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# The Political Economy of Health Citizenship: Welfare, Legitimacy, and Institutional Capacity in Telangana

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**ABSTRACT:** Health care has always held one of the more visible components of the state and citizen relationship, being one of the most visible forms of social welfare/human development. In today's welfare state, health care is conceptualized not only as a service to be provided technically, but also as a social system that is the arena for debates on equality, citizenship, and justice. The growth of health care systems has all to do with political decisions, ones which involve questions of state responsibilities in healthcare, distribution of public resources, and citizenship's conceptions. According to Marshall's (1950) theory of social citizenship, democratic citizenship is not limited to civil and political rights, but also social rights that allows people to play their full role in society. Healthcare is thus a seminal aspect of substantive citizenship as it directly affects people's access to social and economic rights.

This article studies on the healthcare transformation in Telangana which is a double political procedure. On the other hand, the expansion of health-care has been a consequence of processes of nationally building a sense of developmental identity through welfare delivery, to enhance the effectiveness of social protection, and to increase access to health-care. At the same time, it exposes the problems of relying on welfare development if provincial and district capacities, quality, equity and sustainability are not adequate. Expansion of healthcare is one way to increase state legitimacy, while building entrenched institutions that can provide accountable and equitable healthcare is a more lasting path to legitimacy. Thus, the Telangana case brings to light the extent of how social policy operates as a public service provision mechanism and also on the citizen front as a forum for negotiation around public service delivery expectations from the State, in an overall manner helping to contribute to the wider debates regarding Indian Federalism, Welfare Politics and Developmental Governance.

## INTRODUCTION

Healthcare is a politically salient sector, especially in developing societies where health disparities are linked to other social and economic inequalities such as poverty and geographical disparities. In these settings, health care delivery is more than a health care output but can also serve as a proxy for state legitimacy. The ways in which citizens interact with government on a day-to-day basis offer the best window into the quality of government. Governments are judged on the basis of citizens' experiences in their everyday lives with public institutions, welfare programmes, and social protection systems. Sen's capability approach (1999) also emphasizes this connection because she believes it is not economic growth, but real opportunities and freedom that should be used to measure development. In this sense, health is a basic function, as conditions of poor health hinder people's social, economic and political functioning.

Healthcare governance in India is an expression of welfare pledges, development goals, and the political system at the federal level. Though the public health and hospitals are not explicitly mentioned in the Federal List of Indian Constitution, the public health still is subject to the direction of national programmes, financial structures, policy plans, etc. and this influence indirectly permeates at the state level. This shared responsibility has created considerable differences in the nature of governance in healthcare across the States and some States have evolved unique welfare innovations and the enhanced public health systems (Qadeer, 2011; Mahal et al., 2012). Additionally, federal structure has also reinforced the importance of states as key venues of healthcare policymaking innovation. Though there are national programmes like National Health Mission, Ayushman Bharat, etc., and these offer broad guidelines for development, it is observed that state governments are increasingly formulating schemes and programmes tailored to the specific developmental needs of the region, political agenda and administrative ability. States have hence become key policy implementers or spaces of policy-making and contestation of models of welfare delivery and of developmental governance (Rao & Woolcock, 2007).

Formed as India's newest state in 2014 after a long political battle around Telangana identity and their demand for better governance and responsiveness of the Central government due to development disparities. It was created as a new state in India from a prolonged movement that was based on regional identity, redistribution of the areas resources, political representation issues, and development inequalities in 2014 brought hopes of better governance and more responsiveness to the needs of the region. Welfare sectors, especially the healthcare sector, thus emerged as important mechanisms by which the new state asserted its abilities and legitimacy for development.

The State has always been focused on health care development by promoting health related programmes like Rajiv Aarogyasri, access to treatment, maternal & child health, government health facilities, improvement of medical infrastructure and development of health system in Telangana. These programs are labelled by government as progress towards development, but more critical political analysis is needed beyond official discourse. The issue is not just whether healthcare programmes have been expanded, but how they help to change the way citizens relate to the State. Hence, this article focuses on the concept of developmental politics and health citizenship to analyse the healthcare development in Telangana since 2024.

Health citizenship is an idea that extends to the idea of the welfare state, viewing health care as a more social and political relationship between citizens and the state. Health citizenship also looks at whether people have material claims to institutions of health that are accessible, that are equitable, and that are accountable, whereas the traditional approach takes a look at healthcare infrastructure, how people are insured, and where they can receive treatment. This perspective rests on the social citizenship theory of Marshall (1950), which conceives of citizenship as a social entity beyond just civil and political rights and rights based on need that allow citizens to become full participants in society. While no statement with regard to health citizenship was made explicit in Marshall's theories, it is possible to consider healthcare as a social right, rather than the Government's provision of a specific benefit. But welfare schemes do not necessarily lead to substantive health citizenship. It is important to differentiate between formal entitlement (citizens are recognized as beneficiaries through policy and programme) and substantive entitlement (citizens have access to the timely, affordable, dignified and quality of health care).

This is especially significant in developmental settings where service access through expanded health care coverage can be related to a lack of geographical equity, specialists, administrative challenges, and quality differences. This is bolstered by Sen's (1999) capability approach which focuses on development as reflected not just in institutional structures but in actual opportunities and freedoms available to people. As viewed from this angle, effective health governance depends not so much on financial resources as on real capacities to pursue healthy lives through the elements of accessibility, quality, dignity and accountability. When it comes to healthcare in Telangana, the proposed model allows a greater glimpse into whether the scheme increases welfare dependency or allows people to be enabled as health citizens. Programmes for financial support, insurance, and health facilities should thus be evaluated based on their potential to change citizen–state relations.

**Developmental State and Welfare Politics**

The second theoretical dimension is the interface of state capacity, development, and welfare government. The developmental state literature emphasizes the importance of institutional power, government bureaucracy, and strategic acts of public intervention in the process of government-led transformation (Johnson, 1982; Kohli, 2004). The concept was originally developed to describe industrial growth; it can also be used to describe the delivery of public services like health care provision. With the development of a capable state necessitating capable institutions able to mobilise resources and execute policy, act

decisively and deliberate long-term policies, Kohli (2004) claims that effective developmental states require such institutions. In health systems, it means good governance goes beyond policy declarations, it requires administrative capabilities, stable and adequate funding, coordination within the health system, and effective implementation.

The political implications of welfare programmes are also very notable. According to Pierson (1994), social policies could affect citizens' views and expectations about the public sector. Healthcare programs serve as mechanisms of redistribution as well as tools for legitimacy for the state. Health care expansion in Telangana is not only the indication of a concern for social outcomes but is also part of a larger move towards a developmental identity. But it is necessary to consider the developmental approach in terms of the contribution it can make to sustainable institutional change, not just to public policy results.

The third theoretical dimension is on the role of the states in India's federal fabric. The analyses of Indian federalism, over the years, have shown it to be a changing arena where state government can be back for policy innovations. States have been considered as actors beyond the central government, not simply as its extensions, and independent in their efforts to build their own unique models of welfare (Rao & Woolcock, 2007). Given the degree of power held by the states over the administration of public health, healthcare is an especially appropriate case for examining subnational politics. A comparison of health outcomes across states in India provides an indication that political processes, administrative capabilities, and institutional structures can have a large impact on welfare performance. Aside from this, what Telangana has done is an important case study since it has: created a unique regional development story; established it is a relatively new state; and deployed welfare programmes as key governance tools. The analysis of Telangana thus enables the study of the utilization of social sectors (healthcare) to ensure legitimacy and prove developmental efficacy of newly formed states. There is also a need for international inequalities to be instead paid attention at a subnational level. States can appear to be successful developmental state in isolation and yet grapple with other issues such as urban-rural inequities, unequal health service coverage and foundational institutional challenges at the local level. Thus, Telangana's health journey also offers a chance to look at how welfare in today's India is possible and what its challenges are.

**Telangana and Healthcare as a State Legitimacy Issue**

The state of Telangana definitely has its share of challenges. There are challenges in plenty in the state of Telangana national development, regional identity and healthcare governance. The issue of regional identity-development dimension has been the main issue of political trajectory in Telangana. The Telangana movement had been existing for a long time, claiming the need for political recognition, distribution of resources and developmental justice, and the creation of Telangana in 2014 was an institutionalization of this movement. Most of the proposals of Telangana movement have come from the perception that the state of Telangana had been ignored throughout history and that disparities between the region and the rest of the state are most glaring in fields of irrigation, employment, education and infrastructure facilities and amenities. The demands of the Telangana movement can be attributed to what was perceived as the state failing to get the benefits of its contributions to economic growth of the larger state of Andhra Pradesh in terms of irrigation, employment, education and public infrastructure amenities and facilities throughout the historical periods. Thus, the call for a separate state was not only in terms of culture but also in terms of responsive governance and development sensitivity to the local, regional environment (Srinivasulu, 2014).

The reformulation of Telangana resulted in a unique expectation about development, on how the government of a new State is going to bring about positive social changes to the development of autonomy enshrined in a separate political entity. Welfare sectors came into the picture in this context as significant areas of contest where states were able to defend their legitimacy. Healthcare has gained in importance because health institutions are one of the direct interfaces of the citizens with the state. While the impacts of large-scale infrastructure are often more distant, or distributed over a wider population, healthcare institutions can impact citizens' daily lives through material impacts in hospitals, healthcare systems, as well as through emergency services, maternal care and financial risk regulation.

Politically, the health care system, then, becomes at the same time a combination of material services and a symbol of the state's commitment. An increase in health centres conveys messages of the State's ability to safeguard the "weak parties" and its ability to honour its development commitments. The link between welfare provision and political legitimacy has been much discussed in welfare state literature. Pierson (1994) suggests that the relationship between government and citizens effected by social policies can be long-term because of the role played by public expectations of state responsibility. The political significance of

welfare delivery extends to newly established states like Telangana where the welfare delivery process becomes an element that presents the state's efficacy and credibility to the institutions it has set up.

But healthy consumption politics has its limits, because examining health as a political metaphor might overlook the institutional dynamics of health service delivery. Any intention of providing welfare pledges or building new infrastructure cannot alone be considered as a pledge to developmental legitimacy. Whether the administration of the state has the capacity to turn political promises into proper results. Thus, the arena of health care needs to be considered simultaneously from two angles, the dimension of health care as a tool for government building and the dimension of health care as an institutional system which needs long-term capacity, expertise and accountability.

The healthcare schemes of Telangana provide an example of how these issues of welfare provision and the authority and legitimacy of the state are intertwined. The Rajiv Aarogyasri Health Insurance Scheme is an important financial protection policy for vulnerable households, and a highly symbolic policy for a new trend in health service governance in India, a public finance-led governance model now emerging, that uses a strategic procurement approach leading the health service. Financial protection has also been highlighted as a significant objective of the health reform in the National Health Policy 2017 which covers financial protection from catastrophic health expenditure with respect to access to essential services (MoHFW, 2017). However, Aarogyasri is a political issue and not just of funds. It's a way of replacing the private hotel fee with a state obligation or duty ensuring health care. But financial protections have no intrinsic element of health citizenship. Financial assistance will be offered to citizens, but other barriers for which they are suffering will also remain: access and availability of health care services and specialists and quality of services, but also the dependency on private providers. Multiplication of the legitimacy of welfare programmes, then, relies as much on the degree of coverage as it does on the robustness of healthcare institutions to back the schemes.

In addition to the maternal and child health programmes are representative illustrations of the translation of healthcare as a metonym for Telangana's age. These programmes help to bridge the gap between the process of government intervention and the needs for human development and development pledges in SDG 3 to access health services (United Nations, 2015). The development in hospitals and medical education institutes is also some kind of healthcare development and an index of the capacity of the state.

The vision of infrastructure expansion needs to be looked at in more than just terms of vision, however. Hospitals and medical colleges are the indicators of government investment but for effective health care proper man power, proper kits, proper systems of management and continuous allocation of resources is required. It is obvious that developmental states need Policy Ambition as well as institutional capacity, as Kohli (2004) has proposed. It is clear in the health sector that for legitimacy to be seen as long-term, institutional growth should bring about equitable and sustainable outcomes.

**Universal Objectives and State-Level Priorities**

The healthcare governance of Telangana is a part of the national mission for Universal Health Coverage (UHC), Ayushman Bharat and Sustainable Development Goal 3. The goal of UHC is to have everyone be able to get the health services they need without facing financial hardship (WHO, 2019). The PM-JAY, along with Health and Wellness Centres (MoHFW, 2018) and Ayushman Bharat are some of the initiatives undertaken for this goal in India. Rather, the federal system in India breathes a lot of freedom to the states in developing strategies for their healthcare sector based on the region's specific requirements and political priorities.

The state of Telangana is the product of the convergence of national health system and local development goals. The state engages with national goals regarding accessibility, affordability and better health outcomes, but also in regional identity, feelings of welfare responsibility and formation of developmental legitimacy. Nationwide assessment, represented by a single state-wide indicator, or a state ability to respond effectively to their local circumstances, is the question large health systems are asking about this relationship. State have more flexibility and more ease with the development of solutions because there are common objectives in the national frameworks. In fact, several states throughout India are emerging as key hubs of welfare innovation, with Telangana being a key player in this regard. But at the same time, it is essential that there is greater accountability along with increased autonomy because citizens judge governments directly in what they experience from public services.

Post-2024 cases can be an important backdrop to study the healthcare governance of Telangana in relation to the interconnectedness of welfare aspirations and institutional amalgams. But the important questions are not just about the extent

to which healthcare programmes have grown, but about the capacity in which this growth has taken place, and thus a question of whether it marks a more fundamental shift in the politics of healthcare. Hospitals, medical colleges and medical facilities are symbols of development and this has turned to become an important area of healthcare infrastructure as it is an area that is visible to everyone. For the relatively new state of Telangana, infrastructure expansion has a political thrust in that it represents the progress of the region and the political abilities of the administration.

Developmental state investment in medical institutions represents investment in capacity building of healthcare, training of medical personnel, and the security of healthcare provision. But infrastructure is just not enough for ensuring quality health care service. Conduct and competence of staff, nature of professional accountability, efficiency and service continuity of the management of the institution, and the overall quality of the work done in the institution. An expanding hospital structure that doesn't get commensurate upgrades in health care capacity may be a sign of growth. The World Bank (2016) also highlights that efficiency, quality, and good governance in services are as important as increased spending for better health. Thus, the level of the healthcare transformation of Telangana needs to be evaluated by the size of infrastructure as well as the capability of health institutions to provide reliable and equitable healthcare.

**Financial Protection and Welfare Expansion: Access, Affordability, and the Limits of Insurance-Based Models**

A financial protection programme, like Rajiv Aarogyasri, tackles a huge hurdle in accessing health services by mitigating the financial burden of healthcare. Out-of-pocket expenditure may still be important in certain contexts and may contribute to better affordability, thereby lessening household vulnerability through such schemes. But just because money is invested, it does not ensure health care equality. Based on insurance models, economic obstacles might be lowered, and nevertheless, certain structural problems like spatial inequities, lack of experts, and differences in service quality remain unaddressed. Therefore, financial protection is a crucial milestone but is incomplete without robust public health institutions. The healthcare model of Telangana then is a mix of achievements and challenges. It reflects the growing role and role of the State in the financing of healthcare and welfare delivery while also underlining the growing institutional demands and necessity to develop robust institutions that are able to deliver comprehensive, equitable and sustainable healthcare services.

Besides funding and infrastructure, institutional capacity is also a focal point to develop healthcare. Healthcare has expanded into a new way of providing better services, and if this is being utilized, the skills of doctors, nurses, specialists, technicians, and administrators and community health workers need to be put to use. Effective institutions and powerful, competent bureaucracies are vital to developmental states (Kohli, 2004). The ability to do this in health care is translated as having the people, the systems and processes, and consistent deliveries.

Therefore, any initiatives which aim towards the transformation of the healthcare industry in Telangana cannot be comprehended outside of the institutional capability. Political will is indicated by the growth of hospital and welfare programme, but sustainability of the hospital and welfare programme depends on the availability of human resources and administrative capacities of the hospital and welfare programme in the institutions. Therefore, healthcare development is not simply an extension of more resources spent but an institution development capable of ensuring equitable and reliable services. This transition is the one that is necessary to motivate institutional changes, defining a process of transition from welfare provision to health citizenship. The healthcare development of Telangana following 2024 is an example of the political economy of welfare government that makes use of health for the supply of welfare services and as a way of acquiring political legitimacy. Expansion of healthcare has improved the level of State responsibility towards citizens, but geographical, institutional and quality inequalities are yet to influence citizens' healthcare experiences to an extent.

At the heart of this system of healthcare in Telangana is the  paradox. In this state health becomes a state expense and becomes welfare while it becomes more and more a function of access to health workers. Therefore, it is necessary to review development of healthcare programmes not only in terms of programme expansion but also find out how well the healthcare institutions do promote social equality.

**Welfare Inequality and Structural Inequality**

The expansion of the health care plan in Telangana has taken a giant leap towards making a health care a family affair instead of a household affair. Rajiv Aarogyasri type programmes are developed to curtail out-of-pocket expenditure and ensure that the vulnerable households are not facing inordinate OPE costs. The advantage of such programmes would be that they would

also help with the development of legitimacy of the State, the feeling that the State is responsible for caring for the welfare of citizens.

Prolonging welfare may not just be an effort to address structural inequalities. Requirements and geographical location, availability of institutions, awareness for social service, administrative accessibility and quality of services are other factors other than eligibility of the healthcare plans that influence the access to healthcare service. So, not every formal health insurance results in the use of health insurance. A best example of this is the disparity between the rural areas and the urban. What is likely to continue to be a problem is for specialists (although not as much in rural areas) and also transportation and lack of specialists, lack of workforce and poor continuity of service etc. This involves differences in access both nominally and in reality.

Regional inequality in Telangana state attracts special attention of the world since it is closely related with the balanced development concerns of the States formation process. Therefore, health is a key indicator of influence of regional autonomy on equity. There is potential for your inequalities to remain when the spread of health care is largely towards higher capacity areas. The demand also exists for the vulnerable groups of people (i.e. Scheduled Tribes, less economically advanced, distant communities, etc.) who might be marginalized due to other constraints such as lack of information, communication constraint, institutional issues etc. This is consistent with Sen's (1999) capability approach which says that people's capabilities should be the focus of assessment of development, not just institutional arrangements. Therefore, it is important to measure Telangana's healthcare development not based on growth of schemes but on the actual empowerment of the citizens to have a healthier life, five years down the road.

One of the foremost issues in the current governance of health services focuses on the connection between the public funding of health services and private health service delivery. Telangana's healthcare embodies this entire logic as the health expenditure grows, primarily for access, while the provisioning of healthcare services remains private. The Aarogyasri model also works in a similar way to provide financial assistance to financially weak citizens and facilities specialised treatment in empanelled private hospitals. It not only increases the relevance of health care in the present but also poses threats on strengthening the institutions of public health in the long run. A key issue is the trade-off between the ability of welfare that it can achieve in strengthening the public healthcare system and reliance on private healthcare markets. With the increased spending on healthcare, the institutions that are public may not be strong or may be institutionally weaker, when major part of their resources is taken up by buying services from private providers. This results in a paradox that, while the state takes on more welfare responsibility, it fails to expand health-care capacity in certain respects.

One of the most important concepts is that of the Telangana EHS was implemented from 5th December 2013, as a result of the erstwhile Andhra Pradesh Government's health scheme, under G.O.Ms. No.174, Health, Medical & Family Welfare Department dated 1st November 2013. The scheme came into existence for the purpose of rendering cashless medical treatment to the employees of State Government, pensioners and their family members who depend on them. At the initial phase, EHS was implemented via the Aarogyasri Health Care Trust (AHCT) where beneficiaries received care using EHS health cards and the implementing agency ensured empanelment of hospitals, pre-authorisation, claims processing and medical auditing was performed. Later, the Government of Telangana appointed another separate Employees Health Care Trust (EHCT) with Government representation, Employee and Pensioner representation as per G.O.M.No.186 dated 8-10-2023 for implementation of the New Electronic Services Scheme. The scheme is a contributory health-care plan that allows for the derived benefits and receives a matching contribution from the Government, and which enables the beneficiaries and their dependent family members to access cashless treatment at any registered hospital, thus avoiding having to cover the entire cost of their approved medical treatment themselves and then claim reimbursement.

The issue is one of the many that are developing in the developing world in relation to insurance mechanisms for health care. The building of good public health institutions, health public healthcare systems, institutional capacity and institutional accountability are necessary, though not sufficient, conditions of sustainable universal healthcare, as opposed to just financial protection schemes (Qadeer, 2011).

The private healthcare providers are also a challenge to the regulators. It is the responsibility of the state to establish quality requirements, transparency, affordability, accountability and to oversee private sector relationships. Therefore, the governance of the Healthcare system in Telangana can be described as a system of public funding, private delivery, and state control. If

expansion of welfare promotes the strengthening of public healthcare institutions there will be a chance to win the battle to transform health services in Telangana. If the expansion of welfare additionally reinforces the public health facilities, there will be possibilities to win the battle for transformation of healthcare services in Telangana. Reliable institutions that provide continuous, equitable and accountable health services are as essential as financial assistance for achieving health citizenship.

**Developmental Narrative and Healthcare Reality**

In today's India, developments in healthcare have taken a special place in the lives of people as part of developmental narratives. The definition of expanding healthcare is becoming more a 'proof of administration' and social commitment and inclusive development, as governments do more and more so. When it comes to welfare schemes, health programmes, medical colleges and hospitals, they are actual instruments that show states' successes in development. Furthermore, healthcare has special importance in Telangana as it was an essential element of political argumentation for obtaining statehood. There was more impetus within public services at the local level to demonstrate regional autonomy's success. Development itself in the healthcare sector is therefore a state goal, and in turn a yardstick to measure state capacity. However, in academic analysis there needs to be a distinction among the various narratives of development and institutional realities. Legitimacy of politics cannot be based just on policy statements and temporary indicators of infrastructure investment. It should also be measured and analysed on quality, outcomes, sustainability and accountability criteria.

The first is about the quality of health care. Making healthcare available is only a necessary but not sufficient measure. Timeous access to treatment, competent health workers, credible drugs, proper equipment, and health workers' sensitivity are all essential for the citizens. Expanding welfare without improving it has the risks that welfare expectations will increase, expectations that the institutions are unlikely to be able to deliver. In healthcare systems, continuous coordination regarding finances, staff and administration is important. With expansion comes the related long-term responsibilities, as infrastructure requires to be maintained, staffed, and technologies upgraded (or developed) by hospital. Development of institutions therefore alone is insufficient to produce the phenomenon of development and the role of sustaining developed institutions is also very important.

One of the important focusses is on accountability. Welfare programs create links between citizens and the state, and such links must go hand in hand with means for citizens to evaluate welfare programs and demand more. Key elements of a democratic health system are having mechanisms which are open to community voice, to build community voice, and to offer a method for complaints. In turn, this has made the case of Telangana's health a more global theoretical point: that it is not sufficient for a state to be able to instate programmes, it has to create efficient governance. A call for health citizenship demands moving from being visible to being institutionalized, from welfare politics.

The health sector's commitment in Telangana is a reflection of the basic question as to how to practice developmental governance in the current context. The issue now is to know if welfare can become a means of citizen's sustainability. Inclusive welfare measures can help front-end workers' lives but at the back end, a compelling institutional process is crucial for supporting sustainable development and our rights to healthcare. Assessing this change with the help of the concept of health citizenship is an advantageous line of inquiry. Welfare individual is paid benefits by the state, whereas, health citizen has acknowledged rights towards healthcare institutions. The difference lies between the link of citizens and Government. Institutional responsibility, rights and responsibilities of citizenship are all parts of this. Welfare usually implies administration and distribution, whereas citizenship implies rights, responsibilities and institutional responsibility.

Evaluating the future direction of healthcare outcomes from this lens, Telangana's healthcare future relies on success of existing programmes to become a part of a larger shift toward a new governance climate in healthcare. The issue is how to move away from the traditional treatment-support-focused approach to services, and towards an integrated health care system that's whole and end-to-end devoted to prevention, primary care and long-term wellness. Amplifying and improving primary health care is a priority. Financial protection programmes, marketable services - such as specialised hospitals, but quality and importance of primary healthcare systems go a long way to reducing disease burden, improving all disease prevention efforts, and ensuring that early disease prevention measures are put into practice. There is current evidence from around the world that responsive PHCS can serve as building blocks of UHC as services are provided in the community and are available at all times (WHO, 2019).

One of the key objectives is to promote decentralisation. The needs for health care services vary from place to place and local institutions may be better attuned to the issues facing their communities. Better responsiveness and accountability are possible

with greater decentralised decision making. However, this decentralisation should be complemented with adequate resources and administration skills to conduct the decentralisation.

Digital health governance is a new aspect of the health transformation. An increase in patient information, coordination of services, and patient access can be a benefit of digital technologies. Digital systems, however, not only have to be inclusive but have to be designed to be inclusive, otherwise a system not designed to be inclusive can reinforce inequality if citizens themselves are not digitally literate or where there is no infrastructure to support digital system. The final rule for health citizenship is to involve some community. Citizens don't need to be considered as beneficiaries of Gov. programmes, they are required to be participants of healthcare governance programmes. Participating with citizens can improve citizen accountability, help clarify citizens' needs, and improve public-public relations.

A more general question raised by Telangana's story is what the character of the developmental state in the modern India is Unlike the models of economic transformation, developmental governance also takes into account the other social layers of good. Developmental governance is not only economic but also other social areas of good like welfare, health care and education. Through a continuously developing industry, but also through their ability to provide social protection, the States have demonstrated their ability. However, growth process must be in some sense developmental in order to gain developmental legitimacy. It requires institutionalisation. With this, Telangana's healthcare system is a model that is both gained and yet to be fully transformed. It illustrates political promises being made and how they potentially become meaningful health-care citizenship practice in creating a welfare state.

## CONCLUSION

The transition of healthcare in Telangana provides a contemporary overview of the intricate balance of welfare political, developmental state-building, and political legitimacy. The state's health care path beyond 2024 reminds us of the way in which health care is a place of social protection, a place of government responsibility, and a place of conflict for citizenship. In the context of state formation, the development of Health care is an important example in the state of Telangana where it is close to the developmental expectations generated in such a process of becoming. Healthcare development is connected to other developmental expectations arising from state formation, and an example of this is in the state of Telangana. Increased dimension to healthcare programmes, financial protection, medical institutions, and welfare programmes, are reflecting the development of a state in an attempt to build a state with the ability to provide social development.

The article also shows, however, that welfare expansion is not enough to ensure a meaningful health citizenship. Healthcare schemes and facilities require institutional capacity and capacity building, equitable distribution, quality services, and accountability mechanisms. Now the central issue for Telangana is not only to improve access to healthcare, it is to increase access to healthcare capability.

There are three major contradictions evident in the political economy analysis. First, extending health coverage to more people has advanced state accountability, without necessarily ending up in structural inequalities. Secondly, financial protection measures have expanded access but posed problems of dependency on private healthcare providers. Thirdly, infrastructure and investment-based developmental narratives should be subjected to institutional evaluation below the lenses of quality, sustainability and outcomes. This is theoretical in that the Telangana case shows how the healthcare is an instrument of developmental politics in subnational governments of federal systems. The creation of a new State has shown to be dependent upon welfare sectors in the case of Telangana to secure legitimacy and assert its administrative prowess. But long-term legitimacy relies on whether such welfare programs are sustainable programs with long-term success or on a short political term policy success.

Telangana's healthcare model in essence, is a shift from welfare state, to the potential of health citizenship. To achieve a successful transition, the primary healthcare will need to be improved, capacity of institutions will need to be strengthened, access will need to be made equitable, public-private relationships will need to be regulated and citizens will need to be engaged. Healthcare development is as a result an accomplishment in addition to a continuous political venture. Successful developmental governance is not just a matter of the actual numbers of welfare schemes expanded; it is also the development of institutions where people can have an experience of the state as being responsive, accountable and having a human dimension that works for their wellbeing. Telangana shows that developmental government works.

**REFERENCES**

[1] Johnson, C. (1982). *MITI and the Japanese miracle: The growth of industrial policy, 1925–1975*. Stanford University Press.
[2] Kohli, A. (2004). *State-directed development: Political power and industrialization in the global periphery*. Cambridge University Press.
[3] Mahal, A., Karan, A., & Engelgau, M. (2012). *The economic implications of non-communicable disease for India*. World Bank.
[4] Marshall, T. H. (1950). *Citizenship and social class and other essays*. Cambridge University Press.
[5] Ministry of Health and Family Welfare. (2017). *National health policy 2017*. Government of India.
[6] Ministry of Health and Family Welfare. (2018). *Ayushman Bharat: Comprehensive primary health care through health and wellness centers*. Government of India.
[7] Pierson, P. (1994). *Dismantling the welfare state? Reagan, Thatcher and the politics of retrenchment*. Cambridge University Press.
[8] Qadeer, I. (2011). Universal health care: The trodden path and the road ahead. *Economic and Political Weekly, 46*(8), 35–42.
[9] Rao, V., & Woolcock, M. (2007). *Social exclusion and development: Concepts and applications*. World Bank.
[10] Sen, A. (1999). *Development as freedom*. Oxford University Press.
[11] Srinivasulu, K. (2014). Telangana movement: Political economy and identity politics. *Economic and Political Weekly, 49*(28), 31–38.
[12] World Bank. (2016). *Improving health service delivery in India: A case for strengthening public systems*. World Bank.
[13] World Health Organization. (2019). *Primary health care on the road to universal health coverage: 2019 monitoring report*. World Health Organization.