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Transcript Begins:

Yamini Aiyar: Good evening, good morning, good afternoon to all our audience from all parts of the world. It's an absolute privilege for us to have all of you at today's webinar. I'm Yamini Aiyar. And I'm a commission member of the Lancet Commission on Reimagining Health, which is on India, which is currently the sort of umbrella under which today's discussion is taking place. I specifically co-chair the governance workstream of the Lancet Commission. And it's an absolute privilege for us to be able to host this really crucial conversation. Some months ago, when I first started a conversation with Vivek Divan and C-HELP, he sort of reminded me that you've been talking about Universal Health Coverage, but there is an underlying foundation to how to the frameworks of our debates on health, and that's the foundation of rights, an ascent bringing that foundation front and center into our debates and discussions on what it means to imagine a health system, we may well be talking about a health system that isn't anchored in core rights and doesn't effectively shape or respond to the complexities of the dynamics between citizens and the public health system, between citizens and their rights in the context of health. And it is in that spirit that we felt it was extremely important for us to have a dialogue on why debates on universal health care or health coverage need to intersect with the dialogues and discourse on rights. In India, specifically, the courts have played a very, very important role in determining the contours of how policy engages with health, the limits and aspirations of what India's public health system should be about, and how it engages with citizens. And therefore, it is even more important for us to bring the discourse on rights front and center into the discourse on policy and health care. So it's in that spirit that we requested, C-HELP, Vivek and Shivangi here to organize today's discussion. Thank you very much, both of you for doing this, and I've been looking forward to learning from you. And thank you very, very much to our extremely esteemed group of panelists. It's a real privilege for us at the Lancet Commission to be able to host all of you and learn from you. And I hope that not only through the course of today's conversation, but over the course of the commission's work itself, that we get the opportunity to engage more with you and bring to the table some of the ideas that all of you have pushed us to think about. So thank you and over to you Vivek and Shivangi to take us forward. Shivangi, sorry, you're on mute.

Shivangi: Sorry about that. Thank you, Yamini for setting the context of this webinar. We are fortunate to have with us today an exciting area of eminent speakers. A lot can be said about each of the panelists who are all stalwarts in the fields, where I'm going to keep the introductions short as we have a tight schedule. The longer bios are posted in the Chatbox for the benefit of our audience. So we have with us Mr. Dainius Puras. He's a professor of Child and Adolescent Psychiatry and Public Mental Health at Vilnius University, Lithuania. He's also a former UN Special Rapporteur on the Right to physical and mental health 2014 to 2020. Dr. Gita Sen, Director and distinguished professor Ramalingaswami Center on Equity and Social Determinants of Health PHFI Bangalore. She was also a member of the High Level Expert Group

which recommended a roadmap for UHC in India in 2011. Vivek Divan, coordinator at C-HELP, ILS Law College Pune and a lawyer who has worked on the intersections of law, health and rights for over two decades. And finally Meera Sanghamitra an independent human rights activist. She has been associated with National Alliance for People's Movements for over a decade, and has worked on several social justice issues, including women's rights transgender movements. Before we hear from our panelists, a couple of logistical announcements. Each panelist will have 12 minutes to speak, Pooja will alert you at around 10 minutes for you to start winding up your talk. The audience members can post questions addressed to specific panelists in the Q&A box, which will be taken up in the last session. But please do keep them short. So let's dive straight in. I first invite Prof. Puras to talk about the interlink ages between right to health and UHC, as informed by International Human Rights Law obligations.

Prof. Dainius Puras: Thank you. It is a great pleasure for me to be part of this very meaningful event. I will share my experience after serving for last six years as a UN Special Rapporteur on the Right to physical and mental health. As we know, the process of pursuing the transition to Universal Health Coverage is not easy. And one of important issues is to identify all challenges and pitfalls awaiting stakeholders in this way. So the good news is this global powerful consensus on the need the why Universal Health Coverage. Now we need to speak about how to do this, and what could be obligatory safeguards ensuring the success of this process of eliminating the risks of failures. As we know universal health care coverage is a key dimension of the 2030 agenda commitment over the achieving healthy lives and wellbeing for all at all ages. And goal three includes an explicit commitment to achieve Universal Health Coverage including financial risk, protection, access to quality essential health care services and access to safe, effective quality and affordable essential medicines and vaccines. Also to ensure access to sexual and reproductive health care services, including family through for family planning, information and education. So we say well known targets three, eight and three and seven I this important targets however, this is all not enough, because these targets do not make explicit commitments to confer priority to the poor and marginalized either when coverage is expanded, or when services which services should be provided, when there's discussion about services. Now with pandemic COVID 19 pandemic we have new challenges as you all know, about prioritizing and I am just want to highlight that without human rights based approach, there is always a risk that Universal Health Coverage efforts may entrench inequality. So prioritization and participation of the world's most vulnerable is vital to both defining and achieving equitable, Universal Health Coverage. This is also consistent with core obligations and the right to health to guarantee access to health services without discrimination and to take deliberate and targeted and concrete steps to ensure progressive realization of the right to health. Just moving to some examples, the right to health recognizes the importance of prioritizing investments in primary and preventive care and I should say social medicine, which benefits a far longer sector of population over expensive specialized services and investing in Primary Health Care prevents illnesses promotes physical and mental health and intended reduces the need for specialized health care. Health related policies as we know the

implementation of good ideas has always been complicated. Although Universal Health Coverage looks like a simpler idea based on common sense and the need for basic health care to reach everyone, it is important to issue a warning against any simplified way of addressing the universal health care coverage and the process of reaching it. Actually all elements to the right to health analytical framework developed by my predecessors Western second special rapporteurs Paul Hunton, Anand Grover need to be taken very seriously in this regard. If any of these elements, for some reasons ignored or not adequately addressed, the process of reaching Universal Health Coverage may be wrong. Let me just mention some examples which may illustrate the complexity of the goal ahead. First, accountability and transparency need to be seriously addressed. Health care systems remain seriously affected globally, in many countries, and this alarming tendency affected by corruption globally, and this alarming tendency needs to be abandoned in the process of reaching SDGs and Universal Health Coverage. More specifically, meaningful involvement of citizens through partnerships between governments and civil society organizations could be a very good remedy to substantially promote transparency and accountability. And very often NGOs can do not only advocacy, they can be very good and effective service providers. While there are many important managerial and economic questions to be addressed in the process of reaching Universal Health Coverage, I would like to highlight other important issues which should not be ignored by policymakers. These are principles of non-discrimination, accountability, participation, and empowerment, also informed consent, and they need to go beyond narrow biomedical model, so that holistic, equitable and ethical care is provided [distorted audio], and especially, to those belonging to vulnerable and disadvantaged groups. Selective approach to human rights is too often used by many states to achieve short term goals to pick low hanging fruits, including the one and improving health indicators. This has led to serious imbalances in power estimates recent health related policies and services. When some rights and needs have been promoted and protected at the expense of other ones, it is important to identify such imbalances and properly address them. For example, focusing mainly on the access to essential medicines and vaccines, which is we know very important, especially now with COVID. As the huge importance, their accessibility is well recognized, but this still would be too narrow approach for reaching SDGs and Universal Health Coverage. For example, investments in child health needs to prioritize the right to health and holistic development, which is as important as the right to survival. Universal Health Coverage needs to include sexual and reproductive health rights, especially if we wish to empower children and the lessons for healthy and responsible adulthood and parenthood. Promotion of health and healthy development as well as protection from all forms of violence in childhood in later stage of life includes many essential public health, social and psychosocial interventions. Yes, they are of non-biomedical nature, but they should not be seen as some kind of luxury when considering what should be covered by Universal Health Coverage. Furthermore, sustainable development goals and Universal Health Coverage cannot be reached if drug policies remain punitive as they are now very often or if palliative care is not available. SDGs and Universal Health Coverage [distorted audio] be reached if mental health needs of everyone are not taken as seriously as physical health needs, and if mental health policies and

services do not abandon their reliance on institutionalization, [distorted audio] medicalization, paternalism and the tendency of two offers in coercion the name of medicine. So this under the challenges can only be effectively addressed if all elements and principles of the right to health framework are mainstreamed in health policy formulation and implementation. Formulate is often easier to implement is more difficult, more pitfalls than challenges. And this is why we should always include non-discrimination, equality, participation and accountability. Just two words about private sector, private sector should not be demonized, private sector should be involved in national health systems so that to hold it accountable. And then private sector can and must contribute effectively to realization of the right to health, including in reaching Universal Health Coverage. So we come back to the core of what the right to health is about, and to be understanding to the understanding that it is an indivisible part of universal human rights. I mean, health is indivisible part of universal human rights. As we all have now, in moving towards SDGs and Universal Health Coverage, we need to take on board the words of now famous HIV/AIDS activist Jonathan Mann, who tells that the human rights framework provides a more useful approach for analyzing and responding to modern public health challenges, than any framework thus far available within biomedical tradition. And what has been achieved global in addressing HIV/AIDS needs now to be replicated with the same level of global commitment and passion for all remaining global health concerns, such as addressing social determinants of health, burden of non-communicable but also communicable diseases, diseases of poverty, mental health challenges, and many other global health officials. So, any departure from universal human rights principles and modern public health approach would be detrimental for the success of this process, I mean of reaching a Universal Health Coverage. So these were main things which I wanted to highlight. This is my main impressions from working automatic reports, but especially on visiting countries with official and other visits in all the regions we have regional specifics, but most important, global principles, especially human rights based approach. Thank you.

Vivek Divan: Shivangi. You're on mute, Shivangi.

Shivangi: Right. Thank you, Prof. Puras, you made it amply clear that the UN General Assembly and World Health Assembly resolutions have consistently reiterated that the right to health is the overarching framework for UHC, it must follow that states should act in conformity with their obligations to respect, protect and fulfill the right to health when designing and implementing UHC. Well, with that, I now invite Prof. Gita Sen to share her perspectives on Social Determinants of Health and UHC from a gender lens.

Dr. Gita Sen: Thanks very much, Shivangi. Before I share my screen, I just want to say one a couple of things. One is just to reiterate something that Dr. Puras mentioned, which is that without a rights based approach, UHC may actually end up reinforcing inequality. And I think we have the particular challenge here, that because that famous UHC cube, that WHO put out many, many years ago, tells you where you should be going, but doesn't tell us how it can often be done in a way that where states actually find it convenient to pick the lowest hanging fruit.

And if they do that, then in fact, those who are the most marginalized and the most at risk of not having rights to help will be the ones who get pushed further and further behind. And we have many examples of that. This is not something I plan to discuss myself in this talk. Let me share my screen and run you through this. I've said from lip service to realizing the right to health, about to show you in a minute why I'm calling it this. So the core concerns on women and gender equity and health for a long time can be broadly seen to be threefold. First, over focus by public programs on women as child barriers, receptacles for babies, fetuses, breast milk, you name it, the need to address these, but also to go beyond reproductive health and to include a life course approach. Secondly, to recognize women as rights holders with corresponding duty bearers so that we can start pausing exactly what does the right to health really mean for girls and women. And thirdly, the need to go beyond gender equality as a platitude which it has become in too many places and cases to which lip service is paid, how to move to real changes on the ground. And I hope to say a few things about each of those. So lessons from my own prior involvement on these sets of questions, I drove from to place. One, the Women and Gender Equity Knowledge Network that I co-chaired for the WHO's Commission on Social Determinants of Health. That experience was fascinating, because it was at a time in the 2000s, when in fact, gender equity and health had not been sufficiently acknowledged and recognized, or if it was, it was seen as something secondary to economic inequality, poverty, household based inequalities, and so on and so forth. And my experience, to put it bluntly and quickly with working with that knowledge network for that commission, is that although that network had over 60 people, core members participating in the network, in the end, when the report of the commission overall came out, it didn't really pay very much attention to all of the very hard work that had gone into the workings of that commission. Hence, my concerns about lip service. Secondly, the Planning Commission's High Level Expert Group, and I hope to say a little bit more about this going forward. But broadly, what I've understood is that there's many ways in which one can miss the policy bus, or end up reinventing the wheel over and over and over and over again, saying the same things in different words to different audiences, but really not making too much headway. So the HLEG itself had a bunch of recommendations when it came to gender. Broadly, these were improving access, secondly, recognizing women's role as health providers, thirdly, strengthening data analysis and monitoring and evaluation, and fourthly, to support and promote the rights of girls and women to helping families and communities and programs and policies. And then on each of these, there were detailed recommendations, which I won't go to. Broadly, I would still say that the HLEG, in terms of these recommendations was not too far off. Although, you know, 10 years plus on, one might, you know, no one's modify and so on what it was those recommendations considerably. Where do I think we, in a sense, may have missed the bus, or be fated to reinventing the wheel? I think it is that one fundamental question is being corrected, we go round and round it without naming it clearly. And I believe now the plenary talk about rights based approaches, we need to name that, what is that? Power. We don't talk enough about power. We don't talk about the role of power neither at the policy level, nor at the level of programs nor at the level of communities on the ground enough so that we can

actually not keep having to reinvent the wheel. Let me say a bit more about what I mean by this. Why focus on power? Because power often derives from exactly those deep structural inequalities that are not easy to change. Hardy perennials in this country, gender, caste, and others being added to those like religion, but which haven't been such a perennial over millennia, like gender and costs a bit. Secondly, power, as we know seeps into norms and beliefs into what we know as truth, and what we believe about the world and our role within it. And thirdly, gender power exists multiple levels that reinforce each other from the household right up to legislatures, executives, judiciaries and the warm. And these are the reasons why we actually need to name and address power explicitly, and not allow it to continue to hide in the crevices of the UHC discussion, gender power on and health. Our health depends not only on our sex, but also on gender power systems and hierarchies, gender power shapes, which and whose health needs are recognized and prioritized, who gets access to resources and services, what quality those are, and who work at which level of the hierarchy of health workers versus frontline specialists versus frontline workers versus unpaid health care workers at home. In the work of the Knowledge Network for the WHO Commission, we had actually come up with what I believe is a relatively simple framework, which now in the context of our work on COVID-19, we have adapted and modified a bit 10 years later on. I won't go into all of this, but simply say that it has two causal block. And then one is the consequences below. Structural causes which include those larger economic political processes, interacting with the forms of social gender and other forms of stratification and subordination, those long standing inequalities. Secondly, and this is the most crucial for us here, intermediary health factors, which I believe operate at four levels, which we need to bear in mind. First, discriminatory values, norms, practices, and behaviors. Secondly, differential exposures, vulnerabilities to disease, disability, etc. These could be biosocial, or they could be sex gender factors. Thirdly, continuing biases and health systems and policies. And fourthly, reinforcing those biases in health research. All of these four intermediary factors interact with each other, reinforce each other sometime but rarely counteract each other. And we need to pay attention to the way in which all of these work if we are really not to keep having to reinvent the wheel. So we need what in recent work we called power-focused realist evaluations. And there are four sets of questions in any context that are essential, they are necessary, but not sufficient to the particular context. First dimensions and sources of power in any health context, access to resources, knowledge control over decisions in any health context, including service provision. Secondly, how power is built into what we call the artifacts of a program strategy. How is power built into a program's objectives, into its rules, into the its procedures, into its financing methods? These are things we don't sufficiently go into. And it often is the reason why lip service to grand notions of equity, equality, universality, gender, justice and so on, stated at the level of principles get sabotaged under the subterfuge of the nitty-gritty of program strategies. And we need to look at how power is built into this. Thirdly, what does this mean for the incentives, disincentives and behaviors that result in terms of health providers in terms of health seekers in terms of people within households and families? And what are the consequences? There are four policy and program outcomes. Let me give one quick example if I still have the time, and that is just an illustration, what this

mean, in the context, let's say of the quality of institution deliveries in India. We all know that the numbers of institution deliveries, thanks to NRHM have gone up dramatically. We also know that questions about what is actually going down in the name of institutional deliveries is open to question. Still, in my own mind, there's absolutely no question. But these have played a role in reducing the numbers of maternal deaths. But what about quality? And we have the LaQshya Program of the government today, which claims to be moving towards improving quality, and yet a good look at LaQshya tells us that it remains focused, as most government programs tend to do on the bricks and mortar, building better health centers, ensuring that there may be a toilet, and so on, but not to the software of power, where power is embedded. So we need to ask the following kinds of questions what women confront in public overcrowding, routine verbal abuse, lack of cleanliness, or privacy, routine episiotomy, pushing on the abdomen to hasten delivery. And I'm naming only a few. And I'm saying this on the basis of tangible research that my team and I have done. So this is what women confront in public services, despite all of the language of improving quality, versus on the other side, the private sector, highly doubtful quality, lack of accountability, over focus on C-sections, and hysterectomies. Secondly, what does this mean? WHO guidelines and they exist these excellent WHO guidelines. And there are very good domestic guidelines as well. But all from these are often observed in the breach. When we did our fieldwork, the head of department at teaching hospitals would tell us, oh, yes, we absolutely follow the guidelines. The reality is in the labor wards, and in fact, very openly, the people were actually doing the deliveries in the labor wards. The interns, the postgraduate researchers who are actually the ones providing services in the labor wards will tell you, "Well, sometimes we do sometimes we don't." Do you allow? Or do you promote pushing on a woman's abdomen which is an absolute no, according to the guidelines? Sometimes we do, sometimes we don't. So the reality versus what everybody at another level is claiming is what gets done. Thirdly, how can a power analysis help? Start with what a poor Dalit or Muslim woman confronts when she goes in foreign institutional delivery, then move to why she confronts it, and then to how to change it. I don't have time to go into this in greater detail. But I wanted to illustrate to you that in fact, if we have to move from the level of repeating ourselves, and lip service to actually making concrete changes happen, we need focus very centrally, not just on power as an abstract category, but power relations as they impact and hear and are embedded in health systems. Thank you.

Shivangi: Thank you, Dr. Sen. The conceptual push to understand power and its role thinking about UHC programs that you've highlighted, is probably one of the most crucial questions facing not just law and policymakers but civil society as well. This law leads us in an interesting way to the Vivek's presentation, as we often consider laws in jurisprudence as a way to deal with some of the questions you've posed on power. Vivek.

Vivek Divan: Thanks, Shivangi. I think yes, indeed, my presentation will focus on I think, the law largely and the ways in which the courts have really engaged on issues of health. But and I must say that when Dr. Sen spoke about power focused realist evaluations, it made me think about really immediately how, you know, as the discipline of law, we really rarely kind of go into that

kind of a granular analysis of some of some of these social justice issues. The courts ultimately, are places where general solutions are offered, orders are issued, directions are issued, but the granular understanding of how power plays out, for instance, in communities is very rarely does the court get the opportunity to really delve deep into. So I think what the law can do then is really support UHC and show a ways in which and probably hint towards how rights based approaches and the right to health can be one, you know, a framework which supports the larger kind of program. But I will really focus on largely on how the courts have stepped in, in the context of health rights generally, and the right to health in particular, and give a broad description of that in my 10 to 12 minutes. And then I'd like to talk a little bit about how statutory law plays or does not play a role. And in doing so, also hoc, add, you know, speak towards to the some of the points, which the High Level Expert Group on Universal Health Coverage, which Dr. Sen was part of, has actually raised certain critical aspects of and where the law seems possibly not to tackle some of those aspects very well, and where some of that needs to be addressed. So let me start, of course, with the Constitution, where it really all begins. I think the audience probably is not an audience of lawyers entirely. And so I'll kind of, you know, spend a little time just explaining very, very briefly what a little that architecture is. And that architecture really emerges from article 21, in part three of the constitution, which guarantees that no person shall be deprived of his life or personal liberty, except according to procedure established by law. So this is really the fountainhead from which when we talk about the right to life, a lot of the other rights have emerged. And the Supreme Court has read not just Supreme Court, but other constitutional courts in India, has read the fundamental rights to health into article 21. And it has done so by also looking at two other articles in our constitution. So article 21, which forms part of our fundamental rights, which is really the core of our legal framework. And then there is another portion of the constitution, which refers to Directive Principles of State Policy, which is really guidance that is offered by the constitution about how government should be actually implementing policy and the guiding principles by which policy should be devised. And so the court has looked at both article 21, and a couple of these other articles, one of them is article 39 E, which is, requires the states to ensure that health and strength of workers, men and women and the tender age of children are not abused. And article 47, which says that the state should regard the raising of the level of nutrition and standards of living, and the improvement of public health among its primary duties. So you know, this is where really the trust of you know, any attempt to try and give shape to health based rights has really come from, from within the citizenry within civil society, etc. And it has been the constant kind of approach to the judiciary, which has fine-tuned and articulated this understanding of what the right to health may or may not contain. And so I think in 2021, today, we have a much more a better sense of what that these contents are, although it is even though it is not really expressed in very clear terms in a statute, or in very clear terms in a section of the law. One of the earliest articulations of how article 21 is relevant in relation to a health issue emerged in a case where the Supreme Court said that the right to life foists an obligation on not just the state but also the private sector to save life in emergency situations. So this was a case where someone was denied emergency health services and

succumbed and the court said that there is no question that access to such services is absolutely vital to preserve the right to life, which is explicitly stated in article 21. And therefore, emergency care became something that had to be actually something which was incumbent on both the state and the private sector to protect. So this was an interesting thing. And I emphasize private sector here, because I will come hopefully, to how, you know, that is not necessarily been the focus of the courts since this early ruling in 1989. So, such interpretation has been rarely used to expand the meaning of article 21, like I just said, which is the right to life, to include all kinds of other things, everything from human dignity, to essential freedoms, and entitlements like clean water, food security, health care of course, which we'll go into a little more deeply. sanitation, housing, livelihoods. So all of this really now encompasses the right to life and liberty. And so, you know, when those of us who work on these issues actually claim rights constitutionally, we've framed them within article 21, and where the understanding of health rights has been fleshed out even more. So there are various aspects are to the right to health, I think they are way too much to cover in a little limited time one has. But I wanted to highlight a few judgments which are relevant in the context of particularly Universal Health Coverage. I think there are aspects of these judgments which will resonate when we're thinking of Universal Health Coverage and its contents and what really, UHC should comprise of. One of those aspects is, for instance, the issue of the access to medicines, access to just medicines to obtain better health. It's an issue that courts have actually grappled with and recognized and acted on to ensure the fulfillment of the right health. So for instance, in 2017, there was a case where the Delhi High Court declared that access to life saving medicines for rare diseases is inherent to the right to life as a component of the right to health under article 21. And by ruling as such, it directed the state government to take steps to provide access to affordable medicines and treatment in the case of baby Dev Anand, which, you know, of course, has been actually has been discussed, and is important articulation of how treatment access is fundamental to the right to life. Similarly, actually the court, the same court, the Delhi High Court also conducted what is known as the continuing mandamus hearing, which is where it actually supervised the implementation, the mandatory implementation of its orders over time to monitor the finalization of the national policy for rare diseases by the Ministry of Health and Family Welfare. And the court did so because it wanted to oversee that its directions were actually being followed and implemented. So there also you had a case where part of the national policy for rare diseases was around access to treatment in that context. Similarly, in more broader context, courts have said a lot on access to treatment and health care. In the more famous case of National Legal Services Authority versus union of India NALSA as it's known where the court established equality of transgender persons. It also said that transgender persons have access to HIV related health care services, mental health care services, and public health facilities and sanitation services. So although it did not frame it as a right to health issue, it clearly was giving meaning to the constitutional rights of transgender persons by referring to specific health areas. It also has and this is an area which I think is of or has come to the fore in the context of COVID-19, certainly, around the issue of occupational health and safety of workers. And of course, in the case of COVID-19 frontline health care

workers, where the Supreme Court has directed not in the context of COVID, of course, but earlier, has directed employers to undertake appropriate measures for occupational health and safety of workers and ordered them to provide free medical consultations and treatment until cure or for lifetime for occupational diseases. Now, again, this is largely in the context of government employment. And I again want to emphasize that because I think Dr. Puras mentioned the private sector, and I think the private sector is one big area through which health care is delivered, which is not necessarily very clearly governed by a legal frameworks especially around right to health issues. Then there are other issues of access apart from medicines, which the courts have said some really important things around. Again in irrelevant to UHC is the issue of the right to access health insurance as part of the right to health. This came up in the case of genetic conditions in Jayprakash Dayal's case, or mental health conditions, in another case, Shikha Nischal's case. So you have the right to access health insurance, which cannot be denied just because you have a specific genetic condition, which is exclusionary, where the policy is exclusionary or if you have a mental health condition where a policy is exclusionary. Similarly, in quite a few cases around right to sexual and reproductive health, the courts have said that sexual reproductive health rights are integral to the right to health, in one particular case around unsanitary and unethical sterilization procedures against on women. Then the courts have talked also and gone into, you know, really policy issues are not necessarily that domain, but had had to kind of intervene. And this is in the context of deployment of human resources for health. So for instance, reservation and recruitment of health care workers from rural communities as an effective policy to fulfill right to health obligations towards rural communities by ensuring that there's medical staff available, and there is a facilitation of access to health care, goods and services in places where otherwise access is challenging. So that's an interesting intervention by the court where it has actually stepped in and said, the state needs to reallocate its resources in terms of how it designs policy to ensure that competent health, cadres are available in, in rural contexts. And again, very relevant in the context of Universal Health Coverage. There's one whole other area which I will touch on, very briefly, I already see that I'm running out of time, which is the area of social determinants of health. I think Dr. Sen spoke about this, and certainly referred to the context of gender quite clearly. But there are issues around social determinants of health, that have made the link between larger factors at play that affect the right to health. So for instance, I'll give you a couple of examples where the Bombay High Court has recognized that the right to health includes underlying determinants of health like access to public toilets and sanitation facilities. And it has done so particularly to ensure that special measures are made to facilitate women's access to public toilets and sanitation facilities, because it hinders the ability of a city and its citizens to really enjoy rights fully. The Supreme Court has held that the right to food is an integral component of the right to health under Article 21. And therefore, now looking more broadly as health being informed by all these other social determinants. So that's a really important direction in which the court has gone in kind of not necessarily framing it as a right to health issue. But use a you know, certainly make the links with the right to life. And I think as health activists and people who've advocate the right to health, these are important kind of,

you know, pointers towards how right to health can be more fully realized. So this is some of the stuff that I thought is important to highlight in my limited time. I should say two or three more things, though. Shivangi, I hope I have a couple of minutes more. One is that I think while the court has looked at the constitution, it has also looked at the International Covenant on Economic, Social Cultural rights. And it is that international covenant which India is signatory to, and it is that international covenant, which actually very clearly articulates the right to health as a fundamental human right. And it's the courts have often leaned on that to actually give a fuller understanding to what the right to health really comprises of. And Dr. Puras mentioned this briefly also, there are certain elements which have been infused in that right under the International Covenant. And those are the ones which really, the courts have gone more deeply into in analyzing some of the social determinants, which are linked to the right to health. There is, of course COVID of the last 18 months and we have seen the courts being getting more and more active. In many cases of for instance, the Bombay High Court has found gross negligence by a government hospital where a partially decomposed body was found of a person who had died of COVID. And the courts said that actually there's a right to health which is mandated under Article 21 and timely medical treatment is part of the right to health. Similarly, courts have said Madras High Court has said that persons with disabilities should be given priority in vaccination and vaccination centers must be made accessible as part of the right to health of people who are disabled. Again, and a really important component, I think, which gets lost often in conversations on UHC too, but also in the context of delivering fully on the right to health is the issue of Right to Information, where the Patna High Court has directed the state government to provide online information to public on the number of deaths that have taken place due to COVID. As part of actually the fundamental right to information very closely linked to the right to health. Capping of fees of charges by private hospitals is another point on which courts have intervened and actually capped fees, which was a really telling moment in, in the last 18 months around, where the right to health trumped other kind of issues and so called priorities. And so that this gives a hopefully a kind of an overall view of where the courts have come in, and it's largely been the courts which have come in. But I'd like to touch on one more thing before I close, which is that there is also statutory law. So we have the Constitution of India, but we have a few statutory laws, which have actually enabled the right to health in a much more meaningful way. There are many of late, particularly there's the Disabilities Act as the Mental Health Care Act, there is the protection of women from domestic violence and the Transgender Persons Act. But I just want to focus on the HIV Act. And I want to do so largely because there are some aspects which the high level expert group on Universal Health Coverage has noted that are of great relevance in relation to delivering on a robust right to health and UHC. And I think the judicial action on these areas has been rather limited. And I wanted to highlight these three or four because I think statutory law in particular, for instance, the HIV Act tries to address this. I think the courts have, like I've described, looked at various issues and said, well, this is part of the right to health or that is a health right, but the how to of delivering on the right to health has received less attention from the court. And so four issues have come up in the context of the HIV Act. One is on governance of the private sector. It's the

first law followed closely by the Mental Health Care Act where the private sector was included within an anti-discrimination framework. So the private sector became accountable for the manner in which it was delivering health care in the context of HIV. I think that's a really important issue that the high level expert group talks about. The other is citizen participation, which I think Dr. Puras mentioned around accountability and transparency and involvement of citizens. There are ways in which that has been attempted through the HIV Act, which could be a model and suggest ways forward for, you know, a UHC which has these components, which are inherent to delivery of the right to health. The third is the issue of grievance redress. The grievance redress has to be effective and localized. There is no point in trying to provide a right where justice is almost inaccessible, because access to justice is as much of a right as anything else. And so trying to create simple mechanisms for grievance redress if, for instance, Universal Health Coverage is not accessible to someone. And finally, and I think the courts have tried to do this a bit. And certainly Dr. Sen and Dr. Puras both spoke about this is focusing on the needs of the marginalized, I think the HIV Act very much is focused on that. And again, I think these are the three or four groundings, which I think are essential apart from in terms of the how to inter, for a right to health really to have some effect in the context of legal frameworks and Universal Health Coverage. Thanks.

Shivangi: Thank you, Vivek. Your talk really sets out quite well, that the right to health is in fact a poor constitutional right and has been interpreted by the Indian courts expansively in accordance with the right to health framework in international law that you talked about, and also what Prof. Puras had mentioned. And that courts will step in when the right is violated and give directions to expand public health programs. This makes it all the more important than that any UHC program or framework be examined from right to health lens too. With that I finally invite Meera Sanghamitra. Her talk will be on providing meaning to rights based approaches to UHC from marginalized contexts. Meera.

Meera Sanghamitra: Thank you Shivangi, Yamini and Vivek, of course, and all the co-panelists. I have been very keenly listening to all of your presentations and a lot of things, in fact resonate when we, as part of campaigns for a universal access to health care, articulated speak of. And I think what Dr. Sen, she literally hit the nail on the head when she spoke of the whole notion of power and why it needs to be center stage in understanding a lot of the dynamics and politics around access or the denial to health care. So with that context, I would want to start off very briefly, with an observation that in 2021, we are exactly three decades since the whole regime of privatization, and liberalization was set off in India. And it's important, I think, to really acknowledge us to because when we talk of universalization of health care or other, intensifying access to public health and other services in the public sector, it's important also look at how the architecture that existed for the last three years are the policy measures that were followed, in fact, to a large extent contributed to dilution of access to all these services to these rights, basically, to these entitlements and structural denial over decades. And it is therefore important to state very emphatically that the regime of privatization has not worked. And it has in fact, been counterproductive. At the end of it really reviews this entire policy

framework at the end of three decades, it's very, very clear that whether in the context of health care, whether in the context of education, whether in other contexts, it is very amply clear that privatization and liberalization has. And COVID has, in fact added, of course, a very thick layer of vulnerability further to all these marginalized communities. And when we speak of marginalized communities, these are not minorities, but actually the majority of our country, because when we speak of the broader Bahujan umbrella, it includes all the categories that no one really needs to speak of 80% of Dalits, adivasis, transgender persons, queer persons, women across all categories, Muslims and other minorities, remove the NT-DNT communities, persons, not just political prisoners, but people who are into prisons, because a lot of times those who are in prisons also and do not have access to health care over there also are from a lot of marginalized communities, so on and so forth, or persons with disabilities, children, etc. So when we talk of health care, am I audible? Shivangi?

Vivek Divan: Yes, yes, absolutely.

Meera Sanghamitra: Sorry. So when we speak of access to health care, it is something that matters to all these categories of the population who form the bulk of are 80% of our population. But when the policy is determined, or in fact, not just policies, even Vivek spoke extensively about the legal frameworks and the experiences with the judiciary as well. But I would say it has honestly been mixed in some ways, yes, the rights regime has been reinforced. But on certain occasions, it has also been, I mean, there's been a lot of oscillation between rights and rhetoric as well. So it's also important to note that, especially with the Supreme Court, maybe many times I mean, there has been a lot of hope often from the High Courts and where we had certain good orders in specific contexts. And it has been possible to assert some of these rights and connected with the frameworks of health care obligation of the states. But it has also been very, very challenging, because many times these get limited to very specific contexts. And any attempt to kind of use these progressive rulings to have broader context does not really yield much results. So there has also been that kind of experience that practitioners have had on the ground. So having said that, I would want to specifically also bet focus on some of the marginalized communities that I referred to. One could begin with the trans community itself. It's true that yes, after I mean, almost 20 years, 35 years since the Constitution in 2014, we had NALSA, NALSA did recognize, in some ways the right to health services without discrimination, the right of the responsibility of the state to actually guarantee many of these services to transgender communities were one of the most marginalized sections of our population to this day, and we've seen, and in fact, it's not just I mean, COVID or no COVID certain structures of discrimination have always existed, lack of access to public health care structures has always existed for some of these communities. So it has even at the very level of entry, it is so difficult to actually access these services. Of course, I mean, there has been a lot of work and where there has been some amount of work or politicization or work within and with the communities, one has been able to push and hold local health facilities and institutions accountable to principles of non-discrimination. But if one looks at it in a broader framework, and in terms of the accountability of the state, then you I mean, all of these basic

things, like for instance, there are very specific requirements, in addition to all the general requirements that trans people have as equal citizens specific requirements around psychosocial support, I mean, there's absolutely no mental health support, but there is no imagination of the need for any form of mental health support to hormonal therapy, which is not seen as part of the as a public health need for trans people to gender reassignment surgeries and other forms of intervention, so on and so forth. So there are also many, many specifics that trans people require as part of their right to life with dignity and life of equality. But a lot of these things are still not part of me, despite now, yes, we do have the 2019 Act and the rules and all of that. But I mean, that's a longer conversation about, you know, it's one step forward two steps, backward kind of experience we've had. But even beyond that, what is it that this does to trans people on the ground in terms of access to health care services. We've in fact, what we've also seen as many times we certain states, it's possible to push certain things at the level of the state governments and the state policy to maybe get something at a pan Indian level might not always be possible or not be even ideal for the kind of diverse nation that we are, and many times very specific policy interventions that have happened. This is true also for other sectors. But I speak right now in the specific context of health. Measures that say, the Tamil Nadu government has taken for instance, or Kerala government has taken all the one would still wish more on those trends as well. But even those limited kinds of interventions have not happened beyond, you know, some of these states. So there are all these experiences that one has in the context of transgender people. But I think it's also important to locate not just the question that rights of trans persons but also the overall question of right to health within a political framework of the working class population, because and the migrant workers' crisis is, again, a very graphic example of how the whole question of lack of livelihoods, lack of livelihood security, lack of income security, lack of social security is so deeply interlinked with the question of access to public health, right? So we do I mean, again, there are laws since the Migrant Workers Act to the 2008 Social Security Act to now the Supreme Court having woken up very late during last year's pandemic and then having passed some orders, which again, to a large extent, could not be implemented on the ground. So there's this whole experience as well one has, right? So, within this context, if one looks at how 93% of our working population and within that I would definitely include transgender people as working class communities, and also all the other sections of our population as well not having access to social security starting from not I mean, on the one hand, we have a whole surveillance regime and data tracking, you know, but on the other hand, the state still does not have proper mechanism to actually identify people and based on the identification provide essential services to many of these communities. For instance, we saw even in the context of the trans population last year, the COVID relief, which was given that to after a lot of I mean, push and pursued was just for 1% of the overall trans population in the country and that the estimate of the total population was also of the 2011 census, you know, much before the analysis. So definitely, I mean, the population is much huger. And even the bare minimum income support that went to one time support that went to the trans population was only 1% of the entire population in the country. So one can actually imagine that I mean, there is such a lack of imagination at the level of the

central government, in particular, but governments in general as to how does one, in fact, identify these populations that are so vulnerable and neglected and why they would need specific forms of support. For instance, when it has, we are still having to argue as to why pension support is necessary. Some states like say Andhra Pradesh have brought forth pensions support. But in addition to health care, strengthening the health care system, it's also important to provide these forms of social security support, which is still not available for a lot of these populations. So trans people, for instance, in Andhra Pradesh do have now for a couple of years pensioned support. But again, there are a whole list of conditions in that they say you have to be below the poverty line as if I think trans people are above the poverty line, most are below the poverty line. In fact, they say you have to mandatorily undergo the SRS, and only then you will have access to the pensions, they say you have to give up on begging and sex work as if other livelihood options are readily being provided by the state. So these all these conditions apply frameworks that are put in make even the limited schemes less accessible to communities that are vulnerable. So this is just one example case and example, but there are these kinds of riders that governments put in as well with, you know, schemes that come in. So therefore, it becomes all the more important that on the one hand, while we continue to argue for and push for universalization of health care, which we think and across movements, this is a demand that has strengthened, especially in the past few years, to look at how lack of health care in the lack of health care, lack of universalization of health care has actually impacted some of these communities in very, very specific ways. For instance, just a couple of weeks back, we were having a meeting with some of the nomadic community, a youth and they were speaking of how lack of documentation within those communities actually meant that I mean, they were access to health care because of lack of documentation was becoming such a basic issue. So there are so many of these specifics that have not become part of the imagination of the policy regime that what we're also seeing is very worryingly with, I mean, despite these 30 years of experience, negative experience with privatization at all. We are also seeing a further push for privatization with Ayushman Bharat, and I mean, the district hospitals, the solution for district hospitals to be graded privatization. So all of these things, where are we headed is definitely a cause of concern. With this government, honestly, the other cause of concern is also, I mean, of course, yes, one must value and respect traditional knowledge and traditional medical knowledge. But there is a thin line between value and traditional knowledge and how they're actually going onto the other side of I mean, really pushing on scientific methods of health care and medical interventions. And what does that mean to our public health care system, and especially for vulnerable populations is something that I think should be part of our agendas. And we should also equally talk about when we speak of rights of workers, informal workers, largely, there was a reference to frontline workers. Many times there is a warriorlization of the frontline workers. But what actually happens is the everyday concerns or I mean, every single day, we are seeing the ASHA workers or the Anganwadi worker organizing dharna in some part of the country. So on the one hand, there is an increasing feminization of all these frontline workforce happening, the what we call infamously as the paralyzation. Let's say you're the Para teacher, the Para health care worker. So all of these wherever bank models

have been pushed and imposed and being institutionalized and being celebrated as warriors whereas I mean, the basic work security that needs to be provided to these constituencies is not there. And that then directly has an implication on the kinds of services that they're able to provide to a broader mass of people who are already vulnerable because of other social locations. So it's important maybe to connect when we speak of access to public health care and universalization of public health to be able to connect many of these realities on the ground as well and frame are not just asked but I mean, one doesn't know who to ask with the current regime, but it's important to build a political narrative around why certain things have not worked so far. So what needs to be the road ahead in terms of framing a public health campaign and the need for nationalization of health care. When we talk of nationalization, we are, again, not talking of centralization, we are talking of the state being accountable for people's health care, all forms of health care. So I think it is these caveat that we need to also walk the path of nationalization and the universalization demand. And, yeah, let's see how we actually, it's a difficult struggle, and we are constantly in many of the conversations across communities. And because of lack of time, I think I've already overshot my time. So I'm not referring to the specifics of say the displaced communities or migrant populations, the kinds of concerns that they have, I mean, the absolutely pathetic conditions and resettlement colonies of a lot of displaced communities. So I mean, there is a grand plan on paper, but when it comes to implementation, there is so little accountability, and people are constantly being made to run from pillar to post. So how do you actually materialize some of these things which should have been there by now? But there is you only see a further dilution of many of these things with the privatization regime. So fighting that regime on the one hand, and also asserting existing rights. I mean, there was a lot of reference to fundamental rights and the Directive Principles. It's a sad reflection of our 75 years of political journey, that many of the Directive Principles still remain Directive Principles and are not entirely incorporated within the framework of fundamental rights. So that will continue to be an ongoing struggle within the larger framework of the fight that we're having against the Capitol. Yeah, I'll stop.

Shivangi: Thank you, Meera. That was really insightful. Your talk in fact, reiterates one of the criticisms of UHC's narrow focus just on financial exclusion is that it diverts attention from other forms of exclusion, and marginalization experienced by several vulnerable groups done on the basis of caste, religion, sex, gender, sexual orientation, HIV status, etc. There is clearly a need to draw attention to other social determinants of health and issues of discrimination and marginalization within the health system. And be interesting going forward, we see what kind of frameworks of accountability does the right to health afford and can present to right space UHC. But I think the next session was supposed to be like me putting up questions to each of the panelists, but I think we're running out of time. So we are moving straight to the questions posed by the audience. And one of the questions is from Alok Arunam, and he asks it several sociologists like Professor Dipankar Gupta and Professor Andre Patel I hope I'm pronouncing it right, had differentiated between quality as right and equality as policy. Mere rights based approaches without sufficient attention to state capacity are not used. Isn't then the emphasis

on rights based approach, not pragmatic enough? I think that all of you can respond to this. In turns you can take a couple of minutes. So I should I first asked Dr. Prof. Puras to respond to this?

Prof. Dainius Puras: Okay. I don't think that right to health or concept of human rights based approaches not pragmatic. If it is applied in sustainable and consistent way, it can be very pragmatic. And the best example for me is, how this epidemic was managed when the message from experts was to stop discriminating, keep populations, even those political leaders who may not like this idea, realized that that this is essential. It's like remedy. And so the there was another question to me, I think, but it's about the same. When we all are concerned about how to implement properly the, let's say, well formulated policies with the right to health and human rights based approach, present in formulation, I think it's very important about monitoring, independent monitoring on everything what is happening on national policy level on local municipal service provision and an individual, you know, when patient meets health staff what's happening there, and this is about process, and especially about outcomes. And for independent monitoring. Again, transparency is needed. So, not only academics are needed, but civil society is needed to observe and to signal if something is going wrong, and things are going wrong, when or if there is some imbalances, asymmetries, including power asymmetries. Gender based as it was in self-presentation, or based on asymmetries between users and providers of services, like it happens in mental health services. When with good intentions, users of mental health services are disempowered, even if a biomedical model may be helpful. But because of this power asymmetries, which still exists, people are disempowered and not empowered. So this would be my comment.

Shivangi: Thank you, Prof. Puras. Can I ask Prof. Sen to respond to this now please?

Dr. Gita Sen: I will sort of, you know, reframe the question is whether rights based approach is pragmatic enough? Sounds straightforward as that. And of course, I would not argue that it isn't. However, it is, one might argue that a legal approach may be necessary. But it may not be sufficient to realize the full implications of a rights based approach. So the equation of rights based approach with legal approaches seems to underlie this question. And I think that that's a problematic equation. Rights based approaches are not only illegal approaches. And I think that all of us have been trying to point to different ways in which the meaning of the right to health can actually be viewed from different stances, different positions, different perspectives, and also different disciplinary backgrounds. I would say, however, that are secondly, that that challenge is not one primarily of state capacity, it is actually the problem of power. And one of the ways in which power in the context of UHC discussions lies hidden is the fact that UHC itself in the way that it is often promoted, can become an obfuscation. For the larger changes in social, economic and other policies that Meera was speaking about, and that I think, quite often are headed in the opposite direction, to what realization of the right to health or of genuine universality of care for everyone would entail. And we have multiple examples of that. One very powerful example that was detailed quite a bit in the former Health Secretary Sujatha Rao's

book Do We Care is was the problem of what happened to medical education in this country. In the name of moving toward having more capacity in training health providers at all levels, the private sector was invited into medical education. Twenty years later, we still don't have enough health providers in the rural areas, because of the way in which that has happened. So UHC quite often is promoted as a walk in terms of here's the goal towards which we want to go while obfuscating, the how. And the how of privatization, which has come along with the language of UHC, quite often can be quite challenging. Now, let me say one thing, however, as a caveat to this, I'm not against the private sector, per se. I think that there are problems with the public sector, if it doesn't have good challenges coming from the other side. The public sector can be mean vicious, poor, quality, and unaccountable. And there's a problem of the private sector, if it doesn't have a strong public sector pushing it in the other direction. One of the interesting things about the state of Kerala is that you have this kind of balancing battle constantly going on between the private health providers and the public health system. Anyone, and I've lived in Kerala for 10 years. So I can absolutely vouch for this. Anyone can tell you purely left to itself, public health providers don't, especially medical colleges and others don't really provide you with the quality of services that you might want. So it's good to have the private sector breathing down their necks a little bit. On the other hand, you cannot have in health the private sector run rampant and free to do what it likes, without a strong public sector to push in the other direction. I do believe therefore, directions such as the one that Meera mentioned NITI Aayog is turning district hospitals into privatizing district hospitals is a recipe for disaster. District hospitals in many places significantly need to be improved, the quality has to be improved. And they need to be made accountable to the populations that they serve. But calling for accountability is not the same thing as simply privatizing them. Nor are the famous or should I say infamous, public private partnerships taken beyond a very limited frame. Yes, it makes sense, to privatize laundry services to a hospital. Why should a hospital be providing be doing its own laundry, of course, it makes sense to get a decent laundry service provider for a hospital? However, that is not the same thing as bringing unaccountable private provision into what should be solidly publicly provided basis of care that anyone can access. And I think that balance is what we need to find for UHC to work right. So it's not a question of being pragmatic, not pragmatic, etc. We need to be pragmatic, we need to be reasonable, we need to use what we have, but we don't need to be driven by an ideology that somehow the private sector will solve all problems. As I said, in maternal health, you let the private sector run rampant and you will get huge rates of C-sections beyond anything that is the WHO norm, you will get huge rates of hysterectomies because hysterectomies for women are the equivalent of cardiac bypasses for men. Women don't have so many heart problems, but we do have uteruses, and so the private sector goes to town with cardiac bypasses for men and hysterectomy is for women. And that's what you get when you don't have this balance working right. And I would hope that this Lancet Commission can really work towards spelling out what it would mean to get that balance right. Thank you.

Shivangi: Professor Sen, it's so tempting to carry on this conversation about the path to UHC that we've been down in the last decade, especially the financialization and privatization without any accountability frameworks and overarching principles. But we'll have to have that conversations other time. Moving on to Vivek, your comments to the question very briefly.

Vivek Divan: Yes, because I noticed we have very few minutes left. So let me actually echo both the previous responses. Dr. Puras talked about HIV, I think, you know, the problem has been that we have lived in little bubbles of in the HIV world, and we've not shown the world what is possible pragmatically, in working to actually have a better health response. I'll give you one quick example. And I should also say that the rest of the world has not been willing to look at HIV as a model, as much has seen the exceptionalism and has been pushed away by it. I think what, so a simple example of the pragmatics of how to deliver health. 20, 25 years ago, one sat with the bureaucracy in the city of Bombay. And actually, one of us was gay, the other was a sex worker, the other was a person who used to use drugs, another was an HIV positive person, and we sat with a bureaucrat in the Maharashtra Government or the Bombay City Government. And we actually explained our contexts. And those bureaucrats' eyes opened up, they didn't open up immediately, but they opened up over time, and they understood the challenges of our inability to access, forget about health care, just basic fundamental stuff as just occupants of the city. And thereby, dots were connected on what are the other pragmatic ways in which these communities can actually be better served so that their health is protected, and the health of larger community is protected and you saw a change over time. This is painstaking work, this is not work, which is necessarily written in policy or law, but this is the kind of work that needs to happen. And this, according to me, is what rights based approaches also include. I should definitely want to also say that I'm so glad that Dr. Sen spoke about the rights based approaches not equaling legal approaches, it's quite a different thing. But I also want to say that if you want to reign in the private sector, or certainly government, you need a legal framework. You have to have a framework which makes it accountable. And discrimination and equality is one of those things that offers a legal framework. So it has to be married with other pragmatic things. It can't be by itself. But certainly the law is not a solution to the problem, it's got to be a combination of things. There's a lot more I can say I would love to carry it on. And I think I'm going to connect with Dr. Sen and Dr. Puras, also Meera, of course later to see how we can carry this conversation on. Thanks.

Shivangi: Thanks, Vivek. Yes, actually they actually do report has quite a substantive chapter on the regulation and accountability mechanisms for the private sector and can be very instructive in this work moving forward. But now I ask Meera for her final…

Dr. Gita Sen: Child was responsible for by the way.

Shivangi: Yes, yes, Dr. Sen. We know.

Meera Sanghamitra: Yeah, no, I think Dr. Sen responded very well to the question and but just to add, when we speak of equality, I think we also speak in terms of with an understanding of

equity and not just equality. So it's important to again center stage that notion of what we really mean and of course, you are the private sector, he is here to stay, despite, you know, many of our approaches towards what the private sector has really done to public health at a broader level, but it is therefore, all the more important to reign in the private sector and to have these mechanisms of accountability. We definitely have had some examples previously, but there are things that have worked not work for instance, the Consumer Protection Act, in some ways was a measure to hold the private sector accountable, but it has again, I mean, there are huge limitations of the act, the way it was actually implemented, etc. So I think one also needs to revisit as part of these frameworks revisit what kinds of accountability mechanisms have not worked, or how is it that the private sector actually finds ways through you know, all the holes in the law and then, you know, with the huge clouds. So it's I think, also important to look at that. But I entirely agree with Dr. Sen that there needs to be this pressure as well, because yeah, the public sector can be very difficult. So it's important to also hold the public sector actually accountable. So how does one do that also needs to be part of our discourse. Yeah.

Shivangi: That was great. I mean, it's really, it's hard to end the conversation here. But we have to, and I'm sure we carry on this conversation outside of the webinar. But thank you to all the panelists. I now hand over to Yamini for her concluding remarks.

Yamini Aiyar: I knew when we were going to, when we were conceptualizing this discussion that it would be one of the most powerful contributions into shaping our thinking. And, of course, none of you disappointed. This is such a important engagement for us to have as we think about what are the policy implications of Universal Health Coverage, the dynamics of power, how we need to think about how they shape the patient's experiences with the public health system, from the minute they walk in, actually, from the moment they engage with the community health worker to when they go to the primary health center, and all the way up. And it's in that context, then that we can have a discourse around the hierarchies, the structures, the legal frameworks, the regulatory environment. And I think, no matter how nuts and bolts and policy we get in terms of what needs to be done to make the promise of universal health care reality, if we don't anchor this in this understanding, then we may fall into the trap of really giving the wrong recommendations. And I think the important caution that was given to us through this conversation that debating Universal Health Care without anchoring it in the foundations of a right to health may end up creating a deepening of inequalities and inequities, which is precisely what a discourse on Universal Health Care is seeking to avoid, is something that we need to recognize much, much more seriously. I think, also, importantly, this discussion around state capacity is an right is an important one. And in fact, in one of my early conversations with Vivek, I had sort of we were discussing the experiences of rights frameworks and other social policies, and what impact that has had on the actual ability for creating a governance architecture that realizes those rights. But I think it's a discussion that needs to continue. But again, one that where we shouldn't throw the baby out with the bathwater, the lack of state capacity is not a reason why we shouldn't be debating rights framework. In fact,

the argument should be what kind of state capacity do you need to enable, in order for universal coverage to actually become a reality? And therefore, in some ways, where you're pushing us through this conversation is to really get to the heart of the normative role of the state vis-a-vishealth articulating that effectively and building from there, what this architecture of a universal health system should look like, and the relationship between the state, the private sector, and of course, keeping the patient or the citizen at the heart of it. So thank you very, very much. I hope that we can trouble you over the course of the next few months as our own deliberations emerge and evolve. And I hope that, you know, I think it'll mean a lot for us to refine our ideas through a dialogue with all of you. So thank you. Thanks very much, C-HELP for organizing this. Is really one of the most important conversations we've had?