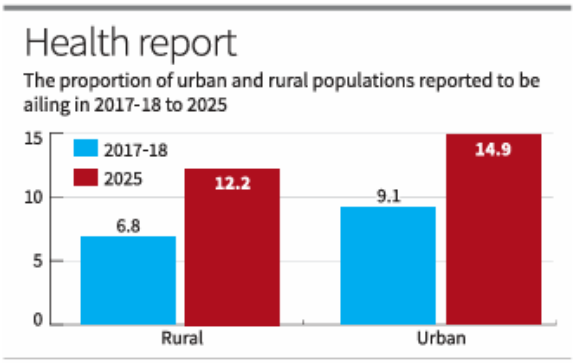
GS Paper II – Social Issue **Date: 30.04.26**

NSO survey shows better health-seeking behaviour, relatively low medical charges

Bindu Shajan Perappadan
NEW DELHI

Health-seeking behaviour in India is improving as the proportion of the population reported ailing (PPRA) in 2025 nearly doubled from 2017-18 figures, with rural area numbers going up to 12.2% from 6.8% and those of urban areas rising to 14.9% from 9.1%, according to the latest findings of the National Statistical Office (NSO) in the 80th round of the household consumption health survey released on Wednesday.

Expansion in coverage under government health insurance and financing schemes rose more than threefold – increasing to 45.5% from 12.9% in rural areas, and 31.8% from 8.9% in urban areas, the NSO reported.



SOURCE: NATIONAL STATISTICAL OFFICE

Institutional deliveries have risen to 95.6% in rural areas, and to 97.8% in urban areas, the survey said.

Covering both rural and urban areas across the country, the survey canvassed 1,39,732 households, including 76,296 households in rural areas and 63,436 households in urban areas.

The findings of the NSO noted that median out-of-pocket medical expenditure (OOPE) per case of hospitalisation in 2025 has been recorded as ₹11,285, indicating that relatively low expenditure was incurred in over half of the cases of hospitalisation in the country.

Only a small number of high-cost cases were observed to push up the average (mean value), the NSO said.

"This shows that high expenditure is not widespread but limited to specific cases requiring specialised treatment. Moreover, the OOPE in more than half of the entire hospitalisation cases in the public health facilities incur only ₹1,100. Importantly, for non-hospitalisation (outpatient) care, the median OOPE in public health facilities is zero, reflecting that a large proportion of citizens are able to access essential healthcare services entirely free of cost," the survey said.

India has also registered a decline in infectious diseases and a rising prevalence of non-communicable diseases, including diabetes and cardiovascular conditions.

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GS Paper II – Social Issue

Why 'digital vigilantism' is not the problem

Prachi Dutta

Corporate lawyer licensed in New York and India, advises companies and funds, and serves as an Adjunct Professor at Jindal Global Law School and Shiv Nadar University

The Delhi High Court recently made some observations about "digital vigilantism", and that statements can sometimes "transcend mere free expression and act as a catalyst for public shaming". The context is a defamation suit brought before the Court by an individual who allegedly misbehaved with a lady on a domestic flight. The lady attempted to amplify his conduct by posting her ordeal on social media, which was shared by media houses and an actress, who apparently did not verify the allegations made in the post.

These observations and statements once again highlight the growing use of social media to amplify claims of harassment and misconduct due to a sense of collective helplessness and people's lack of faith in systems to swiftly and adequately address sexual harassment claims.

Whether it was the role social media played in the #MeToo movement in attempting to bring justice to victims of sexual harassment or videos recording instances of harassment posted on TikTok, the bottom line is that social media is being used to "crowd source" retributive action, wherein exposure offers accountability due to institutional inaction, as per Sara Witmer.

Systemic apathy

Justice systems globally, due to their long-drawn-out processes, deliver justice in a belated fashion. Coupled with the apathy and unwarranted intrusion of police authorities and victim blaming, the process of speaking up against sexual harassment is even more challenging. The redress process often becomes a form of punishment for all parties involved.

Due to the lack of processes, systems and institutions in delivering justice, social media is used by victims to bridge the gap between harassment and redress mechanisms. This leads to problems like allegations being amplified without any mechanism to verify them, false allegations circulating because of the anonymity offered by social media, lack of accountability, and the reputational loss of all parties involved. It creates a public spectacle rather than actually addressing the issue.

Social media is being used to 'crowd source' retributive action, wherein exposure offers accountability due to institutional inaction

However, when processes and systems continue to fail victims, the need to strengthen these processes is of the utmost importance so that victims do not have to use social media as a redress vehicle to achieve justice. It is crucial to ensure a balance between helping victims while protecting the reputation of the alleged harassers, so that one does not trample on the other in the quest for justice. It is important to maintain the principles of natural justice and fair trial.

On 'vigilantism'

Another issue is with the terminology of "digital vigilantism". The word vigilantism in itself invokes a negative connotation. As per Les Johnston, "vigilantism", by its definition, involves the premeditation of participants who are private citizens; their engagement with the issue would be voluntary.

It is also a social movement, which uses or threatens the use of force and arises when an established order is under threat from the transgression of institutionalised norms and aims to control crime or other social infractions by offering assurances of security both to the participants and to others.

Social media posts in the face of harassment do not fall squarely within the purview of vigilantism as there is no established order that is under threat and there is also absolutely no assurance of security to participants. In fact, both the victims and the perpetrators can be recipients of doxxing.

Simply put, when there is a collective failure of processes, then one turns to social media to amplify harassment – this cannot be defined as "digital vigilantism".

Social media redressal

There have been several instances of unwarranted behaviour during air travel. Case in point is the incident that occurred in November 2022, when a man urinated on a woman. The airlines was slow to act upon the complaint and it was only once details were made public that the airlines took action against the individual. The fundamental issue, therefore, is to have adequate processes at all levels so that a timely redress can be carried out. For instance, if airlines had proper systems in the form of strict no-fly lists, one may not have to resort to social media amplification.

To draw a parallel between consumer services, when a consumer has an unpleasant experience, they have the right to take to social media to express their displeasure. The outcome is two-pronged – either the service provider will respond with their defence or apologise for the bad experience. This helps other consumers make informed choices before availing the same service. Moreover, in consumer services there are adequate systems and processes that exist before a person takes to social media to express displeasure. Customer grievance teams are often prompt to act on complaints because of the fear of reputational and financial loss. However, justice systems and processes that help to achieve real, legal justice are significantly different. They are not prompt and often refuse to act on complaints of harassment, leaving victims with no choice but to take to other channels to amplify their grievances.

The issue therefore, is not of freedom of expression versus public shaming but the fact that in the face of abject failure of processes, people are left with no choice but to use social media as a tool to achieve justice. To avoid "digital vigilantism", a collective strengthening of processes and faith in these processes is crucial.

GS Paper II – Social Issue

Increasing coverage, growing distress

Rising insurance coverage has not increased hospitalisation or reduced out-of-pocket expenditure, as more people shift to private sector care with higher costs; govt.-funded health insurance schemes are failing to protect households from financial hardship while disproportionately benefiting the better-off

ECONOMIC NOTES

Indranil
Montu Bose

The latest NSS data of the 80th round on "Household Social Consumption: Health" reveals several concerning results that need wider discussion. The survey, conducted between January and December 2025, shows that while insurance coverage has increased considerably compared to the 2017-18 (75th round), this has not translated into a significant rise in the utilisation of hospital care. A greater proportion of people are now going to the private sector.

Meanwhile, out-of-pocket (OOP) expenditure on hospitalisation has risen sharply between 2017-18 and 2025, particularly in the private sector.

Coverage without care

Currently, 47.4% of rural households and 44.3% of urban households are covered by some form of health insurance. This has been achieved mainly by more than a two-and-a-half-fold increase in coverage between 2017-18 and 2025 of government-financed health insurance (GFHI) schemes such as Prime Minister Jan Arogya Yojana (PMJAY) and Swasthya Saathi (in West Bengal).

The NSS definition of GFHI also includes the Employees' State Insurance Scheme (ESIS), the Central Government Health Scheme (CGHS), and those for State government employees, etc. However, as per official records, increased coverage of ESIS or CGHS would have very little contribution to this significant jump in coverage.

In the 2017-18 round, hospitalisation rates had decreased considerably. Despite the increase in insurance coverage, the hospitalisation rate remains below 2014 levels, though it increased marginally compared to the 2017-18 rate in rural areas. In urban areas, the rate has declined further (Figure 1).

A persistent gap

Latest NSS data* reveal limited gains in hospital use and rising expenses despite a surge in insurance schemes

Table 1: Hospitalisation cases (per 1,000 persons)

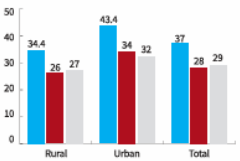
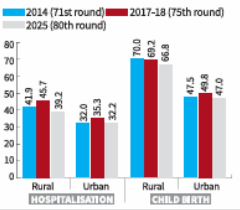


Table 2: Share (per cent) of public sector in total hospitalised episodes and child birth

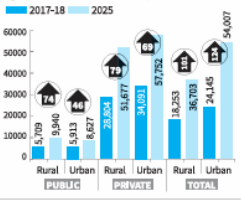


Shift to private care

Between 2017-18 and 2025, there has been a considerable reduction in the use of public institutions for hospitalisation and childbirth. More people are opting for private care. There was a rise in the use of public services between 2014 and 2017-18. For non-hospitalisation care, public sector usage has increased slightly in rural areas but declined in urban areas (Figure 2).

Increased access to insurance coverage is failing to protect people from financial hardship. OOP expenditure on hospitalisation has more than doubled in both rural and urban areas between

Table 3: Average OOP on hospitalisation (₹): 2017-18 and 2025 by location and facility type (growth rate in % within arrow)



SOURCE: AUTHORS' ESTIMATES FROM UNIT RECORDS OF VARIOUS NSS SOCIAL CONSUMPTION: HEALTH ROUNDS

2017-18 and 2025. Even in public hospitals, patients incur significant expenses due to the unavailability of medicines, diagnostic services, and high transport and other non-medical costs. As expected, when people seek care in the private sector, they incur very high costs. Average hospitalisation expenses in private hospitals have increased by 70% in rural areas and 80% in urban areas (Figure 3).

GFHI schemes such as PMJAY are meant to cover high-cost, low-frequency hospitalisation needs for enrolled households. Care can be sought in empanelled public and private facilities, and these schemes are promoted as offering free treatment in private hospitals. Public hospitals are, anyway, largely subsidised and should be either free or more affordable. Of the people enrolled under the GFHIs and needing hospitalisation, 57% sought care in private hospitals. Very few got free care, as promised under these schemes. The average OOP expenditure (excluding childbirth) is ₹31,250 in rural areas and ₹34,259 in urban areas.

Although GFHIs target socio-economically backward sections, many States have extended coverage to non-poor populations. Though there is relatively higher coverage among the poorer income groups, when it comes to utilisation of services under these schemes, it is the relatively better off who benefit disproportionately. Data show that only 13% of those using hospitalisation services under these schemes in urban areas belong to the poorest class. The inclusion of non-poor households has also increased utilisation and placed a greater strain on States' budgets. In Haryana and West Bengal, nearly 15% of their State health budgets are spent on GFHIs. This increased fiscal strain is also leading to delays in reimbursement to private providers.

Essentially, GFHIs use tax money to subsidise care for the private sector. This helps the private sector to have access to markets which were hitherto out of its reach due to low purchasing power. In India, the private sector largely functions on the principles of profit maximisation, with limited motivation for social solidarity and is essentially unregulated. Since GFHI reimbursement rates are below market rates, even though the rates are more remunerative than CGHS, patients are often charged additionally.

Thus, the experience of the first seven years of PMJAY and GFHIs in general shows that these schemes are 'of the rich', 'for the profit', and 'by the poor people'! Is that a desirable consequence? It may be time to rethink the insurance-led model of Universal Health Coverage (UHC) and refocus on strengthening the public healthcare system to deliver universal, comprehensive care. In this context, Ayushman Arogya Mandir (AAM) – PMJAY's relatively neglected counterpart aimed at providing comprehensive primary care, including services for non-communicable diseases – shows a glimmer of hope. However, it remains severely underfunded, much like the National Health Mission.

(Indranil is a Professor at the School of Government and Public Policy, O.P Jindal Global University. Montu Bose is an Assistant Professor at the School of Health Systems Studies, TISS, Mumbai. With CMIE data inputs from Akarsh CO, Research Associate, O.P. Jindal Global University)

THE GIST

- Increased insurance coverage has not led to a significant increase in utilisation of hospital care, with more people going to the private sector.
- Out-of-pocket expenditure on hospitalisation has seen tremendous increases, and insurance is failing to protect people from financial hardship.

GS Paper II – Polity

Why has the creamy layer debate returned to court?

Is the current push based on a misreading of the judgment? Can income be used as a proxy?

LETTER & SPIRIT

Pranav Dhawan
Vignesh Karthik K.R.

Fresh petitions before the Supreme Court are seeking to extend the creamy layer principle to SC/ST reservations, based on a misreading of the 2024 Davinder Singh judgment. The move revives a decades-old debate about whether income can serve as a proxy for caste-based disadvantage, and whether social justice can be trapped inside an economic test.

The renewed push

On March 10, the Supreme Court issued notice to the Centre and all States on a public interest litigation filed by advocate Ashwini Kumar Upadhyay seeking the exclusion of a "creamy layer" from SC/ST reservations. A separate plea, filed in February, sought an income-based prioritisation mechanism within these quotas. Both petitions claim constitutional sanction from the same source: the seven-judge bench decision in *State of Punjab v. Davinder Singh* (2024).

That judgment permitted States to sub-classify Scheduled Caste communities to direct reservation benefits toward the most marginalised within them. Four of seven judges made passing observations that creamy layer logic might apply to SC/ST groups.

A doctrine born in ambiguity

The creamy layer principle entered Indian constitutional law through the judgment in *Indra Sawhney v. Union of India* (1992), where the Supreme Court upheld OBC reservations but held that the more advanced sections, the "creamy layer," should be excluded from benefits.

The 1993 Office Memorandum that followed identified creamy layer exclusion primarily through status, not income. Holding a Class I or Class II post in government was the proxy, a recognition that institutional power compounds across generations.

This architecture was progressively diluted. A 2004 clarificatory letter from the Department of Personnel and Training began treating PSU salaries as a standalone disqualifying criterion. On March 11, the Supreme Court in *Union of India v. Rohith Nathan* struck down that letter, holding that parental salary alone cannot determine creamy layer status. The 1993 OM's status-based logic was restored, but the deeper premise of the doctrine, that economic attainment adequately measures the erasure of social disadvantage, remained intact and unexamined.

The Ambedkar objection

In his 1932 note to the Lothian Committee, B.R. Ambedkar warned that excluding wealthy or educated individuals from the category of untouchables was "a totally erroneous view."

At the Mahar Conference of 1936, Ambedkar put it concretely: the educated, propertied Mahar still cannot open a shop without customers leaving when his caste is known; he still cannot apply for a job without his identity becoming a disqualification. Economic progress and social emancipation travel on different tracks, and the creamy layer doctrine collapses the two.

Data presented in *Jaishri Patil v. Union of India* (2021) showed that even Group D government employees were rendered ineligible for post-matric scholarships due to income-testing. The court noted that a family earning ₹6 lakh a year cannot be equated with one earning ₹24 lakh simply because both exceed a common ceiling. Statistical research published by Nishith Prakash showed that elite capture of quota benefits was a myth. Contrary to the popular notion, the positive impact of quota policy is concentrated among 'the less-educated SC members in rural areas.' The doctrine's bluntness produces what may be called a creamy layer trap: the bar is set low enough to exclude the barely stable, yet the social burdens that reservation addresses persist regardless of salary bracket.

The SC/ST distinction

The case for creamy layer exclusion was always weaker for SC/ST communities than for OBCs. Sub-classification, what Davinder Singh actually authorised, is a different instrument entirely. It asks which sub-communities within the SC list are least represented and directs preference toward them.

Extending creamy layer logic to SC/ST would mean removing individuals from reservation eligibility based on parental income, precisely what Ambedkar argued was constitutionally and sociologically indefensible. Justice B.R. Gavai, who endorsed the broader principle in Davinder Singh, himself acknowledged that the criteria for SC/ST cannot be identical to those for OBCs.

Parliament's moment

The *Rohith Nathan* judgment creates a narrow but real opportunity for legislative recalibration, one that measures social backwardness by the subordination they continue to face. Parliament has both the constitutional authority and the democratic obligation to clarify that sub-classification and creamy layer exclusion are distinct instruments, and that the latter has no application to communities whose inclusion in the Presidential list was never conditioned on poverty.

(Pranav Dhawan is an LLM Candidate at Yale Law School. Vignesh Karthik KR is a postdoctoral research affiliate at the Royal Netherlands Institute of Southeast Asian and Caribbean Studies, Leiden)

GS Paper II – Social Issue

How decentralising therapy can support mental health treatment

Antidepressants are increasingly being prescribed by general physicians, often in busy settings. If a clinician has limited follow-up and no access to psychosocial services, medication becomes the most feasible intervention, and over time reinforced by both clinical habits and patient expectations

The Indian Psychiatric Society recommends a stepped care model, where people with mild-to-moderate issues are first managed with psychosocial interventions before initiating pharmacotherapy. Yet in practice, this step is often bypassed and medication becomes the first-line response even in situations where other approaches may be more appropriate

India has a limited mental health workforce, and psychotherapy remains concentrated in specialist settings. In many rural, tribal and rural areas, pharmacological treatment is the only consistently available form of care. When alternatives are scarce, prescribing becomes more a necessity