EDITORIAL

Rajasthan's Right to Health Act, 2022: Gaps and opportunities

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On March 21, 2023, Rajasthan became the first state in the country to pass an Act implementing the right to health, titled "Rajasthan Right to Health Act, 2022" [1]. This is the realisation of a long standing demand of civil society groups and can be considered a landmark initiative by any state government towards guaranteeing "health for all". While the Act cannot be considered very robust, given some of its shortcomings discussed later, there is no denying that, if implemented in its true spirit, it will give the public healthcare system a huge boost, and lead to reducing out-of-pocket expenditure on healthcare, and safeguarding patients' rights.

The trajectory of the Act and civil society involvement

The passing of the Act has not been smooth sailing, first with Covid-19 putting the entire drafting process on the backburner for almost two years; and then, the draft Bill being received with the most vehement protests in the country's history by doctors [2].

Tracing its chronology, the major push for the Act came from civil society networks, especially from Jan Swasthya Abhiyan (JSA), Rajasthan, actively working in the state for health and health rights. JSA vigorously pushed for the Act, right from its inclusion in the 2018 state election manifestos of political parties, to later engaging with the newly formed government in the drafting of the Bill [3]. The first ever draft of the Right to Health Bill was, in fact, prepared by JSA Rajasthan and given to the government in 2019, based on which the state further developed its own draft — though a much diluted version — in March 2022 [4], and finally put it up in the public domain for suggestions. The private sector resistance to the Act had begun to grow gradually from then onwards.

Considering suggestions from various organisations, groups and individuals, a modified version of the Bill was then tabled in the state legislative assembly on September 21, 2022* which fuelled huge protests by private sector doctors. The Bill was then referred to a Select Committee for further deliberation. The Committee, after several rounds of consultations with the agitating doctors, incorporated most of their demands in the Bill and an amended version was then tabled in the Assembly on March 21, 2023 and passed [1].

The private sector doctors, however, continued to protest against the Bill, demanding its complete withdrawal, condemning it as "draconian", "anti-patient", and completely hostile to the private healthcare sector in the state [5]. It was only after 17 days of vehement protests and complete shutdown of work by the private healthcare sector across the state that an agreement was finally reached between the government and the agitating doctors on April 4, 2023, with the protests being called off, and services resumed. The Bill received the Governor's assent on April 12, 2023.

Key features of the Act

It is important to note that although titled "Rajasthan Right to Health Act", it is largely focused on augmenting people's access to healthcare and has little to do with addressing the diverse determinants of health. Also, unlike the impression projected by the private doctors' associations, the Act primarily concerns itself with strengthening the public healthcare system, rather than regulating the private sector. The single clause concerning the private healthcare sector in the Bill is regarding the patients' right to emergency treatment at private facilities without prepayment [1: Sec 3 (c)]. This remained a major point of contention for the private sector doctors and captured most of the media attention, sidelining many crucial provisions in the Act directed towards revamping the public healthcare system, protecting the rights of patients and healthcare providers, and augmenting transparency and accountability in health systems.

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Rights of the state's residents

The Act emphasises government's commitment to provide all outpatient and inpatient services including drugs, diagnostics, emergency transport, etc, free at public health facilities to all residents of the state [1: Sec 3 (b)]. It also commits itself to providing patients with the right to avail of certain emergency treatments (mentioned earlier) without prepayment at private healthcare facilities. In case the patient is unable to pay for emergency treatment so received, the government would pay on behalf of the patient, for which a mechanism of reimbursement would be developed [1: Sec 3(c)]. This clause however demands more clarity, given the recent agreement between the government and private healthcare associations to pacify the agitating doctors. The agreement suggests that a large section of private hospitals in the state may now remain outside the ambit of this Act [6]. The rules when framed should provide more clarity on this.

The Act also commits to ensuring the patients' right to have access to their own records and itemised bills [1: Sec 3(e)]; to have the company of a female person if a female patient is being examined by a male practitioner [1: Sec 3(i)]; to have information about the rates and charges for services; to be able to choose the facility for medicines or tests [1: Sec 3(m)]; to be able to seek a second opinion [1: Sec 3(t)], and not be denied their treatment summary in case the patient leaves the medical establishment against medical advice, etc [1: Sec 3(q)].

The Act further states that the rules under the Act would specify the responsibilities and duties of patients and the rights and responsibilities of healthcare providers.

Obligations of the government

The Act commits the government to making "appropriate" provision in the health budget for services outlined in the Act, although without specifying the precise share of the state's overall budget or the state's GDP. This needs to be spelt out.

It also provides for developing and institutionalising a human resource policy, setting up quality audit and grievance redressal mechanisms, laying down standards for quality and safety at all levels of the healthcare system, ensuring that there is no direct or indirect denial of guaranteed public healthcare services, etc, as the key obligations of the government. However, no timelines are stipulated for any of these tasks.

Monitoring and grievance redressal

The Act calls for the constitution of two State Health Authorities (One for grievances regarding logistical issues and the other for treatment protocols) and a District Health Authority in each district to advise the government, monitor implementation of the Act, policies and programmes and also function as appellate authorities to adjudicate on complaints [1: Secs 7, 10]. While these Authorities are crucial in terms of decentralisation of healthcare planning and monitoring, it is disappointing that they do not have any public representatives, civil society members, patients' groups or even paramedics as their members; the only members are government officials and doctors from government medical colleges and Indian Medical Association (IMA) representatives [1: Secs 6, 9]. While public health experts and public representatives were included in these authorities in the initial draft of the Bill [1: Secs 6, 9]*, which went to the Select Committee, they were later removed after huge resistance by doctors' associations to having "outsiders" as part of these authorities.

The Act also provides for the establishment of a grievance redressal mechanism wherein the patient can file a written complaint with the in-charge of the concerned health facility who would have to address the grievance within three days, or it would be referred to the District Health Authority, to be resolved within a period of 30 days; and subsequently to the State Health Authority, if no resolution were achieved at the district level. It also provides for a penalty of Rs 10,000 – Rs 25,000 for contravention of any provision of the Act [1: sec 14]. Unfortunately, the revised Act has omitted the provision to file complaints through its web portal and helpline which were present in the earlier draft sent to the Select Committee [1: Sec 11(2) (a)]. This amendment was brought about essentially because the agitating doctors wanted a single-window system for grievance redressal. The sole option provided, of filing complaints in writing to the concerned health facility in-charge, is bound to discourage a lot of patients from raising complaints.

Why were private sector doctors protesting and how legitimate was their protest?

The major objection of the private sector doctors regarding the Act arose from the clause on emergency treatment [5]. They were apprehensive about the lack of clarity in the Bill about what would count as an "emergency"; and that binding them to cater to emergency cases without prepayment would drain them financially. These concerns were acknowledged as valid by the civil society groups in their list of suggestions on the Bill sent out to the government [7]. The Select Committee noted the issue and the definition of emergency was added to the Bill, limiting emergencies to accidental emergency, emergency due to snake bite/animal bite and obstetric emergencies [1: Secs 2 (a), 2 (e), 2 (f), 2 (g)]. The Committee also introduced a clause to provide for due reimbursement to private hospitals by the government if the patient was unable to pay for the emergency care provided [1:

Sec 3(c)]. However, the clause did not specify the model of reimbursement or the rates. These were left to be decided in the rules and quite logically so, as this would have required detailed consideration and rounds of deliberations with the private hospitals. Also, including these details in the rules made for more flexibility, since the model or the rates are bound to change later on.

However, the agitating doctors were uneasy with this arrangement, given their past negative experience of facing delayed reimbursement in the Chiranjeevi Yojana and Ayushman Bharat schemes. They also considered the package rates inadequate. Their concerns were valid, but could have been negotiated on when the rules were being framed. However, they continued to agitate for a complete rollback of the Bill passed by the Legislative Assembly [5].

The doctors also objected to public health experts and public representatives with a non-medical background being part of the State and District Health Authorities and demanded that they be replaced by doctors from IMA. This demand too was accepted by the Select Committee and public health experts and public representatives were later removed from membership of the Authorities [1: Secs 6(i), 6(ii), 9(2)].

Despite these modifications in the Bill, the doctors continued to express dissatisfaction with the amendments, arguing that the Act was meant to sabotage the private healthcare sector in the state by forcing them to provide free healthcare services. This argument is groundless as the Act only mandated the private sector to provide certain emergency treatment without prepayment, for which they would be reimbursed by government [1: Sec 3(c)]. The doctors believed that the Act would increase unnecessary bureaucratic interference and vigilance into their functioning.

The initial agitation by the private hospitals against the Act included their boycott of government schemes such as Chiranjeevi Yojana and Rajasthan Government Health Scheme, forcing patients to pay for the services which were otherwise covered under these schemes, or to shift to public healthcare facilities. As the agitation grew, the various associations of private doctors including the IMA called for complete shutdown of services across the state by private clinics, hospitals and even diagnostic laboratories, in favour of complete roll back of the Bill. This 17-day agitation caused huge inconvenience and distress to patients who sought treatment from private providers and led to a drastic increase in patient load in public healthcare facilities.

It was only on April 4, 2023 that the agitation was called off following an agreement external to the Act between the government and various doctors' associations including IMA and Private Hospitals and Nursing Homes Association [8]. According to this, only those private hospitals with 50 or more beds which come under the category of medical college hospitals, or are being run on the public-private partnership (PPP) model, or which have availed of free or subsidised land or building from the government, would come under the ambit of the Act. The agreement also stated that any police cases registered during the agitation would be withdrawn.

The way forward

While the deadlock arising out of the private doctors' agitation is now over, and the Bill has received the Governor's assent, it is time the government initiates the rule drafting process at the earliest. Although some private hospitals may now be out of the Act's ambit after the agreement, it is a matter of relief that there has been no compromise on the core objective of the Act, which is to strengthen the public healthcare system. The success of the Act will now depend on how robust the rules are and how well they are executed. The government must ensure that the process of framing rules involves the thorough engagement of diverse groups including civil society organisations, public health experts, public representatives and various patient groups, rather than restricting the discussion to just a few doctors and government officials who decide on all the issues. It is also important to ensure that the rules are clearly framed in terms of entitlement to definite rights and services, resources allocated for the same and the timelines to be adhered to for different tasks, leaving no room for ambiguities. This is crucial in eliminating any apprehensions or doubts that healthcare providers may have regarding the Act and to win their confidence. This would also help the public at large to have a clear understanding of what their entitlements are under the Act. Apart from this, it is vital for the government to organise special orientation workshops for healthcare providers to ensure smooth and coordinated implementation of the Act, with clarity among all healthcare providers regarding their rights, obligations and responsibilities outlined in the rules. It is also vital to have similar campaigns across the state — especially in the rural areas — to create awareness about the Act and its provisions. The government must also make generous budgetary allocations to ensure the effective implementation of the Act's provisions.

The Act comes with its own shortcomings and ambiguities as discussed earlier and the challenge would be to see how well these are addressed when the rules are framed. The private healthcare sector although it has withdrawn its agitation now, it still has strong reservations about the Act. The government must ensure that while its concerns are taken into account, this should not dilute the core commitments of the Act or lead to any compromise on what has been committed to patients regarding a revamped and streamlined public healthcare system.

With Rajasthan taking the plunge, other states will be encouraged to introduce similar laws. Some states have already initiated

discussions around it [9]. We have seen Rajasthan's Free Medicines Scheme of 2011 being acknowledged and replicated by several states thereafter [10]. It would be interesting to see how different states now respond to this Act.

**Note:* *The final version of the "Rajasthan Right to Health Bill" which was passed in the Assembly is cited as Reference 1. This was the September 21, 2022 draft with amendments made by the Select Committee. In the final Bill, the sections within square brackets are those points from the September draft that have been omitted by the Select Committee and those underlined are new additions to the draft. All other text has been retained from the earlier version.*

Conflict of Interest: *The author has been an active campaigner for passing and implementing The Right to Health Act in Rajasthan.*

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