Medicine and Society

A critique of the Rajasthan Right to Health Bill, 2022 and suggestions for the way forward

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ABSTRACT

This article discusses a brief history of the concept of Right to Health, the concepts of rights and duties and why both are important and how, in healthcare, one's duty is another's right. The Rajasthan Right to Health Bill, 2022 is analysed and the shortcomings and issues in the Act are discussed. Suggestions to modify the Act and how the same can be implemented are given. In addition, a brief introduction to a successful scheme, the Tamil Nadu Innuyir Kapom Thittam–Nammai Kaakum 48 Scheme, with a similar aim is given. The article concludes that though the Right to Health Act is a noble initiative and is a necessary one; the Act, in its current version, has serious shortcomings and needs to be corrected.

Natl Med J India 2023:36:384–6

INTRODUCTION

The Right to Health was first articulated in the WHO Constitution[1] in 1946 and states that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being…' The preamble of the Constitution defines health as '…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. The 1948 Universal Declaration of Human Rights[2] mentioned health as part of the right to an adequate standard of living (Article 25). It was again recognized as a human right in 1966 in the International Covenant on Economic, Social and Cultural Rights,[3] Article 12:

1. *'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
   - *(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
   - *(b) The improvement of all aspects of environmental and industrial hygiene;*
   - *(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
   - *(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.'*

The Committee on Economic, Social and Cultural Rights, a body composed of independent experts in charge of monitoring the implementation of the Covenant, provided a broad interpretation of Article 12 of the Covenant[4] (General Comments No. 2014): *'The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. (Paragraph 11)*

The Right to Health is relevant to all countries: every country including India has ratified at least one international human rights treaty that recognizes the Right to Health.

The concepts of rights and duties

Rights and duties are two sides of the same coin, and they always go together. The Constitution of India[5] talks about both Fundamental Rights and Fundamental Duties and it is seen that:

- Citizens have fundamental rights, and it is the duty of the government to provide those rights.
- Citizens have fundamental duties, and it is the right of the government to demand those duties.

Tripartite duties and rights in healthcare

For healthcare, there are three major stakeholders involved: (i) the government; (ii) patients (and relatives); and (iii) doctors (and nurses and hospitals). The rights and duties of each stakeholder can be written as follows:

Rights of patients	*Rights of doctor*
1. Duty of doctor (D to P)	1. Duty of patient (P to D)
2. Duty of government (G to P)	2. Duty of government (G to D)
Rights of government	*Duties of patients*
1. Duty of patient (P to G)	1. Right of doctor (P to D)
2. Duty of doctor (D to G)	2. Right of government (P to G)
Duties of doctor	*Duties of government*
1. Right of patient (D to P)	1. Right of doctor (G to D)
2. Right of government (D to G)	2. Right of patient (G to P)

Even though there are six duties and six rights, we can see that when duties and rights are matched with one another, we get a total of only six:

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[**To cite:** Mascarenhas MAB. A critique of the Rajasthan Right to Health Bill, 2022 and suggestions for the way forward. *Natl Med J India* 2023;**36:**384–6. DOI: 10.25259/NMJI_386_2023]

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Rights		*Duties*
Duty of doctor to patient	(D to P)	Right of patient from doctor
Duty of government to patient	(G to P)	Right of patient from government
Duty of patient to doctor	(P to D)	Right of doctor from patient
Duty of government to doctor	(G to D)	Right of doctor from government
Duty of patient to government	(P to G)	Right of government from patient
Duty of doctor to government	(D to G)	Right of government from doctor

A right has to be given if, and only if, it is matched with someone else's duty. A duty will get done only when it is matched with someone else's right. Any law or policy which does not match the rights and duties of the stakeholders is unlikely to be implemented. In case an attempt is made to implement a flawed, incorrect, incomplete law or policy, the complications may be quite high and permanent.

Analysis of the Rajasthan Right to Health Bill, 2022

The Government of Rajasthan introduced the Rajasthan Right to Health Bill, 2022 on 22 September 2022. The Bill was then referred to the Select Committee and later discussed and passed[6] on 21 March 2023. Following this, doctors in general, and from Rajasthan in particular, voiced their apprehensions on various forums. The Bill is available in the official website of the Government of Rajasthan and an analysis of the bill reveals a few points of contention.

Rights and duties are not matched

The Bill has a list of rights and another list of duties (termed as Obligations). These lists are not matched. This does not seem like a practical policy. The aim of the Bill is laudable, but the clauses within have little relation to the name of the Bill. In case the policy is implemented in its present form, doctors will end up paying for the treatment and that is not a sustainable proposal.

'Emergency' is not defined

The term or concept of 'Emergency' is not defined. Let us assume that a patient comes to the hospital with a headache. The headache can be due to a rupture of a berry aneurysm and cause consequent subarachnoid bleeding. Thus, it makes every headache an emergency and a CT scan mandatory for every headache. An acute pain in the abdomen can be an intestinal perforation or a ruptured ectopic pregnancy. This makes every acute pain in the abdomen an emergency. A limb pain can be due to ischaemia. This makes any limb pain an emergency. Scenarios such as these force the hospital to investigate the patient. However, after the investigations if the patient does not have an emergency, is there a provision to reimburse the expenses to the hospital? Or will the invoice raised by the hospital be refused saying that the patient did not have an emergency condition? This point is not clarified yet.

Reimbursement mechanism: Who will pay, How much will be paid, When will it be paid—is not specified

That the title of the Bill and the clauses of it are incoherent can be reiterated by another point. The payment and reimbursement mechanisms are not mentioned. While the Bill talks about State Health Authority and District Health Authority in detail, the duties of the doctors in detail, the penalties against doctors in detail, the payment mechanism and reimbursement mechanism are conspicuous by their absence. There are supporters of the current version of the Bill who say that these can be added later. However, everything other than the payment and reimbursement mechanisms has been spelt in detail in the version of the Bill that was passed in the Assembly. The questions that are not answered are:

1. Who will pay? To whom should the bill be sent?
2. When will the payment be made?
3. Will the amount be paid in full? If no, who will be paying the rest of the amount?

Impression

From the above, the impression one gets is that:

1. The Bill is incomplete, half-baked, incorrect and flawed.
2. Right to Health as mentioned in the Bill is just a mirage and the desired results cannot be attained with the current version of the Bill.
3. If the Bill is implemented in the present version, it will do more harm than good.

THE WAY FORWARD

In my humble opinion, the following suggestions will ensure that the Bill serves the purpose for which it is being brought forward and functions in a manner true to the title of the Act.

Match duties and responsibilities (Obligations)

As explained in 4.1, it is mandatory to match the duties with rights and not have a fancy list.

Define 'Emergency'

The 'Emergency' conditions must be clearly defined. That the investigations will be reimbursed must be specified. Of course, there is a chance of over-investigation, but it is an inherent part of Right to Health. If we want to avoid unwanted investigations, there is a danger that the investigations which are indicated and needed may not be done.

Declare a robust reimbursement mechanism

A clear and simple reimbursement mechanism must be setup and payment must be made within 7 days, preferably earlier. Budget for this must be allotted well in advance.

Proceed in a phased manner

Instead of enforcing the Act throughout the state on the same day, a phased approach would be easier to implement. I would suggest starting with a pilot in one taluk, allot money, frame guidelines, setup a reimbursement mechanism, let all the stakeholders learn lessons from this single taluk pilot scheme. The guidelines may be modified based on the lessons learnt. Then, the same approach may be implemented in one or two other districts as phase I and upscale it to phase II. This will ensure that: (i) minor differences and difficulties are ironed out; (ii) doctors from other districts will have confidence.

An alternative approach would entail a phased progression of conditions. This strategy involves commencing with a single condition and gradually broadening the coverage. For instance, initiating with Free Treatment for Chest Pain, Free Treatment

for Obstetrics, or Free Treatment for Road Accidents, and then integrating other conditions into the coverage, culminating in the comprehensive coverage of all conditions.

A more optimal solution would entail a phased approach encompassing both geographical regions and medical conditions. Commencing with a single medical condition within a specific area and gradually expanding the coverage to encompass the entire state, and ultimately, all medical conditions would constitute a pragmatic and feasible course of action.

Do not 'Shoot the messenger'

Another important suggestion is to not 'Shoot the messenger'. When doctors doubt, clarify; when doctors question, answer; when doctors criticize, change. Do not immediately label the doubters, questioners and critics as 'money-minded', 'business-centric' and 'anti-Right to Health'.

Other successful models

There is a successful model running in Tamil Nadu where at least 1.5 lakh patients have been treated for free. It would be prudent to understand why no doctors opposed the scheme in Tamil Nadu, while there was opposition in Rajasthan.

THE TAMIL NADU INNUYIR KAPPOM–NAMMAI KAAKKUM 48 SCHEME

Need for 48-hours free treatment scheme

Tamil Nadu recorded 55 713 road traffic accidents (RTA) in 2021, in which 14 912 persons died and 17 544 persons sustained grievous injuries.[7] This has been a persistent problem over a decade accounting for about 1400 fatal accidents per month, killing 40–45 persons every day in the state. This preventable public health crisis must be reduced to achieve the Sustainable Development Goal (SDG) 3.6 (to reduce deaths due to road traffic injuries by 50% by 2030).

Nammai Kaakkum 48 (NK 48) scheme under the Innuyir Kappom Thittam (IKT)

Considering the burden of RTA and the unexpected, burdensome out-of-pocket expenditure to the family, Tamil Nadu implemented the NK48 scheme under the IKT. This is to ensure absolute budgetary certainty for road crash victims in the critical first 48 hours. This aims to reduce delays due to denial of treatment and multiple inter-facility transfers, thereby reducing mortality and morbidity to a great extent.

1. A total of 662 (440 private and 222 government) hospitals have been empanelled in accident-prone stretches based on the top 500 accident grids and the time taken to transport from the accident site to the nearest medical facility.
2. District-wise trauma care plan has been prepared where ambulances are mapped to the nearest empanelled hospital to reduce delays and prevent fatalities.
3. There is service mapping of ambulances to ensure that the victim is taken to the right centre within the golden hour of trauma.
4. Eighty-one designated treatment modalities/procedures for damage control measures costing up to ₹100 000 per individual has been extended on a cashless basis on assurance mode to all victims, irrespective of whether they possess the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) insurance card or not.
5. The scheme includes all victims of RTA, who belong to Tamil Nadu, other states, migrants and foreigners, within the boundaries of Tamil Nadu.
6. A sum of ₹50 crore (500 million) as corpus fund has been sanctioned by the Tamil Nadu government. In 2022–23, ₹100 crore (1000 million) has been allotted.

Operational guidelines

1. Accident victims can take treatment in the first 48 hours on a cashless basis on approved procedures in the empanelled hospitals.
2. If the victim continues to be unstable after 48 hours treatment, treatment is continued free of cost in a government hospital. If the victim was admitted in an empanelled private hospital, he or she will be treated as per the following guidelines:
   (a) If the victim is a beneficiary of the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS), the treatment has to be continued as per the existing package.
   (b) If the victim is not a beneficiary of the CMCHIS, the patient is stabilized and then transferred to a nearby government hospital.
   (c) If the victim is not willing to go to a government hospital and is willing to take treatment in the private hospital with payment/under private insurance scheme, the patient will be stabilized and treated in the same hospital or transferred to the hospital of the patient's choice. Such patients pay the hospital fees from their own resources.

Beneficiaries of the scheme

From 18 December 2021 to 31 March 2022, a total of 39 542 patients with RTA have benefited. The 100 000th patient was treated on 4 August 2022, and the 150 000th patient on 15 March 2023.

CONCLUSION

The Right to Health Act of Rajasthan is a noble initiative. However, the shortcomings, in the present version of the Act, need to be corrected.

ACKNOWLEDGEMENTS

I thank all those on X (formerly Twitter) who discussed the topic with me.

Conflict of interest. None declared

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