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Understanding the Universal Health Coverage Framework and Access to Evaluating Assam's Atal Amrit Abhiyan Through the Lens of Right to Health (Care)

Saheb Chowdhury[1*]

[1] *National Law University and Judicial Academy, Assam; saheb.chowdhury@nluassam.ac.in*

***Corresponding Author:** saheb.chowdhury@nluassam.ac.in

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ABSTRACT

This paper provides a right to health analysis of Assam's Atal Amrit Abhiyan (AAA) scheme by also situating it within promises made by the Assam Public Health Act, 2010. While this scheme is an important step in the direction of reducing catastrophic health expenditure for poor households and making costly critical care available, there, nevertheless, are scopes for further improvements, among others, in terms of its design, eligibility criteria, coverage to make it more compatible with the obligations under right to health. Right to health obligations under international law, particularly its concerns for non-discriminatory and equitable access, help us identify its shortcomings and provide the normative framework for suggesting improvements that can make the scheme potentially more universal in its scope and effective in achieving the goals it hopes to achieve.

Keywords: Right to Health, Atal Amrit Abhiyan, Healthcare Access, Out-of-Pocket Expenditure; Health Equity.

INTRODUCTION

There is a unique case in Assam for analysis of healthcare schemes through the lens of right to healthcare, since it has enacted the Assam Public Health Act of 2010. This Act in Section 3 explicitly guarantees the right to health and emphasises on the fulfilment of core obligations and the necessity for the progressive realisation of this right, in light of State's international law obligations. Furthermore, the Act guarantees provisioning of healthcare services. In light of this legislative framework as well as obligations arising under international human rights laws, this study intends to provide a critical analysis of Assam's Atal Amrit Abhiyan Scheme, which intends to provide access to certain critical care to poor households in the state. However, it seems necessary to begin this analysis by first examining some important health statistics in the state. These statistics not only provide a picture of the state of healthcare in the state but also demonstrate the importance of this analysis.

State of Health in Assam:

Despite some substantial improvements in health outcomes, Assam still faces major challenges in ensuring that everyone's health is protected, promoted and respected by ensuring equitable access to healthcare. A preliminary examination of important statistics makes it clear. According to the National Family Health Survey-4 (NFHS-4) conducted in 2015-16, Assam's infant mortality rate (IMR) was 48 per 1000 live births.[1] This figure has

[1] National Family Health Survey-4, Ministry of Health and Family Welfare, Government of India, (April 15, 09:15 AM), http://rchiips.org/nfhs/pdf/NFHS4/India.pdf.

further improved to 31.9 per 1,000 live births, as reported in the National Family Health Survey-5 (NFHS-5).[2] However, this rate is still above the national average of 35.2 per 1000 live births.[3] The under-five mortality rate (U5MR) in Assam has also been reduced, from 56 per 1000 live births under NFHS-4 to 39.1 under NFHS-5.[4] At the national level it is at 41.9.[5] Of particular concern is the state's maternal mortality rate (MMR), in which Assam continues to perform poorly when compared to other states. Despite some degree of improvements, Assam's MMR was reported at 237 per 100,000 live births, which is much higher than the national average of 130 per 100,000 live births.[6] MMR has subsequently improved to an average of 195 per 100,000 live births as reported by the Special Bulletin on Maternal Mortality Rate in India for 2018-20.[7]

While these demonstrate some degree of progress, they also show the urgent need for further improvements. This is clear when Assam's performance is compared with states that have achieved much better health outcomes. To have a clearer picture of where Assam stands in terms of health outcome, it is then of use to compare its health indices under NFHS-5 with that of Kerala, which is one of India's top-performing states, apart also from comparing with national average.

SL. No.	Indicators	Assam	Kerala	India
Infant and Child Mortality rates (per 1000 live births) (NFHS-5)[8]				
1.	Neonatal mortality rate (NNMR)	22.5	3.4	24.9
2.	Infant mortality rate (IMR)	31.9	4.4	35.2
3.	Under-five mortality rate (U5MR)	39.1	5.2	41.9

Maternal Mortality Rate (SPECIAL BULLETIN ON MATERNAL MORTALITY IN INDIA 2018-20)[9]				
4.	Maternal Mortality Rate	195	19	97

While the table above does not provide a detailed picture of the health and healthcare landscape in Assam, it nevertheless reveals some contrasts. The data shows that Assam currently does better than the national average on certain important health indices. It also made substantial improvements since the NFHS-4, in which the state fell behind the national average. A major improvement has been in the reduction of maternal mortality rate. However, the state still remains the worst-performing state on this metric.

Despite these improvements, the comparison with Kerala shows a substantial gap that Assam has to fill. The state's comparative advantage over the national average in certain areas may partly be attributed to the exceptionally poor health indicators in certain northern states, rather than to the performance of the state itself. This necessitates concerted efforts to improve health outcomes in Assam to not just surpass the national average but also to be at par with the best-performing states in India, such as Kerala.

Furthermore, according to Niti Aayog, despite substantial improvements in health in Assam, the state still ranks 12th among the 19 larger states in India.[10] This shows the uphill challenges faced by Assam's healthcare system. A particularly concerning issue is the severe shortage of hospital beds and Human Resources for Health (HRH).[11] A World Bank Project Information Document shows that only 12 percent of district hospitals in Assam are able to meet the required number of doctors, only 4 percent meet the requirement for nurses and 52 percent

[2] 'Factsheet_as.Pdf' <https://nhm.assam.gov.in/sites/default/files/swf_utility_folder/departments/nhm_lipl_in_oid_6/menu/document/factsheet_as.pdf> accessed 22 December 2024.

[3] 'India.Pdf' <https://rchiips.org/nfhs/NFHS-5_FCTS/India.pdf> accessed 15 December 2024.

[4] ibid.

[5] ibid.

[6] 'Maternal Mortality Rate (MMR)' <https://www.pib.gov.in/www.pib.gov.in/Pressreleaseshare.aspx?PRID=1697441> accessed 15 December 2024.

[7] 'India - SAMPLE REGISTRATION SYSTEM (SRS)-SPECIAL BULLETIN ON MATERNAL MORTALITY IN INDIA 2018-20' <https://censusindia.gov.in/nada/index.php/catalog/44379> accessed 15 December 2024.

[8] 'Final Compendium of Fact sheets_India and 14 States_UTs (Phase-II).Pdf' <https://rchiips.org/nfhs/NFHS-5_FCTS/Final%20Compendium%20of%20fact%20sheets_India%20and%2014%20States_UTs%20(Phase-II).pdf#toolbar=0&navpanes=0> accessed 15 December 2024.

[9] 'India - SAMPLE REGISTRATION SYSTEM (SRS)-SPECIAL BULLETIN ON MATERNAL MORTALITY IN INDIA 2018-20' (n 9).

[10] 'NITI-WB_Health_Index_Report_24-12-21.Pdf' <https://www.niti.gov.in/sites/default/files/2021-12/NITI-WB_Health_Index_Report_24-12-21.pdf> accessed 21 December 2024.

[11] Bathula Nagaraj Amith, 'Project Information Document - Assam State Secondary Healthcare Initiative for Service Delivery Transformation (ASSIST) Project - P179337' (*World Bank*) <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099064002162330240/P17933705cb0cf0608f00069d0b86e4c6e> accessed 21 December 2024.

meet the requirement for paramedical staff according to Indian Public Health Standards (IPHS) norms.[12] This inadequacy of access to healthcare is particularly concerning in light of the state's vulnerability to annual floods, which adversely affect a substantial portion of the population of Assam, by, among others, increasing the risk of waterborne diseases during the monsoon season.[13]

In light of these challenges, this paper intends to analyse the Atal Amrit Abhiyan scheme of the state to find out how far it fulfils its right to health obligations.

A Right to Healthcare Analysis of the Atal Amrit Abhiyan (AAA):

The Atal Amrit Abhiyan is one of the most important initiatives of the state of Assam in making critical care accessible to the people. It is a flagship health insurance scheme that has been launched by the Government of Assam in order to provide financial protection and reduce out-of-pocket expenses, particularly for households that are below poverty line and those who are economically vulnerable. The scheme has specifically been designed to meet the healthcare needs of the people by providing coverage for a range of critical conditions and by providing financial assistance for treatment in both public and private hospitals. Hence, we shall look into the extent to which the scheme meets the right to health standards by examining, among others, its disease and financial coverage, its design and effectiveness from a rights based perspective The aim is to understand the strengths and weaknesses of the scheme in terms of its capacity to realise right to health in Assam.

A Brief Introduction to the Atal Amrit Abhiyan (AAA):

The Atal Amrit Abhiyan (AAA) was introduced in Assam with the primary objective of providing healthcare coverage to the residents of the state, particularly those who are from the Below Poverty Line (BPL) category and those from low-income households. It intends to provide protection to these vulnerable populations from catastrophic effects of healthcare expenses by reducing out-of-pocket expenditures. Along with that it also intends to make quality healthcare accessible to such groups and improve their overall health outcomes.[14] By targeting these high-cost and life-threatening conditions, the scheme seeks to alleviate the financial burden on low-income families and ensure they receive necessary medical care without being pushed further into poverty.[15]

The scheme was introduced in the state government's budget speech for the fiscal year 2016-17. Through this scheme, the government aims to address the health challenges that are faced by economically vulnerable residents, improve health outcomes and ensure greater equity in healthcare access in the state.

The Atal Amrit Abhiyan (AAA) scheme has an equity-oriented intent and recognises the universality right to health, as evident from the rationale provided in the guidelines for its implementation. The budget speech that introduced the scheme outlines various reasons for its inception, which show an acknowledgement of the healthcare challenges faced by the economically vulnerable populations in Assam. These reasons include financial Burden of Illness pushing families into financial ruin;[16] Inaccessibility of Healthcare due to excessive costs associated with critical illnesses;[17] Acknowledgement that the highest attainable standard of health is a fundamental right of every human being and a principle also enshrined in the Constitution of India;[18] and high Out-of-Pocket Expenditure and the need to provide financial relief and reduce the economic burden on families.[19] The introduction of the AAA scheme prioritises the concerns of the economically poor and vulnerable, and intends to align with one of the requirements of the right to health. By focusing on making critical and costly healthcare accessible to all, the scheme aims to reduce disparities in access to healthcare and ensure equitable health outcomes for the people of Assam. This policy intends to not only address immediate financial concerns but also the broader concern of ensuring that every individual can exercise their right to health without financial hardship.

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[12] ibid 8.

[13] Jayanti Saha, 'The Pattern of Morbidity and Access to Healthcare Service in the Riverine Flood-Prone Villages of Assam, India' [2023] The Open Public Health Journal <https://openpublichealthjournal.com/VOLUME/16/ELOCATOR/e18749445269914/>.

[14] 'Atal Amrit Abhiyan | Health & Family Welfare | Government Of Assam, India' <https://hfw.assam.gov.in/portlet-innerpage/atal-amrit-abhiyan> accessed 22 December 2024.
The scheme was launched on December 25, 2016, by the Government of Assam, and it focuses on providing cashless and hassle-free treatment in six critical specialties: Cancer, Heart Disease, Kidney Disease, Neurological Disorders, Neonatal Diseases and Burns.

[15] 'Guidelines of Atal Amrit Abhiyan with Annexures-1-25.Pdf' <https://nhm.assam.gov.in/sites/default/files/swf_utility_folder/departments/nhm_lipl_in_oid_6/menu/schemes/Guidelines%20of%20Atal%20Amrit%20Abhiyan%20with%20Annexures-1-25.pdf> accessed 22 December 2024.

[16] ibid 1.Introduction: Health Assurance Scheme-Atal Amrit Abhiyan.

[17] ibid.

[18] ibid.

[19] ibid.

The Backdrop of the Introduction of the Scheme:

Poverty and Healthcare Expenditure:

The background of the guidelines for the Atal Amrit Abhiyan (AAA) highlights an urgent concern, i.e. that high levels of healthcare expenditure have the potential to push a significant number of families into poverty. This is concerning in particular for the Below Poverty Line (BPL) population and Low-Income Households who have an annual income below five lakh rupees, making them susceptible to the financial ruin from serious ailments.[20] Recognizing this vulnerability, the AAA scheme intends to specifically target these populations in the entire state of Assam, in all its districts.[21] Given that the scheme aims to mitigate the economic impact of healthcare and ensure that essential healthcare services are available to all, it is reasonable to infer that equitable access is a central motive behind the initiative. The emphasis on affordability within the scheme also aligns with the broader framework of the right to health, where affordability is a crucial element in ensuring that healthcare is accessible to all individuals, regardless of their economic status.

The Problem of Out of Pocket Expenditure:

Out-of-pocket expenditure (OOPE) in healthcare refers to the direct payments made by individuals or households for healthcare goods and services from their own financial resources. It is a major cause of poverty which has particular bad implications for the economically poor and disadvantaged groups and sections of the society. It has been defined specifically as "*household spending on medicines, health products, out-patient and inpatient care services (such as medical laboratory services) that are not reimbursed by a third party (such as the government, a health insurance fund or a private insurance company). It excludes household spending on health insurance premiums.*"[22] Recognizing the detrimental impact of OOPE, the Atal Amrit Abhiyan (AAA) scheme has been introduced to mitigate these financial burdens and improve access to essential healthcare services.

The Atal Amrit Abhiyan (AAA) scheme, as highlighted, is designed with the primary objective of reducing catastrophic out-of-pocket healthcare expenses by ensuring access to specific, quality healthcare services for the economically poor and vulnerable populations in Assam.[23] This is particularly important in light of the clear connection between high out-of-pocket expenditure on health and inequities in healthcare access, worsening the realisation of the right to health(care). However, despite these intentions, the scheme has certain limitations that need to be addressed for it to fully successfully achieve its objectives. The scheme provides financial coverage of up to two lakh rupees per individual. This amount is certainly not sufficient in the cases of severe and prolonged illnesses. When medical expenses go beyond this limit, it must then be borne by the individual from out of her own pocket. This could still cause financial ruin and compromise the scheme's intended goal of reducing catastrophic expenditures.

Furthermore, the scheme restricts coverage only to a limited number of specialties, implying that many other diseases and health conditions are beyond coverage. This leaves individuals vulnerable still to the high costs of healthcare for conditions which are outside the scheme's scope. Therefore, there is a need to further modify the scheme. Firstly, by expanding the financial coverage beyond the current limit of only two lakh rupees and by providing a more comprehensive protection against such expenses. Secondly, by increasing the range of diseases and ailments covered under it to ensure more people with different conditions have access to such critical care without fear of financial ruin. We will discuss this in greater detail below.

Apart from the above, there is also the urgent need to regulate the cost of healthcare services provided by private providers of care. This is essential to protect individuals from high costs of care charged by such private providers that can be financially catastrophic for the poor, even within the framework of an insurance scheme like AAA. We must highlight this absence in light of the obligations set forth by the Assam Public Health Act, 2010 itself that recognises the role of private healthcare providers in realising the right to health and obliges the state to regulate these providers.

Furthermore, since the scheme identifies beneficiaries at the level of a family based on economic status, there is a great chance of ignoring intra-family economic inequalities. Not all households will have resources distributed equitably among the individual members and certain economically poor and otherwise disadvantaged individuals within the family may be excluded from the benefits of the scheme, even when they are in great need of success. In order to prevent this, it is necessary that the scheme also looks even into socioeconomic situations of individuals within a household. When eligibility criteria is specified and individuals are identified based on their individual

[20] ibid 2. Background, Guidelines for Implementing Atal Amrit Abhiyan.
[21] ibid.
[22] 'Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report' <https://www.who.int/publications-detail-redirect/9789240029040> accessed 22 December 2023.
[23] 'Guidelines of Atal Amrit Abhiyan with Annexures-1-25.Pdf' (n 31) para 2. Background, Guidelines for Implementing Atal Amrit Abhiyan.

situations, the scheme can reach those who are in need of such support more effectively. This change will also make the scheme more compatible with the requirements of non-discriminatory and equitable access under the right to health by ensuring that no one is left behind.

Now, it is important to also note that a healthcare scheme that has been designed exclusively for the poor and vulnerable also results in provisioning substandard care.[24] When only poor and the vulnerable are targeted, it may lead to disparities in the quality of care accessible to them. Hence, a better approach would require that the healthcare scheme targets all individuals ensuring that all have a stake in the quality of care provided. Such an universal approach would also ensure that care is also accessible to those who do not fall in this usual category of extremely poor but are still vulnerable to catastrophic healthcare expenditure.

Lastly, well-intentioned as it may be, the AAA scheme adopts a piecemeal approach to addressing the systemic problem of inadequate access to healthcare. While targeted interventions may be beneficial in the short-run may not be the most effective way of realising the right in the long run.

Suggestions: Ensuring accessibility of critical care and reduction of out-of-pocket expenditures (OOPE) are important objectives of the Atal Amrit Abhiyan (AAA) scheme. To achieve this goal equitably, it is essential that the benefits of such schemes are targeted at individuals directly, rather than solely at the household level. This approach would better address intra-household disparities and ensure that every individual, regardless of their economic status within the family, receives the necessary healthcare support. Furthermore, the AAA scheme's specific focus on the economically poor may inadvertently compromise the quality of care provided. To address this, it is suggested that the reduction of OOPE be implemented equitably by removing such payments completely for the poor, vulnerable and disadvantaged populations at the individual level. Moreover, OOPE should be completely removed for essential healthcare services that fall under the core obligations of the right to health.25 This would ensure that the most critical healthcare needs are met without financial hurdles, particularly for those who are most at risk.

The issue of limited coverage, both in terms of financial caps and the range of conditions covered, could be mitigated by shifting from piecemeal programs that provide care up to a certain amount and only for specific categories of illnesses. Instead, there is a need to adopt a more comprehensive public healthcare system that provides quality care to all, irrespective of their economic status. Such a system would maximise the benefits derived from limited resources by ensuring that quality care is equitably accessible for everyone. By adopting a universal healthcare approach, the government could provide holistic care that reduces the necessity for costly treatments through preventive steps and ensure that when treatment is needed, it is available. This would not only realise the right to health for all but also improve the effectiveness of healthcare delivery, and ensure that the whole population, especially the most vulnerable, receives the care they need.

Beneficiaries Under the AAA Scheme:

The AAA scheme enrols individuals as the primary unit, with each person in a family receiving a unique identification card.[26] Unlike the national-level PMJAY scheme, which targets families as a whole, the AAA scheme focuses on individuals.[27] However, there are certain issues within the scheme's eligibility criteria that need to be addressed, as discussed below.

Eligibility for enrollment and benefits under the Atal Amrit Abhiyan is determined solely based on economic criteria. Broadly, there are two economic categories:

1. Individuals from Below Poverty Line (BPL) families, defined as those with an annual income of up to rupees 1.2 lakh.
2. Individuals from Above Poverty Line (APL) families, with an income between rupees 1.2 lakh and rupees 5 lakh per year.

From the above we can immediately notice two issues:

- The first one is that the AAA scheme targets individuals and fails to account for the economic vulnerability or vulnerability otherwise of individuals within families that are not qualified under the scheme. This means that there may be individuals within such ineligible families who are economically

[24] Manon Haemmerli and others, 'Poor Quality for the Poor? A Study of Inequalities in Service Readiness and Provider Knowledge in Indonesian Primary Health Care Facilities' (2021) 20 International Journal for Equity in Health 239 <https://doi.org/10.1186/s12939-021-01577-1> accessed 23 December 2023.

[25] 'Making Fair Choices on the Path to Universal Health Coverage' 36 <https://www.who.int/publications-detail-redirect/9789241507158> accessed 23 December 2023.

[26] 'Guidelines of Atal Amrit Abhiyan with Annexures-1-25.Pdf' (n 31) para 4.1, Unit of Enrolment, Guidelines for Implementing Atal Amrit Abhiyan.

[27] 'About PM-JAY - National Health Authority | GOI' <https://nha.gov.in/PM-JAY> accessed 2 December 2023.

disadvantaged due to various reasons, such as gender, physical disabilities, illnesses, sexual orientation or other personal circumstances and yet without access to such assistance.

- The second issue with the scheme's eligibility criteria is that to make it truly equity-oriented, it is necessary to consider not only economic criteria but also overlapping vulnerabilities arising from other social factors. Vulnerable groups and individuals who face additional challenges should be specifically included in the scheme, without restricting the scope of such vulnerabilities. Therefore, it is important to ensure that certain marginalised and vulnerable groups are explicitly included, even when the primary focus is on economic criteria.

Addressing Exclusions:

From a right to health perspective, it is necessary to include all poor and vulnerable individuals who would benefit from such inclusion. As discussed, the core obligations under the right to health, such as non-discrimination and the prioritisation of the poor and vulnerable, provide valuable guidelines in this regard. According to the principle of non-discrimination, the state has an obligation not to exclude anyone from the scope of the AAA scheme based on their "*race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social, or other status.*"[28] Furthermore, there are core obligations to ensure equitable access to healthcare and to prioritise the needs of the most vulnerable and marginalised groups in society when implementing and monitoring healthcare policies like PMJAY.[29]

In the context of progressively realising Universal Health Coverage, some trade-offs are inevitable due to financial constraints. However, certain trade-offs are unacceptable, such as excluding those who are unable to pay or marginalising informal workers and the poor, even if such exclusions may seem administratively convenient.[30] A substantive interpretation of equality and non-discrimination requires avoiding these exclusions. Therefore, while the AAA scheme identifies economic criteria, it must also explicitly include other vulnerable groups whose inclusion would majorly enhance their access to healthcare, particularly if they are unable to afford it.

Suggestions: While using economic criteria to identify eligibility is a required point to start, the scheme should also go further by explicitly including all vulnerable and disadvantaged populations who are unable to pay. Their needs should be prioritised due to their greater vulnerability and marginalisation.

Is AAA a Scheme Specifically for the Poor?

While the AAA scheme is a step toward making costly healthcare accessible to the poor who would otherwise be unable to afford it, and thus contributes to the goal of Universal Health Coverage, a major issue is that the scheme is designed exclusively for the poor, making it not truly universal. Although focusing policy on the poor is understandable given their greater deprivation and need for healthcare access, there is ample evidence suggesting that healthcare services designed exclusively for the poor tend often to be of poor quality.[31] Targeting benefits exclusively at the poor reduces the likelihood of effectively addressing poverty and inequality.[32] While targeted approaches are preferred, particularly due to budgetary constraints, there is substantial evidence that poor countries can, and have, reduced poverty more effectively through a universalistic approach to social provision.[33] This success has been particularly evident in the case of healthcare as well.[34] While there are valid concerns that a purely universalistic approach might ignore diversity in its pursuit of equality, it has been argued that it is possible to address specific concerns about diversity while also still striving for universalism, with equality as the ultimate

[28] 'General Comment No. 14: The Right to the Highest Attainable' para The right to the highest attainable, paras, 12 and 18.

[29] ibid 43.f.

[30] Ole Frithjof Norheim, 'Ethical Perspective: Five Unacceptable Trade-Offs on the Path to Universal Health Coverage' (2015) 4 International Journal of Health Policy and Management 711 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4629695/> accessed 23 December 2023.

[31] Manon Haemmerli and others, 'Poor Quality for the Poor? A Study of Inequalities in Service Readiness and Provider Knowledge in Indonesian Primary Health Care Facilities' (2021) 20 International Journal for Equity in Health 239 <https://doi.org/10.1186/s12939-021-01577-1> accessed 23 December 2023.

[32] Walter Korpi and Joakim Palme, 'The Paradox of Redistribution and Strategies of Equality: Welfare State Institutions, Inequality, and Poverty in the Western Countries' (1998) 63 American Sociological Review 661 <https://www.jstor.org/stable/2657333> accessed 23 December 2023.

[33] Thandika Mkandawire, 'TARGETING AND UNIVERSALISM IN DEVELOPING COUNTRIES' <https://www.un.org/en/ecosoc/meetings/2005/docs/Mkandawire.pdf>.

[34] Kanitsorn Sumriddetchkajorn and others, 'Universal Health Coverage and Primary Care, Thailand' (2019) 97 Bulletin of the World Health Organization 415 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6560367/> accessed 17 December 2023.

goal.[35] Moreover, there is evidence demonstrating that targeted health interventions can be effectively implemented within a universalistic framework.[36] It has been suggested that focusing solely on the most disadvantaged will not sufficiently reduce health inequalities. Therefore, an approach known as "*proportionate universalism*" is required, which emphasises that "*actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage*."[37] Moreover, it has been suggested that targeting can lead to "*labelling with all the attendant hazards of stigma*" and that "*a health service for the poor is a poor health service; an education sector for the poor represents poor education*."[38] Further, findings show that lower quality of healthcare only worsens the burden of illness and the costs of healthcare.[39] Explaining why that is the case, it has been noted that "*...in Britain, most of the population have a stake in the National Health Service—a universal service. Were there a special health service for the poor, the middle classes would have less immediate interest in its being of high quality*."[40] Good healthcare is one in which everyone has a stake, ensuring that the quality is appropriate for all. This guarantees that everyone has access to healthcare that is adequate, appropriate, and of acceptable quality. However, this does not mean that special attention should not be provided to those at higher risk or greater vulnerability.[41] Such special attention should nevertheless be provided within a universalist model of healthcare.

Suggestions:

1. The AAA scheme is a piecemeal healthcare initiative designed solely for the poor. Rather than limiting the AAA scheme to only the poor and vulnerable, there should be a comprehensive plan that guarantees universal healthcare for all. Integrating such schemes with national programs like PMJAY could enhance efficiency while also prioritising the needs of the poor, vulnerable and marginalised within this broader framework.
2. Secondly, the scheme should target all poor, vulnerable and marginalised populations, rather than just a few, in line with the principle of non-discrimination and core obligations. This approach would ensure that everyone has access to care.

Hospital Empanelment for AAA:

Eligibility: All public, private, trust and grant-in-aid hospitals that provide hospitalisation and/or daycare services are eligible for empanelment under the AAA scheme, subject to meeting the empanelment requirements as agreed upon by the State Nodal Cell and the Implementation Support Agency.[42] Hospitals will be selected from both within and outside the state. For out-of-state selections, hospitals will be chosen from five cities: Kolkata, Delhi, Bengaluru, Chennai and Mumbai (specifically for cancer cases).[43] However, patients will be referred outside the state only when the required procedure is not available within the state. The selection of hospitals and cities for such referrals will also be subject to a cost-benefit analysis.[44]

Empanelment: Equity and Right to Health: As discussed earlier, equity in healthcare requires "*equitable access to services regardless of socio-economic status.*"[45] It also means "*giving priority to policies benefiting the worse-off, where the worse-off are defined both in terms of health itself and in terms of socio-economic status.*"[46] The WHO defines equity as "*the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically,*

[35] Simon Thompson and Paul Hoggett, 'Universalism, Selectivism and Particularism: Towards a Postmodern Social Policy' (1996) 16 Critical Social Policy 21 <https://doi.org/10.1177/026101839601604602> accessed 23 December 2023.
[36] David Canning and Diana Bowser, 'Investing in Health to Improve the Wellbeing of the Disadvantaged: Reversing the Augment of the Marmot Reports' [2011] PGDA Working Papers 1223 <https://ideas.repec.org//p/gdm/wpaper/7811.html> accessed 23 December 2023.
[37] Michael Marmot, Peter Goldblatt and Jessica Allen, 'Fair Society Healthy Lives (The Marmot Review)' (*Institute of Health Equity*) <https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review> accessed 23 December 2023.
[38] Michael Marmot, 'Commentary: Mental Health and Public Health' (2014) 43 International Journal of Epidemiology 293 <https://doi.org/10.1093/ije/dyu054> accessed 23 December 2023.
[39] 'Low Quality Healthcare Is Increasing the Burden of Illness and Health Costs Globally' <https://www.who.int/news/item/05-07-2018-low-quality-healthcare-is-increasing-the-burden-of-illness-and-health-costs-globally> accessed 23 December 2023.
[40] ibid.
[41] ibid.
[42] ibid 4.4 Empanelment of Hospitals, Guidelines for Implementing Atal Amrit Abhiyan.
[43] ibid.
[44] ibid.
[45] Norheim (n 44).
[46] ibid.

demographically, or geographically or by other dimensions of inequality."[47] Moreover, prioritising the worse-off generally leads to greater overall benefits, as they tend to gain the most from improved access to services.

Furthermore, one of the core obligations under the right to health is the equitable distribution of all health facilities, goods, and services. The right to health mandates that State parties ensure non-discriminatory access to healthcare, particularly for marginalised and vulnerable populations.[48] Additionally, it requires: "*health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups.*"[49] As discussed above, equity also requires that healthcare of appropriate quality is provided to all without discrimination.

Suggestions: Based on the above description, the following suggestions are made**:**

Equity Concern From Reliance on Private Providers: The scheme's reliance on private providers of care raises some concerns about equity in access. Equity requires that healthcare services are accessible to the marginalised and vulnerable groups and an overreliance on private providers reduces chances of such access from more resources expended due to higher costs. Therefore, the government should instead make substantial investments in creating and improving public healthcare infrastructure. This would also ensure that healthcare infrastructure is distributed geographically to bring healthcare closer to the people.

Moreover, reliance on private healthcare may also compromise equity in access by reducing the benefits generated from the limited resources, thereby reducing access. Resources may even be exhausted in providing costly care through private providers. It is also likely that funds allocated are also insufficient in covering costs incurred with private providers of care, even leading to denial of services. Hence, ensuring equitable access requires that the state directly provides quality care and substantially reduces reliance on private healthcare providers.

The need to rely on private providers also suggests that insufficiency of the current public healthcare infrastructure in meeting people's healthcare needs. Hence, there is a need to increase public expenditure in healthcare.

Accountability Under AAA:

Accountability under the scheme is ensured through both internal and external audits. The internal audit, conducted by the Implementation Support Agency, ensures that claims are processed within the prescribed benefit packages and that quality services are delivered.[50] This internal audit is carried out by a specialist doctor and a district-level coordinator.[51] On the other hand, the State Nodal Cell is empowered to conduct external audits, which include concurrent audits of pre-authorization, claims management and administration, as well as the management of empanelment, including surprise audits conducted at regular intervals.[52]

Observations: The accountability mechanism described above primarily functions as an administrative system. However, a rights-based approach to healthcare access must ensure that violations of these rights are effectively redressed. Therefore, it is crucial to establish both administrative and judicial mechanisms for grievance redressal. Apart from the regulatory framework that involves auditing, it is proposed that a rights-based approach is adopted that includes a right to sue those responsible for providing care, when specific rights are violated. Right to healthcare is a right when there is also accountability in case of violations. This would ensure that anyone who is affected by healthcare decisions in violation of their specific rights have "*access to effective judicial or other appropriate remedies at both national and international levels.*"[53] Furthermore, such measures are more effective international law obligations recognising the right are also incorporated into domestic laws, which can further enable redressal of violations of the right through adjudicative mechanisms.[54] This has been partially achieved through the adoption of the Assam Public Health Act, 2010. While there are concerns that litigation could potentially reduce the efficiency of healthcare institutions, legally recognising such rights strengthens the claims of the people. Furthermore, the presence of an internal grievance redressal mechanism can reduce the likelihood of litigation by addressing issues internally. Therefore, while the auditing mechanism ensures that claims are processed within packages and quality care is provided, there should also be a robust grievance redressal system where individuals with claims of rights violations can seek resolution. In other words, a more streamlined complaints or grievance redressal mechanism needs to be established. Since these grievances may involve challenging decisions related to priority setting, there should be an appellate body where such decisions can be contested. Judicial determination should remain an option, available only after these internal avenues have been exhausted.

[47] 'Health Equity' <https://www.who.int/health-topics/health-equity> accessed 23 December 2023.
[48] 'General Comment No. 14: The Right to the Highest Attainable' (n 42) para Core obligations, para 43 (a).
[49] ibid para 12.
[50] Guidelines of Atal Amrit Abhiyan with Annexures-1-25.Pdf' (n 31) para 4.8.1 Internal Audit.
[51] ibid.
[52] ibid 4.8.2, External Audit.
[53] 'General Comment No. 14: The Right to the Highest Attainable' (n 42) para para 59.
[54] ibid para 60.

Moreover, while these auditing bodies include expert representation, it is equally important to involve other stakeholders, including representatives of community interests, human rights advocates, ethicists and health rights activists. Their participation can ensure that the obligations arising under the right are actually fulfilled.

Suggestions:

Diverse Representation in the Grievance Redressal Committees: There is a need to ensure that community representatives are included in the grievance redressal committees, who can discuss and represent the needs of those who are directly affected by the scheme.

There is also the need to ensure representation of various human rights advocates, legal experts, activists and ethicists through a human rights committee mechanism to address concerns about rights-based claims and cases involving priority setting

Complaints Mechanism: There is a need to ensure that all beneficiaries under the scheme have easy access and the ability to complain in case of violations. Hence, the scheme should also clearly define and specify the entitlements of the beneficiaries under it. In this regard it is suggested that such entitlements include the clear obligations under international human right to health and as may have been adopted in domestic legislations, such as the Assam Public Health Act, 2010. In that spirit, as suggested previously, there is a need to establish a body dedicated to addressing grievances regarding violations of rights based claims. Since, healthcare provisioning involves distribution of limited resources, there is also a need to develop and implement procedures for making priority setting decisions and the principles that are involved in making such decisions.

Financial Coverage and Concerns about Affordability: Under the scheme each beneficiary with a family is entitled to a maximum benefit of two lakh rupees, which includes coverage of expenses for hospitalisation and surgical procedures in the empaneled hospitals.[55]

Observations: The maximum benefit of two lakh rupees is certainly not enough to cover hospitalisation and surgical procedures costs in most cases, when particularly availed at empaneled private providers of care. While such costly care may not be availed by everyone, when one does the amount will be inadequate to cover the complete cost of treatment, compelling them to spend money out of their own pockets.

Human Rights and the Healthcare Packages Under AAA Scheme:

The scheme covers an approved list of procedures across six specific specialties. A committee chaired by the Director of Medical Education, Assam, has finalised a list of 436 procedures within these specialties, which include Cardiology and Cardiovascular Surgeries, Neurological Conditions, Burns, Cancer, Kidney Diseases, and Neonatal Diseases.[56] Furthermore, the scheme includes all pre-existing conditions within these categories, as well as follow-up care for the defined procedures, which are to be conducted based on agreed treatment protocols.[57]

However, the Atal Amrit Abhiyan scheme Package Master[58] currently follows the Health Benefit Package 2.0, which includes the following specialties:

1. Burns Managements
2. Cancer
3. Cardiology and Cardiac Surgery
4. Critical Care Pediatrics
5. Encephalitis
6. ICU Packages
7. Kidney Disease
8. Neonatology
9. Neurology and Neurosurgery
10. Paediatric Surgery
11. Supplemental Procedure
12. Trauma

The package rates are to cover consultations, medications, diagnostics, food, hospital charges and other services as specified in the packages determined by the State Nodal Cell (SNC).[59] Package rates will include the following: bed charges (General Ward), nursing and boarding charges, fees for surgeons, anaesthetists, medical

[55] 'Guidelines of Atal Amrit Abhiyan with Annexures-1-25.Pdf' (n 31) para 4.2 Sum Assured, Guidelines for Implementing Atal Amrit Abhiyan.

[56] ibid 4.3 Benefits, Guidelines for Implementing Atal Amrit Abhiyan.

[57] ibid.

[58] 'AAA Package Master | Atal Amrit Abhiyan | Government Of Assam, India' <https://atalamritabhiyan.assam.gov.in/information-services/aaa-package-master> accessed 23 December 2024.

[59] ibid 4.6.1 Package Rates, Guidelines for Implementing Atal Amrit Abhiyan.

practitioners and consultants, as well as costs for anaesthesia, blood, oxygen, OT charges, surgical appliances, medicines and drugs, prosthetic devices, implants, X-ray and diagnostic tests, and patient meals and additionally, the rates will cover expenses for diagnostic tests and medicines for up to ten days following discharge from the hospital for the specified treatment.[60]

As can be observed, the AAA scheme offers financial coverage only for certain specific specialties and does not aim to provide a fully comprehensive range of care. In contrast, it is worth noting that the PMJAY scheme offers coverage for a much broader and more comprehensive spectrum of healthcare services.[61] Therefore, it can be argued that a more integrated healthcare system would be preferable, as it would reduce confusion for people who currently need to navigate through such multiple schemes to avail benefits. Integration would also likely increase the overall benefits derived from available resources. However, the AAA scheme does offer reasonable coverage for a wide range of charges, including both medical and non-medical expenses, as well as post-treatment care. These are some positive aspects of the scheme, despite the limitation of rupees 2 lakh per individual, as discussed earlier. Here, it is also important to examine the scheme and the packages covered from a human rights perspective. In this context, much clarity can be gained by assessing the AAA scheme against the essential health services defined under SDG 3.8.1, which outlines the extent to which the scheme aligns with global standards. This approach is necessary because the Sustainable Development Goals (SDGs) have the potential to realise human rights, and in turn, human rights can drive sustainable development that leaves no one behind.[62]

Essential Health Services under SDG:

SDG 3.8.1 requires coverage of essential health services, defined as "*the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population.*"[63] Essential Health Services are defined as "*services that all countries, regardless of their demographic, epidemiological or economic profile, are expected to provide.*"[64] To operationalise the SDG Indicator 3.8.1, an index of essential health services has been developed following an extensive consultation process.[65] The index followed four guiding principles, with the second principle referring to indicators of different services that include "*prevention, comprising health promotion and illness prevention, as well as indicators for treatment, comprising curative services, rehabilitation and palliation*," and the third principle stating that "*the index should cover all main health areas of reproductive, maternal, newborn and child health (RMNCH), infectious diseases, noncommunicable diseases and injuries*," following which four categories of indicators were established: "*RMNCH, infectious diseases, noncommunicable diseases, service capacity and access.*"[66] The UHC Service Coverage Index (UHC SCI) offers additional parameters for measuring SDG indicator 3.8.1. The UHC SCI is defined as "*the average coverage of tracer indicators in four essential health service areas: reproductive, maternal, newborn, and child health, infectious diseases, noncommunicable diseases, and service capacity and access*."[67] In April 2018, the Inter-Agency Expert Group on Sustainable Development Goals accepted 14 tracer indicators to monitor SDG 3.8.1, with the UHC SCI being considered as the average coverage of these tracer indicators across four essential health service areas: "*reproductive, maternal, newborn, and child health, infectious diseases, noncommunicable diseases, and service capacity and access*."[68] This is understood as the geometric mean of 14 tracer indicators, calculated first within each of the four areas and then across the four category-specific means to obtain the final summary index.[69] While the 14 tracer indicators are not intended to be a complete and exhaustive list of health services and interventions, and domestic UHC efforts may extend beyond them, "they do provide a strong signal on the coverage of health services needed by most populations across socio-demographic settings."[70]

Another important development to look into is the Final Report of the WHO Consultative group on Equity and Universal Health Coverage that provides a three part strategy for fair progressive realisation of Universal

[60] ibid 4.9 Package Rates, Guidelines for Implementing Atal Amrit Abhiyan.
[61] 'About PM-JAY - National Health Authority | GOI' <https://nha.gov.in/PM-JAY> accessed 2 December 2023.
[62] 'UNSDG | Leave No One Behind' <https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind, https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind> accessed 1 May 2024.
[63] 'Coverage of Essential Health Services (SDG 3.8.1)' <https://www.who.int/data/gho/data/themes/topics/service-coverage> accessed 23 December 2023.
[64] 'Tracking Universal Health Coverage: 2017 Global Monitoring Report' <https://www.who.int/publications-detail-redirect/9789241513555> accessed 23 December 2023.
[65] ibid 4.
[66] ibid.
[67] 'Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report' (n 38) 12.
[68] ibid.
[69] ibid.
[70] ibid.

Health Coverage.[71] The first is the requirement to categorise services into priority classes according to relevant criteria that includes "*cost-effectiveness, priority to the worse off, and financial risk protection*".[72] The second strategy requires expansion of coverage for high priority services to everyone that requires "*eliminating out-of-pocket payments while increasing mandatory, progressive prepayment with pooling of funds*".[73] And the third strategy requires that in doing the above "*the disadvantaged groups are not left behind*" and this includes "*low income groups and rural populations"*.[74]

Observations and Suggestions: Based on the above description of the scheme the following observations and suggestions can be made:

1. ***Comprehensive Coverage of Essential Services:*** Essential health services, as defined under international human rights law, are those that all countries should provide regardless of their demographic, epidemiological, or economic profile. The AAA scheme should incorporate a general and comprehensive range of services that meet these criteria, thereby ensuring that all individuals, especially the vulnerable and marginalised, have access to necessary healthcare.
2. ***Participation and Transparency in Determining Coverage****:* The core obligations also require adoption and implementation of *"a national public health strategy and plan of action"* which is *"to be devised and reviewed periodically on the basis of a participatory and transparent process."*[75] Therefore, under the AAA scheme, it is essential to finalise these benefits through a participatory and transparent process that considers the health concerns of the entire population, with particular attention to the needs of vulnerable and marginalised groups.
3. ***Human Rights Compliance in Healthcare Packages:*** The AAA scheme has to align with the core human rights principles outlined in SDG 3.8.1, which emphasise the coverage of essential health services. These services are defined as "*the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn, and child health, infectious diseases, non-communicable diseases, and service capacity and access, among the general and the most disadvantaged populations*." Ensuring that the AAA scheme includes these essential services is critical to meeting human rights obligations.
4. ***Inclusion of RMNCH under a General Scheme****:* Under the SDG 3.8.1 the indicators include "R*eproductive, maternal, newborn, and child health (RMNCH), infectious diseases, noncommunicable diseases, service capacity and access.*"[76] Any healthcare scheme, such as this one, must encompass all these essential health services to ensure comprehensive coverage.

[71] ibid xi.
[72] ibid.
[73] ibid.
[74] ibid.
[75] ibid.
[76] 'Tracking Universal Health Coverage: 2017 Global Monitoring Report' (n 78) 4.

