The Blueprint of a National Health Insurance Law

Concept Paper

Shehnaz Ahmed

Akshat Agarwal

Dr. Dhvani Mehta

Param Pandya

Akriti Gaur

Shreya Shrivastava

Dr. Arghya Sengupta

V | D H | Centre for Legal Policy

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About the Authors

Dr. Arghya Sengupta is the Research Director at the Vidhi Centre for Legal Policy.

Dr. Dhvani Mehta, Shehnaz Ahmed and Akriti Gaur are Senior Resident Fellows at the Vidhi Centre for Legal Policy.

Param Pandya, Akshat Agarwal and Shreya Shrivastava are Research Fellows at the Vidhi Centre for Legal Policy.

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Introduction

The Pradhan Mantri – Jan Arogya Yojana ("PM-JAY") is part of the Government of India's Ayushman Bharat initiative. It is a scheme that is aimed at protecting poor and vulnerable families against financial risk arising out of catastrophic health episodes, which have the potential of pushing such families into impoverishment. The National Health Authority ("NHA") has been created by an executive notification to implement the PM-JAY.[1] Separate structures referred to as State Health Agencies ("SHAs") have been established in the States to implement the scheme at the State-level.[2]

The PM-JAY offers a benefit cover of INR 5,00,000 per family per year towards hospitalisation expenses for secondary and tertiary care.[3] PM-JAY has identified 10.74 crore poor families eligible for such insurance cover on the basis of deprivation criteria in rural areas and on the basis of certain occupation categories in urban areas.[4] This identification is based on the Socio-Economic Caste Census of 2011 ("SECC 2011").[5] Additionally, all families enrolled in the Rashtriya Swasthya Bima Yojana ("RSBY") have also been included within the ambit of the PM-JAY.

The scheme requires the empanelment of hospitals in order for such hospitals to qualify to receive PM-JAY coverage. There are 1350 identified health packages for which individuals will be provided insurance cover at such empanelled hospitals.[6] The actual treatment is envisaged to be cashless thereby obviating any out-of-pocket expenditure for patients.

The costs of the PM-JAY (premium and administrative expenses) are to be shared according to a pre-determined ratio, by the Central Government and the State Governments. The insurance scheme is to be implemented through the following three modes (i) Insurance Company mode (insurance pay-outs are made, and the fund is managed, by a private insurance company to whom premiums are paid by the SHA), (ii) Trust mode (insurance pay-outs are made, and funds are managed, by a trust owned by the SHA), and (iii) Hybrid (a mix of insurance company and the trust models).[7] In all three modes, the role of the SHAs is key since they have the flexibility to decide which mode of implementation to adopt.

As is evident from its description, the PM-JAY is a scheme that is far-reaching in terms of its socio-economic importance. Like most other schemes, it depends on agreement between the Centre and States to implement. Concomitant with such agreement is a transfer of funds from the Centre to the States. Its continued operation depends on the political compact between the Centre and States and currently does not have any legal enforceability.

The lack of legal bindingness of the PM-JAY leads to a conundrum. The right to health is recognised as a fundamental right under Article 21 of the Constitution of India. Further, there is an obligation on the State (including Central and State Governments) under Article 47 of the Constitution of India to improve public health. Providing insurance cover for a wide range of treatments is undoubtedly in furtherance of this obligation for a certain section of persons who are eligible for such insurance cover. However, neither is this cover available universally nor is its availability to a targeted population legally enforceable, i.e. if the provision is faulty or denied, there is no well-defined statutory remedy for it.

It is perhaps to resolve this conundrum that the Government of India is considering a proposal to convert the scheme into a legally enforceable statutory framework.[8] Such a framework will allow the provision of health

[1] Notification dated 1 February 2019 bearing no. F. No. 3(4)/2018-H&FW(Part-III) Vol.2.
[2] NHA, 'About NHA' <https://www.pmjay.gov.in/about-nha> accessed 4 May 2019.
[3] PM-JAY, 'About Pradhan Mantri Jan Arogya Yojana' <https://www.pmjay.gov.in/about-pmjay> accessed 4 May 2019.
[4] *Ibid.*
[5] *Ibid.*
[6] *Ibid.*
[7] See NHA, 'State' <https://www.pmjay.gov.in/state> accessed 4 May 2019.
[8] '"We are going to start working on preparing a bill so that this authority can be set up by an act of parliament. We are also working on a gazette notification", says Indu Bhushan, Chief Executive Officer at the National Health Authority (NHA)', see 'From National Health 'Agency' to

insurance to transcend the possibility of transient political agreements and become a welfare regime backed by law. However, any conversion of such a scheme into an enforceable legal framework faces certain challenges. This Concept Paper focuses on such challenges with a view to ensuring that any proposed framework is not only legally enforceable but also legally sound.

This paper is divided into four parts. Part I analyses what a rights-centric approach to the question of health insurance would entail for legislation. Any legislation providing health insurance must be cognizant of the fact that it is in pursuance of a constitutional obligation. However, the constitutional obligation is not to make every individual healthy but to provide the foundations that allow the right to health to be realised. The implications of such a right on the proposed legislative framework will be studied.

Part II delves into the critical legal question of legislative competence of the Union of India to enact such a law. It is a fact that public health is within the zone of competence of the State Government under Entry 6, List II. At the same time provision of a social insurance scheme is within the concurrent competence of the Central and State Governments under Entry 23, List III. For such a law to be valid, it is essential that it be designed as a framework to establish a health insurance scheme rather than a programme to improve public health or to establish a National Health Authority (as the nodal body administering the PM-JAY is called). The contours of what a legislation can and cannot do constitutionally are provided in Part II.

Part III segues from the lessons of Part II to analyse the Right of Children to Free and Compulsory Education Act, 2009 ("RTE Act"), a statute on a subject in the Concurrent List (Entry 25, List III – 'education'). It looks at the challenges in converting existing educational schemes into a legislation. It also analyses the respective roles of the Union and State Governments pursuant to such legislation. Its lessons have key ramifications particularly on the question of convergence of existing state schemes into the PM-JAY and the legal leeway States have not to converge.

Finally, Part IV uses the arguments in Parts I, II and III to critically appraise select facets of the PM-JAY. This critical analysis is limited to the core foundations of the legislative framework. Needless to say, several matters of operational detail, particularly maintenance of privacy of health records, effectiveness of the process flow will require ongoing monitoring and amendment. These might become part of the legislation but are not commented on here for two reasons: first, either they are already contained in the scheme (like a privacy policy) and only require minor tweaking or second, as legal scholars, we are not best placed to evaluate their suitability.

This Concept Paper is thus a blueprint of what a constitutionally valid and legally enforceable health insurance framework looks like. It recognises that there are different approaches to creating a robust health system and debate over which is most appropriate for India,[9] with some arguing for a legislated right to health instead of an insurance-based model.[10] However, this paper, while cognisant of the challenges with the implementation of the PM-JAY,[11] is neither a comment on the desirability of such a framework nor a comprehensive commentary on the nuts and bolts of any proposed legislation.

'Authority': Ayushman Bharat Body Restructured Yet Again' *The Wire* (3 January 2019) <https://thewire.in/government/ayushman-bharat-national-health-agency-to-authority> accessed 8 May 2019.

[9] For a discussion of the advantages and disadvantages of a health insurance programme, in comparison with a statutory right to access healthcare goods, services and facilities, see generally Chhavi Sodhi and Atif Rabbani, 'Health Service System in India: Is Insurance the Way Forward?' (2014) 49(35) Economic and Political Weekly.

[10] This includes the Nobel Laureate and economist, Professor Amartya Sen, see Raghuvir Srinivasan, 'Time for a 'Right to Healthcare' *The Hindu* (18 December 2013) <https://www.thehindu.com/opinion/interview/time-for-a-right-to-healthcare/article5470806.ece> accessed 7 May 2019; Civil Society Organisations, see Jan Swasthya Abhiyan, 'Realizing the Right to Healthcare: A Policy Brief (2014) <http://phmindia.org/wp-content/uploads/2015/09/Realizing-the-right-to-healthcare.pdf> accessed 7 May 2019; and most recently, the Government of Rajasthan, which is proposing a law on the right to healthcare, see Swagata Yadavar, 'In Rajasthan, India's First Right-To-Healthcare Law Takes Shape' *IndiaSpend* <https://www.indiaspend.com/in-rajasthan-indias-first-right-to-healthcare-law-takes-shape/> accessed 7 May 2019.

[11] Jishnu Das, Yamini Aiyar and Jeffrey Hammer, 'Will Ayushman Bharat Work?' *Centre for Policy Research Blog* (21 September 2018) <http://www.cprindia.org/news/7239> accessed 7 May 2019; Blake J Angell, Shankar Prinja, Anadi Gupt, Vivekanand Jha and Stephen Jan, 'The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the path to universal health coverage in India: Overcoming the challenges of stewardship and governance' (2019) 16 PLoS Med; K Sujatha Rao, 'Deconstructing Ayushman Bharat and Infusing Institutional Reform' *The Hindu Centre for Politics and Public Policy* (20 November 2018) <https://www.thehinducentre.com/the-arena/current-issues/article25545260.ece> accessed 7 May 2019.

Instead, proceeding on the premise that statutory backing for the PM-JAY may be under consideration, it discusses the manner in which a rights-based approach can, and should, inform such a statute. This Concept Paper provides the key normative considerations that must underlie any such legislation and the matters that it must (and must not) cover to avoid constitutional infirmity. Respecting these normative considerations along with meeting other key operational challenges are necessary to ensure that a statutorily backed PM-JAY is able to meet its objectives.

Part I: A Rights-Based Approach to Health

India has international and constitutional commitments to the right to health. These must be respected while creating a statutory framework for the PM-JAY. This part discusses the contours of the right to health in international human rights law as well as the Constitution of India. The first section identifies the key features of this right in the international context and considers their implications for a law governing a targeted, government-run health insurance programme. The second section discusses the manner in which the Supreme Court of India ("SC") has interpreted and applied the right to health as part of the right to life under Article 21 of the Constitution. This jurisprudence will guide the positive obligations and limits that the proposed law must incorporate to enforce this fundamental right. The third section provides an overview of the varied ways in which other jurisdictions incorporate a rights-based approach to health and suggests which elements of these different approaches should be considered in the Indian context.

A. The International Human Right to Health

The International Covenant on Economic, Social and Cultural Rights, 1966 ("ICESCR"), to which India is a party, recognises the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[12] The Committee on Economic, Social and Cultural Rights, which periodically adopts General Comments on the scope of rights recognised by the ICESCR, adopted General Comment No. 14 on the Right to the Highest Attainable Standard of Health in August, 2000.[13] This General Comment is a useful indication of the extent of State obligations to realise the right to health.

The Comment recognises that the right to health cannot be understood as a right to be healthy.[14] At the same time, it cautions against restricting the right to health as a narrowly medicalised right to healthcare and expands its ambit to include the underlying determinants of health, such as access to safe water, sanitation, nutrition, housing and a healthy environment. [15] Essential elements of the right to health are availability, accessibility, acceptability and quality ("AAAQ").[16] Together, these elements require sufficient public healthcare facilities that are culturally sensitive, do not discriminate against any sections of the population and are of a scientifically and medically appropriate standard.

To ensure that these four elements are achieved, States have a tripartite obligation to respect, protect and fulfil.[17] The first requires States to 'refrain from interfering directly or indirectly with the enjoyment of the right to health' (examples of such interference include denying equal access to health services, limiting access to drugs or preventing people's participation in health-related matters), the second requires the State to 'take measures that prevent third parties from interfering with Article 12 guarantees' (regulating medicines, medical equipment and health professionals, preventing harmful traditional or social practices from interfering with the right to health), while the third requires the State to take policy and legal measures to recognise the right to health, as well as to take positive measures to provide health care.

[12] Article 12 (1), The International Covenant on Economic, Social and Cultural Rights, 1966.
[13] E/C/12/2000/4.
[14] General Comment No. 14, para 8.
[15] *Ibid* para 11.
[16] See General Comment No. 14, para 12 for a more detailed overview of the specific components of availability, accessibility, acceptability and quality.
[17] General Comment No. 3: The Nature of States Parties' Obligations, E/1991/23 (14 December 1990), for a fuller discussion of this tripartite obligation.

States are bound by the principle of non-retrogression, which prohibits any lowering in the standard of the right to health already maintained. Although States may work towards the 'progressive realisation' of the right, there is a 'minimum core' of obligations that is to take immediate effect. This includes the preparation of a national plan for the development of a health system, access to health goods, services and facilities on a non-discriminatory basis and their equitable distribution, effective, transparent and independent mechanisms of accountability, as well as the provision of a minimum-basket of health-related services and facilities, which should include, at the very least, access to essential food, basic sanitation and adequate water, essential medicines, immunisation against major infectious diseases, sexual and reproductive health services, and emergency obstetric care.[18]

Although General Comment No. 14 is not prescriptive about the type of health system through which States realise their obligations,[19] it does lay down basic tenets that have implications for health system financing and the privatisation of health care. Specifically, public health infrastructure ought to provide certain minimum services, payment for healthcare services should be based on the principle of equity, health resource allocation should not disproportionately favour curative services at the expense of primary and preventive health care and privatisation should not jeopardise the AAAQ elements of the right to health.

Reports of the United Nations Special Rapporteur on the Right to Health also emphasise the importance of a balance between public and private financing for health, public and private health administration,[20] and cautioning specifically against the prioritisation of specialised medicine over primary care.[21] There are concerns that the PM-JAY will skew this balance between the public and private delivery of healthcare in favour of the latter.[22]

As stated in the Introduction, it is not the purpose of this Concept Paper to comment on the desirability of a targeted government health insurance programme over a legislative right to access a set of healthcare goods, services and facilities free of charge. Nevertheless, a rights-based approach to designing health systems, including health insurance programmes, requires States to move towards universal coverage, to ensure the availability of a minimum basket of goods and services through the public health care system, to check inequity between rural and urban areas caused by privatisation, and to regulate private providers of healthcare services and insurers to ensure that the AAAQ obligations are met.

B. The Right to Health under the Constitution of India

The right to health is not explicitly guaranteed by the Constitution of India. The Directive Principles of State Policy under Part IV of the Constitution expressly mention health and require the State to work towards its protection.[23] The SC, as part of its expansive jurisprudence interpreting the right to life protected by Article 21 of the Constitution, has recognised the right to health as an integral part of the right to life.[24] However, there is no single, free-standing conception of this right as a universal right to access a basket of healthcare goods, services and facilities, nor is there a corresponding obligation on the State to provide such a basket free of charge.[25] Instead,

[18] General Comment No. 14, para 52.
[19] States have an obligation to provide a public, private or mixed health insurance system that is affordable to all, General Comment No. 14, para 36.
[20] A/67/302, Right of everyone to the enjoyment of the highest attainable standard of physical and mental health (13 August 2012), para 3.
[21] A/HRC/29/33, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras (2 April 2015), para 51. See also the declaration of Alma Ata, adopted at the International Conference on Primary Health Care in September 1978, which states that governments have an obligation to strengthen their primary health care as an integral part of their national health systems.
[22] Abhay Shukla, 'Public Health Systems and Privatised Agendas' (2019) 54 Economic and Political Weekly 14-16; Vikhar Ahmed Sayeed, 'Path to privatisation' *Frontline* (12 April 2019) <https://frontline.thehindu.com/cover-story/article26641525.ece> accessed 7 May 2019.
[23] Article 39(e) requires the State to direct its policy towards ensuring that the health and strength of workers, men and women is not abused; Article 39(f) directs the State to give opportunities and facilities to children to develop in a health manner; Article 41 provides that the State should make effective provisions to secure the right to public assistance in cases of sickness, within the limits of its economic capacity and development; Article 47 states that a primary duty of the State is to raise the level of nutrition and to improve public health.
[24] See generally Anand Grover, Maitreyi Misra and Lubhyati Rangarajan, 'Right to Health: Addressing Inequities through Litigation in India' in Colleen M. Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014).
[25] In *Mohammad Ahmed (Minor) v Union of India* MANU/DE/0915/2014, the Delhi High Court, while considering whether a person belonging to an economically weaker section of society and suffering from a rare disease was entitled to free medical treatment stated that "courts cannot direct that all inhabitants of this country be given free medical treatment at state expense.", para 62.

the content of the right has been built incrementally from case to case. While access to medicines and healthcare services have been guaranteed in limited contexts,[26] the bulk of cases use Article 21 to enforce the State's obligations to 'respect' and 'protect' the right to health, largely against third party providers of healthcare goods and services.

There have been 209 right-to-health cases decided by the SC and the High Courts between 1950 and 2006, of which 44 percent of the cases involved regulation,[27] 26 percent of such cases concerned medical practice and hospital management, while 14 percent of the cases concerned medical reimbursement and insurance.[28] The right to health, in such instances, appears to have been used to enforce the standard of care that is owed to patients by medical professionals and clinical establishments. More than half the cases relating to medical negligence were brought against public hospitals and doctors,[29] most likely reflecting the legal ambiguity about the application of the Consumer Protection Act 1986 to government-run healthcare establishments. In such cases, invoking the right to health created a remedy against negligent public hospitals and doctors through the writ jurisdiction of the SC and the High Courts. The right to health has also been used to impose a duty on the State to regulate the manufacture and sale of medicines,[30] and to regulate pharmaceutical companies directly by rejecting the ever-greening of patents for pharmaceutical drugs.[31]

Specifically in the context of insurance, a significant set of claimants have been government employees who were not provided public health of a certain quality under the insurance schemes that covered them, and therefore sought reimbursement from the State for private care.[32] Courts have directed reimbursement when government employees have received treatment at hospitals not approved under the insurance scheme[33] as well as for treatments for illnesses not included under the scheme.[34] They have held that reimbursement cannot be denied merely on the ground that it was received before the patient was issued a medical card under the scheme,[35] or on the ground that the patient paid cash despite the insurance scheme envisaging cashless facilities.[36]

The prohibition on discrimination has also played a prominent role in cases related to the right to health and health insurance. Courts have prohibited discrimination in health insurance against individuals based on their genetic disposition or genetic heritage (in the absence of appropriate genetic testing),[37] they have called for equality in the availability and quality of healthcare facilities for in-service and post-retirement government officials[38] and have rejected distinctions between 'indoor' and 'outdoor' treatment.[39] High courts have also extended the coverage of certain health insurance schemes to new groups[40] and in one instance, the SC has held that a policy floated by the Life Insurance Corporation was unreasonable because it limited the availability of life insurance to the affluent class and had the 'insidious and inevitable effect of excluding lives in vast rural and urban areas.'[41]

In these cases relating to health insurance, the right to health performs a range of functions—in some, it works to expand access to the kind of healthcare facilities available under insurance schemes, in others, it prevents procedural requirements from blocking access. Using the right to health, courts, while ordering reimbursement, appear to give greater weight to the fact that medical expenditure has been incurred for an illness rather than the

[26] These include the right to access emergency medical care (*Paschim Banga Khet Mazdoor Samiti v State of West Bengal* 1996 SCC (4) 37), the right to access anti-retroviral treatment (*Sahara House v Union of India and Others*, Unreported Judgment, 2010, Supreme Court)
[27] Shylashri Shankar and Pratap Bhanu Mehta, 'Courts and Socioeconomic Rights in India' in Varun Gauri and Daniel M. Brinks (eds), *Courting Social Justice* (Cambridge University Press 2009) 153.
[28] *Ibid.*
[29] *Ibid* 156.
[30] *Vincent Panikurlangara v Union of India* AIR 1987 SC 990.
[31] *Novartis AG v Union of India* (2013) 6 SCC 1.
[32] Sharanjeet Parmar and Namita Wahi, 'India, Citizens, Courts, and the Right to Health: Between Promise and Progress?' in Alicia Ely Yamin and Siri Gloppen, *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011) 167. See also *State of Punjab v Mohinder Singh Chawla* (1997) 2 SCC 83.
[33] *S Kulasekarapandian v The Special Secretary to Government, Finance (Salaries) Department, Government of Tamil Nadu, Chennai and Ors* 2017 SCC OnLine Mad 20406; *The Director General of Police and Ors v P. Ramu* MANU/TN/4265/2017 (Madras High Court).
[34] *Dr Loitongbam Nelson v State of Manipur and Ors* MANU/GH/0355/2009 (Gauhati High Court).
[35] *Nongthombam (N) Samadram (O) Chaobi Devi v The State of Manipur and Others* MANU/MN/0013/2018.
[36] *Ali Akbar v The Principal Secretary to Government, Department of Finance and Ors* MANU/TN/5064/2017 (Madras High Court).
[37] *The United Insurance Co Ltd v Jay Parkash Tayal* MANU/SCOR/27056/2018.
[38] *Union of India and Ors v Mohan Lal Gupta and Ors* MANU/PH/0236/2018 (Punjab and Haryana High Court).
[39] *K.K. Kharbanda v Union of India and Ors* MANU/DE/0294/2009.
[40] Shankar and Mehta (n. 27) 157.
[41] *Life Insurance Corporation of India v Consumer Education and Research Centre* (1995) Supp (1) SCR 349.

technical requirements of the insurance scheme. When the right to health is read with the equality and non-discrimination guarantees in Articles 14 and 15 of the Constitution, it works to ensure that arbitrary and irrational criteria are not used to exclude certain groups of persons from coverage and to ensure that all persons benefiting under the scheme receive the same quality of healthcare. While guaranteeing these rights, courts have also kept in mind business and larger public interests and have observed that the State's obligation to make budgetary allocations for the general population, outside its employee insurance schemes, cannot be ignored.[42]

C. The Right to Health in other Jurisdictions

The right to health is expressed formally in other jurisdictions through constitutional declarations,[43] statutory entitlements and judicial decisions, or a mix of them. However, the absence of formal expression does not mean that there is no such right. Countries like New Zealand, Sweden and the United Kingdom, with their welfare models, have some of the strongest health outcomes, despite lacking a constitutional or legislatively embedded right to health.[44]

Where such rights are guaranteed, there are wide variations in scope and specificity, although constitutional guarantees are generally framed more broadly than provisions in domestic law. Statutory expressions of the right to health usually enforce the State's obligation to 'protect', as discussed in the first section, by regulating healthcare providers and health insurers. However, in some instances, legislation may more closely resemble the State's obligation to 'fulfil'—the National Health Service Act, 2006, imposes a duty on the Secretary of State to 'continue the promotion in England of a comprehensive health service',[45] while the National Health Act, 2003, in South Africa, requires the Cabinet Minister responsible for health to provide essential health services to a prescribed population 'within the limits of available resources.'[46]

Several countries with health insurance programmes (whether partially or wholly funded by the State) also have a statutory framework that governs such programmes. These include Canada,[47] Colombia,[48] Israel,[49] the Netherlands,[50] Taiwan[51] and the United States.[52] Broadly, such frameworks establish the responsibility of the State to finance some proportion of the programme, mandate contributions from employers and certain categories of individuals, lay down eligibility criteria for those entitled to receive subsidised coverage, determine the basket of health care goods, services and facilities that may be accessed through the programme, regulate health care providers and impose limits on private insurance contracts. In some instances, domestic laws on health insurance also declare their founding principles. Colombia's Law 100 is based on efficiency, quality and equity,[53] while justice, equality and solidarity guide the Israel National Health Insurance Law.[54]

Litigation in these countries related to the application and interpretation of these laws provides an insight into the rights-based components of health insurance programmes. Questions that courts have had to consider include the extent of State obligations to pay for health care,[55] whether there is an obligation to provide access to

[42] *State of Punjab v Mohinder Singh Chawla* (1997) 2 SCC 83.
[43] An analysis of the constitutions of 191 United Nations countries in 2007 and 2011 revealed that 14% guarantee a right to public health, 38% guarantee a right to medical care while 36% guarantee a right to overall health. See Jody Heymann, Adèle Cassola, Amy Raub and Lipi Mishra, 'Constitutional rights to health, public health and medical care: The status of health protections in 191 countries' (2013) 8 Global Public Health 639-653.
[44] Colleen M. Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014).
[45] Section 1, National Health Service Act, 2006 (United Kingdom).
[46] Section 3(1), National Health Act, 2003 (South Africa).
[47] The Canada Health Act, 1985 lays down principles for the transfer of federal payments to the provinces for healthcare.
[48] Law 100 of 1993 introduced universal coverage in Colombia through a compulsory insurance system.
[49] The National Health Insurance Law 1995, which made health insurance universal and mandatory.
[50] The Health Insurance Act or the *Zorgverzekeringswet* came into force in 2006. It has shifted the Dutch health care system towards universal basic health insurance with multiple private health insurers.
[51] The National Health Insurance Act was promulgated in 1994, which creates a universal, government-run health care programme with compulsory enrollment.
[52] The Patient Protection and Affordable Care Act, 2010, which expanded the coverage of Medicaid, a public insurance programme and introduced the 'individual mandate' or 'shared responsibility payment', which is a penalty that must be paid by those who can afford health insurance but choose not to purchase it.
[53] Everaldo Lamprea, 'Colombia's Right-to-Health Litigation in a Context of Health Care Reform' in Flood and Gross (eds) (n. 44) 131, 133.
[54] Aeyal Gross, 'The Right to Health in Israel between Solidarity and Neoliberalism' in Flood and Gross (eds) (n.44) 159, 160.
[55] In the United States, this obligation was dismissed several decades before the enactment of the Patient Protection and Affordable Care Act. See *Harris v. McRae* 448 U.S. 297, 311 (198); *Maher v. Roe* 432 U.S. 464, 469 (1977), as cited in Alison K. Hoffman, 'A Vision of an Emerging Right

healthcare goods and services that have been excluded from the basket of the insurance programme,[56] the manner in which elements of the programme require updating,[57] and criteria that can legitimately be used to exclude persons from the benefits of the programme.[58] This litigation confirms the key elements of a rights-based approach to health identified in the first section. The content of the basket of goods and services guaranteed through health insurance programmes is a question of *availability* and *accessibility*, while the obligation to subsidised healthcare for vulnerable sections of the population is concerned with *affordability*. The grounds of exclusion of potential beneficiaries are linked directly to *non-discrimination*, while the need to update health insurance programmes periodically relates to the obligation of *monitoring*. A closer look at such litigation is merited while creating a statutory framework for the PM-JAY to learn more about the challenges that other countries have faced in designing a rights-compatible health insurance programme.

Countries also differ in the manner in which they make remedies available to enforce the right to health. Some have separate laws on patient rights. In New Zealand, the Health and Disability Commissioner Act 1994 empowers the Commissioner to draw up a Code of Health and Disability Services Consumers' Rights, which guarantees rights to informed consent and privacy, while imposing duties on health care providers to respect the dignity of individuals, to provide services of an appropriate standard and to establish procedures to deal with complaints by health consumers.[59] The Act also contains provisions on the investigation of complaints by the Commissioner and proceedings before the Human Rights Review Tribunal.[60] In Israel, the Patient Rights Act 1996 accompanies the National Health Insurance Law, which contains limited rights to medical care,[61] a prohibition on discrimination[62] and the right to receive proper medical care with regard to its professionalism and quality.[63] These rights are enforced through a set of investigative, control and quality and ethics committees.[64] The Patient Protection and Affordable Act in the United States also grants consumers the right to appeal a health insurance company's decision to deny payment for a claim through an 'internal appeal' process which requires the company to conduct a full audit of its decision. If payment is still denied, consumers have the right to an 'external review', which allows independent third parties to make a decision. [65]

Colombia's experience with health rights litigation demonstrates the importance of an effective complaints or grievance redressal mechanism at various stages of a health insurance programme. Studies have demonstrated that insurance companies routinely deny access to goods and services that are included in the basket. The lack of dispute resolution processes and the failure of government agencies to take appropriate disciplinary action against such defaulting companies has flooded courts with right to health claims.[66]

to Health Care in the United States: Expanding Health Care Equity through Legislative Reform' in Flood and Gross (eds) (n. 44) 345, 355. In contrast, in Taiwan, the Constitutional Court, in J.Y. Interpretation No. 472, imposed a positive obligation on the State to 'give appropriate assistance and relief' to those who could not afford to pay premiums under the National Health Insurance Law. See Y. Y. Brandon Chen, 'Lending a Helping Hand: The Impact of Constitutional Interpretation on Taiwan's National Health Insurance Program, Health Equity, and Distributive Justice' in Flood and Gross (eds) (n. 44) 236, 247.

[56] The Colombian Constitutional Court, in SU-480 held that insurance companies were required to provide excluded medicines or health services when the lack of such medicines or services threatened the person's right to life and corporeal integrity, when the exclusion could not be substituted by a medicine or service already in the basket, when the claimant could not afford to acquire the medicine or service and if the medicine or service had been prescribed by a doctor affiliated to the claimant's health insurer. See Lamprea (n. 53) 143.

[57] In 2012, the Israeli High Court of Justice held that the government acted unreasonably by failing to update the health cost index to reflect the development of new medicines and technologies and the costs of an aging population. The Israeli National Health Insurance Law, at the time of the decision did not have a mechanism to revise the Health Services Basket established by the law. See HCJ 8730/03 *Macabee Health Services v Minister of Finance*, as cited in Flood and Gross (eds) (n. 44).

[58] In the Netherlands, although immigrants without a residence permit are excluded from the AWBZ scheme (for uninsurable risk), the Central Appeals Tribunal has applied Article 8 of the European Convention on Human Rights, which guarantees a right to privacy, family life and home) to nullify this exclusion. See Andre den Exter, 'Health Care Access in the Netherlands: A True Story' in Gross and Flood (n. 44). In Sweden, the Equality Ombudsman has taken up cases concerning discrimination in access to in vitro fertilisation treatment on the grounds of sexual orientation. See Anna-Sara Lind, 'The Right to Health in Sweden' in Gross and Flood (n. 44) 51, 73.

[59] Section 20, Health and Disability Commissioner Act, 1994 (New Zealand).

[60] Part 4, Health and Disability Commissioner Act. 1994 (New Zealand).

[61] Section 3 (a) of the Patient Rights Act, 1996 (Israel) confers a right to receive medical care to all persons in need in accordance with relevant laws, policies and arrangements prevailing at the time. Section 3(b) confers an unconditional right to receive emergency medical care.

[62] Section 4 of the Patient Rights Act, 1996 (Israel) lists the prohibited grounds as 'religion, race, sex, nationality, country of birth or other such grounds.'

[63] Section 5, Patient Rights Act, 1996.

[64] Chapter 6, Patient Rights Act, 1996.

[65] 'U.S. Department of Health and Human Services' <https://www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/appealing-health-plan-decisions/index.html> accessed 1 May 2019.

[66] Lamprea (n. 53)140-141.

As the second section demonstrates, any person denied their entitlement under the PM-JAY will always be able to approach the High Courts or the SC by invoking Article 21. In one sense, a remedy to enforce rights under the PM-JAY is already available. However, the existence of this remedy cannot discount the necessity of a robust grievance redressal process to address complaints against all actors within the programme, including the State, healthcare providers and health insurers. Complaints may range from the provision of an inadequate basket of goods and services to poor quality of care, denial of treatment or excessive out-of-pocket payments. The design of the grievance redressal process should take into account the potential for different kinds of disputes (budgetary, quality, discrimination) as well as the different kinds of actors involved. The various rights available to beneficiaries of the programme, to the extent that they are not already protected,[67] should also be defined clearly so that the grievance redressal process may function effectively.

The three sections above have identified the building blocks of a rights-based approach to health. Their specific application to a statutory framework for the PM-JAY requires such a law, at a minimum, to:

- Recognise the rights of eligible beneficiaries to access healthcare goods, services and facilities guaranteed under the scheme;
- Apply the principle of non-discrimination by ensuring that criteria for the identification of beneficiaries are rational and have a legitimate nexus with the purpose of PM-JAY;
- Ensure that there is a correlation between the packages available under the scheme and the minimum core obligations of the State under Article 12 (1) of the ICESCR;
- Regulate empanelled health care providers, insurers, trusts and any other third parties involved in the administration of the scheme;
- Prevent operational mechanisms from acting as a barrier to access;
- Design a robust grievance redressal mechanism;
- Make available information about the design of the scheme, the rights of beneficiaries, and standards and obligations for third party providers;
- Create opportunities for public inputs on the design and operation of the scheme;
- Develop indicators[68] to assess the functioning of the scheme, including its impact on the balance between public and private financing of healthcare and to this end, establish an independent monitoring mechanism; and
- Revise key components of the scheme (beneficiaries, premium, packages) periodically to reflect the findings of the monitoring exercise.

[67] Article 21 of the Constitution already protects the right to privacy, while deficient providers of medical services can be brought to book under the Consumer Protection Act, 1986 or the Clinical Establishments (Registration and Regulation) Act, 2010, where applicable. However, they might still require some clarification in the specific context of a health insurance programme.
[68] For guidance on developing such indicators, see Human Rights Indicators: A Guide to Measurement and Implementation HR/PUB/12/5, (United Nations Human Rights, Office of the High Commissioner, 2012).

Part II: Legislative Competence

A critical legal question that arises while enacting any law is one of legislative competence of the Union and/or State Governments. This in turn determines what exactly a law can and cannot do. Part II of this paper determines the most appropriate entry of the Seventh Schedule of the Constitution under which a statutory framework for the PM-JAY may be enacted. In the first section, the law on legislative competence including the settled principles for the interpretation of entries of the Seventh Schedule of the Constitution have been analysed. The second section briefly outlines the contours of the PM-JAY to explain more exactly what it does and does not do. This part further identifies the relevant entries of the Seventh Schedule which may be attracted by such a law. The third section discusses the legal interpretation of each of these entries by analysing relevant case law. On the basis of the functioning of the PM-JAY, the last section determines the most appropriate entry under which a law may be enacted. Further, considering the framework of the PM-JAY, it also deals with the constitutional questions of imposing duties on State Governments and the interplay of such a law with state health insurance schemes.

A. Law Relating to Legislative Competence

I. Understanding Legislative Competence in the Constitution

Clauses (1) and (2) of Article 246 of the Constitution confer legislative powers on the Parliament to legislate on subjects enumerated in the Union List (List I) and the Concurrent List (List III) of the Seventh Schedule, respectively. According to Article 245, the Parliament can make laws for any part or whole of the territory of India. Thus on a combined reading of Articles 245 and 246, the Parliament has the competence to legislate on subjects enumerated in Lists I and III for the whole of the territory of India.

The Seventh Schedule of the Constitution classifies fields of legislation into three lists viz. Lists I, II and III which allocate legislative power among the Union, the States and concurrently between the Union and the States. Therefore, the Parliament and the State Legislature have the competence to legislate on subjects that have been allocated to them as per the lists of the Seventh Schedule. The residuary powers, however, have been vested with the Parliament under Article 248 of the Constitution read with Entry 97, List I. Laws enacted by the Parliament and the State Legislatures should thus be in pursuance of their legislative power and should fall within the legislative competence that is demarcated for them by the lists of the Seventh Schedule. In case a law made by the Parliament encroaches upon a subject allocated to the State Legislatures or *vice versa*, then such an enactment may be beyond the legislative powers of the concerned legislature and consequently be held to be unconstitutional for lack of legislative competence.

II. Rules for Interpreting the Lists

The SC, through judicial decisions in cases where the legislative competence of impugned laws was challenged before it, has settled the principles of interpretation of entries.[69] While considering the enactment of a law under a particular entry, a key principle to be considered is the rule of pith and substance. The rule implies that while considering whether a particular legislation falls within the legislative competence of one legislature or the other, the pith and substance of the whole legislation needs to be considered.[70] Ascertaining the pith and substance of a legislation implies determining its 'true nature and character', irrespective of whether an aspect of the legislation incidentally encroaches on a subject matter in any of the other lists. Determining the true nature and character of

[69] These principles are, (i) entries to be broadly interpreted, (ii) harmonious interpretation of statutes, (iii) inter-relation of entries, (iv) the rule of pith and substance and (v) the doctrine of colourable legislation. For further details, see *M. P. Jain Indian Constitutional Law* (Vol. I, 6th edn., Justice Ruma Pal and Samaraditya Pal eds., Lexis Nexis 2013).
[70] *Ibid.*

a legislation requires consideration of the legislation as a whole, including its object and scope, and the effect of its provisions.[71]

In *State of Bombay* v. *Balsara*[72] ("*Balsara*"), while enunciating the rule of pith and substance the SC observed that if a law, "*substantially falls within the powers expressly conferred upon the legislature which enacted it then it cannot be held to be invalid merely because it incidentally encroaches on matters which have been assigned to another legislature*" (emphasis supplied). In *Balsara* the SC was dealing with the constitutionality of the Bombay Prohibition Act, 1949 enacted by the State of Bombay, with respect to Entry 31, List II which deals with the "production, manufacture, possession, transport, purchase and sale of intoxicating liquors" and Entry 19, List I which deals with the, "import and export across customs frontiers…". While the impugned Act essentially dealt *inter alia* with the possession of alcohol, it was argued that 'import' in Entry 19, List I did not merely mean landing of the goods on the shore but possession of the goods in the hands of the importer. The Court however held, that even if this argument was accepted, the encroachment on Entry 19, List I was only incidental and in pith and substance the impugned Act was one dealing with matters under Entry 31, List II and therefore was validly enacted.

Therefore, incidental encroachment by the legislation enacted under a particular entry on another entry would not render it invalid, if the legislation has substantially been enacted under that particular entry. This position of law has been approved and followed consistently by the SC and the High Courts in upholding a number of enactments such as the Industrial Disputes Act, 1947,[73] state laws dealing with prohibition,[74] and the Central Reserve Police Force Act, 1949[75] amongst others.

While the rule of pith and substance is applied in ascertaining whether a legislation falls under a specific entry, complimentarily, judicial interpretation has also emphasised on a liberal interpretation of the entries itself. This is because, while Article 246 actually confers legislative powers, the entries merely demarcate the fields of legislation. In *The Elel Hotels and Investments Ltd.*, v. *Union of India*[76] the SC was dealing with the constitutionality of a Parliamentary law called the Hotel Receipts Tax Act, 1980 which imposed a special tax on the gross receipts of a certain category of hotels. It was argued that the Union did not have legislative competence to enact the Act since it did not fall under Entry 82, List I – 'Taxes on Income' but was essentially a tax on 'luxuries' under Entry 62, List II. This was because a tax on gross receipts (arising out of payment for accommodation, food, drink etc.,) could not be considered 'income' under settled definitions of income. The SC however rejected this argument and held that the term 'income' could not be understood in a narrow sense but the widest possible construction according to the ordinary meaning of the words in the entry should be put on it. Further, elucidating this rule in *Jilubhai Nanbhai Khachar* v. *State of Gujarat*[77] the SC has held that, "…language of the respective entries should be given the widest scope of their meaning, fairly capable to meet the machinery of government settled by the Constitution. Each general word should extend to all ancillary or subsidiary matters which can fairly and reasonably be comprehended in it." Therefore, it is well-settled that words in the entries should be given their broadest possible interpretation.

Thus considering the two principles together implies that in determining legislative competence, while on the one hand individual entries must be interpreted liberally, on the other, the whole legislation must be considered in its pith and substance irrespective of incidental encroachment.

B. Contours of the PM-JAY

The PM-JAY, as discussed in the 'Introduction', provides financial risk protection for out-of-pocket health expenditure arising out of catastrophic health episodes. The scheme targets beneficiaries comprising disadvantaged sections of the population in urban and rural areas, as per the SECC 2011. The NHA at the central level and the SHAs at the State level have been tasked with the implementation of the scheme. The insurance

[71] *Ibid* 784.
[72] *State of Bombay v Balsara* AIR 1951 SC 318.
[73] *D.N. Banerji v P.R. Mukerjee* AIR 1953 SC 58.
[74] *Krishna v State of Madras* AIR 1957 SC 297.
[75] *State of West Bengal v Tarun Kumar* AIR 1975 Cal. 39.
[76] *The Elel Hotels and Investments Ltd., v Union of India* AIR 1990 SC 1664.
[77] *Jilubhai Nanbhai Khachar v State of Gujarat* AIR 1995 SC 142.

cover itself, as discussed before, is administered through the trust mode, the private insurance company mode or a hybrid model. Since the SHAs are key to the implementation of the PM-JAY, State Governments have a significant role to play. Further, the NHA also seeks to bring about convergence of existing state health insurance schemes. Lastly, the PM-JAY is portable and therefore allows beneficiaries to access insurance benefits for hospitalisation in any part of India.

The PM-JAY however does not cover primary healthcare and does not directly deal with the regulation of hospitals or healthcare generally. The scheme is thus primarily concerned with providing health insurance to poor and disadvantaged families and thereby preventing impoverishment by covering financial risk.

In the context of enacting the PM-JAY into law, the following entries of the Seventh Schedule become relevant, (i) Entry 23, List III - Social security and social insurance; employment and unemployment, (ii) Entry 47, List I – Insurance, and (iii) Entry 6, List II - Public health and sanitation; hospitals and dispensaries. Therefore, in the constitutional scheme of the Seventh Schedule, while the Union has competence over subjects relating to insurance and social insurance (concurrently with the States), the States have sole competence over public health.

C. Analysis of the Entries of the Seventh Schedule

I. Entry 23, List III

In *Gasket Radiators Pvt. Ltd.* v. *Employees' State Insurance Corporation*[78] ("*Gasket Radiators*") the SC held that the Employees' State Insurance Act, 1948 ("ESIA") which creates the Employees' State Insurance Scheme and sets-up the Employees' State Insurance Corporation to administer it, was enacted under Entries 23 and 24 of List III. The Act and the Scheme *inter alia* provided for employee insurance, towards which the employer is mandated to make a contribution. The Court observed that the legislation was one of social welfare, which was in tune with Articles 41, 42 and 43 of the Directive Principles of State Policy that deal with labour welfare. The SC has thus interpreted the ambit of Entry 23 as including social welfare legislations on social insurance such as the ESIA. Similarly, the High Court of Madhya Pradesh in *R.C. Pandey* v. *State of Madhya Pradesh*[79] also held that a state law creating an advocates' welfare fund, contributions for which were to come from stamp fees used in court proceedings, would derive its legislative competence from Entry 23, List III.

The ambit of Entry 23, List III has further been clarified in the constitution bench judgment of *Koluthara Exports Ltd.* v. *State of Kerala*[80] ("*Koluthara Export"), which* approved of the decision in *Gasket Radiators*, observing that welfare legislations relating to insurance can be enacted under Entry 23. Admittedly, however, *Koluthara Exports* restricted the ambit of Entry 23 in this case by holding that the burden of impost may only be imposed on the contributor if a relationship of an employer-employee existed between the contributor and beneficiary. This may however be inapplicable in the context of the statutory framework for a scheme such as the PM-JAY where premium contributions towards insurance cover are the responsibility of the State alone. The SC's decisions in *Gasket Radiators* and *Koluthara Exports* thus clarify the ambit of the Entry 23 as including legislation that create an insurance scheme for social welfare and create/confer powers on an authority to administer the same.

Though the decisions in *Gasket Radiators* and *Koluthara Exports* interpreted Entry 23, List III in the context of laws relating to employment, the ambit of Entry 23, List III goes beyond issues of labour welfare. The High Court of Allahabad in *Sarika* v. *State of U.P.*[81] has held that the erstwhile Persons with Disabilities (Equal Opportunity, Protection of Rights and Full Participation) Act, 1995 which sought to achieve social welfare measures for persons with disability by way of reservations, and was not confined to employment only, was also enacted under Entry 23, List III. The judgment however did not specify whether the impugned law was enacted under 'social security' or 'social insurance' and only broadly referred to Entry 23, List III. Since the observations of the High Court were

[78] *Gasket Radiators Pvt. Ltd. v Employees' State Insurance Corporation* (1985) 2 SCC 68, para 2.
[79] *R.C. Pandey v State of Madhya Pradesh* 1987 SCC OnLine MP 25.
[80] *Koluthara Exports Ltd. v State of Kerala* (2002) 2 SCC 459.
[81] *Sarika v State of U.P.* 2005 (4) ESC 2378, para 34.

regarding Entry 23 as a whole, it can be concluded that the ambit of Entry 23, List III is not restricted to matters relating to labour welfare and legislation dealing with social welfare generally can also be enacted under it. Such a reading of Entry 23, List III is also in line with the well-settled rules of judicial interpretation, as discussed above, requiring entries to be interpreted in the broadest possible manner.

II. Entry 47, List I

Entry 47, List I deals with 'Insurance'. In *Corporation of Calcutta* v. *Liberty Cinema*[82] it was observed that the Parliament has created the Life Insurance Corporation under the Life Insurance Corporation Act, 1956 due to the powers conferred by Entry 47, List I. Similarly, in *United Insurance Company* v. *Mohanlal Aggarwal*[83] the High Court of Gujarat attributed a Parliamentary legislation to nationalise the general insurance business to Entry 47, List I. Therefore, laws relating to life insurance or general insurance, including regulation thereof, have been attributed to Entry 47, List I.

III. Entry 6, List II

Since the PM-JAY is a health insurance scheme, Entry 6, List II which reads 'public health and sanitation; hospitals and dispensaries' also becomes relevant. In the *State of Rajasthan* v. *Shri G. Chawla and Dr. Pohumal*[84] it was held that the Ajmer (Sound Amplifiers Control) Act, 1952, which controlled the use of amplifiers in the interests of health, could be attributed to Entry 6, List II since use of amplifiers had the potential to create manifest nuisance for others. In *Sai Traders and Others* v. *State of Goa*[85] the High Court of Bombay held that the 2005 amendments to the Goa Public Health Act, 1985 that dealt with articles injurious to public health (notifications prohibiting consumption of food products containing tobacco were issued under the enactment) did not impinge on central laws on tobacco regulation and food adulteration. This is because public health had been assigned to the States under Entry 6, List II and therefore the State of Goa was competent to enact laws the subject matter of which related to public health. The legislative competence of States on matters relating to public health has thus been broadly construed to cover aspects that have a bearing on the health and well-being of the population.

D. Enacting the PM-JAY into Law

It can be concluded that the PM-JAY deals with the provision and administration of health insurance for which it undertakes a number of tasks including the identification of eligible beneficiaries, formulation of covered health packages (treatments for which insurance coverage will be provided), empanelment of hospitals (minimum standards are laid down as conditions for empanelment), and regulation of private insurance companies and other third parties who may be involved in administering the insurance scheme. However, the PM-JAY is still primarily a health insurance scheme that incidentally touches upon other aspects such as those relating to public health and healthcare.

As discussed in Part B above, the rule of pith and substance is applied in determining legislative competence and to attribute a particular law to a specific entry in the Seventh Schedule. In light of the above, the PM-JAY upon being enacted into law, would in pith and substance be a law relating to health insurance and would only have an incidental bearing on the health and well-being of the population. Since such a legislation would essentially be a social welfare legislation, the most appropriate and specific entry in this regard would be 'social insurance' in Entry 23, List III. In line with judicial precedent, the term 'social insurance' in Entry 23, List III will also have to be understood liberally as providing legislative competence for the enactment of a social welfare law dealing with health insurance for covering financial risk for the disadvantaged.

However, such a law should be narrowly tailored to ensure that in substance the law only concerns itself with creating a health insurance scheme and setting up an authority (at the national and State levels) to administer it.

[82] *Corporation of Calcutta v Liberty Cinema* AIR 1965 SC 1107.
[83] *United Insurance Company v Mohanlal Aggarwal* 2003 SCC OnLine Guj 182.
[84] *State of Rajasthan v Shri G. Chawla and Dr. Pohumal* 1959 AIR 544.
[85] *Sai Traders and Others v State of Goa* 2006 (4) Bom CR 1.

Being enacted in such a way, the law in its pith and substance would be a law dealing with health insurance and therefore the competence to enact it can appropriately be derived from Entry 23, List III.

Translating PM-JAY (which has a national authority i.e. the NHA and state authorities i.e. the SHAs) into law would mean that it will have to be enacted by Parliament (since Entry 23 is a Concurrent List entry, it gives legislative competence to both the Parliament and the State Legislatures). Due to the operation of the rule of pith and substance, any incidental encroachment on Entry 6, List II (which is bound to happen) will not affect the constitutionality of the legislation *per se* as long as the legislation in substance deals with health insurance. Incidental encroachments on Entry 6, List II could be in terms of minimum standards regarding quality of healthcare as preconditions for empanelment of hospitals or nature of medical treatments that would be covered by such insurance, amongst others. However, as long as the law substantially deals with administering the health insurance scheme and only deals with those questions relating to health generally which necessarily arise as a consequence of administering such a scheme, the law's encroachment on Entry 6, List III will only be incidental. Further, since the law would be a Parliamentary law anyway, any encroachment upon Entry 47, List I (which is a Union subject) would be immaterial.

In the current scheme of the PM-JAY, the States have a key role to play since they are ultimately responsible for implementing the scheme. Upon enactment of the PM-JAY into a central law, therefore, various obligations may be cast upon State Governments to implement the law. The Union's ability to impose obligations and duties upon State Governments through a legislation is well-settled. Article 154(2)(b) of the Indian Constitution stipulates that the Parliament or the Legislature of the state are empowered to confer by law functions on any authority subordinate to the Governor. This ability to allocate functions exists, irrespective of whether the Parliamentary law has been enacted under a List I[86] or List III subject. Specifically, with regard to Concurrent List entries, ordinarily, due to the proviso to Article 73(1) the executive powers reside with the States.[87] The Union may through a law enacted by it deal with the allocation of executive power in any of the following the ways, (a) it may allocate such powers to itself, (b)it may allocate powers to the States, and (c) it may create a concurrent field with some powers being allocated to itself and some to the States.[88] Instances of Union legislation that allocate powers/functions to the States are plenty. For instance, under Section 7 of the RTE Act (enacted under Entry 25, List III[89] of the Seventh Schedule) both the Centre and the States share concurrent responsibility for providing funds to carry out the provisions of the Act. Further, provisions such as Section 8 cast specific duties on the 'appropriate government' which under Section 2(a)(ii) would be the State Government for a large number of schools established in the territory of such a state. Thus if the Parliament were to enact the PM-JAY into legislation then it would be constitutionally permissible for it to allocate duties and functions under such a law to the State Government.

Another related question that may arise with regard to a central enactment under a Concurrent List entry is that of repugnancy with other state laws. Currently, several States have their own health insurance schemes and one of the mandates of the NHA is to foster linkages and convergence with such schemes.[90] Under Article 254(1) of the Constitution, in case of conflict between a law enacted by Parliament and a law made by the legislature of a state, the law made by Parliament shall prevail. The law made by the State Legislature to the extent to which it is repugnant to the central law will be void. Specifically, with regard to legislation under Concurrent List entries however, if a law made by the State Legislature is repugnant to a central law, then under Article 254(2) it may prevail in such a State if it has been reserved for the consideration of the President and received her assent. Post the enactment of the PM-JAY into law the States may continue with their schemes as long as they do not conflict with the central law.[91] In case of conflict and in case the States desire for such schemes to continue, such States

[86] With regard to Union List entries, the ability to allocate functions to the State Government is further clarified in Article 258(2) of the Constitution that specifically refers to allocation of functions under subjects with respect to which the Legislature of the State has no power to make laws.
[87] The proviso to Article 73(1) stipulates that the executive power of the Union which ordinarily extends to all matters over which the Parliament can make laws (under Article 73(1)(a)) however does not extend in any State to matters with respect to which the Legislature of the State also has the power to make laws.
[88] See M. P. Jain (n. 69) 953.
[89] *Chandan Kumar Neog and Ors. v The State of Assam and Ors* MANU/GH/0423/2016.
[90] See NHA, 'About NHA' <https://www.pmjay.gov.in/about-nha> accessed 3 May 2019.
[91] Under Article 162 of the Constitution, the exercise of executive power by the States is subject to any law made by Parliament.

will have to enact their schemes into law and the same will have to receive presidential assent under Article 254(2) for them to prevail in the territory of the State.

Enacting the PM-JAY into law may also be seen as being in furtherance of the Part III and Part IV constitutional obligations of the State. Article 47 of the Directive Principles of State Policy (Part IV) imposes a duty upon the State to improve public health and in Part III the right to healthcare has been read as part of the right to life in Article 21 of the Constitution of India, as discussed in Part I above.[92] Thus, apart from being a concurrent power vested in the Union and States, enacting a law such as the PM-JAY may also be seen as a constitutional duty.

E. Conclusion

Therefore, a national health insurance law that provides statutory backing to the PM-JAY can be enacted by the Parliament under 'social insurance' in Entry 23, List III if in its pith and substance such a law concerns itself with establishing a health insurance scheme and creating an authority to administer it. Any incidental encroachment on 'public health' in Entry 6, List II would not affect the constitutionality of such a legislation. Further, the Constitution permits such a Parliamentary law to impose duties on State Governments for the implementation of such a law.

[92] See *Vincent Panikurlangara v Union of India* (1987) 2 SCC 165; *Paschim Banga Khet Mazdoor Samity v State of W.B.* (1996) 4 SCC 37.

Part III: Transition and Convergence

Since India is a welfare state, the State and Central Governments have initiated a number of welfare schemes for the underprivileged and the disadvantaged from time to time. Broadly, such schemes may be classified in three categories: Social Insurance, Social Assistance and Labour Market Programmes.[93] Many a times these schemes are incorporated into a law to give them statutory backing. As a result, a scheme goes through a series of changes in order to be harmonised with such law. Before providing a statutory backing to PM-JAY, it is necessary to understand the process of such transition. The first section of this Part explores the possible reasons behind providing a statutory backing to a scheme. It further stipulates the process of transition by way of a case study of Sarva Shiksha Abhiyan ("SSA") after it became the implementation vehicle for the RTE Act.

Further, as the PM-JAY framework suggests its convergence with other state health insurance schemes and programmes,[94] it is important to understand how convergence takes place, what its possible outcomes could be, and to identify the possible issues that may arise with respect to convergence. The second section throws light upon some of the modes of convergence and their outcomes. Further, the possible approaches and issues of the convergence of PM-JAY with state schemes have been discussed by way of a case study of the convergence of the Megha Health Insurance Scheme ("MHIS") in the State of Meghalaya with the PM-JAY.

A. Transition

I. Introduction

Ambitious welfare schemes introduced in India have often failed to achieve their desired outcomes. Most of the time, the funds allotted under a scheme remain underutilised.[95] Some of the possible reasons are the lack of proper implementation mechanisms, the lack of information about the scheme amongst the expected beneficiaries and the lack of justiciability of the benefits under a scheme.

Thus, in order to make the benefits under a scheme justiciable and to have a proper implementation mechanism in force, statutory backing for a scheme becomes important. A law provides a legal guarantee of the benefits provided by the scheme, some laws even extend to making benefits a legally enforceable right. This places a judicially enforceable obligation on the state and gives bargaining power to beneficiaries. By contrast, a scheme does not involve any legal entitlements. Further, schemes are temporary and may be changed or terminated with the changing governments. A scheme can be trimmed or even cancelled by a bureaucrat, whereas changing a law requires an amendment in Parliament.[96]

There are many examples in India, where welfare schemes have been given statutory backing by their incorporation into an Act. For instance, the Targeted Public Distribution System was incorporated into the Food Security Act, 2013. Similarly, the RTE Act made SSA a legally justiciable programme by incorporating it into a statutory enactment. The government took one step ahead in the National Pension System ("NPS") by establishing

[93] Raghbendra Jha, 'Welfare schemes and social protection in India' (2014) International Journal of Sociology and Social Policy 34 (3/4), 214.
[94] NHA, 'About NHA' <https://www.pmjay.gov.in/about-nha> accessed 7 May 2019.
[95] As per the CAG Report on Performance Audit of Reproductive and Child Health under the National Rural Heath Mission, the financial management at both Central and State levels was not satisfactory with substantial amounts remained unspent with the State Health Societies at the end of each year. In 27 States, the unspent amount increased from INR 7,375 crores in 2011-12 to INR 9,509 crores in 2015-16, see 'CAG Report on Performance Audit of Reproductive and Child Health under the National Rural Heath Mission' <https://cag.gov.in/sites/default/files/audit_report_files/Report_No.25_of_2017_-_Performance_audit_Union_Government_Reproductive_and_Child_Health_under_National_Rural_Health_Mission_Reports_of_Ministry_of_Health_and_Family_Welfare.pdf> accessed 6 May 2019.
[96] Nikhil Dey and Jean Drèze, '[India] Employment Guarantee Act: A Primer' (*South Asia Citizens Web*, October 2004) <http://www.sacw.net/Labour/EGAprimer.html> accessed 4 May 2019.

an Authority called the Pension Fund Regulatory & Development Authority ("PFRDA") via a notification for the implementation of the NPS.[97] Ten years later, it was given statutory backing by the Pension Fund Regulatory & Development Authority Act, 2013.

In order to understand the transition of a scheme after its incorporation into an Act, a case study of the transition of SSA after the enactment of the RTE Act is given below.

II. Case Study: SSA and RTE

Background

SSA has been operational since 2000-01 as an effort to universalise elementary education. It aims to provide universal education to children between the ages of 6 to 14 years. Some of the key interventions of SSA include the opening of new schools and alternate schooling facilities, construction of schools and additional classrooms, toilets and drinking water, provisioning for teachers, regular teacher in-service training and academic resource support, free textbooks and uniforms and support for improving learning achievement levels/outcome.[98]

SSA was started as a partnership between the Central, State and the Local Governments. It provided an opportunity for States to develop their own vision of elementary education. Hence, it was introduced as a framework within which States could formulate context-specific guidelines.[99]

Later, to fulfil the mandate of the Constitution (Eighty-sixth Amendment) Act, 2002 which made free and compulsory education for children of 6-14 years age a Fundamental Right under Article 21A of the Constitution of India, the RTE Act was enacted. With the passage of the RTE Act, SSA was designated as the primary vehicle for its implementation. As a result, certain changes were incorporated into the SSA approach, strategies and norms in order to harmonise it with the RTE Act.

Transition of SSA

To facilitate the transition of SSA, the Government set up the Anil Bordia Committee in September 2009 to suggest follow up action on SSA *vis-a-vis* the RTE Act. The Committee submitted its report titled "*Implementation of the RTE Act and the Resultant Revamp of SSA*". Based on the recommendations of the Committee, the SSA framework was revised. The revised SSA Framework for Implementation ("Revised Framework") provides a broad outline of approaches and implementation strategies with States being able to frame more detailed guidelines keeping in view their specific social, economic and institutional contexts.[100] Some of the key revisions are:

1. *Approach*- SSA followed an incentive-based approach, where incentives in the form of scholarships, free uniforms, textbooks, meals etc. were provided to attract children to schools. However, after the enactment of the RTE Act, it has been transitioned into an entitlement-based approach. Under the RTE Act, in order to remove any financial barrier in pursuing and completing elementary education, these resources are provided as entitlements to children. It is now mandatory for SSA to ensure that the approach and strategies for universalisation of elementary education are in conformity with the rights perspective mandated under the RTE Act. For instance, as per the revised framework, SSA will provide two sets of uniforms to to all girls, Scheduled Caste, Scheduled Tribe children and Below Poverty Line ("BPL") children, wherever (i) State Governments have incorporated provision of school uniforms as a child entitlement in their State RTE Rules, and (ii) State Governments are not already providing uniforms from the State budgets. [101]

[97] Set up by the Central Government through Resolutions No. F. No. 5/7/2003-ECB&PR, dated the 10 October, 2003 and F. No. 1(6)/2007-PR, dated 14 November 2008.
[98] Department of School Education and Literacy, Ministry of Human Resource Development ("MHRD"), '*Samagra Shiksha Abhiyan*' <https://mhrd.gov.in/ssa> accessed 8 May 2019.
[99] MHRD, Government of India, 'Sarva Shiksha Abhiyan: Framework for Implementation Draft' (Education for All, December 1999) <https://www.educationforallinindia.com/SSA1.htm> accessed 4 May 2019.
[100] Department of School Education and Literacy, MHRD, 'Sarva Shiksha Abhiyan: Framework for Implementation based on the RTE Act, 2009' (MHRD, March 2011) <https://mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/SSA-Frame-work.pdf> accessed 4 May 2019.
[101] Department of School Education and Literacy, MHRD, 'Sarva Shiksha Abhiyan: Framework for Implementation based on the RTE Act, 2009' (MHRD, March 2011) <https://mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/SSA-Frame-work.pdf> accessed 4 May 2019.

2. *Management Structure*- At the Centre, the SSA was governed by a General Body chaired by the Prime Minister, an Executive Committee and a Project Approval Board. At the State level, it was implemented by means of separately registered societies called the State Implementation Societies ("SIE"). Other bodies that were functioning at the State level were the Governing Body, the Executive Committee and the State Project Director ("SPD"). SPD's responsibility was to oversee the SSA at the State level, in addition to the already existing Director/Commissioner of Education. SSA also provided for a Joint Review Mission (JRM) to review the progress of the project every six months. The developmental partners of SSA, namely the World Bank, the DFID and the European Commission were also a part of this JRM exercise.

   The RTE Act on the other hand provides for the National and State Advisory Councils to advise on the implementation of the Act. Further, the implementation of the Act is the responsibility of the State Government and the local authority.[102] For monitoring purposes, it involves the National Commission for Protection of Child Rights ("NCPCR"), the State Commissions for Protection of Child Rights ("SCPCR") and the School Management Committees ("SMCs"). In order to achieve the objectives of the RTE Act, the Revised Framework provided for the convergence of SSA with other state departments, for instance, the Finance Department for providing adequate funds, the Public Works Department to redesign schools and the Water and Sanitation Departments to provide drinking water and toilet facilities to fulfil the mandate of the RTE Act. Further, the Revised Framework suggested the integration of the SSA project management and the directorate of elementary education at the State level.[103]

3. *Free and Compulsory Education in a Neighbourhood School*- Under the RTE Act, providing free and compulsory education is an obligation of the appropriate government[104] and the local authority. Further, making a neighbourhood school available for the same is also the responsibility of the appropriate government and local authority.[105] Some of the implications that it had on SSA are:

   - *Upgradation of Alternate School Facilities*- SSA provided for alternate schooling through the Education Guarantee Scheme ("EGS") and Alternative and Innovative Education ("AIE") centres. However, the EGS centres were envisaged as transitory measures to provide schooling till regular, full-time schooling facilities are available in the area concerned. AIE centres catered to the bridging needs of out of school children till they were mainstreamed into regular schools. Post-RTE the EGS centres, thus, had to be upgraded to regular neighbourhood schools. In place of AIE centres, a provision for 'Special Training' to out-of-school children who have been admitted to school was made.[106]

   - *Opening of new schools*- In order to fulfil the mandate of making available a neighbourhood school within the geographical range determined by the Central Government, new schools had to be opened under SSA. These schools had to fulfil the required norms and standards as mandated by the RTE Act. Residential facilities may be provided under SSA for children in areas where it is difficult to get land for establishing schools and for homeless and street children, who require not merely day schooling facilities, but also lodging and boarding facilities. [107]

[102] Section 2(h), RTE Act.
[103] Department of School Education and Literacy, MHRD, 'Sarva Shiksha Abhiyan: Framework for Implementation based on the RTE Act, 2009' (MHRD, March 2011) <https://mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/SSA-Frame-work.pdf> accessed 4 May 2019.
[104] As per Section 2(a) of the RTE Act, "appropriate Government" means--
(i) in relation to a school established, owned or controlled by the Central Government, or the administrator of the Union territory, having no legislature, the Central Government;
(ii) in relation to a school, other than the school referred to in sub-clause (i), established within the territory of--
(A) a State, the State Government;
(B) a Union territory having legislature, the Government of that Union territory.
[105] Section 8 and Section 9, RTE Act.
[106] Department of School Education and Literacy, MHRD, 'Sarva Shiksha Abhiyan: Framework for Implementation based on the RTE Act, 2009' (MHRD, March 2011) <https://mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/SSA-Frame-work.pdf> accessed 4 May 2019.
[107] Department of School Education and Literacy, MHRD, 'Sarva Shiksha Abhiyan: Framework for Implementation based on the RTE Act, 2009' (MHRD, March 2011) <https://mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/SSA-Frame-work.pdf> accessed 4 May 2019.

4. *Timelines*- When SSA was introduced in 2000, it had certain time time-bound objectives including the objective to have all children in school by 2003 and that all children should complete five years of primary schooling by 2007 and eight years of elementary schooling by 2010. Further, it aimed to bridge all gender and social category gaps at primary stage by 2007 and at elementary education level by 2010. It also targeted at achieving universal retention by 2010 by ensuring that children who were admitted in schools, retain schooling till the completion of their elementary education.[108] The RTE Act too provided for certain timelines for the implementation of various obligations discussed above. Some of these timelines are the establishment of neighbourhood schools within 3 years from the commencement of the Act (by 2013),[109] fulfilment of norms and standards for schools within 3 years (by 2013),[110] acquisition of minimum qualifications by teachers within 5 years (by 2015)[111] and fulfilment of pupil-teacher ratio within 3 years (by 2013).[112] These timelines became immediately applicable to SSA.[113]

5. *Funding pattern*-The originally approved fund sharing pattern between the Centre and States other than the North-Eastern States under SSA for the duration of the 11th Plan (2007-2012) was 65:35 during the first two years of the 11th Five Year Plan. It was to be revised to 60:40 in the third year, 55:45 in the fourth year and 50:50 thereafter. On the other hand, the approved funding pattern for North-Eastern states was 90:10. Post-RTE, the funding pattern for states other than the North-Eastern States was replaced with 65:35 for a period of 5 years with effect from 2010-11.[114] With the higher devolution of funds to the States from 32% to 42% as recommended by the 14th Finance Commission, the funds sharing pattern of SSA was again revised to 60:40 between Centre and States with effect from the year 2015-16. However, it was decided to be 90:10 for the North-Eastern States as well as for 3 Himalayan States.[115]

   The RTE Act provides that the Central Government and the State Governments shall have concurrent responsibility for providing funds for carrying out the provisions of this Act. The Central Government after consultation with the State Governments will provide such percentage of expenditure as grant-in-aid to the State Governments as determined from time to time. The Central Government may also request the President to make a reference to the Finance Commission under Article 280 of the Constitution of India to examine the need for additional resources to be provided to any State so that the said State Government may be provided its share of funds for carrying out the provisions of the Act. However, the State Governments are responsible for providing funds for implementation of the provisions of the Act, after taking into consideration the sums provided by the Central Government as grant-in-aid and its own resources, irrespective of any such request.[116]

6. *Monitoring and Grievance Redressal*- SSA had a community-based monitoring system. Under SSA, the Educational Management Information System provided the correlation of school-level data with community-based information from micro planning and surveys. It also had a provision for periodic quality checks by external teams. The paradigm shift to the rights perspective under the RTE Act has also brought changes to the monitoring mechanisms as existed under SSA. As discussed above, the RTE Act continues to involve community-based monitoring by way of SMCs, which monitor the working of a school and utilisation of its grants.[117] It further involves statutory bodies like the NCPCR and the SCPCRs to perform this role and ensure that child rights under the Act are protected[118]. This sets a precedent in the

[108] MHRD, Government of India, 'Sarva Shiksha Abhiyan: Framework for Implementation Draft' (Education for All, December 1999) <https://www.educationforallinindia.com/SSA1.htm> accessed 4 May 2019.
[109] Section 6, RTE Act.
[110] Section 19, RTE Act.
[111] Section 23, RTE Act.
[112] Section 25, RTE Act.
[113] Department of School Education and Literacy, MHRD, 'Sarva Shiksha Abhiyan: Framework for Implementation based on the RTE Act, 2009' (MHRD, March 2011) <https://mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/SSA-Frame-work.pdf> accessed 4 May 2019.
[114] Department of Education and Literacy, MHRD, 'The RTE Act: The 1st Year' (MHRD, March 2011) <http://seshagun.nic.in/docs/reports/RTE_1st%20Year.pdf> accessed 4 May 2019.
[115] Press Information Bureau, Government of India, 'Funding Pattern of Sarva Shiksha Abhiyan' (MHRD, 3 December 2015) <https://mhrd.gov.in/sites/upload_files/mhrd/files/RJ540.pdf> accessed 4 May 2019.
[116] Section 7, RTE Act.
[117] Section 21, RTE Act.
[118] Section 31, RTE Act.

legislative history of India as an autonomous statutory authority has been charged with monitoring the implementation of a fundamental right.[119]

The RTE Act has made local authorities the grievance redressal agencies and the SCPCRs the appellate bodies at the State level.[120] The SSA structure had to be revised with the new Grievance Redressal and Monitoring aspects of RTE Act implementation. Some of the key implications included the allocation of responsibilities to SSA and local authorities in developing a mechanism for grievance redressal. It also involved developing links with other government departments such as Tribal Affairs, Social Justice and Labour through SSA in order to cover schools set up by these departments and other specified category schools and private schools.[121]

B. Convergence

I. Introduction

There is no one meaning to convergence, however, in the context of schemes, it can be understood as consolidating one or more components of various schemes. Convergence can occur in different ways depending on the subject area of schemes and the components being converged. Two schemes on completely different subject matters can converge on the basis of activities/work involved or the benefits provided under such schemes.[122] Further, the schemes covering different aspects of one broad theme may also be converged.[123] Another possible type of convergence is the convergence of parallel Central and State schemes. The convergence of PM-JAY with state health insurance schemes will fall under this third category.

The convergence of schemes may also have different outcomes based on the scale of convergence. Different schemes may come together only to the extent of being coordinated by one central body. In some cases, different elements of schemes may come together but remain unchanged, while in other cases, some changes may occur. Finally, different elements of schemes may also converge into being administered by a single body for a common goal.[124] Thus, the mode and outcome of convergence is flexible and varies from case to case.

II. Convergence of PM-JAY with State Health Insurance Schemes

As discussed in Part II, NHA will have a critical role in fostering linkages as well as the convergence of PM-JAY with health and related programmes.[125] Responsibilities of the SHAs also include the convergence of PM-JAY with State-funded health insurance scheme(s).[126] However, there is no clarity on how this convergence will occur.

[119] Department of School Education and Literacy, MHRD, 'Sarva Shiksha Abhiyan: Framework for Implementation based on the RTE Act, 2009' (MHRD, March 2011) <https://mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/SSA-Frame-work.pdf> accessed 4 May 2019.
[120] Section 32, RTE Act.
[121] Department of School Education and Literacy, MHRD, 'Sarva Shiksha Abhiyan: Framework for Implementation based on the RTE Act, 2009' (MHRD, March 2011) <https://mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/SSA-Frame-work.pdf> accessed 4 May 2019.
[122] The Task Force on Convergence for schemes under the Mahatma Gandhi National Rural Employment Guarantee Act, 2005 ("MGNREGA") in 2008 suggested its activity-wise convergence for works like pond construction. It suggested that the kuchcha work can be undertaken through NREGA and lining/concrete work can be done through schemes like National Agricultural Development Programme (NADP) and Repair, Renovation and Restoration ("RRR") of water bodies schemes by converging with them. It also suggested the convergence with schemes like the Integrated Child Development Services Scheme ("ICDS") for women labourers under NREGA to get benefits provided under ICDS.
[123] MHRD decided to integrate five different schemes namely Inclusive Education of the Disabled at Secondary Stage ("IEDSS") (formerly IEDC), Girls' Hostel, Vocational Education, and Information and Communication Technology ("ICT") in schools with the Rashtriya Madhyamik Shiksha Abhiyan ("RMSA"). Recently, Sarva Shiksha Abhiyan ("SSA"), RMSA and CCS on Teachers Education have been integrated into Samagra Shiksha Abhiyan <http://rmsaindia.gov.in/images/A_Guide_to_Integration_of_the_5_schemes_under_RMSA.pdf> accessed 4 May 2019.
[124] RMSA- Technical Cooperation Agency, 'A Guide to Integration of the 5 Schemes under RMSA' (RMSA, November 2013). <http://rmsaindia.gov.in/images/A_Guide_to_Integration_of_the_5_schemes_under_RMSA.pdf> accessed 4 May 2019.
[125] NHA, 'About NHA' <https://www.pmjay.gov.in/about-nha> accessed 7 May 2019.
[126] Annexure 2, Capacity Building Guidelines, AB PM-JAY <https://www.pmjay.gov.in/sites/default/files/2019-02/Capacity%20Building%20Document%2C%2022.01.2019_Approved.pdf> accessed 7 May 2019.

Currently, 24 states have their own health insurance schemes.[127] To name a few, the Mahatma Jyotiba Phule Jan Arogya Yojana ("MJPJAY") in Maharashtra, the Bhamashah Swasthya Bima Yojana ("BSBY") in Rajasthan, the Chief Minister's Comprehensive Health Insurance scheme in Tamil Nadu, Mukhyamantri Amrutam Yojana ("MAY") in Gujarat, Aarogya Bhagya in Karnataka, Arogya Raksha Health Insurance Scheme in Andhra Pradesh and MHIS in Meghalaya. The exact details of these health insurance schemes relating to beneficiaries, coverage, packages and operational mechanisms vary substantially from PM-JAY's components.

For instance, Gujarat provides benefits under its schemes to those with an annual income less than INR 2,50,000 including reporters and fix pay employees of class-3 and 4 appointed by the State Government. MJPJAY in Maharashtra extends these benefits to all ration card holders. On the other hand, PM-JAY's beneficiaries are limited to the SECC 2011 database. Further, the insurance coverage in Gujarat is INR 2,00,000 under MAY; in Maharashtra under MJPJAY, INR 1,50,000; whereas, the BSBY in Rajasthan provides INR 30,000 for general illness and INR 3,00,000 for critical illness as compared to coverage of INR 5,00,000 under PM-JAY.[128] Similarly, health packages and operational mechanisms also vary from state to state.

This raises several issues with respect to convergence including what components of these schemes will converge with PM-JAY and to what extent. Other issues include the imposition of an additional financial burden on States for covering beneficiaries under their own schemes and PM-JAY in parallel, especially given the enhanced coverage as per PM-JAY requirements. The duplication of beneficiaries is also a concern if the state schemes converge with PM-JAY. So far, only two states, Meghalaya and Tamil Nadu have converged their state schemes with PM-JAY. In order to understand this process better, a case study of the convergence of MHIS in Meghalaya with PM-JAY is presented below.

MHIS in Meghalaya has been launched in three phases so far. Phase-IV of MHIS has been launched in convergence with PM-JAY. The scheme has been converged in the following aspects:

1. *Beneficiaries*: MHIS provides health insurance to all persons that are resident in the State excluding State and Central government employees. On the other hand, the beneficiaries under PM-JAY are restricted to specified persons in the SECC 2011 database. Post-convergence, around 3.47 lakh SECC beneficiaries in the State will be covered under PM-JAY. However, around 7 lakh remaining beneficiaries will be covered under MHIS in Phase IV.[129] This implies that the Central Government will provide 60 per cent funds for the coverage of 3.47 lakh SECC beneficiaries eligible under PM-JAY.

2. *Coverage*: The cover available to enrolled beneficiaries for an enrolment fee of INR 31 was INR 1,60,000 in Phase-I, INR 2,00,000 in Phase II and INR 2,80,000 in Phase III. However, the coverage under PM-JAY is INR 5,00,000.[130] All beneficiaries will be provided with enhanced coverage of up to INR 5,00,000 per family on a floater basis with no restrictions on family size and age post-convergence.[131]

3. *Package*: The MHIS-IV provides 2365 benefit packages as compared to 1350 packages under PM-JAY. This includes outpatient department and dental care among other additional packages that are excluded under PM-JAY.[132]

4. *Operational Mechanism*: Beneficiaries will be issued an individual E-card i.e. the PM-JAY/MHIS card on completion of their registration after payment of INR 30. Approved beneficiaries under the scheme

[127] 'States reluctant to push Modicare over own health insurance schemes' *Business Standard* (New Delhi, 15 February 2018) <https://www.business-standard.com/article/economy-policy/states-reluctant-to-push-modicare-over-own-health-insurance-schemes-118021500034_1.html> accessed 7 May 2019.
[128] 'States reluctant to push Modicare over own health insurance schemes' *Business Standard* (New Delhi, 15 February 2018) <https://www.business-standard.com/article/economy-policy/states-reluctant-to-push-modicare-over-own-health-insurance-schemes-118021500034_1.html> accessed 7 May 2019.
[129] MHIS, 'About MHIS' <http://mhis.nic.in/about-us> accessed 4 May 2019.
[130] '1.98 lakh Meghalaya Residents Registered with Megha Health Insurance' *The Shillong Times* (Shillong, 23 March 2019) <http://www.theshillongtimes.com/2019/03/23/1-98-lakh-meghalaya-residents-registered-with-megha-health-insurance/> accessed 7 May 2019.
[131] MHIS, 'About MHIS' <http://mhis.nic.in/about-us> accessed 4 May 2019.
[132] 'Meghalaya Launches Health Insurance Merging it with Ayushman' *Business Standard* (Shillong, 20 December 2018) <https://www.business-standard.com/article/pti-stories/meghalaya-launches-health-insurance-merging-it-with-ayushman-118122000754_1.html> accessed 5 May 2019.

(known as Golden Records) can avail benefits in all MHIS and PM-JAY empanelled hospitals in the State and identified health facilities/hospitals in any other state.[133] Under PM-JAY, there are certain minimum conditions that all hospitals have to fulfil as a prerequisite to empanelment like the availability of a minimum number of beds, medical and nursing staff, ambulance services, emergency services, etc.[134] whereas, under MHIS, there is no clarity about criteria for empanelment, although all public hospitals and health centres of the state are empanelled,[135] as are five private hospitals.

There is no single way to converge these schemes as there is substantial variance in approaches from state to state. Further, as discussed in Part II, States may decide not to converge with PM-JAY and will have leeway to continue their own schemes as long as they do not conflict with PM-JAY once it gets statutory backing. However, this comes with additional financial and administrative costs of running two schemes in parallel.

C. Lessons

The above two case studies on the transition and convergence of schemes respectively suggest a way forward for the incorporation of PM-JAY into a law and its convergence with other schemes. The case study on the transition of SSA suggests that once a scheme is incorporated into an Act, its approach will also change from provision to entitlement. This in turn will impose legally justiciable obligations on the authorities. As a result, substantial changes will have to be made in the grievance redressal mechanism to ensure that these obligations are fulfilled. Further, in order to have a proper implementation mechanism in place, changes will also have to be made to the existing management structure. The share of funding between the Centre and States for a scheme varies from a case to case basis and it may or may not change after its incorporation into a law.

With respect to convergence, it can be deduced that States can either run their parallel schemes or converge them with PM-JAY. If States decide to converge, they will have to fulfil certain statutory obligations under PM-JAY and maintain the minimum standards as mandated by law. The way Meghalaya has increased its coverage to INR 5,00,000 as required by PM-JAY is an example of such an obligation. However, if States decide not to converge and run their schemes in parallel, they will have to be cognizant of duplicating expenditure.

[133] MHIS, 'Frequently Asked Questions' <https://mhis.org.in/faq> accessed 4 May 2019.
[134] Guidelines on Process of Hospital Empanelment, Ayushman Bharat–pradhan Mantri Jan Arogya Yojana <https://www.pmjay.gov.in/sites/default/files/2019-04/NHA_Guidelines_on_Process_of_Empanelment_for_Hospital_Revised_0.pdf> accessed 7 May 2019.
[135] MHIS, 'Frequently Asked Questions' < https://mhis.org.in/faq> accessed 4 May 2019.

Part IV: Critical Analysis of PM-JAY

PM-JAY is a significant step in the direction of realising the vision of right to health for all. Since PM-JAY was envisaged as a scheme, the existing framework merits review if a national legislation guaranteeing health insurance is enacted. This part critically analyses key aspects of the existing PM-JAY framework from this perspective and provides certain recommendations.

A. Structure of the National Health Authority and State Health Authority

A review of the existing guidelines governing the PM-JAY framework indicates that there are several entities that are responsible for implementing different facets of PM-JAY, primary among them being the NHA and SHAs. The effectiveness of the legal design of a social welfare legislation largely depends on the capacity and structure of the institutions responsible for monitoring and implementing the scheme. In light of this, issues pertaining to the structure of NHA and SHA and their respective roles and responsibilities under the proposed legal framework for implementing PM-JAY assumes a central point of deliberation.

I. Existing Position

The National Health Agency was set up as a society under the Societies Registration Act, 1860 ("SR Act") to act as the apex national body to implement the PM-JAY with effect from 8 May 2018.[136] Pursuant to a cabinet decision on 02 January 2019, the Union Cabinet approved the restructuring of the National Health Agency to NHA for better implementation of PM-JAY.[137] Notably, one of the primary reasons for this restructuring is to replace the multi-tier decision making structure as envisaged under the National Health Agency with a governing board chaired by the Minister of Health & Family Welfare, Government of India ("MoHFW") to enable decision making at a faster pace, required for smooth implementation of the scheme.[138]

By way of a notification dated 1 February 2019 ("NHA Notification"), the constitution of NHA along with its broad contours were notified.[139] As per the NHA Notification, NHA will operate as an attached office of MoHFW and will have full functional autonomy. Further, NHA will be governed by a governing board ("Board") consisting of a Chairman and 11 members. The CEO of NHA will be responsible for the day-to-day administration of NHA. The composition of NHA is set out in **Annexure A.**

The primary functions of the NHA include formulation of guidelines related to PM-JAY, development and enforcement of standards for treatment protocols, quality protocols, minimum documentation protocols, data sharing protocols, data privacy and security protocols, fraud prevention and control including penal provisions, coordination with various State Governments for implementation of PM-JAY, and grievance redressal for all the stakeholders at various levels.[140]

While the NHA is the national level authority for implementation of the PM-JAY, the SHA is responsible for implementation of the scheme at the State level. Under the existing framework, the State Government may set up a SHA or designate this function to an existing authority (trust or society) set up for implementing a State

[136] Ministry of Health and Family Welfare, 'Year Ender 2018: Ministry of Health and Family Welfare' (*Press Information Bureau*, 11 January 2019) <http://pib.nic.in/PressReleaseIframePage.aspx?PRID=1559536> accessed 4 May 2019.
[137] Notification dated 1 February 2019 bearing no. F. No. 3(4)/2018-H&FW(Part-III) Vol.2.
[138] NITI Aayog, Government of India, 'Cabinet approves restructuring of National Health Agency as "National Health Authority" for better implementation of Pradhan Mantri - Jan Arogya Yojana' (*Press Information Bureau*, 2 January 2019) <http://www.pib.nic.in/Pressreleaseshare.aspx?PRID=1558214> accessed 4 May 2019.
[139] Notification dated 1 February 2019 bearing no. F. No. 3(4)/2018-H&FW(Part-III) Vol.2.
[140] *Ibid* para 6.

insurance scheme or the State nodal agency for implementing the RSBY. The SHA can either implement the scheme directly (either through a trust/ society mode) or it can use an insurance company to implement the scheme. The guidelines issued by NHA also provide for a suggested composition of the SHA, set out in **Annexure A.**[141]

The functions of the SHA include empanelment of network hospitals which meet the stipulated criteria, monitoring of services provided by health care providers, fraud and abuse control, administration of hospital claims, package price revisions or adaptation, adapting PM-JAY treatment protocols for listed therapies to State needs, convergence of PM-JAY scheme with State funded health insurance/ protection scheme and adapting operational guidelines in consultation with NHA, where necessary.[142]

II. Key Issues

From the aforesaid discussion, it is evident that the NHA and the SHAs are performing critical roles for the implementation of PM-JAY without statutory backing. These include identification and verification of beneficiaries, collection and processing of personal information and dealing with grievances in relation to the operation of the scheme. In certain cases, as discussed below, guidelines issued by the NHA envisage imposition of penalties by grievance redressal committees set up by the NHA and SHA without any authority of law.

Issues pertaining to composition of the NHA and SHA will assume significance in designing a legal framework for implementing the PM-JAY. For instance, currently, the NHA is chaired by a Union Minister. This may raise concerns regarding the independence and functional autonomy of NHA if it is to be made a statutory authority. Under the existing framework, while the scheme suggests a possible composition for the SHA, the same is not binding on the State Government. Further, States may also designate any existing authority implementing a State insurance scheme as the SHA. Unlike the NHA, there is no requirement for the SHA to have any domain experts. In view of the critical functions performed by SHA for the implementation of the scheme at the State level, a broad governance structure is a pre-requisite even if it includes the flexibility to be provided to States to vest the responsibility in an existing body.

Under the existing framework of PM-JAY, functions are distributed among different institutional authorities. In addition to NHA and SHA, there are other entities like District Empanelment Committees ("DEC") and State Empanelment Committees ("SEC") appointed by the SHA who are responsible for empaneling hospitals. Further, there are grievance redressal committees at the district, State and Central level, which are appointed by the SHA and the NHA, respectively. The existence of multiple entities may result in overlap of roles and responsibilities, may make inter-agency and inter-State coordination and fixing accountability challenging. Accordingly, the roles and responsibilities of the NHA, SHA and other entities (including non-government entities such as private hospitals and insurance companies) involved in implementing different facets of the scheme will have to be clearly delineated in the proposed law.

Key themes that may be considered while structuring the institutional architecture of the NHA and SHA in the proposed legislation are discussed below.

III. Way Forward

Rights created under the proposed law for implementation of the PM-JAY will also create corresponding obligations on institutions such as NHA and SHA that have been entrusted with the task of ensuring the fulfilment of these rights. Accordingly, one of the primary tasks of the proposed law is to set up a well-structured NHA and SHA (where necessary) with a robust governance framework. Key themes that may guide the legal institutional framework while setting up these authorities are clarity of purpose, precisely defined powers and functions of the NHA and SHA, operational and political independence and a framework for ensuring accountability of these authorities.

[141] NHA, 'Formation of State Health Agency and District Implementation Unit under Ayushman Bharat-National Health Protection Mission', <https://www.pmjay.gov.in/sites/default/files/2018-07/State%20and%20District%20ToRs%20for%20AB-NHPM%20Revised_0.pdf> accessed 4 May 2019
[142] *Ibid.*

There is a strong case for independence of the NHA and SHA. Independent authorities bring about legal certainty by ensuring that the regulatory/supervisory approach does not fluctuate with political changes. It also helps the authority to develop a specialised workforce as compared with the functioning of mainstream Government departments.[143] This will enable the statutory authority to respond to the unique needs of the scheme it is implementing. One primary manifestation of independence of such supervisory authorities is in its composition. Currently, the NHA is chaired by the Minister, MoHFW. As argued earlier, this may raise concerns regarding the independence and functional autonomy of NHA. Typically, when a statute sets up a separate authority, it is not headed by the Minister of the nodal Ministry responsible for implementing the statute.[144] In case of NHA, such issues assume significance, since it will be discharging executive, legislative and adjudicatory functions. Another crucial requirement of independence is that the members of the NHA and SHA should be protected from arbitrary interference in their operations through change in their terms and conditions of appointment. This may be dealt with by providing the conditions of appointment of members in the statute, which includes duration of appointment, entitlements, mechanism for removal and dealing with conflict of interest. Such a framework will also ensure functional autonomy of the NHA, one of the objectives for restructuring the National Health Agency as NHA.

A review of the existing mandate of the NHA and SHA as envisaged under the existing guidelines indicate that there may be areas of overlap, particularly in the context of empanelment criteria, determination of package rates, grievance redressal, fraud control, etc. While the NHA is empowered to formulate the operational guidelines related to PM-JAY to ensure standardisation and inter-operability, it is not clear if the State Government has any room for flexibility insofar as compliance with these guidelines is concerned. Accordingly, the law should clearly spell out the powers and functions of the NHA, SHA and other entities implementing various facets of PM-JAY. Basic standards that must be complied with by entities implementing the scheme should be clearly set out in the law, providing necessary flexibility to the State as and when it is required and keeping in mind the unique needs of each State. In prescribing the powers and functions of SHA and NHA, regard must be had to issues of legislative competence as discussed in Part II above.

Along with the independence of a supervisory/implementation agency, there is also a requirement for accountability mechanisms. This can be achieved by ensuring that the law sets out the standards of governance that the authority must adhere to, clear processes for discharging its functions under the law, including the process for issuing regulations / guidelines under the law, reporting and audit mechanism, including financial reporting, etc.

Under the existing framework, the State Government is given the flexibility to either set up a SHA or designate an existing agency implementing a state insurance scheme or the RSBY with the powers and functions of the SHA as envisaged under PM-JAY. From a good governance perspective, it may be argued that the law should mandate setting up a separate SHA. Issues pertaining to independence, functional autonomy and accountability of the SHA may be better addressed through a separate authority, unless the authority so designated possesses the same virtues. However, since State Governments can implement PM-JAY by converging it with a State scheme, the existing framework has permitted the flexibility discussed above. Given that various institutional and capacity related issues may have to be considered before mandating State Governments to set up a separate SHA, the existing flexibility may be retained in the proposed law. However, in doing so, the law should clearly set out the basic standards of governance that the SHA should meet, including number of members of SHA, the basic qualifications of the members and processes that must be followed by the SHA for discharging its functions under the law. Key themes discussed above may also guide the governance structure of SHAs.

[143] Ministry of Finance, Government of India, 'Report of the Financial Sector Legislative Reforms Commission' (March 2013) < https://www.dea.gov.in/sites/default/files/fslrc_report_vol1_1.pdf> accessed 4 May 2019.
[144] For instance, the Unique Identification Authority of India ("UIDAI") may be chaired by either a part-time or full-time Chairperson who should have experience and knowledge of at least ten years in matters relating to technology, governance, law, development, economics, finance, management, public affairs or administration. See Section 13, Aadhaar (Targeted Delivery of Financial and Other Subsidies, Benefits and Services) Act, 2016.

B. Population Coverage, Beneficiaries and Exclusions

The PM-JAY has been envisaged to reduce the financial burden on poor and vulnerable groups arising out of catastrophic hospital episodes and ensure their access to quality health services. Thus, the identification of targeted beneficiaries is central to the governance and success of the PM-JAY scheme.

I. Existing Position

As mentioned earlier, the SECC 2011 data is used as a source / base data for validation of beneficiary households under PM-JAY. Based on the SECC 2011 data, six deprivation criteria have been determined for identification of beneficiaries in rural areas, while occupational criteria have been used to identify urban beneficiaries of PM-JAY. Further, households not having a shelter and meeting certain criteria are automatically included as beneficiaries under the PM-JAY. It is unclear whether these beneficiaries who have been automatically included as beneficiaries are required to be verified or not. The complete eligibility criteria are set out in **Annexure B**. Further, enrolled beneficiaries of the RSBY who do not form part of the SECC 2011 data have also been included within the fold of PM-JAY. Based on the aforesaid criteria, the number of households in each State that are eligible for the benefits under PM-JAY have been identified.

It may be noted that the PM-JAY operates on a targeted basis and a centralised database has been prepared based on the SECC 2011 data after a rural and urban data collection drive.[145] While determining whether a person is a beneficiary or not, her name is matched with the database. If the exact name is mentioned then, upon verification, such person is provided with treatment at a hospital. If the name of the concerned person is not expressly stated and a name of any of her close family members is mentioned in the database, then upon determination of 'closeness' (during verification), health cover would be provided. We understand that since PM-JAY is an entitlement-based scheme and there is no enrollment process, no new additional families can be added under PM-JAY at this time.[146]

II. Key Issues

Identification of beneficiaries

The PM-JAY uses a master-list for determination of eligible beneficiaries which is based on the SECC 2011 data. This reliance on the SECC 2011 data for providing health assurance merits attention. An analysis of the SECC 2011 data reveals certain serious concerns of under-enumeration of the poor.[147] For instance, the Census of 2011 classifies 4.7 million as homeless households while the SECC 2011 data reveals that 1.65 million are households without shelter, destitute, living on alms, manual scavenger families, vulnerable tribal groups and legally released bonded labour.[148] The SECC 2011 data has also been criticised for over-reporting of the rich.[149] For example, an owner of a fishing boat has been automatically excluded from the scope of the SECC 2011, thus, denying her the benefit of targeted schemes.[150]

While an Expert Group constituted by the Ministry of Rural Development, Government of India, chaired by Shri Sumit Bose, Former Finance Secretary, Government of India in 2016 ("Expert Group"), recommended using SECC 2011 data for "*all the Centrally Sponsored Schemes, Central Sector Schemes and the Schemes of the States Governments to refine them and reorient the focus of these schemes towards the focused group and to obviate exclusion and inclusion errors*," it also felt the need for having "*a grievance redressal mechanism which would address issues of exclusion and*

[145] Please note that these data collection drives which were conducted at local level did not include addition of more households within the PM-JAY database. See Point 9, Guidelines for Additional Collection Drive in Urban Area <https://www.pmjay.gov.in/sites/default/files/2018-07/AB-NHPM-Urban-Guidelines-ADCD_Rev1.pdf> accessed 2 May 2019.
[146] PM-JAY, Frequently Asked Questions, <https://www.pmjay.gov.in/faqs> accessed 2 May 2019.
[147] N C Saxena, 'Socio Economic Caste Census, Has It Ignored Too Many Poor Households?' 50 Economic and Political Weekly 30, (2015)<https://www.epw.in/journal/2015/30/commentary/socio-economic-caste-census.html> accessed 2 May 2019.
[148] *Ibid.*
[149] *Ibid.*
[150] 'SECC 2011 Frequently Asked Questions' <https://secc.gov.in/faqReportlist> accessed 6 May 2019.

inclusion errors".[151] In absence of any such grievance redressal mechanism to address inclusion (and exclusion errors),[152] the infirmities of the SECC 2011 data would creep into PM-JAY as well, leading to some "*real*" beneficiaries being deprived of the benefits and the "*ineligible*" ones that have somehow been included into the list getting the benefit.[153]

When health assurance takes the form of a justiciable right, it is essential that PM-JAY, which is in the nature of a targeted scheme becomes dynamic to allow for the entrance of new eligible beneficiaries and continue to exclude those who are no longer eligible. This is believed to be a key determinant of effective targeted schemes.[154] In case of PM-JAY, currently, there is no process for enrolling new households in the scheme despite the fact that these households may meet the eligibility criteria but may have inadvertently been left out of the master list prepared by the NHA based on the SECC 2011. In early 2018, it was reported[155] that 6.5 million beneficiaries of the 10.74 million and poor vulnerable eligible for PM-JAY were untraceable at the time when NHA was preparing the list of eligible beneficiaries. While we are not aware how many households have finally been left out in the list prepared by NHA, it is evident that there will be instances when eligible households will be left out due to various factors, particularly in case of migrant workers/ destitute persons. These issues assume more significance in the context of a rights-based approach for health insurance.

Questions pertaining to eligibility are not new, previous schemes have faced exactly this problem.[156] In fact, it was reported that the PM-JAY's pilot scheme, rolled out in Mewat district, Haryana faced the same problem.[157] Problems with eligibility criteria are heightened in the absence of any provision for revising or updating the list of eligible households, absence of any audit mechanism to ensure that registration lists have been verified at the community level, etc.

Subjectivity in beneficiary identification

Another issue with the beneficiary identification framework is the definition of 'household'. It must be noted that under SECC 2011 the following will be eligible for being recorded as members of a household: (a) all persons normally living together; and (b) all persons normally living together but staying away from the household on a short term seasonal migration and expected to come back within 6 months from the date of enumeration. Notably, if the household head is staying from the household for more than 6 months in the last one year, his / her individual particulars will not be recorded with the household. Further, the following will not be treated as members of a household: (i) temporary visitors or guests whose total period of stay is less than 6 months in the past one year; (ii) members who have permanently migrated or left the household on marriage, employment, etc. even if they occasionally visit the household; (iii) a resident employee, domestic servant or a paying guest taking common meal and living with the household; and (iv) those who are not considered a normal member. It is not clear from a reading of the Beneficiary Identification Guidelines[158] if the same criteria as set out in SECC 2011 will be applicable for determining if a family member is eligible for benefits under PM-JAY. If such a vague definition is applicable in case of PM-JAY, then it may be difficult to prove or disprove inclusion/ exclusion of beneficiaries of a household.

[151] Department of Rural Development, Ministry of Rural Development, 'Report of the Expert Group on Socio Economic and Caste Census (SECC) 2011' <https://rural.nic.in/sites/default/files/Report_of_the_expert_group_on_SECC_2011_0.pdf> 35 accessed 2 May 2019.

[152] PM-JAY has addressed the issue of false positives by using the exclusion criteria provided under the SECC 2011 data and *vide* a circular dated 30 August 2018, the NHA advised the district authorities to, after proper representation, exclude such beneficiaries which meet the exclusion criteria listed in the said circular.

[153] Anil Swarup, 'PM Jan Arogya Yojana a game-changer, but it will face these huge challenges' *Business Standard* (15 November 2018), <https://www.business-standard.com/article/economy-policy/pm-jan-arogya-yojana-a-game-changer-but-it-will-face-these-huge-challenges-118111500351_1.html> accessed 2 May 2019.

[154] Human development Unit, South Asia, World Bank, 'Draft Policy Note - Regional Study on Targeting Systems and Practices' (2010) <https://openknowledge.worldbank.org/bitstream/handle/10986/12745/702850ESW0P1100000Final000June02010.pdf?sequence=1&isAllowed=y> accessed 2 May 2019.

[155] Rhythma Kaul, '6.5 million beneficiaries missing from Ayushman Bharat first list' *Hindustan Times* (31 July 2018), <https://www.hindustantimes.com/india-news/6-5-million-beneficiaries-missing-from-ayushman-bharat-first-list/story-SJDi1EoiXrcuCJamYHrDeJ.html> accessed 2 May 2019.

[156] Radha Khan and Suvojit Chattopadhyay, 'Does India really have the capacity to implement Modi's mega health scheme?' (*Scroll.in*, 1 October 2018) <https://scroll.in/pulse/896382/does-india-really-have-the-capacity-to-implement-modis-mega-health-scheme> accessed 2 May 2019.

[157] Abantika Ghosh, 'Pradhan Mantri Jan Arogya Yojana: Meet beneficiary number 1 in India's most backward district' *Indian Express* (21 September 2018) <https://indianexpress.com/article/india/pradhan-mantri-jan-arogya-yojana-scheme-meet-beneficiary-number-1-in-indias-most-backward-district-5367392/> accessed 2 May 2019.

[158] PM-JAY, 'Beneficiary Identification Guidelines', <https://www.pmjay.gov.in/sites/default/files/2018-07/GuidelinesonProcessofBeneficiaryIdentification_0.pdf> accessed 2 May 2019.

Also, the verification process under the PM-JAY is required to be robust to avoid misuse. At the same time, it should not deny health cover to any eligible beneficiary. There appears to be some subjectivity involved in this process as well in the determination of proximity/ closeness in case of a person whose family member's name is mentioned in the PM-JAY database, as it does not enlist all members of the household (who will be eligible for the health insurance cover). It is pertinent to note that if such subjectivity or vagueness is also provided under the rights-based framework, then it may become a ground for challenge of relevant provisions in so far as it becomes difficult to define the scope of such provision.[159]

These uncertainties in the beneficiary identification and verification process are required to be reduced by resorting to timely updation and audit of the list of PM-JAY beneficiaries.

Exclusion criteria

In 2018, certain persons who were not eligible under the PM-JAY's deprivation criteria were found to be included in the PM-JAY database.[160] It was in this context that NHA had issued a circular dated 30 August 2018 enlisting automatic exclusion criteria in the SECC 2011 data. These criteria include households having motorized 2/3/4 wheeler/fishing boat, a household where at least one member is a government employee, a household where at least one member is earning more than INR 10,000/- per month, etc. A detailed list of these exclusions has been provided in **Annexure B**. Further, State Governments have been advised to empower district authorities to exclude such false positive cases after obtaining a written representation and a summary inquiry in this regard. However, abundant caution must be exercised in such instances because an inadvertent error can deny healthcare to the needy.

While we understand that the automatic exclusion criteria that has been relied on for excluding a beneficiary from the PM-JAY is based on SECC 2011 data, the same may require a closer relook in the event of formulating a rights-based legal framework for PM-JAY. Any criteria which excludes a class or classes of the populace from PM-JAY will be tested against the touchstone of Articles 14 and 21 of the Constitution of India. Thus, such exclusion criteria which represents a group of those households which will not be provided with the benefits under the PM-JAY "*must be founded on an intelligible differentia which distinguishes those that are grouped together from others and that that differentia must have a rational relation to the object*" sought to be achieved by the rights-based legislation for PM-JAY. [161]

III. Way Forward

A massive population and limitation of state funding have been major issues that have impacted the success of social welfare schemes in India. It may particularly be because of these reasons that PM-JAY's design is based on a pre-defined target population. However, as is clearly evident from its implementation, there is ample room for both - false positives and false negatives. Thus, for the scheme to be made more equitable, a phased enrollment plan may be prepared. The enrollment process may be expanded based on experience and state capacity. Additionally, timely updation and audit of the list of eligible beneficiaries would go a long way in strengthening the robustness of the entire PM-JAY infrastructure and curbing leakages. Further, automatic exclusion criteria may be re-assessed in light of the proposed rights-based approach so as to ensure that such automatic exclusion criteria are based on some intelligible differentia which has a rational relation with the objective of the proposed law, failing which such exclusions may be susceptible to a constitutional challenge on the grounds of being arbitrary.

[159] *State of Bombay And Another v F.N. Balsara* 1951 AIR 318; *Shreya Singhal v Union of India* AIR 2015 SC 1523.
[160] Prabha Raghvan, 'Govt asks districts to weed out names that should not be in list of Ayushman Bharat beneficiaries' *Economic Times* (29 August 2018) <https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/govt-asks-districts-to-weed-out-names-that-should-not-be-in-list-of-ayushman-bharat-beneficiaries/articleshow/65586724.cms?from=mdr> accessed 2 May 2019.
[161] *The State of West Bengal v Anwar Ali Sarkar* AIR 1952 SC 75.

C. PM-JAY Grievance Redressal & Enforcement Framework: Scope for Improvement

I. Existing Position

To ensure that disputes and grievances of PM-JAY beneficiaries, healthcare providers and other stakeholders in the PM-JAY ecosystem are resolved in an efficient, transparent and time bound manner, NHA has developed Grievance Redressal Guidelines ("GR Guidelines"). There is a centralised portal which records the complaints received and the respective nodal officers have been given the responsibility to enter any grievance they receive for maintenance of records.

The stakeholders who can approach the grievance redressal framework include:

- PM-JAY beneficiary;
- Healthcare provider;
- Insurer or its employees;
- Implementation Support Agency[162] or its employees;
- SHA or its employees or nominated functionaries for implementation of PM-JAY; and
- Any other person having interest or participating in the implementation of the PM-JAY.

However, it may be noted that any person who is not a PM-JAY beneficiary and is not acting on behalf of a PM-JAY beneficiary should resort to other channels of feedback and not use the PM-JAY grievance redressal framework.

The GR Guidelines envisage a three-tier grievance redressal structure and lay down the framework illustrated below:

The composition of the District Grievance Redressal Committee ("DGRC"), State Grievance Redressal Committee ("SGRC") and the National Grievance Redressal Committee ("NGRC") has been provided in **Annexure C**. These agencies and the nodal officers need to be appointed within 15 days from the date of the memorandum of understanding between NHA and the State Government.

[162] An Implementation Support Agency would be an agency which would conduct certain specific functions of the SHA. The SHA is required to enter into a contractual arrangement for appointment of such agency.

Functions

- DGRC is the redressal mechanism of the first instance. It can call information, conduct proceedings and is required to adhere to principles of natural justice.
- The SGRC acts as the appellate authority for the grievances referred to it from the DGRC. However, it can also hear original matters.
- NGRC acts as the final arbiter in matters pertaining to PM-JAY and can only adjudicate on appeals from the SGRC. It may send matters or issues or complaints received at its instance to the SGRC for adjudication.
- These committees have also been provided with *suo moto* powers.

In addition to these committees, nodal officers have been appointed at each level. They are:

- District Grievance Nodal Officer ("DGNO") – She is nominated by the SGRC and has the power to address grievances of stakeholders or refer it to the DGRC. The DGNO shall determine whether the case at hand is a fit case to exercise her authority (Direct Channel) or it should be referred to the DGRC (GRC Channel).
- State Grievance Nodal Officer ("SGNO") – She is nominated by the SGRC. She can also address grievances of stakeholders or refer it to the SGRC.
- National Grievance Nodal Officer ("NGNO") – She is nominated by the NGRC. She forwards the grievances received at national level to the concerned SGNO for further actions and refers grievances to Convener of NGRC.

II. Key Issues

Redressing Inclusion and Exclusion Errors

The Expert Group while recommending that SECC 2011 data be used to determine eligibility for all central and state social welfare schemes categorically felt the need to have a grievance redressal framework that addresses complaints pertaining to inclusion and exclusion errors.[163] However, as detailed above, since PM-JAY is an entitlement-based scheme, the PM-JAY grievance redressal framework does not envisage redressing the grievance of an otherwise eligible beneficiary whose name does not appear in the PM-JAY database. This is a crucial issue which must be addressed in the proposed legal framework.

Penalising Fraudulent Conduct

Social welfare schemes and their success increasingly rely on implementation and public perception. Public perception is dented by leakages and frauds, which impact overall efficacy of such social welfare schemes. While anti-fraud preventive measures are required to be put in place in the PM-JAY infrastructure, there is a need to deal with fraud more strictly in the *ex-post* sense as well.

Fraudulent apps claiming that that they register eligible beneficiaries for PM-JAY have proliferated.[164] The MoHFW has also issued a clarification in this regard.[165] Further, while certain hospitals have been charging directly from PM-JAY beneficiaries, one hospital was caught admitting more patients than the number of beds.[166] Thus, it is clear that frauds can be committed not only by the players within the fold of the PM-JAY infrastructure

[163] Department of Rural Development, Ministry of Rural Development, 'Report of the Expert Group on Socio Economic and Caste Census (SECC) 2011' <https://rural.nic.in/sites/default/files/Report_of_the_expert_group_on_SECC_2011_0.pdf> accessed 2 May 2019, 35.
[164] 'Government has issued warning against these 64 apps, check the list here', (*Gadgets Now*, 22 December 2018), <https://www.gadgetsnow.com/slideshows/government-has-issued-warning-against-these-64-fake-health-apps/Government-has-issued-warning-against-these-64-apps-check-the-list-here/photolist/67195647.cms> accessed 4 May 2019.
[165] 'Ayushman Bharat: Beware of fraudsters! JP Nadda issues clarification on Pradhan Mantri Jan Arogya Yojana 'registration'' *Financial Express* (21 September 2018) <https://www.financialexpress.com/india-news/ayushman-bharat-beware-of-fraudsters-jp-nadda-issues-clarification-on-pradhan-mantri-jan-arogya-yojana-registration/1321364/> accessed 4 May 2019.
[166] See Sumi Sukanya Dutta, 'First fraud cases detected in Modi's national health scheme' *The New Indian Express* (26 February 2019) <http://www.newindianexpress.com/nation/2019/feb/26/first-fraud-cases-detected-in-modis-health-scheme-1943866.html> accessed 4 May 2019; Himani Chandna and Amrita Nayak Dutta, 'Control fraud under Modicare, govt tells states as hospitals charge for free treatment' (*The Print*, 9 March 2019) <https://theprint.in/india/governance/control-fraud-under-modicare-govt-tells-states-as-hospitals-charge-for-free-treatment/203215/> accessed 4 May 2019.

for which the current penalties under PM-JAY are envisaged, but also by other entities. Delay in investigation and adjudication of such frauds may cause irreparable harm to the people at large and also cause a huge dent in public perception of the scheme. Thus, a rights-based framework should also envisage a framework for penalising such fraudulent conduct.

Streamlining Powers and Functions of Grievance Redressal Bodies

Under the existing framework, separation of powers between executive and adjudicatory functions is not clearly mandated. For instance, the PM-JAY Grievance Redressal Matrix enlists certain grievances against the SHA, which are required to be heard at the State level by the SGNO/ SGRC. The SGNO and SGRC are appointed by the SHA itself. Such a framework may arguably lead to concerns that those responsible for the implementation of the scheme are also responsible for adjudicating on grievances that arise from its implementation. To deal with such concerns, in designing a grievance redressal framework, issues pertaining to separation of adjudication and executive functions should be considered, especially in the context of the composition of DGRCs and SGRCs.

Further, in order to ensure a prompt and coordinated approach for serious violations including frauds, a co-ordination mechanism may be envisaged between grievance redressal bodies and other relevant regulators including health sector regulators/authorities and the Insurance Regulatory Development Authority of India.[167]

Presently, certain grievances concerning the health care provider are also redressed by respective empanelment committees.[168] Further, certain grievances against the SHA are being handled at the district level. These committees have the power to impose penalties without any authority of law. In order to avoid duplication, clear determination of the powers and jurisdiction of grievance redressal committees at all levels must be provided in the statutory enactment. Further clarity will be required in the context of portability. This is particularly relevant in case of empaneled healthcare provider grievances against the insurer/SHA which can currently be raised in both States. It is not clear from the existing guidelines whose decision prevails in case of a difference of opinion between the grievance redressal committees of both States.

III. Way Forward

Since a rights-based enactment would provide a justiciable right, enabling a statutorily recognised grievance redressal mechanism (at all three levels of governance) with enforcement powers could go a long way in ensuring greater compliance as compared to a scheme-based or contractual framework as currently provided. A robust grievance redressal framework is a necessary corollary of a rights-based framework, particularly so, in case of adjudication of inclusion and exclusion errors. Thus, the PM-JAY grievance redressal framework must encompass a mechanism to adjudicate upon inclusion and exclusion errors. Statutory recognition to the PM-JAY grievance redressal framework also requires that the powers and functions are streamlined to avoid duplication and ensure greater efficacy. Further, the statutory framework must envisage a framework for penalising fraudulent conduct.

D. Quality of Healthcare under PM-JAY

I. Existing Position

While PM-JAY is a health insurance scheme, providing quality healthcare services under the PM-JAY infrastructure is an incidental but essential requirement for the effective implementation of the scheme. Thus, the empanelment criteria for healthcare providers plays a crucial part in ensuring quality healthcare for the beneficiaries of PM-JAY.

[167] Based on publically available information, we understand that the NHA has set up a working group with the Insurance Regulatory Development Authority of India to have a coordinated approach for successful implementation of PM-JAY. See, 'NHA, IRDAI to set up working group for Ayushman Bharat implementation' (*Moneycontrol*, 6 March 2018) <https://www.moneycontrol.com/news/business/economy/nha-irdai-to-set-up-working-group-for-ayushman-bharat-implementation-3614281.html> accessed 4 May 2019.

[168] See PM-JAY, 'Guidelines On Processes For Empanelment Of Hospitals' <https://www.pmjay.gov.in/sites/default/files/2018-07/GuidelinesonProcessesforEmpanelmentofHospitals_0.pdf> accessed 2 May 2019.

The PM-JAY Guidelines on Process of Empanelment for Hospital ("Empanelment Guidelines") provides creation of empanelment committees at the district and the State level, which are appointed by the SHA.[169] The DECs are required to conduct field verification of hospitals and recommend relaxation of criteria, if required. The SEC is empowered to empanel healthcare providers and finally determine if any relaxation may be given. The Empanelment Guidelines prescribe minimum criteria required for empanelment under PM-JAY. These criteria cannot be relaxed for any hospital and are applicable to all public and private healthcare providers. Speciality criteria are provided based on specialist services required for secondary or tertiary care. These may be relaxed by the SEC based on various factors with prior approval of the NHA.

Also, healthcare providers are not allowed to pick and choose the services they want to offer (based on monetary factors or otherwise) and are required to be empanelled with PM-JAY for all services that the said provider has the necessary infrastructure for.

II. Key Issues

From the perspective of a rights-based framework, provision of health care services should not be discriminatory. While all public hospitals are deemed to be empanelled under PM-JAY, the Empanelment Guidelines provides that "*the State Health Department shall ensure that the enabling infrastructure and guidelines are put in place to enable all public health facilities to provide services*" under the PM-JAY.[170] Thus, the State Government is required to ensure that the infrastructural facilities for all public hospitals match the minimum criteria prescribed under the Empanelment Guidelines.

Further, the issue of discrimination is particularly relevant in terms of determination of relaxation of applicable criteria. The Empanelment Guidelines provides that minimum criteria cannot be relaxed. However, the empanelment criteria to provide speciality services may be relaxed by the SEC based on factors such as local context, availability of providers, and the need to balance quality and access with prior approval of the NHA. Such relaxation must be provided after careful consideration such that private and public healthcare providers are not subject to essentially different standards and the general quality of healthcare for PM-JAY beneficiaries does not suffer. Further, such relaxations should not dilute or be contrary to the standards otherwise applicable to a hospital under a separate law. Most importantly, private healthcare providers must not be able to enrich themselves at the cost of beneficiaries by providing lower quality services owing to relaxed criteria.

While the Empanelment Guidelines clarify that the minimum criteria cannot be relaxed, Paragraph 1.3 of the guidelines states that all public facilities with the capability of providing inpatient services (Community Health Centre level and above) are deemed empaneled under PM-JAY. While both these provisions will have to be read harmoniously, it is significant to clarify that the automatic empanelment is subject to compliance with minimum criteria set out under the law.

III. Way Forward

Minimum criteria for empanelment of hospitals must be provided as a schedule to the proposed legislation. These minimum criteria will be such from which no derogation should be permissible and must be equally applicable to both government and private hospitals. It must be clarified that the criteria laid down under the Empanelment Guidelines are over and above the requirements under applicable healthcare laws such as Clinical Establishments (Registration and Regulation) Act, 2010 or other laws and regulations at the State level. Relaxations provided to the SHA / State Government to derogate from any criteria should not dilute or be contrary to the otherwise applicable standards to a concerned hospital under the applicable law. Further, the minimum criteria and their enforcement must be made robust so as to ensure that basic quality standards are maintained. Subject to state capacity, the health infrastructure of public healthcare providers should be improved so that delivery of healthcare under the PM-JAY also improves.

[169] See PM-JAY, 'Guidelines On Processes For Empanelment Of Hospitals' <https://www.pmjay.gov.in/sites/default/files/2019-04/NHA_Guidelines_on_Process_of_Empanelment_for_Hospital_Revised_0.pdf> accessed 2 May 2019.
[170] *Ibid.*

Conclusion

A national health insurance law must be informed by a rights-based approach to ensure that it is not discriminatory, is accountable and transparent and provides for a robust grievance redressal mechanism. This is necessary in order to account for India's international obligations and is also a constitutional imperative. Such a law can be enacted by Parliament under 'social insurance' in Entry 23, List III as a health insurance scheme with a regulatory authority to administer it. Incidental encroachments on 'public health' in Entry 6, List II should not affect the constitutionality of such a law *per se*. However, such encroachments should be minimal. Further, past experiences of transition of schemes into legislation and convergence of state and central schemes provide instructive lessons for drafting such a law. Ultimately, all these considerations should be accounted for to create a robust and constitutionally sound statutory framework that enables the PM-JAY to meet its objectives.

The blueprint of a rights-based legislation for providing health insurance for the Indian population must contain provisions relating to the following aspects:

- **Right to Health Insurance**: The proposed law must guarantee a justiciable 'right to health insurance' and set out the contours of the targeted scheme of health insurance.

- **Statutory Authorities**: NHA and SHA (or any other existing entity/ authority which may be designated by the State Government) must be provided statutory recognition. In setting up these authorities, the key principles of independence and accountability should be factored in. The powers and functions of these authorities should be clearly laid down for effective implementation.

- **Eligibility**: The eligibility criteria for determination of beneficiaries of such scheme should be specifically provided in the proposed law. A broad outline of the process to determine/ verify such eligible beneficiaries and exclusions thereto may also be provided. Further, subject to state capacity, a provision to enroll beneficiaries who meet the eligibility criteria should be incorporated. In order to curb leakages, timely review and audit of the beneficiary criteria/ list should be provided for.

- **Empanelment of Health Care Providers**: The law should impose an obligation on health care providers offering health services under the scheme to comply with minimum standards. Such standards should not be lower than those applicable to these providers under any other laws. Process for providing relaxations in case of certain specialty criteria must be fair and clearly laid out.

- **Sharing Responsibilities and Co-ordination:** There should be a clear demarcation of the responsibilities between Central Government and the State Government(s). Mechanisms for inter-se coordination among Central Government, State Government/s and concerned authorities responsible for implementation of the scheme under the proposed law should be provided for.

- **Grievance Redressal Mechanism & Enforcement:** There should be a statutorily recognised grievance redressal mechanism (at all levels of governance) which adjudicates on inclusion and exclusion errors among other issues. Further, the grievance redressal bodies should have powers to enforce its orders. Penal provisions for dealing with fraudulent conduct may also be considered. Co-ordination mechanism between various relevant regulators such as Insurance Regulatory and Development Authority of India, health sector regulators should also be envisaged.

- **Monitoring Mechanism:** There should be an independent monitoring mechanism to audit the functioning of the scheme, to take into account external inputs and recommend periodic revisions to its key components.

If the law is built on the foundations listed above, it will provide a sound legal framework to effectively provide for health insurance with the ultimate objective of improving overall standards of public health in the country.

Annexure A - Composition

Composition of NHA

- Minister of Health and Family Welfare – **Chairman**;
- Chief Executive Officer, NITI Aayog - **Member, *ex-officio***;
- Secretary, Department of Expenditure, Ministry of Finance - **Member, *ex-officio***;
- Secretary, Department of Health and Family Welfare, Ministry of Health and Family Welfare - **Member, *ex officio***;
- Two domain experts from the fields of administration, insurance, public and private health care providers, economics, public health management, etc. appointed by the Government of India – **Member**;[171]
- Five Principal Secretaries (Health) of the State Governments, one representing five zones of the country (*viz.* North, South, East, West and North East) on a rotational basis – **Member**; and
- Chief Executive Officer, NHA - **Member, *ex-officio***.

Suggested Composition of SHA

- Chief Secretary - **Chairperson, *ex-officio***;
- Principal Secretary to Government, Health & Family Welfare Department - **Vice-Chairperson, *ex-officio***;
- Secretary, Finance Department - **Member, *ex-officio***;
- Secretary, Department of Rural Development - **Member, *ex-officio***;
- Secretary, Department of Housing and Urban Affairs - **Member, *ex-officio***;
- Secretary, Department of IT - **Member, *ex-officio***;
- Secretary, Department of Labour - **Member, *ex-officio***;
- Managing Director, National Health Mission or Commissioner, Health Department - **Member, *ex-officio***;
- Director of Medical Education or his/her nominee - **Member, *ex-officio***;
- Director of Health Services or his/her nominee - **Member, *ex-officio***;
- Chief Executive Officer, SHA - **Member Secretary, *ex-officio***;
- Representative of NHA - ***Special Invitee***; and
- Subject matter experts as nominated by the State Government - ***Special Invitee.***

[171] The two domain experts of the Governing Body (Member 4 and Member 5) shall be persons of ability and integrity having experience and knowledge of at least fifteen years in matters relating to health insurance, governance, law, economics, finance, management, public affairs or administration and shall be appointed by the Government of India.

Annexure B – Beneficiaries of PM-JAY

Rural
For Rural Total Deprived Households targeted for PM-JAY who belong to one of the six deprivation criteria amongst D1, D2, D3, D4, D5 and D7:

Only one room with kucha walls and kucha roof (D1)

- No adult member between age 16 to 59 (D2)
- Female headed households with no adult male member between age 16 to 59 (D3)
- Disabled member and no able-bodied adult member (D4)
- SC/ST households (D5)
- Landless households deriving major part of their income from manual casual labour (D7)

Automatically included Households without shelter:
- Destitute/ living on alms
- Manual scavenger families
- Primitive tribal groups
- Legally released bonded labour

Urban
Occupational Categories of Workers

- Rag picker
- Beggar
- Domestic worker
- Street vendor/ Cobbler/hawker / Other service provider working on streets
- Construction worker/ Plumber/ Mason/ Labour/ Painter/ Welder/ Security guard/ Coolie and another head-load worker
- Sweeper/ Sanitation worker / Mali
- Home-based worker/ Artisan/ Handicrafts worker / Tailor
- Transport worker/ Driver/ Conductor/ Helper to drivers and conductors/ Cart puller/ Rickshaw puller
- Shop worker/ Assistant/ Peon in small establishment/ Helper/Delivery assistant / Attendant/ Waiter
- Electrician/ Mechanic/ Assembler/ Repair worker

- Washer-man/ Chowkidar

In addition, all enrolled families under Rashtriya Swasthaya Bima Yojana (RSBY) that do not feature in the targeted groups as per SECC 2011 data will be included as well.

Exclusions[172]
As per the SECC 2011, the following beneficiaries are automatically excluded:

- Households having motorized 2/3/4 wheeler/fishing boat.
- Households having mechanized 3/4 wheeler agricultural equipment.
- Households having Kisan Credit Card with credit limit above INR 50,000/-.
- Household member is a government employee.
- Households with non-agricultural enterprises registered with government.
- Any member of household earning more than INR 10,000/- per month.
- Households paying income tax.
- Households paying professional tax.
- House with three or more rooms with pucca walls and roof.
- Owns a refrigerator.
- Owns a landline phone.
- Owns more than 2.5 acres of irrigated land with 1 irrigation equipment.
- Owns 5 acres or more of irrigated land for two or more crop season.
- Owning at least 7.5 acres of land or more with at least one irrigation equipment.

There may still be some instances, where some of those who have to be automatically excluded in SECC 2011, are figuring in the list of eligible beneficiaries. In such cases, States have been advised to authorize the District Collectors/ District Magistrates or Deputy Commissioners to exclude such beneficiaries from the eligible list.

[172] As provided under the NHA Circular dated 30 August 2018.

Annexure C – Composition of PM-JAY Grievance Redressal Agencies

District Grievance Redressal Committee
The DGRC shall consist of:

- Head of the District or District Magistrate or District Collector or Deputy Commissioner – **Chairperson**;
- Chief Medical Officer of the district – **Convener**;
- Representative of Rural Development Department of the State Government;
- District Coordinator of the Insurer (in case of insurance mode);
- DGNO; and
- Other experts for specific cases as determined by the Chairperson or the Convenor on behalf of the Chairperson.

State Grievance Redressal Committee
The SGRC shall consist of:

- CEO of SHA / State Nodal Agency - **Chairperson**;
- SGNO of the SHA - **Convenor**;
- Representatives of the Departments of Rural Development, Women & Child Development, Labour, Tribal Welfare;
- Director Health Services;
- Medical Superintendent of the leading State level government hospital or the Dean of the leading medical college in the State;
- Representative of Insurance Company (Applicable only where scheme is in insurance mode); and
- Other experts for specific cases as determined by the Chairperson or the Convenor on behalf of the Chairperson.

National Grievance Redressal Committee
The NGRC shall consist of:

- Deputy CEO of NHA - **Chairperson**;
- Executive Director, Monitoring and Evaluations & Operations, NHA – **Convenor**;
- General Manager, Operations - **Member**; and
- Other experts for specific cases as determined by the Chairperson or the Convenor on behalf of the Chairperson.

Vidhi Centre for Legal Policy
D-359, Defence Colony
New Delhi – 110024

Phone: 011-43102767/43831699

E-mail: vclp@vidhilegalpolicy.in