

# The Rajasthan Right to Health Act, 2023: Analysis and Recommendations

**V I D H I** | Centre for  
Legal Policy

This is an independent,  
non-commissioned  
piece of work by  
the Vidhi Centre  
for Legal Policy,  
an independent  
think-tank doing legal  
research to help make  
better laws.

# About the Authors

---

Shreyashi Ray is a Research Fellow at the Vidhi Centre for Legal Policy.

Dr Dhvani Mehta is Co-founder and Lead, Health at the Vidhi Centre for Legal Policy.

The authors would like to thank Aditya Prasanna Bhattacharya, Senior Resident Fellow and Yogini Oke, Research Fellow at the Vidhi Centre for Legal Policy, for their contribution to related pieces of work which inform some of the analysis in this note.

Any errors are the authors' alone.

# Table of Contents

---

<b>Executive Summary</b>	<b>4</b>
<b>Introduction</b>	<b>5</b>
<b>I. Important Substantive Concerns</b>	<b>7</b>
A. Need to distinguish between healthcare and public health	7
Current position	7
Vidhi's Comments	8
Key recommendations	9
B. Lack of clarity regarding interaction with existing laws & schemes	9
Current position	9
The Clinical Establishments Act, 2010	9
• Laying down and enforcement of quality standards	9
• Fundamental definitions	10
The National Health Mission Framework	10
State-level health insurance schemes	10
Vidhi's Comments	11
Key recommendations	11
C. Lack of clarity regarding applicability of provisions	11
Current position	11
To whom do the rights apply?	11
To whom do the responsibilities apply?	11
Vidhi's Comments	12
Key recommendations	13
D. Over-delegation of important issues	13
Current position	13
Vidhi's Comments	13
Key recommendations	14
E. Issues pertaining to authorities envisaged in the law	14
Current position	14
Issues in demarcation of responsibilities	14
Issues in composition	15
Issues in the functioning of these bodies	15
Vidhi's Comments	15
Key recommendations	16
<b>II. Scope for clarification in language</b>	<b>17</b>
A. Inaccuracies in drafting	17
B. Ambiguities and inconsistencies in language	17
Key recommendations	19
<b>Potential issues and concluding remarks</b>	<b>20</b>

# Executive Summary

---

The Rajasthan Right to Health Act of 2023 (“RTH Act/ the Act”) is a laudable pioneering law in the domain of health rights in India. The public narrative surrounding the Act has been fraught with pushback from many members of the medical community, most of which are based on an erroneous understanding of the law and the scope of the right to emergency care. However, some aspects of the Act require careful re-examination and modification, and should be considered in any subsequent amendment of the Act. They are summarised below:

## **Need to distinguish between healthcare and public health**

The RTH Act currently has provisions pertaining mainly to healthcare, while public health (including public health emergencies) has been mentioned in passing - leaving both its vision and implementation to delegated legislation and executive decision. In order to appropriately address both aspects of health rights, the Act should be divided into two parts, clearly distinguishing the kinds of rights and responsibilities that are expected as a part of public health delivery from the regulatory mechanisms needed to govern healthcare.

## **Lack of clarity regarding interaction with existing laws & schemes**

The RTH Act makes no reference to existing health laws and schemes operating in the state which have direct overlaps with some of the provisions in this Act. There is a need to conduct a thorough compatibility review and harmonise the provisions of all pertinent laws and schemes. For example, comprehensive definitions of health establishments and emergency existing in the Clinical Establishments Act, 2010 should be incorporated in the RTH Act, prevalent understandings of health centres under the National Health Mission should be followed, and overlaps between this Act and state-level health insurance schemes should be clarified - especially in the context of cashless or free treatment.

## **Lack of clarity regarding applicability of provisions**

The rights recognised under the RTH Act are applicable only to residents of the state, and the definition of ‘resident’ is unclear. Ideally, the rights should be recognised for all patients/ users. Further, the current definitions of health establishments are ambiguous - for instance, it is not clear where both government and non-government health establishments are responsible for facilitating the implementation of certain rights. Such provisions should hence be amended in a way that makes the applicability of rights and responsibilities under the RTH Act clearer, distinguishing between government and non-government institutions where required.

## **Over-delegation of important issues**

Some critical substantive provisions in the Act have been left to prospective prescription by delegated legislation, or executive discretion. The determination of a medical condition as emergent, all details of grievance redressal and reimbursement mechanisms, and even the rights and responsibilities of healthcare providers are examples of such provisions. Although the operational details of the same may be left for prescription and discretion, the basic principles and contours must be contained in the parent Act.

## **Structure and composition of authorities proposed under the Act**

There is a mismatch in the nomenclature of the authorities that are proposed under the Act and the scope of functions that they are expected to perform. The composition of the authorities raises concerns about their efficiency, neutrality, and expertise in performing these functions, including the adjudication of grievances. The structure and composition of these authorities should be tailored to fit these different functions-strategic planning, implementation, standard-setting, and grievance redressal. Moreover, the composition of the authorities should include representatives of patient rights groups and civil society organisations, as well as public health experts.

## **Inaccuracies and ambiguities in the language of the Act**

There are some typographical errors in some provisions of the RTH Act, as pointed out in the note, that should be rectified. Further, there are ambiguities/ inconsistencies in the phrasing of certain provisions - such as the definitions of emergency and first aid, as well as the rights to emergency medical care, free health services, and free transportation - which require modification to enable consistent understanding and implementation.

# Introduction

---

The RTH Act, passed by the Rajasthan Legislative Assembly on March 21, 2023, is a pioneering law in many ways. It is the first of its kind to legislatively codify the right to health, and include rights recognised under the Charter of Patient Rights within a state-level law.<sup>1</sup> Although the right to health has been read to be part of the constitutional fundamental right to life, dignity, and personal liberty under Article 21<sup>2</sup>, codifying its different components in legislative provisions enables realisation of the right in more tangible ways. The RTH Act, by laying down rights, duties, and mechanisms for justiciability, as well as assigning financial responsibility to the State, is a commendable step towards realising health rights in India.

Apart from codifying rights in the law, the RTH Act provides for a grievance redressal mechanism in section 11, thus potentially improving access to resolution and justice. Since the law envisages in-house complaint centres with helplines and web portals for hearing grievances, it is likely to enable the speedier resolution of grievances, now that courts, tribunals or commissions will no longer be the only or first recourse.

Despite the appreciable intent of the law, there are significant roadblocks to its practical implementation. Many members of the medical community of Rajasthan, with support and assent from the Indian Medical Association (“IMA”), have vehemently protested some of the provisions of the law, in particular the rights-based approach to emergency medical care. According to section 3(c) of the RTH Act, a resident has the right to emergency medical treatment and care at any ‘public health institution, health care establishment and designated health care centre’ without requisite prepayment - if the patient does not pay the charges after emergency care, stabilisation, and transfer, the healthcare provider shall be entitled to reimbursement from the state government. A series of legally and ethically untenable arguments regarding the “draconian nature” of this provision formed the basis of a long-drawn protest spanning a couple of weeks, which significantly hampered healthcare services in the state. Thereafter, on April 4, 2023, a memorandum of understanding (“MoU”) was signed between the IMA, United Private Clinics & Hospitals Association of Rajasthan (“UPCHAR”), Private Hospitals and Nursing Homes Society (“PHNHS”), and the state government.<sup>3</sup> According to this MoU, among the non-government establishments/institutions, only private medical college hospitals, hospitals established on the basis of public-private partnerships, hospitals established after taking land/ subsidies from the government, and those run by trusts, shall be bound by the provisions of the RTH Act.

The legal validity of such an MoU insofar as it will form the basis for a legislative amendment, as well as the arguments made during the protests, need to be re-examined. Contrary to the arguments claiming that provisions such as section 3(c) of the RTH Act infringe upon the rights of healthcare providers and institutions, the right to emergency medical care is well-recognised in the Indian legal system. In 1989, the Supreme Court relied on the Code of Medical Ethics drawn up by the Medical Council of India as well as the fundamental right to life to hold that medical professionals have a duty to provide immediate medical aid in an emergency.<sup>4</sup> This is also reflected in the Patient Rights and Responsibilities Charter under Ayushman Bharat, which enjoins empanelled hospitals to provide basic emergency medical care even if a patient cannot pay.<sup>5</sup> In a way, the RTH Act actually

---

<sup>1</sup> The Act may be found here - <<https://assembly.rajasthan.gov.in/LegislationGovernmentBills.aspx>> accessed on April 20, 2023.

National Human Rights Commission, ‘Charter of Patient Rights’ -

<<https://main.mohfw.gov.in/sites/default/files/PatientCharterforcomments.pdf>> accessed on April 20, 2023.

The West Bengal Clinical Establishments Rules of 2017 codify some of the rights from the Patient Rights Charter, but the RTH Act is the first to codify them within the parent legislation,

<[https://www.wbhealth.gov.in/uploaded\\_files/go/SPSRC-2603.pdf](https://www.wbhealth.gov.in/uploaded_files/go/SPSRC-2603.pdf)> accessed on April 17, 2023.

<sup>2</sup> See *State of Punjab v. Ram Lubhaya Bagga* [(1998) 1 SCR 1120], *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anr.* [(1996) AIR SC 2426].

<sup>3</sup> Announcement by IMA - <<https://twitter.com/IMAIndiaOrg/status/1643163687891644418>> accessed on April 16, 2023..

<sup>4</sup> *Parmanand Katara v. Union of India*, (1989) 4 Supreme Court Cases 286: 1989 SCC (Cri) 721.

<sup>5</sup> National Health Authority, ‘Patient’s Rights Responsibilities Charter’,

<<https://mhis.org.in/wp-content/uploads/2023/02/1.Patient-Rights-Responsibilities-Charter.pdf>> accessed on April 16, 2023.

supplements the responsibility of healthcare providers to provide such care, with the right to reimbursement from the state government.

However, some of the arguments regarding the need for greater clarity and direction within the law, need to be considered carefully. Civil society organisations such as Jan Swasthya Abhiyan, which have long-term experience in working on health and allied rights across India and in Rajasthan, have voiced the need for clarity on certain definitions, categorising obligations on the basis of capacity, and for mechanisms to ensure smooth and time-bound reimbursement.<sup>6</sup> They have also urged the government to formulate and publish the Rules under the RTH Act as a priority, in order to aid clear and meaningful implementation of the law.<sup>7</sup>

The Vidhi Centre for Legal Policy (“**Vidhi**”) is taking this opportunity to analyse the RTH Act in a more detailed and holistic manner, and raise issues and recommendations that may be taken into account by the Government of Rajasthan to make suitable amendments to the law - as well as formulate clear and comprehensive Rules under the Act.

---

<sup>6</sup> Joe Mathew, ‘Civil society groups laud Rajasthan's ‘Right to Health’ law’ (Fortune India, April 4, 2023), <[https://www.fortuneindia.com/macro/civil-society-groups-laud-rajasthans-right-to-health-law/112125#:~:text=Jan%20Swasthya%20Abhiyan%20\(JSA\)%2C,Assembly%20on%201st%20March%202023](https://www.fortuneindia.com/macro/civil-society-groups-laud-rajasthans-right-to-health-law/112125#:~:text=Jan%20Swasthya%20Abhiyan%20(JSA)%2C,Assembly%20on%201st%20March%202023)> accessed on April 16, 2023.

<sup>7</sup> ‘Frame rules under Right to Health Bill in Rajasthan at the earliest, say activists’ (The Hindu, April 9, 2023), ‘<<https://www.thehindu.com/news/national/other-states/public-health-experts-call-for-early-implementation-of-rth-act-with-framing-of-rules/article66714313.ece>> accessed on April 17, 2023.

# I. Important Substantive Concerns

---

## A. Need to distinguish between healthcare and public health

### *Current position*

The RTH Act currently deals primarily with the healthcare aspects of the right to health - but it also contains some provisions pertaining to public health in general and public health emergencies in particular. The relevant provisions of the Act related to public health are listed below:

- Section 5(a) imposes an obligation on the state government to formulate and prescribe a model of public health
- Section 5(e) requires the state government to align health services and schemes and empower residents for better preventive, promotive and protective healthcare
- Section 5(j) of the Act states that the state government should set up co-ordination mechanisms among the relevant government departments to facilitate nutritionally adequate and safe food, adequate supply of safe drinking water and sanitation
- Section 5(k) requires the state government to institute effective measures to prevent, treat and control epidemics and other public health emergencies

In the context of these public health-related obligations of the state government, the State Health Authority for logistical grievances has also been charged with specific functions. These are:

- Section 7(1)(a) states that the SHA for logistical grievances will formulate State health goals
- Section 7(1)(b) states that the SHA will advise the state government regarding strategic plans for the implementation of the Act, including action on the determinants of healthy food, water and sanitation
- Section 7(1)(c) imposes an obligation on the SHA to advise the state government regarding a comprehensive written State Public Health Policy to prevent, track, mitigate and control public health emergencies, as well as situations of outbreak or potential outbreak in the State
- Section 7(1)(d) requires the SHA to monitor the preparedness of the state for the management of public health emergencies.

The Act, therefore, appears to cover several important aspects related to public health within its ambit. However, it has not correspondingly created the appropriate governance architecture for the performance of these functions, nor has it separated the public health aspects from those related to healthcare regulation. This creates confusion.

For instance, it is not clear whether grievances related to the performance of the state government's public health-related obligations fall within the scope of the grievance redressal mechanism created under section 11 of the Act. To take a hypothetical example--a resident of Rajasthan may wish to raise a grievance that appropriate provision in the State budget has not been made for healthcare, in breach of the state government's obligation under section 5(b) of the Act, thereby resulting in a denial of the realisation of the right to health and well-being of all residents in the State. There are two problems with how the Act deals with a claim of this nature:

- First, there is no clear indication under the Act whether the breach of the government's obligation to make appropriate budgetary provisions constitutes an infringement of a resident's right to health. At the same time, there is nothing in the Act that bars a resident from alleging such infringement either.
- The grievance redressal mechanism that the Act proposes is completely inadequate to deal with a grievance of this nature. This grievance requires a complex assessment of the appropriateness of the State's budgeting mechanism, and cannot be undertaken by the individual officer to whom grievances are expected to be forwarded under section 11(2)(b) of the Act.



In effect, the Act does not create an appropriate accountability mechanism to ensure that the Government fulfils the public health-related obligations that have been imposed on it.

Additionally, to the extent that the Act aims to govern public health comprehensively, its provisions are inadequate and require more careful articulation and implementation mechanisms. Other states that have public health legislation have detailed provisions on drinking water supply, sanitation, drainage, and the control of infectious diseases. The experience with the Covid-19 pandemic also indicates that there is a need to modernise public health legislation, and include provisions on isolation, quarantining, vaccination and data collection that are in accordance with the principle of proportionality, and that balance the rights to autonomy, dignity, liberty and privacy of individuals against the need to protect public health. The RTH Act is silent on all these aspects.

## Vidhi's Comments

The field of health law has traditionally recognised a distinction between public health and healthcare. This distinction is generally captured in the following terms:

*"[public health] is a collective ("public") responsibility, geared toward improving the health and well-being of an entire community—or state, or country—as opposed to diagnosing or treating particular individuals. In addition, public health addresses the "conditions to be healthy," meaning that it is focused on "the prevention of disease and the promotion of health" ... as opposed to medical care for those who are already ill...Public health studies the causes and distribution of disease and injury in populations. This is one of the defining differences between public health and healthcare."*<sup>8</sup>

Further, the World Health Organisation has defined 'public health law' in the following terms:

*"Public health law refers to the formal set of laws – and to the legal processes for implementing and enforcing them – that seek to ensure the conditions for people to live healthy lives. Apart from laws pertaining directly and palpably to health infrastructure and health regulation, a robust public health system uses a combination of laws, regulations, public awareness, public trust, and public participation mechanisms – under an umbrella of recognized human/ health rights – to promote community and individual health (physical, mental, social, etc.) in the society. Such mechanisms include focus on larger social, economic, and political factors that promote or discourage health behaviours."*<sup>9</sup>

Thus, laws relating to public health generally aim to prevent the potential outbreak of diseases, tackle public health emergencies, and generally ensure the overall health and well-being of a population. On the other hand, laws relating to healthcare aim to provide citizens with the best possible standards of medical diagnosis and treatment by, *inter alia*, regulating clinical establishments.

The aims being distinct, the rights and duties as well as regulatory approach which is adopted to secure them are also different. As such, India (as well as other jurisdictions) has traditionally enacted separate legislations to address each aspect. For example, the state of Rajasthan itself addresses public health through third-tier laws such as the Rajasthan Municipalities Act, 2009 and the Rajasthan Panchayati Raj Act, 1994, or through specific laws such as the Rajasthan Vaccination Act, 1957, while healthcare is addressed through laws such as the Rajasthan Medical Act, 1952 and the Clinical Establishments Act, 2010.

In the interests of clarity, ease and efficiency of administration, and enforceability of the rights and duties, the RTH Act should be divided into two clear Parts. The Part which addresses public health may contain, *inter alia*, provisions relating to the public health functions of the state government and third tier bodies, rights and duties of citizens, etc. while the Part relating to healthcare may contain, *inter alia*, provisions relating to the rights of

---

<sup>8</sup> Scott Burris et al, 'The New Public Health Law: A Transdisciplinary Approach to Practice and Advocacy' (Oxford University Press, 2018), pp.4-5.

<sup>9</sup> World Health Organisation, 'Advancing the right to health: The Vital Role of Law', 2017, <<https://apps.who.int/iris/handle/10665/252815>> accessed on April 20, 2023.

patients, duties of clinical establishments etc. A common authority with oversight over both may be envisaged, provided that its functions and powers in relation to public health and healthcare are clearly delineated.

The Part dealing with public health should have a chapter solely dedicated to public health emergencies, given the powers required to be exercised in order to tackle them, and the special duties and responsibilities which arise in such conditions. Instead of leaving the management of public health emergencies entirely to a prospective State Public Health Policy, the RTH Act should lay down some basic principles, criteria, and safeguards - leaving the more minute operational details to the policy and executive orders.

### *Key recommendations*

- The RTH Act should be divided into two parts - one on public health and the other on healthcare.
- The part on healthcare should include a section dedicated to public health emergencies
- A common authority may be created at the state-level, with oversight over both public health and healthcare-related functions, provided these are clearly delineated.

## **B. Lack of clarity regarding interaction with existing laws & schemes**

### *Current position*

The current version of the RTH Act lacks mention of other laws and schemes within the domain of healthcare and health rights in the state of Rajasthan. Assessment for compatibility, overlap, conflict, and interaction should ideally be done prior to enforcing a new law.

Section 20 of the RTH Act says -

*“Saving - Any rules, regulations, guidelines or orders made or issued in respect of providing any health care facilities, whether free or otherwise, to the residents of the State shall be deemed to have been made or issued under this Act and shall remain in force until they are repealed, modified or replaced in exercise of the powers conferred under this Act.”*

Therefore, there is a need to analyse some of the most prominent laws and schemes operating in the state, and attempt to harmonise the RTH Act with them.

### ***The Clinical Establishments Act, 2010***

Rajasthan adopted the Clinical Establishments Act, 2010 (“CEA, 2010”) in 2011, and issued the Rajasthan Government Clinical Establishment (Registration and Regulation) Rules in 2013 (“RGCEA Rules, 2013”).

The following are the major aspects with respect to which harmonisation would be required -

- LAYING DOWN AND ENFORCEMENT OF QUALITY STANDARDS

Currently, both the CEA, 2010 and the RTH Act have undertaken the responsibility of laying down quality standards for healthcare and healthcare establishments.

Section 12 of the CEA, 2010 states -

*Condition for registration.—(1) For registration and continuation, every clinical establishment shall fulfil the following conditions, namely:—*

- (i) the minimum standards of facilities and services as may be prescribed;*
- (ii) the minimum requirement of personnel as may be prescribed;*
- (iii) provisions for maintenance of records and reporting as may be prescribed;*
- (iv) such other conditions as may be prescribed.*

Section 5(f) of the RTH Act mentions the following as an obligation of the state government -

*“to lay down standards for quality and safety of all levels of health care as may be prescribed”*

Related to this, one of the functions of the State Health Authority for Treatment Protocols, under section 7(2)(a) of the Act is to

*“develop mechanisms and systems for regular medical, clinical, and social audits for good quality of health care at all levels.”*

In contrast, under section 33 of the CEA, 2010, the district authority set up under section 10 of the Act or any officer authorised by it have the power to conduct an inspection or inquiry of any registered clinical establishment.

Therefore, there seems to be clear overlap in the functions provided for under the two laws, both as regards the laying down of quality standards as well as ensuring compliance with them. Notably, the RGCEA Rules, 2013 have not yet laid down the conditions referred to in the CEA, 2010. Creating more laws under which quality standards may be prescribed through delegated legislation, instead of envisaging compatibility within the existing legal framework, may create further inconsistencies.

## ● FUNDAMENTAL DEFINITIONS

Some of the definitions laid out in the RTH Act may benefit from compatibility with those laid down in the CEA, 2010. For example, section 2(c) of the RTH Act states that the definition of clinical establishments would be the same as that under the CEA, 2010, but the former law goes on to add more definitions of terms such as “healthcare establishment”, “healthcare provider”, and “public health institution”<sup>10</sup>.

Further, terms such as emergency medical condition have a much more accurate and clear definition under the CEA, 2010 in comparison with their definition under the RTH Act -

*“emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) of such a nature that the absence of immediate medical attention could reasonably be expected to result in—*

- (i) placing the health of the individual or, with respect to a pregnant women, the health of the woman or her unborn child, in serious jeopardy; or*
- (ii) serious impairment to bodily functions; or*
- (iii) serious dysfunction of any organ or part of a body*

Multiple definitions of the same term under different laws will inevitably cause confusion in implementation.

## **The National Health Mission Framework**

In India, the term ‘health centre’ is typically associated with community health centres, primary health centres, and health sub centres set up by the appropriate government under the National Health Mission (“**NHM**”) framework. Defining “designated health centres” differently under the RTH Act, and leaving the same to be prescribed by the Rules, creates avoidable confusion as regards the existing framework for health infrastructure.

## **State-level health insurance schemes**

The Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (“**AB-PMJAY**”) does not apply within the state of Rajasthan. In 2021, the state introduced the Ayushman Bharat Mahatma Gandhi Rajasthan Swasthya Bima Yojana (“**AB-MGRSBY**”), which is an integration of AB-PMJAY and the state-level Bhamashah Swasthya Bima Yojana (“**BSBY**”), and is partially funded by the centre.

<sup>10</sup> Section 2(t) of the RTH Act - *“public health institution” means governmental organizations that is operated or designed to provide in-patient or out-patient treatment, diagnostic or therapeutic, interventions, nursing, rehabilitative, palliative, convalescent, preventative, promotive, medical research program or other health services to public.*

The Mukhyamantri Chiranjeevi Yojana was introduced in 2021 with the goal of ensuring state health insurance for all residents of Rajasthan without any other eligibility criterion. It provides cashless medical insurance to permanent residents of Rajasthan, with an upper limit of INR 5 Lakh. Beneficiaries of AB-MGRSBY, families recognised by the Social Economic and Caste Census (SECC) 2011 and National Food Security Act, 2013 (NFSA), small farmers, and all government samvida workers are also eligible under the Chiranjeevi Scheme, apart from 'permanent residents'. In addition to cashless treatment at government health institutions, it provides universal coverage at "network hospitals" under the scheme.

### **Vidhi's Comments**

The RTH Act should bring the definitions of establishments and 'emergency medical condition' in line with those provided under the CEA, 2010, specify under which law quality standards shall be prescribed, and do away with terms such as 'designated health care centre' which could create ambiguity.

Further, it should clarify whether 'government funded health care services' defined under section 2(d) of the Act would include the network hospitals mentioned above. It should also clarify whether treatment availed by those registered under AB-MGRSBY or Chiranjeevi Yojana would be covered under cashless treatment under the scheme, or rights to emergency medical treatment and free healthcare services recognised under sections 3(c) and 3(d) of the RTH Act.

### **Key recommendations**

- Definitions of 'establishments' and 'emergency medical condition' should be aligned with existing, comprehensive definitions in the CEA, 2010. An emergency medical condition should not be defined on the basis of factors leading to it, but the characteristics of the condition. This would reduce ambiguity both in terms of understanding of these terms, and parity across different laws applying in the state.
- The definition of 'designated health care centre', which strays from the dominant understanding of government healthcare centres and is left entirely to prescription by delegated legislation, may be removed.
- The RTH Act should clarify the scope of operation of the Act vis-a-vis existing state-level health insurance schemes.

## **C. Lack of clarity regarding applicability of provisions**

### **Current position**

#### ***To whom do the rights apply?***

The rights provided in section 3 of the RTH Act apply to "every resident in the State of Rajasthan". As per section 2(w) of the Act -

*"resident" means an ordinary resident of the State of Rajasthan.*

This definition is not only ambiguous, it is also restrictive from a rights-based standpoint and impractical from an implementation standpoint. The rights recognised in the RTH Act should be enjoyed by any person availing healthcare services in Rajasthan. There is no correlation between their health rights (such as right to informed consent, confidentiality, dignity, etc.) and residential status - which may in any case be difficult to determine especially in emergency situations.

#### ***To whom do the responsibilities apply?***

Sections 3(c) and 3(d) of the RTH Act talk about the right of a resident to avail emergency treatment or care without prepayment, and to avail free health care services, respectively, from -

“public health institution, health care establishment and designated health care centres”

According to section 2, the above terms are defined as follows-

(d) “designated health care centres” means health care centres as prescribed in the rules

(m) “health care establishment” means the whole or any part of a public or private institution, facility, building or place, whether for profit or not, that is operated to provide inpatient and/or outpatient health care, and a “public health care establishment” shall accordingly refer to a health care establishment set up, run, financed or controlled by the Government

Thus, these terms have been defined in such a way in the RTH Act, that it is unclear which kinds of healthcare institutions or establishments would be bound by the rights under sections 3(c) and 3(d). Currently, the language used in Section 3(d)-

“... the right to avail free health care services from [any clinical establishment] public health institution, health care establishment and designated health care centres in the prescribed manner and subject to be terms and conditions specified in the rules”

suggests that all healthcare services may be availed free of cost from both government and non-government institutions, given that “health care establishment” has been defined to include both public and private institutions. This is clearly not the intention of the provision, but the manner in which it is currently drafted lends itself to that interpretation.

### Vidhi's Comments

While benefits from state-level insurance schemes may be restricted to residents of the state, rights such as those recognised in the RTH Act (right to emergency medical care, right to information and medical records, right to informed consent, right to privacy and human dignity, etc.) should be enjoyed by all users of the healthcare system.

From an implementation perspective, the current position in the Act raises concerns. For instance, would the right to emergency medical care without the need to prepay apply to an interstate truck driver availing treatment for injuries sustained during a highway accident? Would the question regarding their residential status become important while claiming reimbursement from the state government for such treatment? Lack of clarity regarding such concerns might result in refusal of emergency care, especially to socio-economically marginalised or unaccompanied patients.

Therefore, rights recognised in the RTH Act should be enjoyed by all users of the healthcare system in the state of Rajasthan, not just residents. For this, the legislature may refer to the definition of “user” in a previous iteration of the Rajasthan Right to Health Care Bill, 2022<sup>11</sup> -

“User” means one who seeks, accesses, or receives any health care services, as an outpatient or inpatient, from a facility or provider whether any public or private health care establishment

This may be modified in the Act such that “user” is defined as one who seeks, accesses, or receives any in-patient or out-patient healthcare services, from any healthcare establishment or healthcare provider.

Further, the RTH Act should be amended in such a way that definitions of clinical establishment are at par with those under the CEA, 2010, the designation of health centres is not left to prospective decision, and there is clear mention of the kind of establishments and healthcare providers that have obligations in relation to different health rights.

---

<sup>11</sup> The Bill dated March 8, 2022, inviting public comments, may be found here - <https://rajsvasthya.nic.in/PDF/94%20Dt.08.03.2022%20Website.pdf> accessed on April 20, 2023.

### Key recommendations

- Health rights recognised in the RTH Act should be available to all users, not just residents of the state.
- By defining clinical establishments in line with the provisions of the CEA 2010, the RTH Act should clearly indicate the applicability of rights and responsibilities under this Act, especially as regards government and non-government establishments.

## D. Over-delegation of important issues

### Current position

The RTH Act leaves crucial provisions to be prescribed by delegated legislation (Rules and regulations made under the Act) or by authorities created by this law. For example, the following provisions are unclear in the parent Act, and are left entirely for prospective prescription -

*Section 2(d) - "designated health care centres" means health care centres as prescribed in the rules*

*Section 2(c) - "to have emergency treatment and care...any other emergency decided by State Health Authority under prescribed emergency circumstances..."*

*Section 2(c) - "...after proper emergency care, stabilisation and transfer of patient, if patient does not pay requisite charges, healthcare provider shall be entitled to receive requisite fee and charges or proper reimbursement from State Government in prescribed manner as the case may be."*

*Section 3(c) - "...Provided that after proper emergency care, stabilisation and transfer of patient, if patient does not pay requisite charges, healthcare provider shall be entitled to receive requisite fee and charges or proper reimbursement from State Government in prescribed manner as the case may be."*

*Section 4 - "Responsibilities, Rights and Duties:- (1) Residents and patients shall have the responsibilities and duties towards healthcare establishments and healthcare workers as adopted by the National Human Rights Commission in the prescribed manner and as specified in the rules.*

*(2)Health care providers and establishments will have rights and responsibilities vis-à-vis patients in the prescribed manner as specified in the rules."*

*Section 5 - Obligation of the government - (a) to formulate and prescribe a model of public health known as "Rajasthan Model of Public Health"*

*Section 11 - Grievances Redressal Mechanism:- (1) The Government shall prescribe Grievances Redressal Mechanism for health care establishment, health care provider and residents, within six months from the date of commencement of this Act.*

Therefore, decisions such as what would constitute an emergency, what reimbursement and grievance redressal mechanisms would look like, substantive rights and responsibilities, and something as substantial as the proposed 'Rajasthan Model of Public Health' have been left entirely up to prescription by rules or designated authorities.

### Vidhi's Comments

The purpose of delegated legislation is to lay down detailed operational guidelines pertaining to substantive provisions of the parent law. Ideally, the contours and fundamental aspects of the provisions identified above should be laid down in the RTH Act.

For example, reimbursement should not be left entirely to operational discretion. While the operational details of the reimbursement process may be left to the rules, the following must be mentioned in the RTH Act -

- Waiting period after which one can assume non-payment by the patient
- A direction to set up a fund for reimbursement for unpaid emergency medical care
- Timeline for processing reimbursement
- Grievance redressal mechanism may include non-fulfilment of reimbursement claim as a ground for registering a complaint by a healthcare establishment.
- Clarity regarding who can claim reimbursement - healthcare providers or only institutions/ establishments.

Similarly, the provision on grievance redressal should specify what kinds of grievances may be redressed under which mechanism - a grievance relating to dysfunctional toilets in a non-government hospital and another relating to the failure of the progressive realisation of state mandates to ensure adequate health centres in rural areas, should not be examined by the same body or be resolved using similar procedures. It should also specify separate adjudicating authorities for different kinds of grievance redressal.

Further, while it is commendable that section 4 refers to formulations of the National Human Rights Commission, substantive rights and responsibilities for residents, patients, healthcare providers and establishments should be laid down in the parent Act, with an explanation specifying that efforts would be made to harmonise the Act with the National Human Rights Commission's formulations on a regular basis.

The primary vision or objective of the proposed Rajasthan Model of Public Health should be mentioned in the RTH Act; its details may be formulated by designated authorities.

### *Key recommendations*

- The RTH Act should include key substantive provisions within the parent Act, leaving only the operational details to rules, regulations, and executive orders issued under the Act.
- The provision on reimbursement for unpaid emergency treatment should include fundamental directives such as setting up of an appropriate fund, waiting period and timelines, and avenues for grievance redressal.
- The provision on grievance redressal should specify what kinds of grievances may be redressed under which mechanism, and designate or create appropriate adjudicating bodies for different categories of grievances.
- Substantive rights and responsibilities of residents and users should be part of the RTH Act.
- The primary vision of the Rajasthan Model of Public Health should be mentioned in the parent Act.

## **E. Issues pertaining to authorities envisaged in the law**

### *Current position*

The RTH Act directs the setting up of two State Health Authorities ("**SHAs**") - one for logistical grievances and the other for treatment protocol. It also mandates the constitution of District Health Authorities ("**DHAs**"). Some points of concern are as follows:

### ***Issues in demarcation of responsibilities***

- The SHA for Treatment Protocol has been accorded functions pertaining to, *inter alia*, advising the government on matters of public health, and developing mechanisms for audits and implementation. These functions go beyond framing treatment protocols. In this context, the nomenclature seems inappropriate. Similarly, the SHA for logistical grievances has been assigned substantive functions such as implementation of the right to health in line with other determinants such as healthy food, water, and sanitation [section 7(b)].
- The function of ensuring quality and cost-effective health and diagnostic services by the health sector appears to have been assigned to both SHAs [See sections 7(1)(h) and 7(2)(d) of the Act].



- The DHA has been assigned the function of ensuring implementation of the policies, recommendations, and directions of the SHA. Given that some of the members of the DHA include pramukhs and pradhans, the Act should specify what kinds of responsibilities are expected to be executed by which members.

### ***Issues in composition***

- None of the SHAs or the DHA have representation from departments concerning allied rights such as food, water, and sanitation. This is especially important since section 7 mentions that the SHA for logistical grievances has the responsibility *"to advise Government regarding state level strategic plans for implementation of Right to Health as provided under this Act, including action on the determinants of healthy food, water and sanitation"*.
- Both the SHAs provide for ex-officio members from selected educational institutions, making the composition of the bodies inflexible, and limiting the expertise that may be relied on.
- Both the SHAs and the DHA have representation from the IMA (which has taken a resistant stance to a rights-based approach to health in Rajasthan), to the extent that two out of nine members would be IMA representatives. As opposed to this, there are no representatives from patient rights groups or other civil society organisations.

### ***Issues in the functioning of these bodies***

- The DHA has been assigned the function of investigating and deciding complaints received under section 11 of the Act. Officials such as the District Collector, Chief Executive Officer of the Zila Parishad are ex-officio members of multiple institutions including the DHA and the District Health Society. In case grievances envisaged under the RTH Act include complaints regarding the state health machinery, it may not be appropriate for such members to investigate and adjudicate upon these complaints.
- There is no demarcation between members responsible for implementation functions and those responsible for top-level planning and decision making.
- Since the SHA is the appellate body within the grievance redressal mechanism, it needs to meet more frequently than the minimum prescription of once in six months as per section 8.

### ***Vidhi's Comments***

- A common authority with oversight over both public health and healthcare functions may be envisaged, provided that its functions and powers in relation to public health and healthcare are clearly delineated.
- Instead of dividing the SHA into one handling 'logistical grievances' and the other handling 'treatment protocols', both SHA and DHA should have demarcated functionaries for public health and healthcare functions.
- Among the functionaries for both public health and healthcare functions in the SHA and DHA, there should be clear demarcation between members responsible for the following categories of functions -
  - Functions pertaining to planning and strategising. This would include functions such as planning of health goals, advising the government regarding formulation of health policies, and formulation of other plans and strategies.
  - Functions pertaining to monitoring implementation of the RTH Act and rules/ regulations. This would include monitoring preparedness for handling public health emergencies.
  - Functions pertaining to the regulation of healthcare establishments, especially as regards quality standards and the cost of treatment, to the extent this is not already covered by the CEA, 2010.
  - Functions pertaining to adjudication of grievances. Within this category, subcategories of functionaries may be created and the kinds of grievances that may be adjudicated by every subcategory must be clearly mentioned. The delineation of adjudication responsibilities should be dependent on the expertise and neutrality of the functionary vis-a-vis the subject matter of the grievance.
- Representatives should not be from pre-decided institutions such as SMS Medical College, Jaipur and RUHS, Jaipur. Such details should be left to the operational decisions - the parent law should merely provide the criteria for such membership or nomination.
- The SHA and DHA must include representatives from departments dealing with drinking water and



sanitation, food security, etc.

- The SHA and the DHA must include one representative from a patient rights group and another from a non-government body that works with local communities in general.
- Public health experts should also be part of the team working on public health planning and strategy.

### *Key recommendations*

- The SHA and DHA should have a common authority for oversight, and sub-categories of functionaries that are assigned public health and healthcare responsibilities.
- Functions such as planning, monitoring implementation, regulation and adjudication should be clearly delineated, with further assignment of adjudication responsibilities according to expertise and propriety.
- Membership of representatives from pre-determined institutions should not be codified in the parent law.
- The SHA and DHA must include public health experts, and representatives from patient rights groups and civil society organisations.

## II. Scope for clarification in language

### A. Inaccuracies in drafting

Provision	Issue	Recommendation
Preamble - <i>Whereas, the State of Rajasthan aims, to provide [for] protection and fulfilment of rights and equity in health and well- being under Article 47 of Constitution of India and to secure the Right to Health as per the expanded definition of Article 21 of Constitution of India and, also to provide for free accessible to and equality in, health care for all residents of the State with the progressive reduction in out of pocket expenditure in seeking, accessing or receiving health care;...</i>	Inaccuracy - “provide for free accessible to”	‘accessible’ should be modified to ‘access’
Section 2(b) - <i>“bioterrorism” means the international use of any microorganism, virus, infectious substance (including toxins), or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product to causes, death, disease or other biological malfunction in a human, an animal, a plant, or another living organism</i>	Inaccuracy - since there is no necessary international component to bioterrorism, it appears that the legislature meant ‘intentional’.	‘international’ should be modified to ‘intentional’
Section 2(h) - <i>“epidemic” means occurrence of cases of disease in excess of what is usually expected for a given period of time and includes any reference to “disease outbreak” nevertheless specifically stated otherwise</i>	Inaccuracy - it appears that the legislature meant ‘unless specifically stated otherwise’.	‘nevertheless’ should be modified to ‘unless’

### B. Ambiguities and inconsistencies in language

Provision	Issue	Recommendation
<p>Definitions of emergency - Section 2(a) - “accidental emergency” means any unforeseen, unexpected or unintentional occurrence of an event which results in the risk of death or injury to any person and includes road, rail, water or air accident</p> <p>Section 2(e) - “emergency” means accidental emergency, emergency due to snake bite/animal bite and any other emergency decided by State Health</p>	<p>There are multiple definitions of emergency, focusing primarily on the events leading to the emergency.</p> <p>Section 2(f), again, introduces another element to these definitions, i.e., incident of crime.</p>	As per the Emergency Medical Treatment and Labor Act in the USA, an emergency medical condition includes “ <i>medical conditions with acute symptoms of sufficient severity that, in the absence of immediate medical attention, could place the health of a person (including pregnant patients) in serious jeopardy, or result in a serious impairment or dysfunction of bodily functions or any bodily organ.</i> ”

Provision	Issue	Recommendation
<p>Authority;</p> <p>Section 2(f) - “emergency care” means any reasonable measure to render first-aid, advise or assistance to an injured person of an accident or incident of crime or any other emergency;</p> <p>Section 2(g) - “emergency obstetric care” means to treat (and therefore save the life of) a woman experiencing a complication of pregnancy or childbirth</p> <p>Section 3(c) - “...accidental emergency, emergency due to snake bite/animal bite and any other emergency decided by State Health Authority under prescribed emergency circumstances...”</p>	<p>Section 3 leaves decisions regarding whether or not a situation amounts to an emergency to the SHA.</p> <p>Effectively, there is no cogent definition of emergency in the law, nor is there a set of criteria laid down to assess the same. Further, important emergency conditions such as allergic reactions to drugs, worsening of chronic health conditions, etc. are not captured in these definitions. The SHA should not be expected to make timely or accurate decisions regarding whether or not a medical condition is an emergency.</p>	<p><i>Further, an emergency medical condition exists if the patient may not have enough time for a safe transfer to another facility, or if the transfer might pose a threat to the safety of the person.”</i></p> <p>As per the CEA, 2010 - “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) of such a nature that the absence of immediate medical attention could reasonably be expected to result in—</p> <p>(i) placing the health of the individual or, with respect to a pregnant women, the health of the woman or her unborn child, in serious jeopardy; or</p> <p>(ii) serious impairment to bodily functions; or</p> <p>(iii) serious dysfunction of any organ or part of a body</p> <p>The above examples illustrate how an emergency in the context of the RTH Act should be characterised by the medical condition itself and not the reasons leading to it. The RTH Act should be amended to reflect such a definition</p>
<p>Section 2(i) - “first aid” means the immediate basic care given to an injured person of an accident or crash or incident of crime or any other emergency situation so as to stabilise his condition by any person including a medical professional before any decisive treatment</p>	<p>This provision too refers primarily to injuries and the factors leading to the injury. First-aid should be legally defined in much broader terms - injury is not the only medical condition requiring such care.</p>	<p>The definition should be broadened to include injuries as well as illnesses, irrespective of factors causing the same.</p>
<p>Section 2(s) - “public health” means the health of the population, as a whole, especially as monitored, regulated, and promoted by the Government</p>	<p>This definition is inconsistent with the widely accepted definition of public health.</p>	<p>According to the World Health Organization (WHO), “Public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases.”<sup>12</sup></p> <p>This can be referred to for suitably amending this definition.</p>

<sup>12</sup> ‘What is Public Health?’ (Capital Area Public Health Network), <http://www.capitalareaphn.org/about/what-is-public-health> accessed on April 17, 2023.

Provision	Issue	Recommendation
<p>Definitions of “stabilise” and “transfer or transport” are provided in Section 2.</p> <p>While describing the right to emergency medical care, the proviso to Section 3(c) states - <i>Provided that after proper emergency care, stabilisation and transfer of patient, if patient does not pay requisite charges, healthcare provider shall be entitled to receive requisite fee and charges or proper reimbursement from State Government in prescribed manner as the case may be.</i></p>	<p>Currently, the essential elements of emergency care are not properly laid down in the provisions. This may lead to inconsistent understanding of the right to emergency medical care under this law.</p> <p>Given the definition of ‘healthcare provider’ in section 2(n) of the Act, the use of ‘healthcare provider’ in the proviso raises questions about whether individual providers, not just institutions/ establishments, can claim reimbursement.</p>	<p>Stabilisation and transfer should be part of the mandatory steps involved in emergency care. These steps should be explained in the main part of section 3(c) or in the definition of emergency care in section 2(f).</p> <p>There should be clarity regarding who can claim reimbursement - healthcare providers or only institutions/ establishments.</p>
<p>Section 3(s) - to avail free transportation, free treatment and free insurance coverage against road accidents at all health care establishments accordantly to their level of health care available in the health care institution for emergency care, first aid or stabilize and transfer as per guidelines with appropriate financial provisions by State Government in the prescribed manner and subject to the terms and conditions specified in the rules</p>	<p>It is not clear why road accidents have been privileged here for free transportation, treatment, and insurance cover. Moreover, it may not be possible to ascertain whether a patient arriving in an emergency condition is a ‘resident’ of Rajasthan.</p>	<p>This provision may be amended to recognise the right to avail free transportation in the case of any accident, road or rail or otherwise. The right should not be restricted to the residents of Rajasthan, and free transportation may be availed by any user.</p> <p>Rights pertaining to free treatment and insurance cover may be clarified in the RTH Act separately, vis-a-vis the Chiranjeevi Scheme and the AB-MGRSBY as well as section 3(d).</p>

### Key recommendations

- The inaccuracies in drafting should be rectified.
- The RTH Act should define emergency not in terms of factors leading to it but in terms of the characteristics of the condition. The essential components of emergency treatment should be clearly mentioned in a substantive provision under section 3.
- The definition of ‘first aid’ should be broadened to include injuries as well as illnesses, irrespective of factors causing the same.
- The definition of ‘public health’ should be amended to reflect the globally understood meaning of the term.
- The right to avail free transportation should apply to all users and in case of any accident - road, rail, or otherwise. Rights of free treatment and insurance cover may be clarified vis-a-vis existing state-level insurance schemes.

# Potential issues and concluding remarks

---

A combination of some of the issues discussed above may lead to potential issues in the implementation and impact of the RTH Act. The resistance to the right to emergency medical care, although largely informed by incorrect understandings of both the new law and the pre-existing legal framework on this right, illustrates the need to thoroughly examine and suitably modify the RTH Act to leave little room for ambiguities.

The unclear definitions of 'emergency medical condition' and 'emergency care', and wide discretion left to the SHA to make that judgement, make it unclear to assess in which situations a resident is entitled to emergency medical care without prepayment, and what kind of treatment such emergency care would entail. Restriction of this right to 'residents' not only deprives non-residents from accessing such a basic health right, but may also raise issues when reimbursement is claimed by the healthcare provider - especially because the definition of 'resident' is also unclear. The state government may refuse reimbursement if it decides, post-facto, that the patient who availed emergency care was not a resident after all - thus disincentivising healthcare establishments from providing emergency care, especially to marginalised or unaccompanied patients. Pending the establishment of a fund and a clear mechanism for claiming reimbursement, healthcare establishments and healthcare providers may not be willing to trust the state government on its promise of a right to reimbursement - as has been amply demonstrated by the long protest by healthcare professionals in Rajasthan leading to the MoU mentioned in the introduction to this note. The current provisions leave some ambiguity regarding who can claim reimbursement - a healthcare provider or an establishment/ institution, or both. Further, although section 11 states that grievance redressal mechanism shall be "for health care establishment, health care provider and residents", it is unclear whether complaints regarding reimbursement claims can be brought by an establishment or a provider under such mechanism. At the same time, owing to the ambiguity in the definitions of emergency and emergency care, it is unclear as to what amounts to violation of the right to emergency medical care, on the basis of which a resident may seek grievance redressal.

This is just one example of a health right which may not be meaningfully implemented unless appropriate amendments are made to the RTH Act, and rules and regulations are drafted carefully. The recommendations in this note, and inputs from other civil society stakeholders, would help in suitably modifying the commendable RTH Act into a more implementable and defensible pioneering law on progressive health rights in India. The state of Rajasthan has both a responsibility and an opportunity to be a real pioneer in health rights legislation in India by incorporating these recommendations and formulating effective rules and regulations, particularly those related to the development of sound grievance redressal mechanisms to realise the important health rights recognised in the RTH Act.

**[www.vidhilegalpolicy.in](http://www.vidhilegalpolicy.in)**

**Vidhi Centre for Legal Policy  
A-232, Defence Colony  
New Delhi – 110024**

**+91-11-43102767**

**[vcip@vidhilegalpolicy.in](mailto:vcip@vidhilegalpolicy.in)**