RIGHT TO HEALTHCARE ACT, 2022: ENTRUSTING OR ENCUMBERING?

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ABSTRACT

The World Economic Outlook 2023 appreciates India as the fastest-growing major economy, however, inequitable access to opportunities and resources particularly in healthcare is well acknowledged. Despite a rising healthcare expenditure due to increasing incidence and prevalence of non-communicable diseases, antimicrobial resistance and road traffic accidents , budgetary allocations remain below 3% of GDP. This exacerbates the burden of out-of-pocket healthcare expenditure (OOPHE) and poses serious hurdles to realize the Right to Health, enshrined in the global human rights mandate, Indian constitutional frameworks and judicial pronouncements of the Supreme Court. OOPHE pushes millions below the poverty line every year reversing the decades of efforts of the government on poverty alleviation . In this regard, the Right to Healthcare Act, 2022 enacted by Rajasthan Legislature appears to be a promising statute making right to health a statutory entitlement for the residents of Rajasthan. However this also raises concerns over economic feasibility and quality of services, resulting in protests and disrupting private healthcare services. With 70% of outpatient and 58% of inpatient services provided by the private health sector, any policy intervention affecting it demands thorough consideration, consultation and consensus. Beyond short-term challenges, the Act poses long-term risks, notably the potential "brain drain" of healthcare professionals, exacerbating workforce shortages. The Act's impact on hospital specializations and the trust factor in doctor-patient relationships also warrants policy and research attention. This article underscores the importance of addressing these three less-discussed long-term consequences, emphasizing the need for a comprehensive, holistic policy attention. Business Process Innovations (BPI) strategies like cross-subsidization in private hospitals and tech-enabled approaches enhance accessibility , affordability, transparency and accountability. Healthcare policy initiatives like Tamil Nadu's "Healthcare at your Doorsteps" model and the development of Hub and Spoke Mini clinics in rural areas can be

potential interventions to alleviate the issues of OOPHE and pave the way for a more accessible Right to Health for all.

Right to health : Current status and challenges

The International Monetary Fund in its World Economic Outlook 2023 has described India as the fastest growing major economy in the world. Despite India's economic growth potential, the issue of inequitable distribution of resources and opportunities particularly in the field of healthcare is well acknowledged. Rising burden of emergencies due to road traffic accidents, non-communicable diseases, antimicrobial resistance juxtaposed with growing awareness and expectations of the population from the healthcare system has resulted in overall rise in healthcare expenditure. However, the budgetary allocation for health in India remains less than 3% of GDP which is far less when compared to the BRICS counterparts. According to National Health Account Estimates 2019-20, 52% of Current Health Expenditure is addressed in the form of out of pocket expenditure. WHO's Indian Health System Review – 2022 depicted that the high Out of Pocket Healthcare Expenditure (OOPHE) drags 55 million Indians below poverty line annually and nearly 17 % of households incur catastrophic health expenditures.

Right to Health is an integral part of Article 25 of the Universal Declaration of Human Rights – 1948 and Article 21 of the Indian Constitution as upheld by the Supreme Court in the landmark judgement of Bandhua Mukti Morcha vs Union of India & Others in 1984. However, OOPHE is a major obstacle in realizing this indispensable right. The policy interventions aimed at addressing OOPHE like Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and various state specific insurance schemes have various structural and functional bottlenecks in terms of coverage issues due to eligibility income criteria (exclusion of lower middle income group – "Missing middle"), exclusion of certain emergency treatments, not taking into consideration of associated opportunity cost and other hidden costs (like transportation cost, loss of wages for caregivers), skewed geographical distribution of empanelled hospitals etc.,

The Statute and its externalities

In this regard, the Right to Healthcare Act, 2022 enacted by Rajasthan makes access to healthcare an entitlement of the inhabitants of Rajasthan. This act has a huge potential to empower people in terms of access to free emergency healthcare services. However, this act

also encumbers private healthcare facilities under the aegis of entrusting state's responsibility to private hospitals and

doctors. The perusal of Section 2 (m) and 2 (l) and 3(d) which define terms "healthcare establishment", "health care" and "rights of residents" respectively would shed light on some of the most contentious issues contained in this statute. Despite appearing to be exhaustive, these clauses have raised questions over economic feasibility and envisaged quality of services considering the magnitude of healthcare workforce shortage in the state. These may also increase the prospective risk of pervasive litigation against private healthcare providers and widen the trust deficit. Owing to their vagueness, these clauses had resulted in huge doctor's protests leading to near total disruption of private healthcare services in the state.

In India, the majority of the healthcare provisioning capacity has been with the private sector which is evident from the fact that the private sector contributes to 70 % of outpatient services and 58 % of inpatient services according to WHO – IHSR 2022. Any policy intervention that affects the private health sector will have huge ramifications on the overall health status of the population at large. Attempts by any state to bring in a statute like RTH needs thorough deliberation owing to its repercussion potential. With respect to RTH statute, majority of the focus was given on the short-term issues like reimbursement, acquisition over evasion of state's responsibility in provision of healthcare, financial constraints – budgetary allocation, lack of stakeholder consultation in legislation etc., However, there are many less deliberated issues with long-term, far-reaching consequences which also needs adequate policy attention.

Human capital flight: Causes and consequences

The first one is the risk of human capital emigration popularly known as "brain drain" of healthcare professionals. This medical brain drain has significant repercussions in a state like Rajasthan where the healthcare workforce is overburdened due to manpower shortage . This statute may perhaps unintentionally incentivise the doctors to move to other states where there is no RTH statute or even to other countries for pursuing an economically profitable medical career. A research published in Journal of Preventive Medicine and Holistic health has stated that the doctor to population ratio in Rajasthan is 0.32 doctors for 1000 population whereas 0.7 doctors per 1000 population for India against the WHO recommendation of 1 doctor for 1000 population (Pankaj 2021). Implementational issues in RTH may further skew

this ratio and aggravate healthcare professional shortage. Moreover this would disincentivize the development of private healthcare infrastructure in the long run. This human capital flight would also aggravate the interstate healthcare disparities in terms of availability, accessibility and affordability making equitability in Right to Health a distant dream for all.

When Specialisation may not be good

The second one is with respect to hospital specializations. Some specialized hospitals like Oto Rhino Laryngology (ENT) hospitals, Ophthalmology (Eye) Hospitals may not be equipped with relevant professionals or sophisticated medical devices and diagnostics to attend medical or surgical emergencies. This dilemma has not been addressed in the statute. Even if this apprehension is addressed through provision of exemptions for specialized hospitals from mandatory emergency services. There is also a probability that existing general hospitals may rebrand themselves as specialized hospitals like ENT hospitals, Eye hospitals to evade their responsibility of providing free emergency medical services. This may result in a specialization spree just for the sake of exemption and this could paralyze the intended purpose of the statute

Trust as an indispensable factor

The third one is with respect to the trust factor. The success of any medical intervention and smoothness in delivery of health service depend on the degree of trust and hope the patient entrusts on the treatment and healthcare provider. This has been reaffirmed and reiterated by various researches published in BMJ, NEJM, Harvard Business Review. Moreover, this trust also encourages the healthcare professionals to work at their optimal capability without being burnt out. However the negative public perception about protesting private doctors without knowing their rationale would widen the trust deficit between doctors and patients. Since this statute provides for free emergency care at hospitals, any delay in initiation of treatment even due to genuine reasons like lack of specialized medical equipment may lower the threshold of patient's attenders and family members towards emotional outburst and violence. This would eventually raise the severity and frequency of incidence of violence against doctors, doctor's burnt out and doctors protest paralyzing the private healthcare delivery system.

Business Process Innovations: The way forward

Since the role of the private healthcare delivery system is inevitable in the present

context, revamping private healthcare services through Business Process Innovation is a potential and viable policy solution. Business process innovation refers to the heterogeneous set of strategies that augments the efficiency of the process and the effectiveness of its outcomes, which are beneficial to both those who carry out the process and those who benefit from it. One such BPI could be allocation of a certain percentage (say for example 20 %) of the hospital beds in private hospitals for underprivileged patients through Cross Subsidization strategies. This benefits the underprivileged patients in terms of affordable , quality healthcare as well as the hospitals for their reputation, CSR requirements and tax exemptions for philanthropic services and more importantly the economic viability of private healthcare delivery. In addition to this, tech enabled BPI like mobile app based repositories of information about certain proportions of bed vacancies dedicated for free emergency services in private hospitals can also be worthwhile in this regard. The real time data regarding the availability and allocation of beds could be displayed in an app (similar to some of the apps that helps in finding availability of beds during Covid 19 pandemic), so that transparency, accountability can be ensured. Healthcare Policy initiatives like “Healthcare at your Doorsteps" model of Tamil Nadu (Makkalai Theedi Marutuvam), Promoting Cooperatives in the development of Hub and Spoke Model of Mini clinics in rural areas, etc., also have huge potential to reinvigorate this statute in addressing the issues of OOPHE and making Right to Health for all an achievable outcome.

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