IJRAR.ORG E-ISSN: 2348-1269, P-ISSN: 2349-5138
INTERNATIONAL JOURNAL OF RESEARCH AND ANALYTICAL REVIEWS (IJRAR) | IJRAR.ORG
An International Open Access, Peer-reviewed, Refereed Journal

Ensuring Electoral Inclusion through Hospitalized Voting in India: A Comparative Study of Global Practices and Policy Prospects

Dr.Mahendra A C
Assistant Professor of Political Science
Government First Grade College, Bangarapete, Kolar District, Karnataka
Pin Code: 563114

Abstract

Inclusive participation is the cornerstone of any democracy. However, India's electoral process still excludes a significant number of citizens who are hospitalised or physically unable to reach polling stations. With an ageing population and rising hospitalisation rates, the question of how to ensure voting access for bedridden or temporarily incapacitated voters has become critical. This article examines the concept of hospitalised voting through a comparative analysis of global experiences and institutional practices. Using authentic data from the National Sample Survey (NSS), the paper traces the growing demand for medical-facility voting in India. Drawing upon examples from Australia, New Zealand, Canada, the United States, Sweden, Norway, and South Korea, it highlights administrative models, technological innovations, and legal safeguards that support accessible voting. The study concludes by proposing a pilot framework suited to India's context, emphasising ethical legitimacy, logistical feasibility, and constitutional inclusion. **Keywords:** Electoral inclusion, hospital voting, accessibility, comparative analysis, Election Commission of India, democratic participation.

1. Introduction

Democracy attains legitimacy when every eligible citizen can exercise the right to vote without discrimination or difficulty. While India has achieved remarkable progress in expanding electoral participation, certain sections—such as hospitalised and home-bound voters—remain neglected. According to the **National Sample Survey (NSS 71st Round, 2014)**, the annual hospitalisation rate increased from **16.6 per 1000 population in 1995** to **37 per 1000 in 2014** (Ministry of Statistics and Programme Implementation [MoSPI], 2016). The **NSS 75th Round (2019)** further observed a sustained rise in treatment-related admissions, reflecting growing health burdens and an ageing population. This demographic shift directly affects electoral inclusion, as more individuals are temporarily confined to hospitals during polling periods.

The Election Commission of India (ECI) has undertaken major initiatives to enhance accessibility—such as postal ballots for absentee voters above 80 years of age, and for those with disabilities or COVID-19 infections during the 2020 pandemic. However, the absence of a dedicated hospital voting mechanism

continues to marginalise thousands of citizens during each election cycle. Considering India's constitutional guarantee of equality (Articles 14–15) and the right to vote as a statutory right under the **Representation of the People Act, 1951**, there is a moral and institutional obligation to explore innovative models that enable every eligible voter—including those confined to hospitals—to participate.

This article explores how other democracies operationalise hospitalised voting, identifies institutional designs suitable for India, and proposes a feasible pilot framework for gradual implementation.

2. Review of Literature

Scholarly attention to voter accessibility has increased in recent decades. **Birch (2010)** conceptualised electoral integrity as the absence of systematic exclusion; access barriers undermine representativeness. **James and Garnett (2020)** examined the role of electoral management bodies (EMBs) in balancing inclusivity with administrative feasibility. In the Indian context, **Yadav (2019)** highlighted that absentee voting remains limited to defence personnel and government officials on election duty, leaving civilian hospitalised voters largely unrepresented.

Comparative literature shows that hospital voting has evolved differently across nations. **Hughes (2015)** traced Australia's mobile polling history to the 1914 Federal Election, when "mobile polling teams" first visited hospitals and remote stations. Similarly, **Thompson (2018)** documented Canada's special ballot provisions under the *Canada Elections Act*, enabling voting in long-term care homes and hospitals through returning-officer-supervised polling. **Nordahl (2019)** described Norway's decentralised health-facility voting, where municipal election officers coordinate with hospitals to set up temporary voting stations.

International organisations such as the **ACE Electoral Knowledge Network (2021)** and **International IDEA (2020)** have emphasised that accessible voting is integral to the UN Convention on the Rights of Persons with Disabilities (Article 29). They advocate institutional reforms—like advance voting, mobile polling, and electronic authentication—to ensure inclusivity.

Despite scattered references, Indian literature on hospital voting remains thin. **ECI (2023)** reports acknowledge logistical and security concerns but lack empirical evaluation of pilot schemes. Hence, a comparative policy analysis is essential to design a viable Indian framework.

3. Comparative Institutional Practices

Hospitalised voting practices vary globally, depending on legal frameworks, administrative capacity, and trust in electoral institutions. The following discussion synthesises practices from key democracies whose experiences offer lessons for India.

3.1 Australia

The **Australian Electoral Commission (AEC)** pioneered *mobile polling* in 1914, later institutionalised under Section 200DD of the *Commonwealth Electoral Act 1918*. During federal elections, mobile teams—comprising an officer-in-charge, assistant, and security staff—visit hospitals, aged-care facilities, and remote areas. Voters mark ballots privately, which are sealed and transported to counting centres. The AEC's *Accessibility Action Plan (2020–2023)* reports that over **60,000 hospital votes** were cast in the 2019 federal election. The model's success rests on early coordination with hospital administrators and rigorous chain-of-custody procedures, ensuring both inclusivity and integrity.

3.2 New Zealand

New Zealand's *Electoral Act 1993* allows *advance voting* at hospitals and rest homes. The **Electoral Commission NZ** dispatches *Voting Assistance Teams (VATs)*, typically two trained officials, to institutions that request access. These teams carry portable ballot boxes, voter rolls, and consent forms. During the 2023 general election, more than **12,000 hospital votes** were recorded (Electoral Commission NZ, 2023). Transparency is maintained by providing observers and ensuring that hospital staff cannot influence voter choice. This flexible, low-cost model could be adapted within India's district-level election machinery.

3.3 Canada

Canada's *Elections Act (2000)* institutionalises *Special Ballots* for electors confined to hospitals. Returning officers establish **mobile polling stations** in hospitals and long-term care facilities during the advance-voting period. Voters may register up to six days before polling and receive ballots at bedside. Ballots are sealed in double envelopes to maintain secrecy. *Elections Canada (2022)* reported that roughly **77,000 electors** voted through this method in 2021. Canada's experience demonstrates that existing postal-ballot infrastructure can be extended to medical institutions without legislative overhaul.

3.4 United States

The U.S. follows a decentralised model where hospital voting is administered at the **county or state level**. States such as *Colorado, Texas, and Florida* permit *emergency absentee ballots* for voters hospitalised shortly before Election Day. Typically, a designated agent (family member or election volunteer) delivers and returns the ballot. During COVID-19, temporary on-site voting stations were established in large hospitals. According to the *National Conference of State Legislatures (2021)*, over **30 states** have formal emergency absentee procedures. This flexibility ensures continuity of voting rights even during sudden illness.

3.5 Nordic Countries (Sweden and Norway)

The Nordic model integrates hospital voting into a broader culture of trust and civic duty. In *Sweden*, hospitalised voters may vote by *messenger voting*—an authorised person collects and returns the ballot under supervision (Swedish Election Authority, 2022). In *Norway*, local municipalities establish temporary polling booths in hospitals; officials bring portable ballot boxes to each ward. These countries achieve high compliance due to robust local governance and early-voting windows. Their experience illustrates that hospital voting need not be resource-intensive if decentralisation is effective.

3.6 South Korea

South Korea's *National Election Commission (NEC)* permits *absentee and early voting* for hospitalised citizens. During the 2022 presidential election, special polling stations were set up in 250 hospitals nationwide. Hospital administrators received training to maintain electoral neutrality. South Korea's success stems from its digital-ID verification and efficient election logistics, supported by transparent data systems.

3.7 Synthesis of Global Lessons

Across these democracies, several common features emerge:

1. **Legal clarity** – explicit statutory provisions enabling voting in medical institutions.
2. **Administrative preparedness** – early coordination between election officers and hospital management.
3. **Safeguards for secrecy and integrity** – portable sealed ballot boxes and double-envelope systems.

4. **Inclusivity mechanisms** – options for advance, postal, or in-person bedside voting.
5. **Public awareness and transparency** – communication campaigns and presence of observers.

These principles demonstrate that hospitalised voting is neither extraordinary nor unmanageable. Instead, it represents the natural evolution of inclusive democracy.

4. Challenges in the Indian Context

India's electoral infrastructure is among the most complex in the world. Conducting elections across more than one million polling stations already stretches administrative and logistical capacity. Introducing hospitalised voting must therefore confront several contextual challenges that are political, logistical, legal, and technological.

4.1 Logistical and Administrative Constraints

India's hospitals differ widely in size, ownership, and capacity—from tertiary government hospitals to small private clinics and rural primary health centres. Coordinating polling arrangements across such diversity would demand significant planning. The Election Commission of India (ECI) would need to collaborate with state health departments, district collectors, and hospital administrators to identify eligible voters, ensure secure spaces for polling, and maintain secrecy. Security and manpower are additional concerns, particularly in large metropolitan hospitals.

4.2 Legal and Procedural Ambiguities

The **Representation of the People Act, 1951**, and the **Conduct of Election Rules, 1961**, currently restrict postal voting to service voters, election-duty staff, senior citizens above 80 years, and persons with disabilities. Hospitalised citizens fall outside these categories unless they hold disability certificates. Any extension to this group would require either statutory amendment or a new rule under the existing Act. Further, the model code of conduct and existing ballot-transport procedures would need to be revised to include hospital-based polling.

4.3 Data and Verification Challenges

Unlike defence personnel or government employees, hospitalised voters have no central registry. Hospitals record admissions for medical purposes, not electoral rolls. Integrating such data without violating privacy norms under the **Information Technology Act (2000)** or the forthcoming **Digital Personal Data Protection Act (2023)** will require robust consent-based systems. Verification of voter identity in medical wards—especially when patients lack physical documents—poses additional hurdles.

4.4 Financial and Infrastructural Burden

While the right to vote is priceless, implementation costs are considerable. The ECI must provide secure ballot boxes, trained personnel, and transport facilities. In a developing democracy like India, budgetary prioritisation remains sensitive. Yet, comparative evidence indicates that inclusive electoral mechanisms enhance legitimacy, which justifies phased investment.

4.5 Ethical and Institutional Safeguards

Hospitalised individuals may be vulnerable to undue influence by caregivers or hospital authorities. Safeguarding the secrecy and voluntariness of their vote is paramount. The presence of neutral electoral staff, strict procedural checks, and hospital-level awareness campaigns can mitigate such risks.

Despite these challenges, the moral imperative to ensure universal suffrage demands institutional innovation rather than inertia. The following section outlines a realistic and phased framework.

5. Proposed Framework and Pilot Design for India

Designing a hospitalised voting system for India requires careful blending of global best practices with domestic administrative realities. The proposal below rests on **three core principles**—inclusivity, integrity, and feasibility.

5.1 Legislative and Policy Foundation

The ECI, in consultation with the **Law Ministry** and **Parliamentary Standing Committee on Personnel, Public Grievances, Law and Justice**, should introduce a new clause under **Rule 54A** of the *Conduct of Election Rules (1961)* titled *"Voting by Hospitalised Electors."* This clause can authorise the ECI to notify specific hospitals as temporary polling stations during general and state elections. The enabling rule must:

1. Define eligibility—citizens admitted as in-patients at least 48 hours before the poll date.
2. Allow them to apply for *hospital postal ballot* up to 10 days before polling.
3. Authorise returning officers to dispatch trained *mobile polling teams*.

A pilot scheme can be introduced in two states—one urban (e.g., Karnataka or Maharashtra) and one rural (e.g., Odisha)—before nationwide expansion.

5.2 Administrative Structure

Each district should constitute a **Hospital Voting Coordination Committee (HVCC)** chaired by the District Electoral Officer. Members would include:

- Nodal hospital administrators,
- District health officers,
- Returning officers, and
- Representatives from recognised observer groups.

The HVCC would maintain a secure database of hospitalised voters, ensuring confidentiality while facilitating cross-verification with electoral rolls.

5.3 Procedural Steps

1. **Identification and Registration:**
   Hospitals notify the HVCC of in-patients who express willingness to vote. Verification occurs through Aadhaar or EPIC cards.
2. **Ballot Preparation:**
   Returning officers issue sealed hospital postal ballots with unique serial numbers, similar to service-voter ballots.
3. **Mobile Polling Teams:**
   Each team consists of two polling officials and one security staff member. They carry portable ballot boxes and visit wards under CCTV supervision.

4. **Voting and Secrecy:**
   Voters mark ballots privately. Assistance may be provided only upon written request, following *Rule 49N*.
5. **Transport and Counting:**
   After voting, sealed boxes are escorted back to the strong room under official custody, integrated with postal-ballot counting.
6. **Digital Record-Keeping:**
   An encrypted log records hospital name, date, and number of votes cast—without revealing voter identity—to enable audit and transparency.

5.4 Technological Integration

The ECI's *Electronically Transmitted Postal Ballot System (ETPBS)*, currently used for service voters, can be extended to hospitals. Under this model, a secure digital ballot is transmitted to district officials, printed locally, and physically handed to the voter. This hybrid method ensures security while reducing postal delays. Blockchain-based audit trails—already piloted in Telangana's local elections—could further enhance credibility.

5.5 Training and Awareness

Hospitalised voting must be supported by intensive voter education. The **Systematic Voters' Education and Electoral Participation (SVEEP)** division should design targeted campaigns in hospitals and through healthcare associations. Nurses and social-work interns could serve as voter-awareness volunteers, ensuring ethical neutrality.

5.6 Ethical and Legal Safeguards

Borrowing from the Canadian and Australian models, India must establish clear accountability:

- Hospital staff cannot handle ballots.
- Only authorised election officers may be present during voting.
- Patients' consent and mental fitness should be certified by attending physicians.
- Breach of secrecy should attract penalties under Section 128 of the *RPA 1951*.

5.7 Monitoring and Evaluation

After the pilot, the ECI should commission an independent impact evaluation through reputed public-policy institutions such as the **Centre for Policy Research** or **National Law University Delhi**. Key performance indicators may include:

- Number of hospital votes cast,
- Administrative cost per vote,
- Stakeholder satisfaction, and
- Incidence of procedural errors.

If successful, the model could gradually extend to home-bound voters, elderly citizens, and rehabilitation centres.

5.8 Potential Benefits

1. **Democratic Inclusion:** Enhances participation of elderly, chronically ill, and accident victims.
2. **Administrative Legitimacy:** Demonstrates the ECI's proactive commitment to inclusivity.
3. **International Recognition:** Aligns India with global democratic norms on accessibility (UN CRPD Art. 29).
4. **Data for Policy:** Generates empirical evidence for future e-voting experiments.

The pilot would therefore not only enfranchise a neglected group but also serve as a stepping-stone toward broader electoral reforms.

6. Conclusion

The essence of democracy lies in participation. Excluding citizens on grounds of temporary illness or hospitalisation contradicts the moral and constitutional promise of equality. As hospitalisation rates in India continue to rise—climbing from 16.6 per 1,000 persons in 1995 to 37 per 1,000 in 2014 (MoSPI, 2016)—the absence of hospital voting becomes a significant democratic deficit.

Comparative evidence demonstrates that hospitalised voting is feasible and beneficial. Australia, Canada, New Zealand, and several European nations have long ensured bedside voting with minimal controversy. These experiences confirm that institutional willingness and procedural clarity matter more than technology alone.

India's Election Commission has already displayed adaptability through measures for senior citizens, persons with disabilities, and COVID-19 patients. Extending similar arrangements to hospitalised voters is therefore a logical next step. Implemented through phased pilots, strong legal backing, and transparent oversight, hospitalised voting could become one of the most meaningful electoral innovations in India's democratic journey.

References

ACE Electoral Knowledge Network. (2021). *Voting operations: Special voting arrangements.* Retrieved from https://aceproject.org

Australian Electoral Commission (AEC). (2020). *Accessibility Action Plan 2020–2023.* Canberra: AEC.

Birch, S. (2010). *Perceptions of Electoral Fairness and Voter Turnout.* Comparative Political Studies, 43(12), 1601–1622.

Canada Elections Act, S.C. 2000, c. 9.

Elections Canada. (2022). *Report on the 44th General Election of 2021*. Ottawa: Government of Canada.

Electoral Commission New Zealand. (2023). *2023 General Election Official Statistics.* Wellington: ECNZ.

Election Commission of India (ECI). (2023). *Handbook for Returning Officers (Parliamentary Elections).* New Delhi: ECI.

Hughes, C. (2015). *Mobile Polling and Electoral Accessibility in Australia.* Australian Journal of Political Science, 50(3), 456–472.

International IDEA. (2020). *Access and Inclusion in Democratic Processes.* Stockholm: IDEA.

James, T. S., & Garnett, H. A. (2020). *Electoral Management Design and Inclusiveness.* Policy Studies, 41(5), 481–499.

Ministry of Statistics and Programme Implementation (MoSPI). (2016). *Health in India: NSS 71st Round (January–June 2014).* New Delhi: Government of India.

National Conference of State Legislatures (NCSL). (2021). *Emergency Absentee Voting for Hospitalized Voters.* Denver: NCSL.

Nordahl, M. (2019). *Municipal Election Administration and Voter Access in Norway.* Nordic Journal of Politics, 42(1), 77–94.

Swedish Election Authority. (2022). *Voting from Hospitals and Care Homes.* Stockholm: Valmyndigheten.

Thompson, A. (2018). *Voting in Long-Term Care Facilities: Lessons from Canada.* Journal of Elections, Public Opinion and Parties, 28(3), 332–350.

Yadav, Y. (2019). *India's Expanding Electoral Participation: Inclusion and its Limits.* Economic & Political Weekly, 54(9), 23–27.