association. (2023, October 30). Right to Health: An Inclusive Right for All. Right to Health. Retrieved November 10, 2023, from https://bit.ly/3tzPnf6

2 CBHI. (2023, October 30). NHP 2022. Central Bureau of Health Intelligence. Retrieved November 5, 2023, from https://bit.ly/3tzSYK7

3 State of Punjab & Ors. v. Mohinder Singh Chawla Etc. AIR 1997 SC 1225

4 Desai, M., & Mahabal, K. B. (2023, October 30). Health Care Case Law In India A Reader. ESCR. Retrieved November 11, 2023, from https://bit.ly/3tzsngo

5 C.-E. A. Winslow, The Untilled Fields of Public Health, 51 SCIENCE 23 (1920).

6 MoH&FW, GoI. (1996, June). Report of the Expert Committee on Public Health System. People's Archive of Rural India. Retrieved November 08, 2023, from https://bit.ly/48vuKQ2

7 Desikachari, B. R., Datta, K. K., Gupta, M. D., Padmanaban, P., Shukla, R., & Somanathan, T. V. (2010, Mar 6). How Might India's Public Health Systems Be Strengthened? Lessons from Tamil Nadu. Economic & Political Weekly, 45(10). https://bit.ly/47gNLVA

8 Ibid.

9 Academy Health. (2023, October 30). The Return on Investment of Public Health System Spending. Academy Health. Retrieved October 31, 2023, from https://bit.ly/3REnmLn

10 Ibid.

11 NITI Aayog. (2023, October 30). Incremental Performance (Health Index). NITI Aayog. Retrieved November 11, 2023, from https://bit.ly/3RHZIgX

12 NITI Aayog. (Oct, 2023). NITI Aayog. NATIONAL HEALTH SYSTEMS RESOURCE CENTRE. Retrieved November 12, 2023, from https://bit.ly/3txFGxT

13 V.R. Muraleedharan, Umakant Dash & Lucy Gilson, Tamil Nadu 1980s to 2005: A Success Story in India, in GOOD HEALTH AT LOW COST: 25 YEARS ON 159 (2011), https://bit.ly/41E7zkg. How To Improve Public Health Systems : Lessons From Tamil Nadu, POLICY RESEARCH WORKING PAPERS (2019), https://bit.ly/3TKepDa

14 CHELLAMUTHU, S., & RAMANATHAN, S. (2022, Jan 27). The Dravidian model of public health. The Hindu. Retrieved November 11, 2023, from https://bit.ly/48m5gVS

15 Jacob, M., & John, J. (2016). Local governments and the public health delivery system in Kerala: Lessons of collaborative governance. Cambridge Scholars Publishing.

16 United Nations. (1975). UN Department of Economic and Social Affairs, Poverty, Unemployment and Development Policy : A Case Study of Selected Issues with Reference to Kerala /: Department of Economic and Social Affairs. United Nations Digital Library. Retrieved November 12, 2023, from https://bit.ly/4aEUhIl

17 The first vaccination for small pox was introduced in 1813, in 1879 vaccination was made compulsory for students, prisoners, and public servants. Anand Lali Seena, Evolution of Health System in Travancore, UNIVERSITY (2011), https://bit.ly/3vkfyqP

18 Elamon, J., Franke, R. W., & Ekbal, B. (2004). Decentralization of health services: the Kerala People's campaign. International Journal of Health Services, 34(4), 681-708.

19 https://bit.ly/48dqBQZ

20 Prajitha, K. C., Babu, V., Rahul, A., Valamparampil, M. J., Sreelakshmi, P. R., Nair, S., & Varma, R. P. (2023). Combatting emerging infectious diseases from Nipah to COVID-19 in Kerala, India. Public Health Action, 13(1), 32-36.

21 Ministry of Health and Family Welfare, GoI. (2015, February 27). Evaluation of Accredited Social Health Activists (ASHA). PIB. Retrieved November 15, 2023, from https://bit.ly/48vuTD4

22 Aayog, N. (2015). Social Sector Services Delivery: Good Practices Resource Book 2015.

23 Ibid.

RAJASTHAN RIGHT TO HEALTH ACT, 2022

The Idea, Implementation, and the Journey So Far

Chhaya Pachauli*

Photo credit: im4change.org

While health is a state subject in India and the states have the power to legislate laws guaranteeing the right to health, no state came forward to do so until Rajasthan passed an Act on the right to health, titled 'Rajasthan Right to Health Act, 2022' on March 21, 2023.

The Act is thus a significant development in the sphere of health in the country and is being hailed as a pivotal step towards ensuring universal healthcare. However, the rules of the Act are yet to be framed and with the change in the government in the state after the recent elections, the future of the Act remains uncertain.

The Journey

The Rajasthan Right to Health Act 2022 which happened as a result of a long-standing demand and sustained advocacy efforts by civil society groups, particularly Jan Swasthya Abhiyan Rajasthan (JSA Rajasthan), along with the political will exhibited by the then government, had a tumultuous journey of its own marked by two years of severe pandemic and massive protests by doctors against the Act.

> ***"The private sector hostility to the Act had begun to build up in the state"***

JSA Rajasthan played a crucial role as a pressure group advocating for the Act right from persuading political parties to committing to bringing such an Act in their 2018 state election manifestos, to consistently advocating for it and engaging with the government post elections in the drafting of the Bill. All this was done while also countering the anti-Act rhetoric publicised by the groups opposing such an initiative. It was JSA Rajasthan which provided the first blueprint of the Bill to the newly formed government by the Congress Party in 2019. The party had committed to bring the Act in their election manifesto.

Followed by the JSA blueprint and a series of deliberations, the government put up the first draft of the Bill in March 2022 in the public domain for suggestions. The draft though was a much diluted version of what JSA had proposed. The private sector hostility to the Act had begun to build up in the state right since then which later transformed into a nationwide Anti Right to Health Act movement. The Bill was first tabled in the state legislative assembly on September 21, 2022. Followed by vehement protests by various groups of private medical practitioners

** Chhaya Pachauli works with Prayas and Jan Swasthya Abhiyan in Rajasthan. She specialises in issues related to Public Health and Health Rights.*

including the Indian Medical Association (IMA), the Bill was referred to a Select Committee for reconsideration the next day. The Committee took into account the concerns raised by the agitating doctors and made multiple amendments in the Bill in their favour, which also led to more dilution in the provisions of the Bill.

The amended Bill was then tabled in the Assembly on March 21, 2023 for discussion and was passed the same day. The agitating doctors though were still not convinced and called to escalate their protest until the Bill had to be withdrawn. The initial protests by the private doctors which were marked by rallies and temporary suspension of the government's Chiranjeevi and Rajasthan Government Health Scheme (RGHS) soon turned more vigorous. A complete shutdown of private hospitals and laboratories across the state was announced, thus systematically paralysing health care services in the state. The government, however, stood its ground. Following negotiations with the agitating doctors, compromises were made and an agreement was reached on April 4, 2023 bringing things back to normal after over two weeks of vehement protests and a complete shutdown of private health services across the state.

Salient Features

The Rajasthan Right to Health Act 2022 in its preamble refers to Article 47 and Article 21 of the constitution and aims to protect and fulfill rights and equity in health and also to provide for free accessible and equal healthcare for all residents of the State with "progressive reduction in out-of-pocket expenditure in seeking, accessing or receiving healthcare." It must be noted here that although titled 'Right to Health Act', the provisions in the Act largely cater to enhancing access to healthcare and safeguarding patients' rights rather than addressing the various determinants of health. So the Act is more appropriately a Right to 'healthcare' Act rather than a 'right to health' Act.

> ***"Treatment for medical emergencies (comprising accidental emergency and snake or animal bite cases) cannot be delayed or denied by any health institution on the grounds that the patient wasn't able to make an advance payment."***

The Act is also majorly focused on strengthening the public healthcare system and hardly talks of regulating rates or standards in healthcare under the private sector. This is contrary to what was being falsely propagated by the agitating doctors. The only section in the Act which could have had some financial implication on the private healthcare sector, and which had also been a major reason of contention among the private doctors, is section 3(c) of the Act which mandates that treatment for medical emergencies (comprising accidental emergency and snake or animal bite cases) cannot be delayed or denied by any health institution on the grounds that the patient wasn't able to make an advance payment. The section was later expanded by the Select Committee to also include that if the patient is unable to pay for the emergency care so received from a private healthcare provider, the government would reimburse the payment on the patient's behalf. Apart from this, most of the other sections in the Act are directed towards revamping the public healthcare system, and others cater to safeguarding patients' rights in both public and private health institutions as also laid down in the 'Patients' Rights Charter' of the National Human Rights Commission (NHRC). Thus, the narrative publicised by the agitating doctors that the Act would financially drain private healthcare providers and sabotage private healthcare in the state was baseless.

One of the most important provisions in the Act is the right to receive all OPD and IPD services including drugs, diagnostics and emergency transport free from all public health facilities. This provision is crucial in terms of realising

> ***Some of these loopholes were inherent in the draft of the Bill, the others ensued from the amendments made by the Select Committee under pressure from the agitating doctors.***

the aim of enhancing access to treatment and reducing out-of-pocket expenditure on healthcare which the preamble of the Act outlines. The other crucial provision is the right to receive emergency treatment and care for accidental emergency and emergencies due to snake bite/animal bite without prepayment of requisite fee or police clearance (in case of a medico-legal case). This applies on both public and private health institutions. However, following the agreement between the government and the agitating doctors, this provision may now apply only on select private hospitals as discussed later.

The Act also obligates the government to set standards for healthcare delivery and make adequate budgetary allocations for health. It lays down the rights of the patients to have access to their medical records and itemised bills; to have the company of a female person if a female patient is being examined by a male practitioner; to have information about the rates and charges of the services; to be able to choose the source of obtaining medicines or tests; to be able to seek second opinion and not be denied treatment summary in case the patient leaves the medical establishment against medical advice etc.

The Act further states that the rules of the Act would specify the responsibilities and duties of the patients and the rights and responsibilities of the healthcare providers. It also obligates the government to develop and institutionalise human resource policy, set up quality audit and grievance redressal mechanisms and ensure that there is no direct or indirect denial of guaranteed public healthcare services.

The Act stipulates the constitution of two State Health Authorities (One for logistical grievances and the other for treatment protocols) and one District Health Authority at each district. These Authorities are meant to advise the government, monitor the implementation of the act, policies and programs and to also function as appellate authorities to adjudicate on the patients' grievances.

The Act also has the provision of penalty of up to twenty-five thousand rupees if anyone knowingly contravenes any provision of the Act.

Main Weaknesses

While the Act is quite comprehensive and holds some significant provisions directed towards revamping the public healthcare system, protecting patients' rights and augmenting transparency and accountability in the health systems, it leaves certain loopholes which are quite concerning. While some of these loopholes were inherent in the draft of the Bill, the others ensued from the amendments made by the Select Committee under pressure from the agitating doctors.

A major drawback in the Act is that it applies only to the residents of Rajasthan. This would mean that a large section of the vulnerable population including migrant laborers, refugees, nomads, homeless etc. who do not have proof of residence would be out of its ambit. This amounts to discrimination and violates the spirit of equity emphasised in the Act's preamble.

The other area of concern is the composition of the State and District Health Authorities listed in the Act. The members of these Authorities are solely government officials and representatives of government medical colleges and IMA. Civil society, public health experts, people's representatives, patients' groups and even the paramedics whose representation is extremely crucial to ensure that these Authorities function in a fair and impartial manner have all been kept out of it. While public health experts and public representatives were included as

members of these authorities in the initial draft of the Bill, they were eliminated by the Select Committee in the amended version succumbing to the demand of the agitating doctors to not have any non-medicos or 'outsiders' in these Authorities.

The Select Committee in its amendments also eliminated the provision of patients being able to file complaints through web portal and helpline. As per the Act, the complaints can now only be filed in writing to the concerned health facility in-charge. This would certainly deter a lot of patients from raising grievances.

Also, the Act leaves a lot to be specified in the rules and doesn't provide any clarity on the budgetary allocation, the standards of care which would be adopted and the timelines for fulfilling various obligations, thus making it seem vague and ambiguous in many places.

The Act has further been compromised by the settlement between the government and the agitating doctors. Based on the agreement, the Act would now apply only on private hospitals with more than 50 beds, private medical college hospitals, hospitals being run on PPP model and those which have availed free or subsidized land or buildings from the government. This would mean that a large number of private hospitals in the state would not fall under the ambit of the Act.

> ***"While it has generally been observed that there's a serious undermining and neglect of schemes, programmes and laws introduced by the outgoing government as the new government takes over"***

Challenges and the Way Forward

It's disappointing that even after over eight months of the passage of the Act, its rules haven't been framed as yet without which the Act only remains on paper and its implementation stays in limbo. With the change in the government in Rajasthan after the recent legislative assembly polls with BJP taking over Congress it would be interesting to see how the new government responds to the Act. While it has generally been observed that there's a serious undermining and neglect of schemes, programmes and laws introduced by the outgoing government as the new government takes over, one can only hope that this Act would be given the attention it deserves and that the rules would be framed at the earliest.

How the rules are framed would be crucial for the future of the Act. The process must widely engage experts and representatives beyond the bureaucratic and medical realm to make it more patient-centric and to align it effectively with the ground realities and practical challenges that inhibit access to healthcare and curtail patients' rights. Civil society, public health experts, people's representatives and patient groups must therefore be taken on board. A fair implementation of the Act would also require gradual but adequate enhancements in budgetary allocations and adequate deployment of human resources. It would also be crucial to generate wide awareness about the Act and its various provisions both among the health care providers and the people at large.

OPTIONS FOR THE WELFARE STATE:

Public Investment Vs Insurance-Based Models

Ashok Kumar*

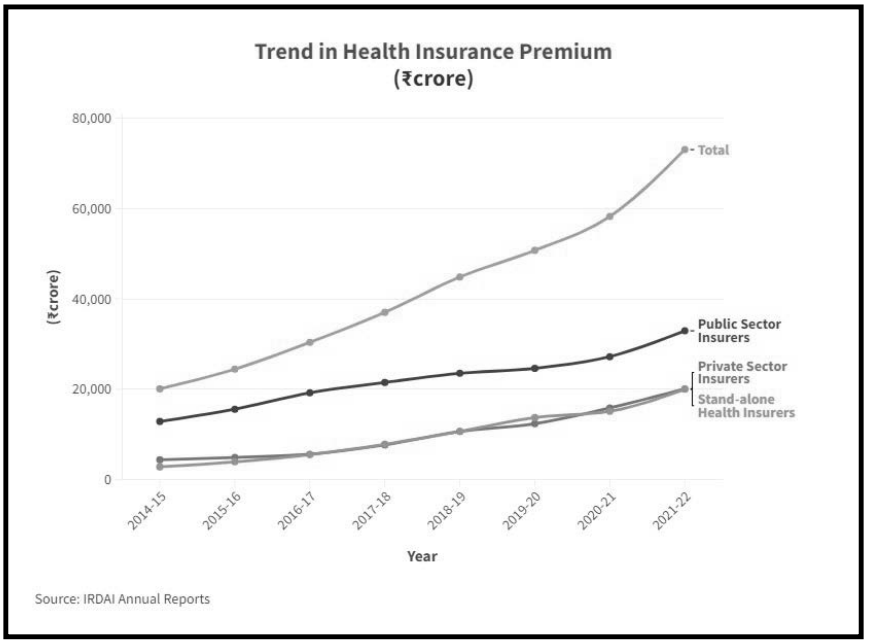
Even though the Constitution of India embodies the spirit of a welfare state committed to securing justice and wellbeing of all citizens, a specific mention of the welfare state is contained in the Directive Principles of the State Policy in Part IV (Articles 36 to 51). The Drafting Committee of the Constitution identified these as the ultimate objectives of the nation. These objectives included many things, from abolition of untouchability to removal of discrimination and legal disabilities on the women.

However, the concept of 'welfare' remains a contentious issue. Even well-known theorists of the welfare state such as T. H. Marshall, William Beveridge and Richard Titmuss avoided using the term 'welfare'. A reason behind this was that the term welfare state tends to evoke images of a mendicant clientele receiving undeserved benefits from an overbearing state. Some people believe that better ways are available to secure upliftment and well-being of the people than to hand out doles. Some others believe that providing welfare through public spending on the social sector goes a long way in bringing people out of abject poverty. But the controversy apart, the use of the term welfare has indeed become common by the supporters and opponents of the concept alike.

The duties of the Welfare State generally include devising policies and programmes ranging from securing the welfare of the poor to providing social security, social justice, infrastructure and opportunities for growth and establishing economic equality for the citizens. Providing adequate healthcare for all, from this perspective, comes across as one of the fundamental duties of the Welfare State.

The governments all over the world provide healthcare facilities to the citizens broadly in two major ways. The first is the public infrastructure-based healthcare model where the emphasis is on larger public expenditure on health infrastructure and the second is the insurance-based healthcare model where the importance is given to providing an insurance cover for the people leaving the task of building the infrastructure mainly for the private sector.

Under the public infrastructure-based healthcare model, governments lay maximum emphasis on providing medical treatment to the citizens either free of cost or at affordable



**Ashok Kumar is an Assistant Editor at im4change.org*

Photo credit: im4change.org

prices. The task here requires building of new hospitals and primary health centres, recruiting human resources like doctors, nurses and paramedics on government payrolls and providing treatments to one and all at affordable prices. On the other hand, under an insurance-based healthcare model, governments provide insurance of a specific price range to a particular section of society, mainly those living below the poverty line and the non-taxpayers.

The insurance-based healthcare model comes across as something quite easily done by the governments without committing humongous resources which are required for building a public healthcare system. No wonder, the popularity of the insurance-based model has gone up in the last few decades. Many state governments and the Central Government have been adopting the insurance-based healthcare models and touting them as the citizens' right to health without doing much by way of policies or programmes.

This flies in the face of the fact that the public health infrastructure in all such states could be crumbling, while posing tremendous difficulties for the common citizens in getting treatment. Since the budget for the health sector is highly limited, the insurance based healthcare model could lead to further deterioration of the public health system if we are not careful.

> ***"Earlier, India's healthcare system was mainly based on public infrastructure which is now also adopting a public-funded insurance model"***

Are Governments Hiding Their Failures?

When the colonial British left, about 70 percent Indians were mired in deep poverty. The first few governments had to face immense challenges on many fronts where building of systems was required from scratch. Providing healthcare for the poor and deprived sections of this vast country was one such challenge. The government built new hospitals, medical centres and tried to cover villages to cities under a rudimentary public health system. This was the time when deadly diseases like smallpox, polio and leprosy which are curable today, wiped out millions of people in short spans of time. In the first few decades after Independence, multispecialty Hospital like AIIMS were also built to provide treatment for difficult diseases at affordable prices.

The infrastructure built in the first few decades was nowhere near adequate but some of the systems built then, such as district hospitals in urban areas and primary health centres in rural areas, are still visible today. These systems were not expanded over time, partly because India was spending a much smaller portion of its budget on public health than

required. India has traveled a journey of 75 years after independence and it is a good time to evaluate our successes and failures in providing a decent healthcare system for our citizens.

For some time now, particularly since the liberalisation of the economy in the early nineties, a shift became visible in the healthcare sector of India. More and more private hospitals started coming up for those who could afford them. These provided world-class medical facilities even though these services came at exorbitant prices. Earlier, India's healthcare system was mainly based on public infrastructure which is now also adopting a public-funded insurance model[1]. One reason behind its adoption is that the healthcare model based on public infrastructure is not meeting the needs of the citizens. We will look at the advantages and disadvantages of public funded insurance model further. But let us also check as to why the public health infrastructure is crumbling.

One of the obvious reasons behind this is underspending of public money and resources on this sector. For the year 2019-20, Government Health Expenditure (GHE) was Rs. 2,71,544 crores which is 1.35% of GDP[2] (As per the National Health Policy (NHP) 2017, the Government aims to increase the health expenditure up to 2.5 % of the GDP by the year 2025).[3]

As author P. Sainath writes in his book- 'Everybody Loves a Good Drought' that "Never in history have government spent more than 1.8 per cent of GDP on health."

Neighboring country China was also facing comparable challenges of high population and impoverishment While it also achieved Independence around the same time as India (in 1949). If we look at the data of the last two decades, China's current health expenditure as a percentage of GDP has been higher than India[4]. From 2012 to 2022 its health expenditure has been between 5.2% and 7.05%. Similar trends emerge when compared with Sri Lanka, United Kingdom and United states.

If we look at the figures of the year 2019-20, United states had spent 18.82% of GDP as current health expenditure and United Kingdom had spent 11.8% of its GDP[5].

The result of low expenditure was that public infrastructure could not be built at the desired speed. As a result, India's public health infrastructure remains woefully inadequate today. For example, in terms of hospital beds, India has 0.5 hospital beds[6] (In 2017) per 1,000 population, compared to 4.2 beds in Sri Lanka, 2.9 in the US, and about 4.3 beds in China. Similarly, in the case of primary health workers, the WHO recommends one doctor per 1,000 population and one nurse per 300 population, whereas India is functioning with only one doctor for every 1,511 people and one nurse for every 670 people[7].

> ***"No wonder, the popularity of the insurance-based model has gone up in the last few decades."***

Poor people suffer the worst effects of weak public health infrastructure. In such a situation where the public infrastructure is going to stay below expectations for the foreseeable future, the public funded insurance model has come as a boon for people from the weaker socio-economic background struggling to meet their ends. In such a situation it cannot be rejected even though it comes at the cost of taking healthcare to the doorsteps of common people.

In the light of this, let us evaluate the existing challenges associated with this model:

1. Change in the Nature of the State

In the welfare state, it is the duty of the state to provide better healthcare to the citizens. Adoption of these insurance schemes as healthcare models may lead to absolving the state of its basic duties which may encourage the deterioration of the existing public health systems.

The central government and many state governments are promoting health insurance schemes. The central government runs the PM-JAY scheme for health insurance. As per the estimates of Budget 2023-24, about 8 percent of the total budget of the Ministry of Family and Welfare has been allocated for this scheme[8]. Similarly, the Rajasthan government has allocated Rs 5,186.45 crore for the Medical and Health Department in the budget 2023-24[9] around 40 per cent of which has been reserved for Chiranjeevi Insurance Scheme. In the case of Kerala's public health sector about 20 per cent is spent on insurance schemes called Karunya Arogya Suraksha Padhathi[10].

There are also significant variations between and within states in terms of public health infrastructure, according to the Rural Health Statistics

> ***"The result of low expenditure was that public infrastructure could not be built at the desired speed."***

2020-21 due to which many people are not able to avail the benefits of public healthcare. One reasonable way to address the shortcomings of India's healthcare systems is to use the publicly funded insurance schemes through the private hospitals while we improve the deficiencies in public health infrastructure.

When we invite private players in the healthcare sector, it becomes mandatory to work on strengthening our system of regulation of private hospitals. It is common knowledge that some private hospitals are collecting huge amounts of money from governments and insurance agencies by conducting unnecessary medical tests and by making false bills[11]. An adequate mechanism of regulation and monitoring will ensure that public money is not wasted in the name of public welfare.

2. Need to Work on Insurance Coverage

It is also noteworthy that the insurance coverage of common people in India is low and not uniform across states and union territories. Nearly 400 million individuals in India have zero access to health insurance[12]. According to the National Family Health Survey (NFHS-5), 30% of women in the age group of 15-49 do not have any kind of insurance and there is a huge gender gap in health spending in India.[13] In such a situation, the introduction of a publicly funded health insurance scheme will increase the chances of women

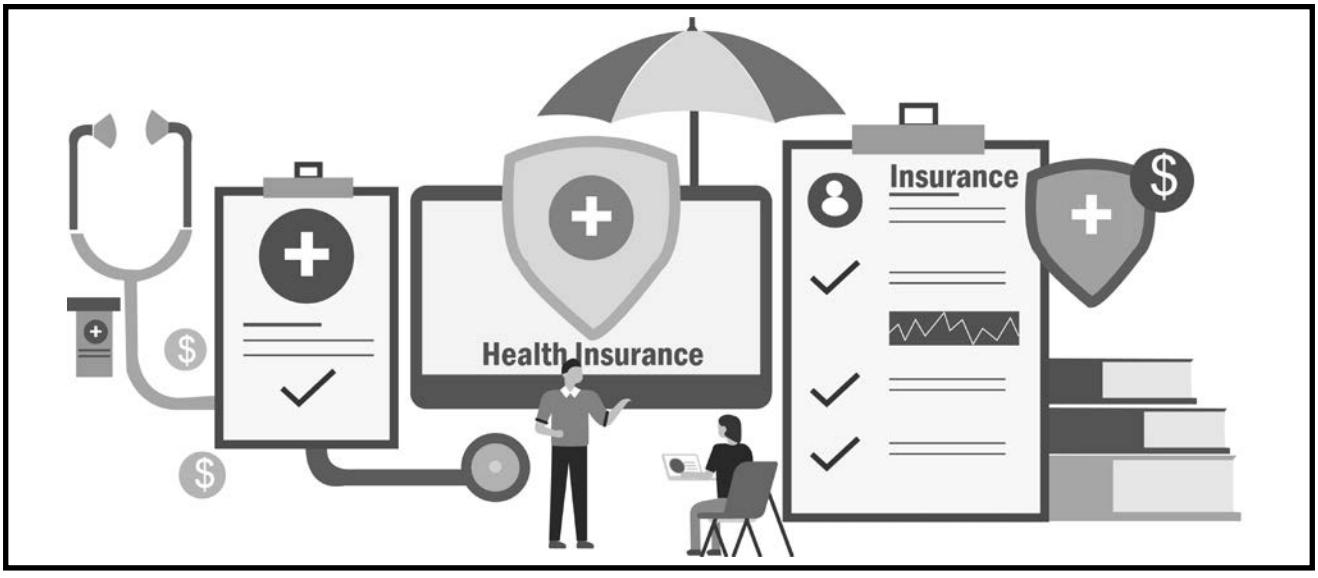


Photo credit: Freepik

getting better healthcare. There is also a variation among states in terms of health insurance coverage. While in Rajasthan the percentage of such families in which at least one member is insured is 88%, in the case of the state of Bihar this figure is 17%[14].

3. Rural-Urban Divide

The divide between rural and urban regions in terms of healthcare facilities is a reality in India. A study titled Bharat Health Index (BHI) 2023 stated that only 25 per cent[15] of the semi-rural population in India have access to modern healthcare within their localities. While, only 28 per cent of the country's population lives in urban areas, they continue to have access to two-thirds of the total hospital beds. While 72 percent of the population who live in rural India are left with access to just one-third of hospital beds.

Along with infrastructure, rural areas are also deficient in terms of human resources. Nearly 21.8 percent of doctors' posts in PHCs in rural areas are vacant. Similarly, Community Health Centres provide specialised medical care to surgeons. According to the Rural Health Statistics 2020-21 out of the sanctioned posts,72.3% of Surgeons, 64.2% of Obstetricians & Gynecologists, 69.2% of physicians and 67.1% of pediatricians are vacant[16].

To ensure better economic health of the common people, it is important that people get health services at affordable prices and the out-of-pocket expenditure remains low. Insurance based healthcare model can be helpful in this. The penetration of the insurance-based models needs to reach the length and breadth of India while simultaneously improving the monitoring and regulation of private hospitals. However, it must be kept in mind that the two models cannot be seen as complete replacement of one another. The real challenge, therefore, is to extend the benefits of the publicly funded insurance schemes to the common citizens while we continue to work towards improving public health infrastructure. There is no rule that the two systems cannot coexist. This is particularly so because becoming completely dependent on the insurance based model will increase the arbitrariness of the private sector and compromise the country's ability to deal with pandemics and health emergencies.

Endnotes

1 Dubey, S., Deshpande, S., Krishna, L., & Zadey, S. (2023). Evolution of Government-funded health insurance for universal health coverage in India. The Lancet Regional Health-Southeast Asia, 13.

2 National Health Accounts Estimates 2019-20.

3 Ibid.

4 The World Bank's Data Bank.

5 Ibid.

6 The World Bank. (2023). The World Bank Data. The World Bank. Retrieved November 12, 2023, from https://bit.ly/3vkg8Vx

7 Kwatra, N., & Imad, S. (2022). Covid-19: Trauma from India's second wave may have lingering effects on its frontline workers. Accessed February, 12 November, 2023 on https://bit.ly/48ylx9N.

8 Union Budget 2023-2024, Budget at a Glance.

9 Rajasthan Budget 2023-2024.

10 Kerala Budget 2023-2024.

11 Kumar, V. (2022, Aug 6). 26% fake Ayushman Bharat scheme claims from Punjab, Haryana. Times of India. Retrieved October 15, 2023, from https://bit.ly/3tztOeM

12 Health Insurance for India's Missing Middle, Report by NITI Aayog.

13 Laccourreye, O., & Maisonneuve, H. (2019). French scientific medical journals confronted by developments in medical writing and the transformation of the medical press. European Annals of Otorhinolaryngology, Head and Neck Diseases, 136(6), 475-480.

14 National Family Health Survey (NFHS-5), 2019-21.

15 Business Standard. (2023, Aug 11). Only 25% of semi-rural, rural population has health facilities within reach. Business Standard. Retrieved November 11, 2023, from https://bit.ly/3vi5ped

16 Rural Health Statistics 2021-22.

MOTHER OF ALL DISCRIMINATIONS:

Tackling Denial of Healthcare to India's Women

Mohd Aasif*

Women's health is a crucial component in the development of a nation. A woman's poor health has a direct bearing on the health of her children, from infancy to adulthood, and indeed on her entire family as a unit. It is well-established today that if a woman is healthy, and is in a positive frame of mind, the whole family benefits. Can there be a simpler justification for expanding gender representation in the larger society and the political economy of the country and its workforce?

Article 25 of the Universal Declaration of Human Rights endorses health as a basic human right. It lays emphasis on the issues related to the health of women and children. "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family."[1] Yet, gender discrimination, at all levels, is a sad reality of our world irrespective of demography and culture even 75 years after the first publication of the Universal Declaration in 1948. It seems we are not even moving in the right direction of bridging the gender gap, particularly in areas like law and justice. The way things are going, it will take 286 years to close gender gaps in legal protection and remove discriminatory laws.[2]

In India, gender discrimination is attributed to factors like poverty, lack of education, awareness, and deep-rooted feudal-patriarchal mindset in our society. Some of our regressive social customs, beliefs and practices also play a role in the suppression of women.

According to United Nations' Sustainable Development Goal number 5 (SDG-5) Gender equality, in 2022, India scored 60.32 points on a 0-100 scale. Although India's ranking sees an improvement over the years, it lags behind its South Asian neighbours such as Nepal (66.18) and Sri Lanka (70.03)[3]. The index score signifies a country's position between the worst and the best or target outcomes on a scale of 0-100.

Discrimination occurs at all levels such as food intake, early age or child marriage, lack of access to educational institutions, and unequal pay at work. This discrimination further expands to the healthcare due to women's lack of influence in decision-making in the family. As an outcome, India is the only large country globally, where more girls die than boys. Girls are also more likely to drop out of school[4] or die during pregnancy or child birth.

> ***"Gender discrimination, at all levels, is a sad reality of our world irrespective of demography and culture even 75 years after the first publication of the Universal Declaration in 1948."***

As per WHO, "Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes"[5].

Anaemia is one of the most prevalent signs of malnutrition among women of all ages in India and one of the reasons for poor health that leads to complications of pregnancy. As per National Family Survey and Health (NFHS-5) women are two times more susceptible

* *Mohd Aasif is a Research Executive at Common Cause.*

Photo credit: im4change.org

to any type of anaemia as against their male counterparts. Unfortunately, India sees a rise in anaemic women in NFHS-5 as compared to NFHS-4. Women with anaemia and high Hb concentrations in early pregnancy are associated with an increased risk of developing miscarriage[6] and risk of maternal and foetal morbidity and mortality[7].

A study on Perinatal iron deficiency and neurocognitive development, shows that an anaemic mother gives birth to an unhealthy baby. Maternal anaemia also increases the risk of low birth weight, either due to premature birth or foetal growth restriction, which is associated with delayed neurocognitive development and even psychiatric illness. As iron deficiency inhibits learning as well as motor and emotional development, individuals exposed to perinatal iron deficiency are at high risk for failing to reach educational milestones later in life[8].

In 2020, the birth rate of India has been estimated at 19.5, whereas the death rate has been estimated at 6.0, according to the sample registration system (SRS) Bulletin May, 2022. The estimate of Infant Mortality rate (IMR) for the year 2020 is 28 deaths per thousand live births. In the same year, the maximum IMR has been reported for Madhya Pradesh (43) and the minimum for Mizoram (3).

> ***"The country has indeed made some steady progress in some areas of gender equality but the fact remains that our challenges are even bigger than our achievements."***

IMR is widely accepted as a crude indicator of the overall health status of a country or a region. Although India has achieved its IMR target, it still needs to achieve its Neonatal Mortality Rate (NMR) and Under 5 Mortality Rate (U5MR) which currently is 22 and 35 respectively.[9]

The major causes of child mortality in India as per the SRS reports (2010-13) are: Prematurity & low birth weight (29.8%), Pneumonia (17.1%), Diarrheal diseases (8.6%), Other non-communicable diseases (8.3%), Birth asphyxia & birth trauma (8.2%), Injuries (4.6%), Congenital anomalies (4.4%), Ill-defined or cause unknown (4.4%), Acute bacterial sepsis and severe infections (3.6%), Fever of unknown origin (2.5%), and all other remaining causes (8.4%)[10].

Despite all the hurdles and setbacks, India, as a developing country has made some progress towards its goal of gender equality, and women's good health and well-being. The country has indeed made some steady progress in some areas of gender equality but the fact remains that our challenges are even bigger than our achievements. For instance, governments at the Centre and in several states have come up with legislations and schemes to safeguard the women's rights to health. Maternal Mortality Ratio and Maternal Mortality Rate are the most concerning events in the lives of women. Reducing

these rates is a daunting task given the condition of health infrastructure of the developing nations.

Existing Legal Provisions for Women's Health

Health as a fundamental human right for women has travelled a long way. Starting from the Maternity Benefit Act to the Mental Health and Surrogacy bill (pending in parliament), every legislation has tried to address the needs of the hour. Several welfare schemes have been launched for the benefit of the mother and child at the central and state levels. A glimpse of the existing legal provisions on women's health is as follows:

Maternity Benefit Act, 1961 and Maternity Benefit (Amendment) Act, 2017

The Maternity Benefit Act (MBA) regulates the employment of women in certain establishments for certain periods before and after childbirth and provides maternity benefits along with other benefits. These Acts entitle a mother to paid leaves for a period of up to 26 weeks. In case a woman is deprived of her maternity benefits or medical bonus or both, the Act gives her the right to appeal in front of the prescribed authority. It gives her a window of sixty days starting from the date on which the order of such deprivation is communicated to her. It also prescribes the punishment for such employers who contravene the provisions.

Medical Termination of Pregnancy Act, 1971 and Medical Termination of Pregnancy (Amendment) Act, 2021

The Bill, at the stage of deliberations, invited controversy and started a debate on pro-life or pro-choice stands on the matter of termination of pregnancy. The act provides the legal framework for making medical termination of pregnancies by RMPs and for matters connected with that. The amendment to the principal act increases the time limit for accessing safe and legal abortion series from 20 to 24 weeks (of gestation) in certain circumstances. It removes the limit in case of foetal abnormalities.

The amendment to the principal act has increased the upper gestation limit from 20 to 24 weeks for special categories of women, including survivors of rape, victims of incest and other vulnerable women like differently abled and minors. It also extended MTP services, under the clause of failure of contraceptive, to unmarried women to provide access to safe abortion based on a woman's choice, irrespective of marital status[11].

National Food Security Act, 2013

Food security for an individual ensures her right to life pragmatically. National Food Security Act, 2003 provides that all people at all times get access to the basic food for their active and healthy life. Section 4 of the Act deals with matters concerning pregnant women and lactating mothers including (a) meal, free of charge, during pregnancy and six months after childbirth, through the local Anganwadi; and (b) maternity benefit of not less than rupees six thousand.

The Mental Healthcare Act, 2017

The Act provides for the protection and promotion of the rights of persons with mental illness during the delivery of healthcare in institutions and in the community. The act recognises that every person with mental illness shall have a right to live with dignity. Every person with mental illness shall be protected from cruel, inhuman or degrading treatment in any

> ***"While India's MMR further declined to 113 in 2016-18, It was the lowest (43) for Kerala for the same period, and the highest (215) for Assam."***

mental health establishment and shall have adequate provisions for wholesome food, sanitation, space and access to articles of personal hygiene, in particular, women's personal hygiene be adequately addressed by providing access to items that may be required during menstruation.

Drawbacks and Way Ahead

While the statutes mentioned above provide a good cover to women in distress and health emergencies, their implementation is patchy and inadequate to say the least. Besides, inadequate allocation of resources to healthcare infrastructure and services continues to be a cause for concern. The health budget of the Union Government has seen only a marginal rise in the past five years, from 1.2% of its GDP in 2014-15 to 1.8% in 2020-21. The share of the budget for the National Health Mission (NHM) in the total health budget of the Union Government has also declined from 60.25% in 2018-19 to 52.12% in 2020-21, adversely affecting the quality of healthcare including reproductive healthcare services[12].

Another cause for concern is that the benefits of the Maternity Benefit Act are limited to the permanent or regular employees of the establishments in the organised sectors. Informal employees or contractual employees of the organised sector as well as unorganised sector remain outside the ambit of the Act[13].

> ***"The status of healthcare has improved not only because of enhancement in services but also due to better primary education and a relative stability of the economy."***

Implementation of maternity oriented schemes also remains a challenge for the state governments. A study by CEDAW (Convention on Elimination of all forms of Discrimination against Women) notes that the Matru Vandana Yojana (Maternity Benefit Program), 2017 —meant to support lactating mothers and pregnant women by compensating them for loss of wages during their pregnancy — has been able to reach less than a third of the eligible beneficiaries[14]. Further, the benefit is restricted to only the living child, thereby, excluding a large number of pregnant women in the country.[15]

Government bodies need to constantly monitor such pitfalls and work on them while learning from our mistakes and good practices. Further, eligibility conditions stipulated for availing the benefits of the Matru Vandana Yojana (reproductive health services) should also be made easier and more approachable.

Although India has performed well in reducing the Maternal Mortality Ratio and IMR over the years. Maternal Mortality Ratio (MMR) in India was exceptionally high in 1990 with 556 women dying during child birth per one lakh live births against a global MMR of 385. In the next two decades, the MMR in the country has declined to 167 (2011-13) against a global MMR of 216 (2015), according to the Ministry of Health and Family Welfare. Yet, A wide gap among the states of India continues to be a cause for concern. While India's MMR further declined to 113 in 2016-18, It was the lowest (43) for Kerala for the same period, and the highest (215) for Assam.

It is heartening to see a positive change in at least some of the health indicators of SDGs in India even though we still have to cover a lot of ground. The status of healthcare has improved not only because of enhancement in services but also due to better primary education and a relative stability of the economy. On the flip side, the situation continues to be dismal in the more backward states of Northern and Eastern India and even worsening in some places. For a quantum change in the status of women and their healthcare, however, the

ratio of female-to-male labour force participation rate and seats held by women in national parliament and state assemblies also need to show a perceptible improvement. India's backward states also need to learn from the experiences of our own better performing states which have shown remarkable success in areas of women's health and overall wellbeing.

Endnotes

1. UNSD. Department of Economic and Social Affairs Statistics. UNSD. Retrieved Oct 21, 2023, from https://bit.ly/3S1aIYc
2. Hasan, Z. (2023). Gender Inequality in South Asia: Tracing Impediments to SDG 5 of UN Sustainable Development Goals.
3. UNICEF. Gender equality. unicef for every child. Retrieved November 15, 2023, from https://bit.ly/4aHOnWU
4. GoI. (2022, November). Census Of India. Census Digital Library. Retrieved November 21, 2023, from https://bit.ly/48CcTad
5. Díaz-López, A., Ribot, B., Basora, J., & Arija, V. (2021). High and low haemoglobin levels in early pregnancy are associated to a higher risk of miscarriage: a population-based cohort study. Nutrients, 13(5), 1578.
6. Shah, T., Khaskheli, M. S., Ansari, S., Lakhan, H., Shaikh, F., Zardari, A. A., ... & Shar, A. H. (2022). Gestational Anemia and its effects on neonatal outcome, in the population of Hyderabad, Sindh, Pakistan. Saudi journal of biological sciences, 29(1), 83-87.
7. Radlowski, E. C., & Johnson, R. W. (2013). Perinatal iron deficiency and neurocognitive development. Frontiers in human neuroscience, 7, 585.
8. GoI. (2022, May 25). India - SAMPLE REGISTRATION SYSTEM (SRS)-BULLETIN 2020 VOLUME 55-I. Census of India. Retrieved November 12, 2023, from https://bit.ly/3NNTmf4
9. GoI. National Health Mission. NHM. Retrieved November 11, 2023, from https://bit.ly/48bGBmC
10. CHAKRABARTY, S. (2023, October 15). Why are abortion laws in the spotlight again? The Hindu. Retrieved November 15, 2023, from https://bit.ly/41OxdD5
11. NHRC. (2021). Women's Rights in India. National Human Rights Commission. Retrieved October 25, 2023, from https://bit.ly/41Fcfq4
12. Lal, N. (2016, August 21). The New Maternity Benefits Act Disregards Women in the Unorganised Sector. The Wire. Retrieved November 21, 2023, from https://bit.ly/3RJ1JJP
13. Chandra, J. (2019, November 19). Maternity scheme reaches only one-third of beneficiaries. The Hindu. Retrieved December 1, 2023, from https://bit.ly/4aCNpLH
14. Supra note 11.
15. Supra note 11.
16. Supra note 4.

COMMON CAUSE

DIRECTOR'S ANNUAL REPORT 2023

2023 has been a steady and productive year for Common Cause. Several of our PILs were taken up during the year with judgment being reserved by a Constitutional Bench in the Electoral Bonds case in which Common Cause is a co-petitioner. The organisation brought out its sixth flagship study, the Status of Policing in India Report 2023 on Surveillance and the Question of Privacy and started work on the next report dedicated to the use of force, violence and torture by the police, to be released in 2024. We also continued our advocacy around the rule of law and governance reforms. As part of engagement with students and young people, we helped in conceptualising and introducing a full-fledged academic course on Development and the Rule of Law at the Shiv Nadar University recognised as an institution of Eminence.

Advocacy and Research Initiatives:

(a) Police Reforms

Status of Policing in India Report (SPIR) 2024

The Status of Policing in India Report (SPIR), a policy-oriented study of law enforcement in India, which has become an important part of the organisation's portfolio of activities since 2018, is continuing despite all odds. Our main philanthropic partner, the Tata Trusts, discontinued support beyond the first four reports ending in 2021 but we were able to sustain the endeavour, thanks to continuation of project grants from the Lal Family Foundation. Many other philanthropies have admired the reports and shown deep interest in the organisation's police reforms programme but their praise is yet to get translated into tangible grants.

However, it is gratifying to note that the year 2024 will see the sixth comprehensive and nationwide SPIR on policing, the use of violence and custodial torture in India. Like all our earlier reports, this too will be first study of its kind in India on the subject. The main aim is to examine the nature, causes of and factors that contribute to the perpetuation of violence by the police in India. The term violence is used to clarify that the report's focus is distinct from the lawful use of force by police. While each of the previous SPIRs addresses police violence in some way or the other, this report seeks to offer analysis as to why violence is normalised in police practice, in spite of legal safeguards and institutional mechanisms in place to prevent it.

As part of this study, elaborate surveys are being conducted with police personnel across the country on their views, experience and attitudes towards custodial violence. The team is also analysing the existing official data and conducting in-depth interviews with key stakeholders of custodial violence including doctors and magistrates, also a first of its kind. The surveys for the SPIR series are being steered by the Lokniti network of the Centre for the Study of Developing Societies (CSDS) our long-term academic partners. The earlier SPIR studies have covered citizens' trust/ satisfaction in the police, police attitudes, working conditions, policing during the pandemic/ insurgency and digital surveillance by the state and the police in India.

Translation of the SPIR series into Hindi

A modest effort to translate the SPIR studies into Hindi started in the beginning of this year and is continuing. So far, about two third of the translation work has been completed for the reports on citizens' trust and

satisfaction in the police, a Study of Performances and Perceptions (SPIR 2018), and Policing in the Covid-19 Pandemic (SPIR 2020-21, Volume1). The reports will be released sometime in 2024. We hope that this will be a precursor to their translations in other major Indian languages.

(b) India Justice Report 2024

Common Cause continues to bring out the India justice Report (IJR) along with its partners, Commonwealth Human Rights Initiative (CHRI), Centre for Social Justice, Daksha, TISS-Prayas, and Vidhi Centre for Legal Policy, under the chief editorship of Ms Maja Daruwala. The IJR uses the official statistics, compiled and brought out by the government agencies, to rank the capacity of the justice system operating in various states of India. The IJR tracks improvements and deficits in each Indian state's capacity to deliver justice based on quantitative measurements of budgets, human resources, infrastructure, workload and diversity across the four pillars of the justice system, i.e., police, prisons, judiciary, and legal aid.

IMORTANT EVENTS

SPIR 2023 Launch – India Habitat Centre, New Delhi, March 21, 2023

Common Cause in collaboration with Lokniti Programme at the Centre for the Study of Developing Societies (CSDS) released the Status of Policing in India Report 2023: Surveillance and the Question of Privacy (SPIR 2023) on March 31, 2023.

Radhika Jha, the lead researcher of SPIR, began the event with a brief introduction of the survey and the research followed by Dr Sanjay Kumar, Co-Director of Lokniti programme of CSDS, talking about the methodology used in SPIR 2023. Dr Vipul Mudgal, the Director of Common Cause, explained how SPIR 2023 tried to make sense of public attitudes and the use of surveillance technologies by the government and police. Justice Jasti Chelameswar, former Judge, Supreme Court of India who was part of the nine-judge bench that recognised Right to Privacy gave the Keynote Address and made a strong pitch for enacting a law to regulate data collection.

The well-attended event also featured a panel discussion on rethinking surveillance which was moderated by transparency and accountability activist Ms Anjali Bhardwaj. The speakers were Mr Prakash Singh, former DGP of Uttar Pradesh, Assam, BSF, and Chairman, Indian Police Foundation; Prof. Ruchi Sinha, Associate Professor of Criminology at the Tata Institute of Social Sciences, Mumbai; and Mr Apar Gupta, Executive Director, Internet Freedom Foundation. The speakers also took questions from the audience.

IJR 2023 Launch – India International Centre, New Delhi, April 04, 2023

Common Cause in collaboration with Centre for Social Justice, Commonwealth Human Rights Initiative, DAKSH, TISS-Prayas and Vidhi Centre for Legal Policy released the India Justice Report 2023 (IJR 2023) on April 04, 2023. Introducing the report, the Chief Editor of India Justice Report, Ms Maja Daruwala, pointed out how India still has a long way to go in achieving access to justice for everyone and that making justice affordable, efficient and accessible.

The keynote address by Dr Bibek Debroy, Chairman of the Prime Minister's Economic Advisory Council, was about access to justice and highlighted issues that may be addressed in the future editions of IJR. Former Supreme Court Judge, Justice (Retd) Madan Lokur also joined virtually and shared his views on the improvement made by the states. Speaking on the occasion, Common Cause Director, Dr Vipul Mudgal emphasised that the police fell short of expectations because of miserable allocations for the training of the staff. The key findings of the report were later highlighted and discussed.

(c) Seminars/Webinars and Conferences:

Justice Capacity in Karnataka: A Data-Driven Perspective - January 21, 2023

Ms Radhika Jha from Common Cause participated as a speaker in a seminar on 'Justice Capacity in Karnataka: A Data- Driven Perspective', organised by the India Justice Report team, in collaboration with the Vidhi Centre for Legal Policy and Deccan Herald, in Bangalore on January 21, 2023. Mr TM Vijay Bhasker, Chairman, Administrative Reforms Commission gave the inaugural address, followed by expert panels that discussed the capacity of justice delivery systems in Karnataka across the four pillars of police, prisons, judiciary and legal aid. The panels featured representatives from CHRI, Daksh, Dhwani Legal Trust, The Justice Initiative and Vidhi Centre for Legal Policy, along with representatives from government agencies such as KLSLA, prisons and judiciary.

139th National RTI Webinar - February 19, 2023

Common Cause Director participated as a keynote speaker at a webinar jointly organised by the RTI Revolutionary Group of India, National Federation of Societies for Fast Justice (NFSFFJ) and Mission Free Legal Education to discuss "While most Indians are becoming poorer, how MPs and MLAs accumulate huge wealth within a few years of being elected". The other notable speakers present included Dr. Jagdeep Chhokar of the Association for Democratic Reforms (ADR), Dr Hari Desai of IJC, former CIC Mr Shailesh Gandhi, former and current SICs of MP, Mr Aatmdeep and Mr Rahul Singh, along with Mr Pravin Patel, General Secretary NFSFFJ.

CJAR & LiveLaw Seminar on Judicial Appointments & Reforms - February 18, 2023

Campaign for Judicial Accountability and Reforms with media partner LiveLaw organised a seminar and brought together Former Chief Justice of India, Supreme Court and High Court Judges, academics, lawyers and experts from the field to talk about Judicial Appointments and Reforms. The event featured three sessions on: Executive Interference in Judicial Appointments, building a Transparent and Accountable Collegium and Principles and Framework for Judicial Appointments, which were followed by a round of Q & A. Common Cause was represented by Ms Radhika Jha, Ms Anshi Beohar, and Dr Vipul Mudgal.

International Seminar on Media and Development: Retrospect and Prospect, Manipal University, Jaipur - May 12, 2023

Director Common Cause Dr Vipul Mudgal joined Ms Lyndee Prickitt, the Director of Village Square and Prof Sanjeev Bhanawat, formerly of Rajasthan University at an International Seminar on Media and Development: Retrospect and Prospect held at Manipal University, Jaipur, on May 12, 2023. The issued covered at the seminar included the significance of the Sustainable Development Goals (SDGs), the function of alternative media, and the role of the media in connection to rural development. The Chief Guest at the event was Prof (Dr) Ram Mohan Pathak, former Vice Chancellor, Nehru Gram Bharti, Prayagraj.

In his keynote address, Dr Mudgal highlighting the dilemmas of rural India facing multiple crises such as lack of investment, low productivity, agrarian distress, and dismal social indicators. He introduced im4change.org, a repository for media persons on issues affecting marginalised communities in rural India. The event concluded with a question & answer session.

India Justice Report discussion by Citizens' Forum India - Sept 16, 2023

The Citizens' Forum India organised a virtual discussion on India Justice Report (IJR) and invited two of its authors, Radhika Jha of Common Cause and Nayanika Singhal of India Justice Report to speak. Ms. Radhika Jha elaborated on the role of the police, one of the four pillars of the justice system. She spoke about the low expenditure on police training, slow filling of vacancies, dismal diversity in the police force and other indicators used in the report.

(d) Meetings with

Academics/Faculties and Experts: Run up to SPIR 2024

The Common Cause team reached out to various reputed national and international experts and academics in the field of criminology and policing for discussions around the ongoing SPIR and other research projects. Individual meetings were held with Prof Beatrice Jauregui from the University of Toronto, Prof Andrew Ferguson from Washington University, Prof Arvind Verma, from Pennsylvania University and Prof Shishir Jha, Dr Kalindi Kokal and Prof Parthasarthy from the Ashok Desai Centre for Policy Studies, IIT Mumbai.

Mineral Inheritors Rights Association (MIRA) meeting - August 28, 2023

Common Cause team participated in a meeting of the Mineral Inheritors Rights Association (MIRA) on August 28, 2023. The meeting started with various stakeholders from the mining-affected regions raising their issues and MIRA members attempting to resolve them. Following this, Vaishnavi Varadarajan of International Accountability Project (IAP) delivered a talk on the Early Warning System (EWS), the first web-based tool to organise, summarise and standardise projects at 13 development finance institutions and extending support to people affected by the proposed mining project.

16th National Conference of the Association for Democratic Reforms (ADR) Gokhle Institute, Pune, July 15-16, 2023

The Association for Democratic Reforms (ADR) and the Maharashtra Election Watch (MEW) organised the 16th Annual National Conference at the Gokhale Institute of Politics and Economics (GIPE), Pune, on July 15 and 16, 2023. Released at the event were the 'Analysis of Sitting MLAs from 28 State Assemblies and 2 Union Territories of India 2023 Report' and the ADR's Annual Report for FY 2022-23. The two-day event started with a focus on the urgent requirement of addressing the most pressing problems in the electoral and political arena. Keynote speakers at the event included Justice (Retd) Narendra Chapalgaonkar, former CEC of India Dr Nasim Zaidi while Dr Vipul Mudgal, Director Common Cause and Trustee, ADR, participated in a panel discussion on decoding the controversial electoral bonds scheme which the two organisations have challenged in the court.

26th Meeting of Chemical Division Council, Bureau of Indian Standards - February 15, 2023:

Common Cause's Swapna Jha represented the organisation in the 26th Annual meeting of the Chemical Division Council, Bureau of Indian Standards on February 15, 2023.

Lecture on Indian Legal System and Access to Justice - August 29, 2023

Radhika Jha, Lead (Rule of Law Programme) at Common Cause was invited to deliver a guest lecture to the law students from the National Law School of India University (NLSIU), Bangalore, on Police violence and discrimination in India on August 29, 2023. The lecture focused on findings of the SPIR series that highlighted the systemic biases within the police in India. Simultaneously, the students were introduced to survey methodology as a research tool for studying the Indian criminal justice system. It was part of an elective course titled 'Indian Legal System and Access to Justice'.

Police Reforms Day, 2023 - Mumbai, September 22, 2023

Common Cause joined the Indian Police Foundation (IPF) and Public Concern for Governance Trust (PCGT) to observe the Police Reforms Day, 2023, at a well-attended function that was held at the Hall of Culture, Nehru Centre, Mumbai. Hon'ble Justice Gautam Shirish Patel, a sitting Judge of the Bombay High Court, was the chief guest of the event. Speaking on behalf of Common Cause, a co-organiser of the function, its Director, Dr Vipul Mudgal highlighted the civil society's unique perspective to policing. He said the civil

society wants an effective and accountable policing where the balance of power is not tilted in favour of the rich and the powerful. Their real obligation, therefore, is not only to control crime and maintain peace but to do so while treating people with dignity and respect, he said. He said that there must be consequences for violating the law even for the police. When someone is tortured or killed in custody, or in a fake encounter, the guilty must face the punishment for murder. We understand that politicians are also to blame but most custodial killing do not happen because of the politician – they happen because the officers responsible know that they can escape the consequences. And, that is why, we want a fine balance between effective & accountable policing, he said.

One of the highlights of the day was to confer a Lifetime Achievement Honour on a highly decorated former police officer Julio F. Ribeiro. Mr Ribeiro, 94, served as Mumbai Commissioner of Police and Director General of CRPF. Speaking on the relationship between police and politicians Mr Ribeiro candidly spoke in favour of operational independence of the force without undue interference of the political executive. The other notable speakers included the IPF's Chairman Emeritus Mr Prakash Singh, Acting Chairman, Mr M L Kumawat and its President Mr N Ramachandran.

India's Justice System- Achieving Consumer Satisfaction – Nov 5, 2023

Speaking as the keynote speaker Dr Vipul Mudgal, Director of Common Cause emphasised on the need for extensive police reforms. He said that a prosperous and forward-looking nation cannot be built on an archaic justice system. He also apprised the audience of activists and intellectuals with the vision of Mr H.D. Shourie, the founder of Common Cause who laid the foundation of public interest litigation in India. Highlighting the organisation's mission to work for probity in public life and governance reforms, he introduced some of the organisation's landmark PILs such as Prakash Singh v UOI; the 'living will' case, banning of the unscrupulous business of private blood banks, and controversial appointments of CBI directors, among others. The well-attended meeting was chaired by the Chief Editor of the India Justice Report, Ms Maja Daruwala.

Academic Curriculum on 'Development and the Rule of Law in India' at Shiv Nadar University – October 30 to November 06, 2023

The Common Cause team comprising its Director Dr Vipul Mudgal, Ms Devika Prasad and Mr Udit Singh successfully conducted an extensive and in-depth Academic Course on 'Development and the Rule of Law in India' for the students of MA (Rural Management) at Shiv Nadar University, Uttar Pradesh, from October 30 to November 06, 2023. This was a first attempt of its kind by Common Cause where its successive SPIR studies and IJRs formed the bedrock of an academic course at a leading university.

The Course was divided into 16 lectures delivered in four ninety-minute sessions devoted to the Indian Constitution and the Rule of Law; an introduction to policing in India; An introduction to India's justice system; and a primer on Crime and Justice in Rural India, Prison System and Legal Aid.

The Course introduced the students to the foundational legal framework of the country and a critical examination of the functioning of justice institutions. It aimed to build amongst the students an understanding of the roles, scopes and importance of the various pillars of the country's justice system, i.e., policing, judiciary, prisons and legal aid, and introduced them to concepts such as basic structure doctrine, fundamental rights, separation of powers and due process. A total of 42 students of MA (Rural Management) Program and several faculty members of the Shiv Nadar University attended the Course.

Training and Development of Staff

(a) Mohd Aasif, research executive at common cause, attended a quantitative

Photo Credit - Umesh Rawal

research training program. It was organised by the CSDS as part of their summer workshop in Bangalore, Karnataka, from June 21, 2023 to July 1, 2023. The workshop aimed at sharpening the participants' skills about quantitative data analysis which is extensively used by the organisation for its policing reports.

(b) Radhika Jha (Project lead, Rule of Law) and Mohd Aasif (Research Executive) attended one-day training workshop on qualitative research tool NVivo on October 18, 2023. It was organised by the Indian Population Council, India Habitat Centre, New Delhi. The one-day introductory course included the analysis of textual data and collective use of the software as a team.

(c) Ashok Kumar, assistant editor at IM4Change, attended a training workshop at Sambhaavnaa Institute, Palampur, Himachal Pradesh. It was four-day workshop on Petrochemicals, Plastics, and Politics from September 30 – October 3, 2023. It focused on harmful impacts of plastic use and the pollution caused in its disposal.

Special Training and Awareness Session on the Drafting of Living Wills - October 21, 2023

Common Cause Director, Dr Vipul Mudgal, was invited as a speaker and the Guest of Honour for a special training and awareness session on the Drafting of Living Wills. The event was organised by the Pro Bono Club from Maharashtra National Law University. Dr Mudgal said there was a need for setting up pro bono committees of lawyers and para legals at every law university in India. Explaining the process of writing a Living Will, he said the idea of passive euthanasia should not be confused with assisted deaths which continued to be illegal in India. He explained to students that these are documents prepared by a person while he or she is in complete command of her/ his senses. Elaborating on who will finally operate the living will, he said there was a need to further simplify the procedure of writing and administering an advance medical directive (AMD) or a living will.

Ask Me Anything Conference

Dr Vipul Mudgal and Radhika Jha from Common Cause were invited for an Ask Me Anything session organised by 101Reporters and conducted by writer and journalist Ms Pranoti Abhyankar. Besides presentations on the rule of law and police reforms in India, there was a rich discussion on the role of media in making sense of policing. The session was centred around news stories that are trending and how to come up with ideas for grassroots stories that one can cover particularly about the rule of law. The online session was attended by a large number of working journalists across India.

Publications:

Book Reviews:

1 https://www.hindustantimes.com/books/review-liberty-after-freedom-by-rohan-j-alva-101672926951217.html

About the triumph of due process within the scope of Article 21 of the Constitution (Liberty After Freedom by Rohan J Alva reviewed by Vipul Mudgal).

2 https://www.business-standard.com/book/nano-tales-from-an-indian-prison-123102501269_1.html

A glimpse into the lives of prisoners in a colonial-era prison in Pune (From Phansi Yard by Sudha Bharadwaj, reviewed by Vipul Mudgal).

News Articles:

3. https://hindi.feminisminindia.com/2023/10/18/agriculture-women-worker-daily-life-in-rajasthan-hindi/

4. https://hindi.feminisminindia.com/2023/09/25/women-reservation-bill-obc-quota-hindi/

5. https://hindi.feminisminindia.com/2023/09/18/indian-politicians-crime-record-adr-report-hindi/

6. https://hindi.feminisminindia.com/2023/09/05/gender-of-caste-charu-gupta-review-in-hindi/

(All four articles by Ashok Kumar)

Public Interest Litigation

Supreme Court Cases

Illegal Mining in Odisha:

On February 23, 2023 Common Cause filed an IA focussed on directing the Union of India and State of Odisha to impose limit on extraction of minerals and on constituting a committee of two or three independent experts to suggest and recommend such limit and submit its report in a time-bound matter. The IA also asked for an updated status report with regard to amount of penalty deposited by the lessees including the amount to be recovered, lease-wise details of the ore reserve, extraction permitted, current status of mining lease, total iron ore reserves and total permitted extraction in the State as directed in judgment dated August 2, 2017.

Other than this, the IA sought complete details of the work done for the benefits of the tribal community in the affected districts and other area development works. As it involved public money in such a large quantity, the IA pointed that the Special Purpose Vehicle (SPV) must fall under the purview of the Comptroller and Auditor General of India and the audit accounts of the receipts and expenditure of the SPV must be provided to the Apex Court. The matter was taken up on February 27, 2023, where the Court directed the service of IA to the standing counsel for the Union of India. Subsequently the matter was listed on March 17 and April 6, 2023 when the Court heard the IAs filed by the parties.

The matter was taken up several times during May 2023 till October 2023. The Court directed that the applicant mining company be granted three months' time to sell the iron ore in question, otherwise the State was granted the liberty to take over and sell the iron ore in question. The Court directed that the amount so realised from the sale shall mandatorily be credited to the SPV in terms of the Courts order dated August 2, 2017. In the meantime, the Court granted the State the liberty to simultaneously begin the process for conducting the auction of the Leasehold Area in accordance with law and also to proceed with the recovery of the amount due from the applicant, which was said to be in the region of Rs. 600 crores plus interest.

On May 1, 2023 the Court noted that "from the perusal of the affidavit filed in response (Annexure A/1), it is clear that only a sum of Rs.305.32 Crores has been recovered in terms of compensation due from the defaulters. This is when total amount of compensation is reckoned as 3308.35 Crores. It is clear that the balance amount excluding interest shown due is Rs.3003.03 Crores. A supplementary affidavit to be filed by the Respondent-State indicating as to for what reason the entire amount has not been recovered and what steps have been taken for speedy recovery of the entire amount."

In its order of August 14, 2023, the Courts' direction was as follows:

(i) The State Government shall take expeditious steps to pursue the recovery proceedings in accordance with law and shall take necessary steps by attaching the assets of the defaulting entities; and

(ii) Hereafter, the terms and conditions of tender shall expressly clarify that no tender shall be entertained at the behest of an entity against which outstanding are due or companies in which the same promoters are interested."

Our counsel, Mr Prashant Bhushan, highlighted the need for imposing a cap on mining in the State of Odisha as has been imposed both in respect of the States of Karnataka and Goa. In the note submitted by him, in the context of the State of Odisha, the data on the record indicated that the yearly mining permissions cover 58 leases with permissible excavation to the extent of 227.13 million tonnes and the total reserves was 4748.52 million tonnes. He pointed out that as a consequence of this, the reserves are liable to come to an end within twenty years.

The State of Odisha, submitted that the estimate of iron ore reserves on the geologically explored strata at present is 9220 million tonnes and there is a likelihood of this increasing in future. In view of this the Union of India was directed to consider the position and decide whether a cap on mining was necessitated in the case of State of Odisha and, if so, the modalities to be followed for determining such a cap. The Union of India was also directed to examine the basis on which a cap was imposed in the States of Karnataka and Goa and file its affidavit on this aspect within a period of eight weeks. Regarding the request of Mr A D N Rao, Amicus Curiae, to entrust the task of submitting recommendations on the capping of mining to the CEC, the Court responded that it shall examine this aspect after the response is filed by the Union of India.

In its order dated October 10, 2023 the Court directed that the defects pointed out by the Office in the report under consideration may be cured within a period of three weeks from date, failing which the application for modification of the Court's order dated February 27, 2023 shall stand dismissed without further reference to the Court. The matter is likely to be listed on December 15, 2023.

Miscellaneous Application (M.A. No. 1756 of 2022) **by the Union of India seeking modification of the Supreme Court order in the Common Cause petition challenging re-appointment of the Director, ED:** The Union of India (Respondent No.1) filed a Miscellaneous Application in the Common Cause petition, WP(C) 1374 of 2020, challenging the re-appointment of the ED Director, for modifying the judgment dated September 8, 2021 of the Supreme Court. The modification application, sought deletion of the following from the judgment:

"We make it clear that no further extension shall be granted to the second respondent".

The Union of India claimed that on the basis of the 5th proviso to Fundamental Rule 56(d) and Section 25(d) of the Central Vigilance Act, 2003 as well as various pending petitions challenging the extension of the incumbent ED Director's tenure, the above statement must be deleted from the judgment of the petition challenging the re-appointment of the ED Director.

This application was filed disguised as a Miscellaneous Application, instead of a review petition. Several precedents have established that the Supreme Court disapproves the practice of filing such Miscellaneous Applications seeking "modification" or "recall" or "clarification" in an attempt to bypass Order XL of the Supreme Court Rules, 1966. In addition to this, the Supreme Court has also upheld that change in law or subsequent decisions by itself could not be grounds for review and such petitions shall be accordingly dismissed.

The matter was taken up on January 30, 2023, when the SC gave the Centre three weeks to respond to the petition filed by

Dr. Jaya Thakur questioning the third extension given to director of the Enforcement Directorate (ED) Sanjay Kumar Mishra, while also indicating that it will not entertain any review of its September 2021 judgment that directed against further extension to Mishra based on the law being subsequently changed. "Subsequent legislative change cannot be a ground to review our earlier order (passed on September 8, 2021)," the bench of Justices BR Gavai and Vikram Nath said.

The Solicitor General stated that the petitioner was extensively relying on the September 2021 judgment where the Centre moved an application seeking clarification/modification (MA) and requested for tagging these matters together.

The bench refusing to entertain the MA said, "We will not entertain such an application. It amounts to review of our order." The Court ordered that WP 1106/2022, 456/2022, 204/2022 and MA be tagged together and posted the matter for hearing on February 27, 2023. The Court heard the counsels on March 21 and 23, 2023 and directed that it be listed at number 1 as part heard case on April 20, 2023. The Court concluded the hearing and on May 8, 2023 judgment was reserved.

On July 11, 2023 the SC disposed the batch of writ petitions as well as the MA and ruled that the central government extending the tenure of the director of the Enforcement Directorate (ED) is invalid and directed Sanjay Kumar Mishra, who is presently the director, to vacate the office by July 31, 2023. The court however upheld the validity of amendments to the Central Vigilance Commission Act conferring power on the central government to extend the tenure of ED director.

Petition to restrain the use of public funds for political campaigning through government advertisements:

The Supreme Court in its judgment dated May 13, 2015 in Common Cause vs. Union of India (2015) 7 SCC 1, had issued several guidelines aimed at regulating government advertisements in order to check the misuse of public funds by central and state governments. Despite the clear direction, states continued publishing advertisements using public funds.

Common Cause filed a petition in 2022 to restrain the unnecessary use of public funds on government advertisements in ways that are completely malafide and arbitrary and amount to breach of trust, abuse of office, violation of the directions/guidelines issued by this court and violation of fundamental rights of citizens. Noticing the unnecessary expenditure on advertising campaigns outside the territory of their respective states with no benefit to the target audience or prime beneficiaries of that government's achievements, policies and welfare measures, six specific issues were pointed out in the petition:

- Publication of advertisements by state governments outside the territorial limits of their respective states
- Publication of government advertisements in the form of 'advertorials'
- Publication of government advertisements during/prior to the elections
- Issues concerning the 'Committee on Content Regulation of Government Advertisements' (CCRGA)
- Publication of Photographs of functionaries on Government Advertisements
- Advertisements in the name of Awareness Campaigns

Notice was issued on September 26, 2022, by Justice DY Chandrachud and Justice Hima Kohli. Presently, the matter is pending before the Registrar H. Shashidhara Shetty. As only five states have filed their counter affidavit, on August 10, 2023 the respondents were given four weeks' time to file their counter affidavits. During the record of proceedings on September 21, 2023, the court of the Registrar declined the opportunity of filing counter to the respondent States who had failed to file the counters on previous several occasions. On November 6,

2023, the court of the Registrar ordered to list the matter for hearing before the bench after four weeks. The matter is likely to be listed on December 8, 2023.

Petition Challenging Constitutional Validity of Sedition: Sedition, a colonial law, used to suppress dissent by the British in India, continues to be heavily abused by the law enforcement authorities against citizens for exercising their freedom of speech and expression.

Common Cause filed a petition in 2021, challenging the constitutional validity of sedition under Section 124A of the Indian Penal Code, 1860, as being violative of Articles 14, 19(1)(a), & 21 of the Constitution of India.

In Kedar Nath Singh v State of Bihar, the constitutionality of this section was tested and upheld. The offence of sedition was presumed to be complete if the activities tended to create public disorder or disturbance of law and order or public peace.

In its welcome order on May 11, 2022, the Supreme Court granted interim stay on the use of the provision by governments. It suspended pending criminal trials and court proceedings under Section 124A (sedition) and allowed the Union of India to reconsider the law of the colonial times.

The matter was taken up on May 1, 2023 when the Attorney General for India, stated that, in pursuance of the order dated May 11, 2022, the Government has initiated the process of re-examining the provisions of Section 124A of the Indian Penal Code 1860 and the consultations are at a substantially advanced stage. On September 12, 2023 the Supreme Court declined the request of the Attorney General and Solicitor General to defer considering whether a reference should be made to a larger bench, on the ground that Parliament is in the process of re-enacting the provisions of the Penal Code and the Bill has been placed before a Standing Committee.

The Court in its order mentioned, "We are not inclined to accept the request for deferring the consideration of the constitutional challenge in this batch of matters. The provisions of Section 124A of the IPC continue to remain on the statute book. Even if the new law which is proposed to be placed by the Government before the legislature results in a modification of the existing provision of Section 124A, there is a presumption that a penal statute would have prospective and not retrospective effect. Existing prosecutions under Section 124A will likely be governed by that provision. Consequently, the validity of the prosecutions which have been launched or would be launched so long as Section 124A continues to remain on the statute would have to be assessed under it. The issue of the validity of the provision for the period that it continues to operate would, therefore, need to be determined.

The court appointed advocates Prasanna S and Pooja Dhar as nodal counsels to facilitate the compilation of case laws and other materials before the hearing.

The Court directed the nodal counsel to prepare a common compilation of case law, documents and written submissions filed by the parties in terms of the Circular dated August 22, 2023 issued for regulating the course of submissions in larger bench cases. The parties were directed to file all submissions by December 31, 2023 with the nodal counsel. The nodal counsels were directed to prepare soft copies of the common compilations duly indexed in terms of the above circular, e-file the same on or before January 9, 2024 and make it available to all the parties. The Registry was directed to notify the date for hearing of the reference in the month of January 2024.

Petition to Completely Ban Export of Iron Ore: Common Cause filed a writ petition in April 2021, to completely ban the export of iron ore (whether in the form of pellets or otherwise). Alternatively, it sought the levy of export duty of 30%, on the export of iron

ore in all forms, including pellets (except pellets manufactured and exported by KIOCL, formerly known as Kudremukh Iron Ore Company Limited). The petition also prayed to initiate proceedings under Section 11 of the Foreign Trade (Development & Regulation) Act, 1992 and Section 135(1) of the Customs Act, 1962. In addition, it sought the levy of appropriate penalty as per law against mining companies exporting iron ore pellets in contravention of the provisions of India's export policy. By exporting iron ore pellets, they have been evading the duty chargeable on the commodity.

In addition, the petition prayed for a thorough and independent investigation into the role of public officials in allowing the same. Notice was issued on September 24, 2021, directing the respondents to file their response within four weeks from the date of the order. The UOI filed its response on November 11, 2021, which was taken on record by the Court. The matter was taken up on February 18, 2022 when upon hearing the counsel, the Court ordered the matter to be listed on March 9, 2022 for final disposal. Further date was granted in the matter on March 22, 2022.

However, on May 21, 2022 the government increased the export duty from 0% to 45% on iron ore pellets. Recently, the export duties on certain steel products and iron ore imposed in late May were removed and the duty on iron ore pellets was reduced to nil again. The matter was taken up on January 17, 2023 and after hearing the counsels, the Court directed the matter to be listed for March 29, 2023. On the said date the Court heard the IAs filed by the parties and directed the matter to be listed for May 9, 2023. The matter was taken up on May 9, 2023 by the bench of Justice Bopanna and Justice Dutta who recommended the matter to be listed on a non-miscellaneous day in the 3rd week of July, 2023. On October 16, 2023 the matter was mentioned before the Court and was directed to be listed on November 7, 2023 when the Court heard the counsels and directed the matter to be listed for January 23, 2024.

Miscellaneous Application in Right to Living Will (1699/2019): The Indian Society for Critical Care Medicine (ISCCM) had filed a Miscellaneous Application in July 2019 claiming the SC's guidelines were cumbersome and very few Advance Medical Directives (AMDs) were accepted and implemented. The Court directed the counsels to prepare a chart comparing the SC's 2018 guidelines along with the changes suggested by the parties for the hearing on January 18, 2023.

On January 18, 2023, the counsel for the petitioner attempted to convince the Bench to also include persons in a 'permanent vegetative state' who are not at risk of death but have no hope of recovery and no ability to communicate their wishes. This was not accepted by the Bench. It was suggested that instead of requiring the Judicial Magistrate to sign the AD, it can simply be attested by a notary public. The Bench appeared to be more amenable to this suggestion, although Justice Joseph suggested that someone should keep a copy of the AD for counterchecking purposes.

The counsel provided a possible solution referring to the government portal maintained by the National Digital Health Commission. It was suggested that individuals could upload their ADs to the portal and it could be made available to doctors in the hospital where they eventually sought treatment. Removing the requirement for a second medical board to review the decision of the primary medical board, as well as limiting the number of members to three was also suggested. It was claimed that this would make the process more efficient. The Bench mandated a four-member board comprising the treating physician and three 'subject-experts'.

On January 19, 2023, the Bench directed the parties to submit a joint proposal by January 24, 2023. On that day, the Bench disposed the MA and accepted the joint proposal submitted by ISCC and the Union of India, subject to minor changes

proposed by the Bench during the hearings. Before concluding the proceedings, Sr. Adv. Arvind Datar gave the Bench a parting gift. Each Judge received a signed copy of Arun Shouries' book 'Preparing: For Death'.

The important points from the ruling is as follows:

- **Attestation before gazette officer:** As per the 2023 Order, the requirement to approach the JMFC has been done away with. Now, the AMD-writer can get their AMDs attested before any notary or a gazetted officer who will ascertain the veracity and genuineness of the AMD.
- **Flexibility in appointment of guardians:** While the 2018 Judgment provided for the appointment of "a" guardian or relative as the surrogate decision maker to act when the AMD-writer lost their capacity, the 2023 Order has modified the language to include multiple guardians and close relatives, thereby providing flexibility and the option to address other contingencies.
- **Easing the qualifications for appointment of Primary and Secondary Board:** The teams comprising the Primary Board and Secondary Board were earlier required to have an experience of twenty years each in the relevant field which has now been decreased to five years. This issue was also argued at length in the apex court with the Applicant contending that most districts in India may not have the medical teams with twenty years of experience, which will eventually delay the process of implementing the AMD at a critical stage.
- **Prescribing time limits:** Further speeding up the process, the Court has now clarified that both the medical boards are now required to form an opinion on Medical Futility 'within' forty-eight hours as opposed to no such time limit earlier which could have led to an unforeseen delay in enforcing the wishes of the AMD-writer.
- **Digital health records:** In order to streamline the process of preserving the AMD, the person executing can get their AMD incorporated as a part of their digital health records for easy accessibility at the time of Medical Futility. The implementation of digital health records in India is still at a very nascent stage and is not widely adopted. Further, privacy concerns, regarding uploading AMDs on the relevant digital health record platform, could also be a deterrent in AMDs being linked to the digital health records.
- **Easing of procedural / implementation requirements:** In addition to the changes provided herein, some of the relaxations introduced by the 2023 Order are set out below – (i) the requirement of the AMD being forwarded by the JMFC to the district court has also been done away with under the 2023 Order; (ii) under the 2023 Order, it would suffice for the executor to hand over a copy of the AMD to the decisionmaker (stipulated under the AMD) and the family physician, if any, and the requirement of the JMFC having to inform the executor and family physician (under the Judgement) has been removed; and (iii) the requirement for the JFMC to maintain a copy of the AMD has been deleted.

Contempt Petition against Lawyers Strike: The contempt petition filed by Common Cause against the strike of lawyers in Delhi High Court and all district courts of Delhi on the issue of conflict over pecuniary jurisdiction was eventually taken up on November 2, 2022, where the Court asked for short notes on the proposed submissions and the propositions by the parties within 4 weeks. The matter was listed next on December 6, 2022, when on behalf of the petitioner, advocate Prashant Bhushan told the Bench that the Bar Council of India (BCI) had not suspended those who went on strike. "We expect a serious response from you," the Bench told Advocate Ardhendumauli Kumar Prasad, who represented the BCI.

Noting that suspension was not sufficient, the Supreme Court

said major steps were needed against striking lawyers. "BCI is the apex body and should act like one. What are the preventive measures being taken? This can never acquire the proportions of adversarial litigation," a Bench led by Justice Dinesh Maheshwari said while hearing the contempt petition. The matter was taken up on January 24, 2023 when the counsel appearing for the BCI prayed for yet further time to complete all his instructions as also to advice appropriately. On April 17, 2023 the Chairman, BCI, informed the Court that further process was actively being taken up as regards the framing of Rules. He also indicated that in another matter involving akin issues, order has been reserved in another bench.

On May 8, 2023, the Chairman BCI submitted that further steps have been taken for amending the Rules as submitted before the Court on the last few occasions and in that regard, meeting of the representatives of all the State Bar Councils has also taken place. The Court took note of the submission that pursuant to the decision taken in these meetings, the BCI is actively considering the necessary amendment to the Rules. On July 17, 2023, when the Court gave time to BCI to file an affidavit and said that the petitioner may place the suggestions in response to these Rules within two weeks. The matter is likely to be listed on December 7, 2023.

Petition Challenging Introduction of Electoral Bonds: Common Cause and the Association for Democratic Reforms (ADR) challenged the constitutionality of Electoral Bonds scheme, which was introduced by amending Finance Act 2017. These bonds have not only made electoral funding of political parties more opaque, but also legitimised high-level corruption at an unprecedented scale by removing funding limits for big corporates and opening the route of electoral funding for foreign lobbyists. The PIL sought direction from the Supreme Court to strike down the amendments brought in illegally as a "Money Bill" in order to bypass the Rajya Sabha.

On March 21, 2023, the Court granted three weeks' time to the UoI to file its counter affidavit. It also appointed two lawyers from both the petitioner as well as respondents' side to act as nodal counsel for ensuring smooth hearing of the PILs, and directed them to prepare a common compilation containing the written submissions, copies of judgments and any other material that the parties seek to rely upon at the time of the hearing. The Court said it would consider whether the pleas challenging the validity of the electoral bond scheme for political funding of parties could be referred to a Constitutional Bench for an "authoritative pronouncement". Looking at the current data, electoral bonds have legitimised unaccounted-for money to the tune of more than Rs 12,000 crores in our electoral and political process, where the citizens do not know the names of the donors. Under the circumstances, the Court's observations to decide whether the pleas could be referred to a Constitution Bench assumed great significance.

On October 10, 2023 the submissions by the parties were completed and the Court directed the nodal counsel to file all the submissions online. On October 16, 2023, the petitioners approached the Court during mentioning, to hear the case prior to the 2024 General Elections. A Bench led by Chief Justice D.Y. Chandrachud, with Justices J.B. Pardiwala, and Manoj Misra, noting the "importance of the issue" referred the case to a five-judge Constitution Bench. On October 31, 2023, the five-judge Constitution Bench heard arguments over three days. On November 2, 2023 arguments were concluded and Court reserved its judgment. It also directed the EC to submit up-to-date data until September 30, 2023 regarding details of donations received by political parties under the electoral bond scheme.

Writ for Supreme Court Directions on Police Reforms: The battle for police reforms has been going on for the last 26 years. The Supreme Court took 10 years to give a historic

judgment in 2006, in the petition filed by Prakash Singh, Common Cause and NK Singh. Since then it has been a struggle to get the Court's directions implemented. On July 3, 2018, responding to an interlocutory application filed by the Ministry of Home Affairs regarding the appointment of acting Director General of Police (DGP) in the states, the Supreme Court gave a slew of directions to ensure that there were no distortions in such appointments. It laid down that the states shall send their proposals to the UPSC three months prior to the retirement of the incumbent DGP. The UPSC shall then prepare a panel of three officers so that the state can appoint one of them as DGP. In October 2022 and December 2022, the Court entertained applications filed by the State of Nagaland and the UPSC to finalise the names of DGP for the state. In January 2023, the matter was listed twice, when the Court decided on the IA filed by the State of Nagaland on appointment of DGP.

Petition Challenging the Appointment of Interim Director, CBI: Common Cause had filed a PIL on March 2, 2021, challenging the appointment of an Interim/ Acting CBI Director. It also sought the appointment of a regular Director, as per procedure established by law. As per the Delhi Special Police Establishment (DSPE) Act, 1946, the appointment of Director, CBI is to be made by the High-Powered Committee comprising the Prime Minister, Chief Justice of India (or any Judge of Supreme Court nominated by the CJI) and Leader of Opposition in the Lok Sabha.

The petition prayed for a direction to the executive to initiate the process of selecting a regular Director forthwith. The petition also sought a direction to the Centre to initiate and complete the process of selection of the CBI director well in advance. The selection process should be completed well before the date on which the vacancy to the post is about to occur.

Previously, in another petition in 2019, Common Cause had challenged the appointment of M Nageshwar Rao as Interim Director, CBI on similar grounds. On February 19, 2019, while declaring the decision of the case, the Court indicated that if due process is not followed in appointments, it is always open to any incumbency and the said appointments could be questioned in accordance with the law.

After holding a few hearings in 2021, where the court expressed its displeasure on the interim appointment, the Appointments Committee of the Cabinet, based on the panel recommended by the High-Powered Committee, approved the appointment of Subodh Kumar Jaiswal as the new director of CBI on May 25, 2021. On October 20, 2021, the Court asked the government to continue with the incumbent director till next director was appointed in accordance with the provisions of the law in force. On November 14, 2021, an Ordinance extending the tenure of the Director CBI by up to five years from a fixed tenure of two years was brought in force.

The matter was disposed on August 7, 2023. When Justices Sanjiv Khanna and SVN Bhatti held that:

"In view of the fact that the substantive prayer made in the writ petition has become infructuous, we are not inclined to continue further with the present writ petition and hence, the same is disposed of. However, it will be open to the petitioner(s) to file a fresh petition in case of a change in circumstances or need arising with regard to other prayers made in the present writ petition."

As per news reports, the Union government is mulling the idea of creating a new post of chief investigation officer of India (CIO) to whom the chiefs of the Central Bureau of Investigation (CBI) and Enforcement Directorate (ED) will report.

Petition seeking cancellation of the entire allocation of coal blocks to private companies between 1993 and 2012 and a court monitored investigation of the said allocation: On July 24, 2023, the Chief Justice D Y Chandrachud, Justice JB Pardiwala and Justice Manoj

Misra heard and allowed transfer of the seven investigating officers of ED in the normal course and disposed of the concerned IA. On August 14, 2023, the three-judge bench again heard the matter. The CBI placed on the record a "Note on Administrative Issues" indicating the present status of the investigation and prosecution in the coal block allocation cases. Pursuing this, permission was granted to relieve certain officials from their present charge. Previously, the Supreme Court had said that that no officials who were investigating the coal block allocation cases could be moved out without its prior permission. The matter is likely to be listed on December 11, 2023.

Delhi High Court

SIT on Over Invoicing requested by CPIL, Common Cause: Common Cause and the Centre for Public Interest Litigation (CPIL) approached the Delhi High Court seeking a thorough investigation by a SIT into the over-invoicing of imported coal and equipment. The over-invoicing was carried out by various private power companies as detailed by Directorate of Revenue Intelligence (DRI) in several of its investigative reports. In the last few years, major instances of such over-invoicing have been unearthed by the DRI, involving several prominent and influential companies with virtual impunity.

On December 4, 2018, the CBI was ordered to produce its original records/ investigation file relating to the two preliminary enquiries and the regular case, as mentioned in its earlier affidavits/ reply. The Court directed the DRI counsel to produce the four adjudicating orders concerning various entities. Additionally, the counsel was to file the status report and produce relevant records duly flagged, together with a comprehensive note vis-a-vis each one of them. The matter was taken up on August 8, 2019, when the CBI counsel submitted that there was no necessity for filing another status report as the enquiry stood closed.

The High Court directed that the records be produced before the court on the next date of hearing. The DRI counsel submitted that in three cases the adjudication was complete and it would take the same to their logical end. Arguments in the matter started in September 2023. On October 3, 2023 pursuant to the High Court's order, the co-respondent, CBI submitted sequence of events post the letter dated January 31, 2014 as well as the status of investigation against the 40 firms mentioned in DRI alert dated June 30/31, 2016. It was kept in sealed cover for the purpose of dictating order by the Court. On conclusion of arguments, the Court reserved its judgment.

Finance and Accounts (2022-23)

The Audited Annual Accounts of Common Cause for the year ending March 31,2023 has been received. The Governing Council has accorded its approval on October 31, 2023. Briefly, the non-project expenditure during the year was Rs 121.84 lakh against Rs 116.39 lakh recorded in the previous year. The non-project income during the year was Rs 106.24 lakh compared to Rs 114.97 lakh during 2021-22. Thus there was a shortfall of Rs 15.60 lakh during the year as against a shortfall of Rs 1.42 lakh in the previous year.

NOTICE FOR ANNUAL GENERAL MEETING

To,

All members of COMMON CAUSE SOCIETY

The Annual General Meeting of COMMON CAUSE Society will be held on Saturday, March 16, 2024, at 11:00 a.m. at Common Cause House, Third Floor, 5- Institutional Area, Nelson Mandela Road, Vasant Kunj, New Delhi 110070 with an option of attending virtually, with meeting id and password to be shared closer to the meeting.

The agenda will be as follows:

1. Consideration of Annual Report and adoption of the Annual Accounts along with the Auditor's Report for the year 2022-23
2. Appointment of Auditors for the year 2023-24
3. Presentation of the activities and programmes of the Society
4. Elections
5. Any other item with the permission of the chair

It may kindly be noted that in accordance with Rule 15 of the Rules & Regulations of the society, if within 15 minutes of the beginning of the meeting, the quorum is not present, the meeting would stand adjourned and be held after half an hour of the original scheduled time, and the members present in the adjourned meeting shall form the quorum of that meeting.

Copies of the Balance Sheet and Income & Expenditure statement will be circulated (or screen shared) during the AGM.

We look forward to your participation in the meeting.

A line in confirmation will be highly appreciated.

Vipul Mudgal
Director
COMMON CAUSE

Independent Auditor's Report

To
The Members of Board of Common Cause
Common Cause House, 5 Institutional Area,
Nelson Mandela Road, Vasant Kunj,
New Delhi-110070

Report on the Financial Statements

Opinion

1. We have audited the accompanying financial statements of Common Cause (the "Society"), which comprise the Balance Sheet as at 31 March 2023, the Income and Expenditure Account, Receipt and Payment Account for the year then ended, and significant accounting policies and notes to the financial statements.

2. In our opinion and to the best of our information and according to the explanations given to us the aforesaid financial statements give the information required by the Act in the manner so required and comply, in all material respects, with the conditions laid down in the Scheme for the management and administration of the Society and the rules made thereunder, to the extent relevant and applicable, and give a true and fair view in conformity with the accounting principles generally accepted in India, of the state of affairs of the Society as at 31 March 2023, and its surplus for the year ended on that date.

Responsibilities of the management for the Financial Statements

3. The Management is responsible for the preparation of these financial statements that give a true and fair view of the financial position and financial performance of the Society in accordance with the accounting principles generally accepted in India. This responsibility also includes maintenance of adequate accounting records in accordance with the provisions of the Act for safeguarding of the assets of the Society and for preventing and detecting frauds and other irregularities; selection and application of appropriate accounting policies; making judgments and estimates that are reasonable and prudent; and design, implementation and maintenance of adequate internal financial controls, that were operating effectively for ensuring the accuracy and completeness of the accounting records, relevant to the preparation and presentation of the financial statements that give a true and fair view and are free from material misstatement, whether due to fraud or error.

4. In preparing the financial statements, management is responsible for assessing the Society's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the Society or to cease operations, or has no realistic alternative but to do so.

Auditor's Responsibilities for the Audit of the Financial Statements

5. Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee

that an audit conducted in accordance with Standards on Auditing will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

6. As part of an audit in accordance with Standards on Auditing, we exercise professional judgment and maintain professional scepticism throughout the audit. We also:

   - Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence including the utilization certificates submitted by the sub-recipients, that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

   - Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances.

   - Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the management.

   - Conclude on the appropriateness of Society's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Society's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Society to cease to continue as a going concern.

   - Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation

7. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the Financials Statements and Annexure.

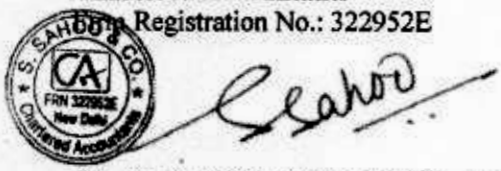
Other Matter

8. We have also issued our audit report as per Form No. 10B pursuant to the requirements of section 12A(1)(b) of the Income-tax Act, 1961.

Opinion

9. In our opinion Annexure for the year ended 31st March, 2023 are prepared, in all material respects, in accordance with the basis of accounting described in notes to accounts annexed to these Financials Statements.

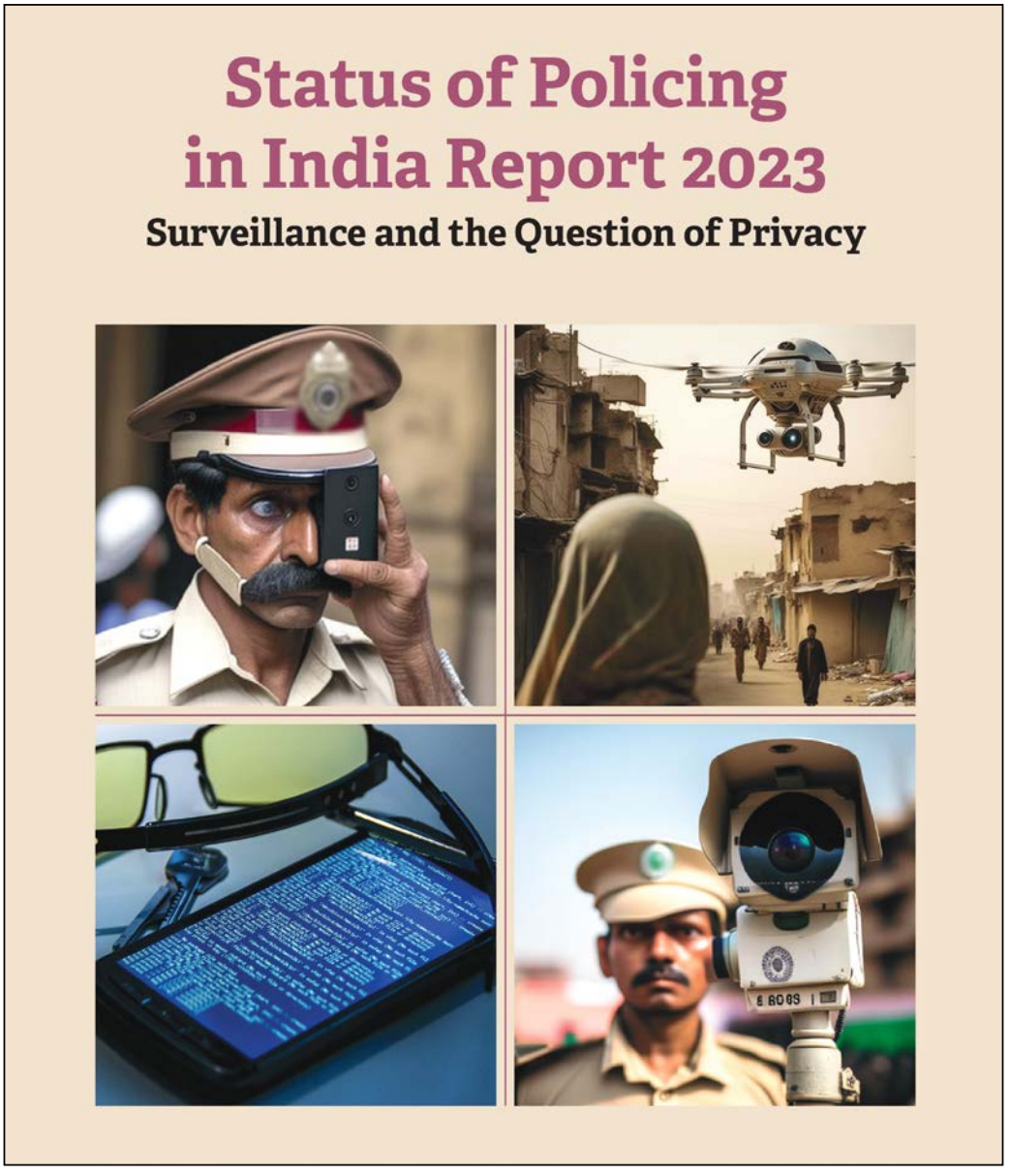
For: S. Sahoo & Co
Chartered Accountants
Firm Registration No.: 322952E



CA. (Dr.) Subhajit Sahoo, FCA, LLB
Partner
Membership No.: 057426

Place: New Delhi
Date: 31.10.2023
UDIN:

Please email us at commoncauseindia@gmail.com if you want a soft copy of the report.



Jointly prepared by Common Cause and its academic partner, Centre for the Study of Developing Societies (CSDS), the Status of Policing in India Report 2023: Surveillance and the Question of Privacy, is a study of public perceptions and experiences regarding digital surveillance in India .

SPIR 2023 analyses data collected from face-to-face surveys conducted with about 10,000 individuals from Tier I, II and III cities of 12 Indian states and UTs to understand perceptions around digital surveillance. The study also involved a Focused Group Discussion (FGD) with domain experts, in-depth interviews with serving police officials, and an analysis of media coverage of surveillance-related issues.

Please email us at commoncauseindia@gmail.com if you want a soft copy of the report. It can also be downloaded from commoncause.in

Printed & Published by Vipul Mudgal on behalf of Common Cause, 5 Institutional Area, Nelson Mandela Road, Vasant Kunj, New Delhi 110070, Printed at PRINTWORKS, C-94, Okhla Industrial Area, Phase - 1, New Delhi - 110020 Editor-Vipul Mudgal Tel No. 26131313, 45152796, email: commoncauseindia@gmail.com, website:www.commoncause.in