Episode 5: The Health and Healthcare Landscape of Rajasthan

TRANSCRIPTION

Speakers:

Chhaya Pachauli - Public Health Expert (Director, Prayas, Centre for Health Equity)
Vivek Divan - Coordinator, Centre for Health Equity, Law and Policy

Vivek Divan:

This is Status of States where we explore health and healthcare across India's diverse regions with a particular focus on policy, programs and ground realities. The Indian Constitution lists public health as the responsibility of states. Join us as we speak with health experts from different states, understanding the unique contexts, challenges and innovations shaping public health. I'm Vivek Diwan, your host for this episode of Status of States, brought to you by the Center for Health Equity Law and Policy at the Indian Law Society in Pune. Let's dive right in.

In this episode, we explore the state of Rajasthan. We are pleased to have Chhaya Pachauli, a public health expert who has been working in the state for nearly two decades, speaking with us today. Chhaya is the director at Prayas, an organization working extensively on public health. She has worked with rural and tribal communities on critical issues related to health, nutrition and access to essential medicines. Her expertise spans healthcare planning, monitoring and policy reform.

Chhaya has been a prominent voice against the privatization of public healthcare facilities in Rajasthan. She played a pivotal role in the Right to Free Medicines campaign, a successful advocacy effort that led to the launch of the Free Medicines Scheme in Rajasthan. She also co-led the campaign for the landmark Right to Health Act, a first-of-its-kind law in the country applicable to residents of Rajasthan. Chhaya wears multiple hats in national and international health networks.

She is the Rajasthan State Coordinator and National Co-Convener of the Jan Swasthya Abhiyan, which is the Indian chapter of the Global People's Health Movement that advocates for equitable health systems. She is also a member of the Centre for Cultures of Reproduction, Technologies and Health at the University of Sussex in the UK.

So Chhaya, let me begin by asking, how would you describe the state of health in Rajasthan? And in this context, of course, please do tell us about social determinants of health, healthcare systems, any disease-specific responses you might have on particular challenges in Rajasthan.

Chhaya Pachauli:

Thanks Vivek, for having me for this discussion. To answer your question, I think the landscape of health in Rajasthan over the years has been a mixed bag of some very good progress made, but at the same time, some very specific and major challenges that have prevailed over the years. I have been working in the area of health in Rajasthan since more than 18 years now, and I can see there has been a significant transition, not just in the way the health schemes, programs, and approaches of the government have transformed, but also in terms of several health indicators. However, it's a bit disappointing that the pace of growth, the pace of improvement in health indicators in the state haven't really been very great. But having said that, I guess it's also very important to acknowledge the fact that Rajasthan is not a very easy state to work in. It's the largest state in the country in terms of geography and also has a very huge population and a very diverse population. Also very diverse in terms of its topography, its geography.

If you go to the west and the northern districts of Rajasthan, you would find that these are desert areas, arid, very dry. And if you go towards the southern part of Rajasthan, you would see lush green forests and tribal dominant districts out there. And hence, also the epidemiology of these areas differs quite a lot from each other. And they are very crucial and very major geographic challenges as well when it comes to accessing healthcare.

I would also say that the progress that has been made over the years in Rajasthan in the area of health has largely been focused on the treatment part, on the healthcare part, and not so much around the prevention part of health. And that's a very crucial area. And when we talk in terms of maternal child health indicators,etc, malnutrition, anaemia, and these issues. These are largely related to prevention rather than treatment. And I guess that has also been one of the reasons why we haven't really been able to fare very well when it comes to improving our health indicator. Just for example, while we have made far more progress in improving IMR (Infant Mortality Rate) which was somewhere around 68 in the year 2005, it has now come to around 30. Yet, it took us almost two decades to come this far.

The Maternal Mortality Ratio (MMR) in Rajasthan is still below the national average, and that's an area of concern. If we talk about the first trimester registration of pregnant women, we are also not doing very well. Almost 30% of the pregnant women do not get registered in Anganwadi centres in the first trimester. 40% of the pregnant women in Rajasthan do not yet get the 4 antenatal care that they should be getting during the course of their pregnancy. A large number of children, about 14.5% of them, are still born underweight. They have their weights below the mandated 2.5 kilograms that is an ideal weight at birth.

So these areas where we lag behind are still a major area of concern. And if you look at the NFHS (National Family Health Survey) data with regard to anaemia, those are even more concerning. And we have seen that if you compare NFHS 4 and NFHS 5 data of Rajasthan, the anaemia has increased. In fact, the anaemia has increased among children under five years of age, it has increased among women as well, and that's something that needs far more focus. At the same time, the government's health spending has also increased. That's something that needs to be acknowledged. Rajasthan would be among the states who spend the highest now around health, somewhere around 8.2% of its overall state budget. However, when it comes to the spending in terms of the state's GDP, it's still much lower, somewhere around 1.3 or 1.4%. But still, the health budget has been growing, but the quantum of growth is not as much as we would have wanted to see. At the same time, as is in other states, we also have very serious gaps in terms of the availability of human resource and trained staff at healthcare facilities and especially at the primary and secondary level of care. At the level of tertiary care, we still have a good amount of stuff, but primary and secondary healthcare facilities, they suffer huge human resource gap. And that's one of the major, major reasons that a lot of patient load get transferred to tertiary healthcare facilities and most of our primary healthcare facilities and some of our secondary healthcare facilities, largely remain underutilized. And this is something that needs to be paid far more attention to by the government.
A range of health schemes, I would say, the Rajasthan government has been able to bring about some very innovative and some very applaudable health schemes, especially over the past two decades, including the free-medicine scheme, which began in the year 2011, a

free-diagnostic scheme, which came about in the year 2013, and then the Chiranjeevi health insurance scheme, which I guess is a bit different from the health insurance schemes in other states, as it has a universal touch to it in comparison to other public-funded health insurance schemes, which are largely targeted on certain population or certain communities which fall under criteria of economic survey or which fit into the criteria of belonging to NFSA (National Food Security Act) category. In Rajasthan, the health insurance scheme is now open to all, and anyone who does not belong to those criteria, they too can enrol to the scheme by paying half the premium amount, which is just about 850 rupees. However, I'm not a very big proponent of health insurance scheme, but the Rajasthan scheme, I think by giving it a universal dimension, I think it is something admirable which the government has done. And I'm sure many other states might also like to replicate it. It has also eliminated all kinds of user charges from public health facilities, which is again something very unique to Rajasthan. I don't think there are many states who have done this as yet. So if you go to other states, you will have to pay OPD (Out-patient Department) or IPD (In-Patient Department) charges. In Rajasthan, you don't have to do so if you are a resident of Rajasthan. But if you are an outsider from some other state, you'll have to pay for the charges and that's a loophole.

So I guess it's a very mixed bag Vivek. We have some very good, very innovative things that the Rajasthan government has come up with. Those are some admirable steps towards universal healthcare. But at the same time, because we haven't really prioritized preventive healthcare services and haven't really focused on localized planning of healthcare, I think many of the health indicators, we still remain to achieve the targets that we are supposed to.

Vivek Divan:

Thanks Chhaya, that was a lot of ground you covered. On one hand there have been positive moves, on the other hand serious challenges do remain. In the course of our discussion we can try and get into some of these in more detail.

The first question which arises to me is related to some of the indicators you mentioned. You said 40 % of pregnant women don't get the complete care of ANC (Antenatal Care), 45 % of children are born underweight. Despite positive moves like health schemes, access to free medicines and elimination of user charges. So where is the gap then? Is it a question of priority? Is it a question of capacity? Or is it to do with commercial interests?

You mentioned the increase in health expenditure. So one would think that it is going to places where the need is felt the most, such as maternal and child health in this case. Am I mistaken in that? Or is the allocation going in other directions?

Chhaya Pachauli:

I think one of the major, major reasons is because of the way the entire public health system functions and the way the policies are framed or the planning part is very centralized. So everything is planned and decided at the level of the state or at the level of the district. There's no participation of officials below the level of the district, say for example, at the level of the block or at the panchayats or even at the level of the health facilities in planning interventions that is required at the local level. And like I said, most of these areas, say for

example, the ANCs or the malnutrition or anaemia and things like that, these are largely related to outreach services and are also related largely to social determinants, components of health. In order to bring about any improvements in these areas, we need to have very local kind of approach for dealing with these issues because the situation is very different in different regions. Situations differ in different districts, and even within districts, there could be different scenarios in different villages, and even within the villages, there could be variance in mohollas or even among different communities. And to deal with this, there's a need to have a very local community-based planning and implementation of things, which hasn't really been happening. And so there has been absolutely top-down approach and things are decided and planned at the state or at the district level. When it comes to delivery or implementation of these policies and plans they mostly fall flat on the ground. And I think this is something that we had been advocating since a long time to have wider participation of community, and the local health workers and the local officers in planning and implementation of programs and to have, locally innovative experiments to be done. Sometimes those experiments can go wrong, but many a times they can go right and can yield very impactful results as well. But we don't see that happening. I find that one of the major reasons why when it comes to health indicators or prevention of diseases, we don't really succeed as much as we should.

The entire focus is largely on treatment, how the health facilities should function, what services should be provided at the level of the health facilities, but not much at how the outreach services, how they can be made more impactful and how do we involve communities more in planning of locally prioritized health interventions. So I see that as a major reason for why we aren't really able to achieve these initiatives. And also, like you said, how we're spending the money. And we see, not just in Rajasthan, but across the country, a lot of money, a lot of health budget is now going into health insurance schemes or into building infrastructure, which is, again, important. But we do not see as much as prioritization of programs or interventions.

Just to give you an example, the entire concept of Village Health Sanitation and Nutrition Committees (VHSNC), which is such an important component of National Health Mission and has been there right since the inception of National Health Mission, this entire concept, this entire approach has been highly neglected. You wouldn't find them active or functioning anywhere in the villages except for in the areas where certain civil society organizations might be working in order to activate them. Even during the time of the COVID, the need for local people's participation in terms of participation of the community, the PRI (Panchayati Raj Institutions) members, it was extremely, extremely felt. And we had realized how not capacitating local people, the PRI members, or the local health workers around planning of health-based interventions actually made the entire COVID control program not succeed the way it should have succeeded.

Vivek Divan:

So I'm interested in this last point you mentioned. Could you give us some examples on how the success was not what it could have been? Had local participation been the method through which health was being engaged within the context of COVID? Could you describe a little bit more if those structures were in place, how COVID could have been handled better?

Chhaya Pachauli:

Yeah, so for example, there could have been local isolation centres which could have been developed. The community could have participated in them. PRI members could have played a crucial role in establishing those isolation centres, which could have prevented the overloading of healthcare facilities, and this was also done in some of the places, very rarely. That was something that was very easily doable, had the PRI members or the community members been capacitated around planning for healthcare services or planning around disease outbreaks or pandemics like this. And they could have played a crucial role, but that didn't happen.

Also when it came to say vaccination around COVID, we did see huge, huge reluctance in the communities, especially in the tribal areas. And it took health workers a very difficult time to convince people to get vaccinated. And during such times, the role of the community members, the local PRI members, or the VHSNC members could have been crucial in convincing people around the significance of the COVID vaccination. We have seen how in certain areas, the health workers, where they just kept waiting in the villages for hours and hours at the health facility for people to come and get vaccinated and they didn't. In some of the villages they were thrown stones at. They were rushed away from the villages because the fear was immense. And the health workers at that time were looked at as some kind of villains who were coming to the villages to harm the community rather than doing any good to them. So there was that trust deficit as well.

I think during such situations, such instances, the role of community members who are well aware about health, who have a scientific understanding about health and have some kind of capacity around how to deal with such situations related to disease outbreak. They could have really, really helped us and could have reduced the load of the grassroots health workers a lot.

Vivek Divan:

So this is very interesting, and I think you gave some very clear illustrations about how community participation in any kind of effort would always benefit when a crisis comes along. In that context, as someone who looks at the connections between law and health, I feel it would be a good time to ask you, especially when you've mentioned local participation and participatory approaches to solutions.

Rajasthan is of course a state where there has been some very powerful civil society efforts. Right to Information Act, NREGA (National Rural Employment Guarantee Act), a lot of very fascinating and vital work has come out of Rajasthan. And I think one of the aspects of the rural employment guarantee scheme is it asks for local participation within the legal framework. And in that context, I'm curious, what do you see the role of law possibly being in a context where things could be better, but they're not reaching their full potential for these various reasons. And local participation itself being one of the ways in which a law could mandate for planning to take place, for programming to happen, etc.

One of the things that NREGA does interestingly is the idea around social audits. And while that might not be perfectly implemented, at least the law contemplates such an idea. I don't

want to talk about the Right to Healthcare Act yet because that's a separate issue to get into. So I'm wondering, do you see the role of law in that manner forcing the hand of government or of different stakeholders to deliver better at the more localized level?

Chhaya Pachauli:

Certainly to a great extent. It always helps and makes it more powerful for people like us to advocate for something when it comes under a legal framework. It's not that the current health policies do not talk about community participation. And like I had just said, the Village Health Sanitation and Nutrition Committee has been a very important component of the National Health Mission since a long time now.

The thing is, it hasn't been prioritized and there hasn't been very wide or a very robust push, even from the side of the civil society, to implement that. We haven't also really been pushing for it enough. Probably now we haven't really been pushing for it as much as we should be. And I think the same would go with an Act as well. We all know that even if something is a part of the Act, it is not necessary that it automatically gets implemented. There have to be pressures on the government and there have to be groups who keep pushing the government to walk the talk to implement what's mentioned in the Act.

I think the same would go with it. In Rajasthan's right to healthcare Act , there are mentions of social audit, there are mentions of community participation, not in very detail, but it's there. But it does not mean that if the Act comes into implementation, things would automatically get implemented in the way they should be or in the right spirit. There would still have to be pressure building groups who look over it or see that the things happen the way they should be, whether they are being implemented the correct way, whether the models being implemented or the approaches in which those things are being done, they're inclusive or not, whether they involve the participation of the people from the most deprived or the impoverished communities or not. So those things will still have to be seen and monitored. And if that happens in an effective manner, I guess things would get implemented.

But I guess we need to come out of this very mindset that if something becomes a law in itself, get implemented. That hasn't been an experience, unfortunately, for us, with regard to any of the laws or Acts you still need to push for them. But I guess then your arguments and your logics and the advocacy efforts, it becomes a bit easier because you have an Act or the rules of the Act to refer to and put pressure on the government.

Vivek Divan:

Thanks Chhaya, I think for reminding us in very clear terms about the fact that you may have a law, but the law will be meaningless unless there's all these other aspects which support its implementation, including the vital participation of civil society and as pressure groups to ensure that things get implemented. In previous episodes, we've had conversations with experts who have said that sometimes the law can be a hindrance because the very fact that it exists is then looked on as the end all and be all of the problem without any effort being really put into implementation. So it's a multi-pronged approach which is required to implement it effectively.

It's a good time to talk a little bit about the Right to Healthcare Act that Rajasthan was the first state to legislate on. Could you describe some of the key aspects of the Act, possibly the one or two key components of it? Also, the sense is that the law remains largely unimplemented. Could you tell us a little bit about that too, about where is it at in terms of implementation?

Chhaya Pachauli:

The Act has some 2-3 very important components, which I would very briefly like to touch on. So the one section of the Act largely talks about a patient's rights and what they would be getting, which includes access to completely free public health facilities. And then it lists out all the patients' rights, including all those rights mentioned in the National Human Rights Commission's patients' charter. All those things have now been given a legal framework. There's a section which talks about what would be the obligations of the state. There's a mention that the state would increase its health budget, allocate adequate health budget, bring about HR policy, a transfer policy, which does not exist in the state of Rajasthan yet. And apart from that, some other important points, it also talks about protecting doctors, the health staff, healthcare providers, their rights, their duties.

Two important things. One, the entire Act also talks about constituting health rights authorities at the level of the state and the district. And these are important in terms of ensuring that there's adequate planning and localized planning. It also talks about creating an entire system of grievance redressal if there's any violation of people's health rights or denial of any of the rights which are mentioned in the Act. And this, guess, is for the first time that any of the Acts, not even the Assam's Public Health Act has a mention of a grievance redressal system. That's very crucial. It also has a component of penalties put on the healthcare providers if they are found at fault. And these states and district health authorities, they, apart from playing the role of planning healthcare services or advising the government, and at the same time monitoring the implementation of healthcare services. They are also supposed to play a crucial role in ensuring that the grievances which are received from the patients in relation to denial of healthcare or violation of their health rights, they are also supposed to deal with those grievances and resolve those. So these are some of the important components, but having said that, the Act also has its own loopholes. For example, these authorities, they do not have any membership or any participation from public health experts or civil society members. So it then becomes questionable, how effectively these authorities would function when it comes to resolving grievances of the patients, etc.

The grievance redressal system, although there's a good amount of mention of it in the Act, there's a need to have further elaboration and more clarity on how the entire grievance redressal system would function. Like you said, the rules of the Act haven't been framed yet and until the rules of the Act would be framed, we wouldn't really have much of a clarity on how the entire Act is going to get implemented.

Also that particular section of the Act which talks about patients being able to receive emergency treatment free from the private healthcare facilities and that's a very important

section and that has also been a section which led to resistance or agitation by the private healthcare providers around the Act, so they had their own reservations with regard to that section.

Vivek Divan:

So you mentioned that the large objection seemed to be on emergency treatment available for all in every healthcare facility, including a private facility, and that there was resistance to that in the law. And I believe the original draft was watered down due to some of this resistance. Could you tell us a little bit about that?

And also, if you could speak to us a little about when are the rules expected or any idea about what the status is on that front?

Chhaya Pachauli:

So yeah, you're right. As a result of the agitation by the doctors, a lot of things in the initial draft of the bill were diluted or modified to meet their demands. One of those was section which talked about emergency treatment. And there was a clause added which said that in case the patient wouldn't be able to pay for the emergency treatment at a private healthcare facility, the government would reimburse it to the head facility so that they don't suffer losses. So that was something which was added to that particular section after agitation by the doctors.

The other modification and a very disappointing one was the removal of public health experts, and the PRI members from the authorities, the district authorities, as well as the state. So the agitating doctors were very reluctant about having people without a medical background in the authority, and they pushed for their representatives to be added into the authorities instead. So after their demand, the representation of IMA doctors was included in the membership of these authorities. These changes were particularly made to calm down the doctors.

Also Vivek, I'm not very sure if this emergency treatment clause was actually the only reason for the doctors agitating because I do not really see that there should be a reason for that huge agitation with regard to that particular section because the government was ready to compromise and had made changes into that particular section. But despite that, the agitating doctors continued to demand that the entire Act be withdrawn. Their slogan in itself was, ‘No to Right to Health Act’. They never in their agitation said that remove this section. They were always like withdraw the Act. And I think, apart from the private doctors, I'm not very sure whether the government doctors were also truly in support of the Act because they never really came out openly in some way,in a tacit manner, they fact supported the agitations. Some of the residents talked in SMS Medical College and elsewhere. They also expressed their support to the agitating doctors by tying black ribbons in their arms and those kinds of things.So yeah, so there was a huge resistance to the Act. I guess it was largely because they did not want any kind of regulation on the part of the government, whether it came to the private sector or government sector. So I think the entire Act made

them very uncomfortable and it was not really just about one section as the narrative was being built.

With regard to when the rules would be framed, we have no idea really. It's very disappointing that even the government, the previous government which brought out the Act, they had enough time to draft the rules and they could have come up with the rules before the elections if they wanted to, but they didn't. Now the government has changed. It's a new political party which has taken over. And there's a general sentence given the rule changes in the state, the programs or schemes or Acts which have been brought about by the previous governments and usually neglected or undermined. Their names change or they are given a different touch.

So right now this current government does not really seem to be prioritizing the Act or they do not really have this Act on their minds it seems. And it's going to be on us, civil society and the people at large to push for the rules to be framed. And I guess an equal amount of effort which we had put in order to get the bill passed, that much of effort will now have to go into putting pressure on the government to come up with the rules for the Act. Because until that happens, this entire Act would only remain on papers and would never be implemented. And we have seen many of the Acts have the same fate.

In India, we have very clear example of Public Health Act of Assam which was a very well drafted Act and very powerful Act and the rules of the Act never got framed. The Act never got implemented. We have the example of Clinical Establishment Act. It's a different Act, it was a central Act. So not talking about it much, but you we do not want the Rajasthan Right to Health Act to meet the same fate and we are quite determined to push for it, build about a people's movement, a civil society movement around it.

Vivek Divan:

We look with hope from outside at Rajasthan and at the civil society there to really try and push through and follow through on the reform that has taken place albeit in a limited manner and in disappointing ways as you articulated through the Right to Healthcare Act.

I quickly want to touch on, you mentioned how succeeding governments don't often continue policies of previous ones. And in that context, if I'm not mistaken, the free medicine scheme that was brought in by a previous government was also something which succeeding governments were reluctant to implement. Can you tell us a little bit about that scheme in a brief manner and whether it is continuing to be implemented in an effective way?

Chhaya Pachauli:

Yeah. So the free medicines scheme was brought about in the year 2011. And when this scheme was started, it was highly talked about because it was one of its kind. After Tamil Nadu, was the only state which had thought of providing free medicines to the patients through public healthcare system. It started with a very limited number of medicines. I guess it was somewhere around 250 essential drugs at that time, but then gradually the numbers were increased. And you're right, when government changed in this state, there was quite a bit of neglect of that particular scheme. It wasn't part of the regular deliberations of the

ministers or the health departments. And then there was this Bhamasha Swasthya Bima Yojna, which was launched by the then government, which became their flagship scheme. And their whole focus was on promoting it at that point of time. The thing with the free-medicine scheme was that it was by then, was so popular and was so talked about, not just at the national level, but also in international forums. WHO talked about it and it was highly applauded. It wasn't possible for any government to shut that particular scheme. So the scheme continued, it was continued and the budget for the scheme also didn't see a decline because there was also, of course, a lot of demand by the people for that particular scheme and the government couldn't have harmed itself by compromising the scheme in terms of reducing its scale or reducing the budget for the scheme. So nothing of that sort really happened, but there was undermining of the scheme for sure. But then again, the old party again came into power, they tried to revamp it. And now in Rajasthan, scale of free medicines being provided from public healthcare facilities and the diagnostics, free-diagnostic being provided from public healthcare facilities have grown immensely. So starting from some 250 drugs, now the free medicines scheme in Rajasthan has some 1200 or 1300 drugs. So now the mandate of the government is to ensure that all public healthcare services, including drugs, diagnostics, everything is provided free to the residents of Rajasthan. So in fact, these schemes have further been scaled up.

The only thing being, initially these schemes were universal in nature. So there was no criteria of one being from the state of Rajasthan to be able to get free medicines or free diagnostics. What is disappointing is that these universal schemes have now criterias being brought about that you have to prove that you are a resident of Rajasthan in order to get access to free medicines or free diagnostics. And that's something that we are very concerned about because it excludes a large population of the state, including migrant workers or refugees, homeless or the nomadic tribes who do not really have any residential proof and they are the most vulnerable who really, really need free healthcare services. So they are not able to get it. So one of our demands with the government is also to ensure that public healthcare services remain open for all and be moved towards more and more universal scheme rather than making them targeted interventions or limiting them to only the residents of Rajasthan.

Vivek Divan:

Very interesting, Chhaya. I think again, something that other states should really consider even with the deficiencies that you pointed out towards the end, something which can aid a lot of people.

I want to cover a little bit more ground. So let me jump straight to a couple more areas. We've talked a little bit about privatization in the context of the Right to Healthcare Act, but there is another aspect of this in terms of accessibility to healthcare in relation to the public-private partnership (PPP), which is something that Rajasthan has espoused in the context of primary healthcare also, where private entities now are involved or at least it was considered that private entities should be involved in the delivery of healthcare at the PHC level. Could you tell us a little bit about how that has worked and panned out and what has it meant for accessibility of the basic health services at a PHC (Primary Health Center) level for those in Rajasthan?

Chhaya Pachauli:

Sure. So it was around 2015-16 that the then government really wanted to get into PPP mode for implementation of healthcare services through PHCs. And their argument was that the PHCs in the remote areas, the rural areas, the government isn't really able to find doctors to serve there, and it's becoming very challenging for the government to find qualified staff or to provide services through those PHCs. And hence, they would now partner with private bodies, private agencies to ensure that these PHCs function properly. Now, that was a very lame argument. And we had no clue if the government wasn't able to find doctors for these PHCs, how these private agencies are going to find the doctors. And most of these private bodies, these private agencies who came forward to run these PHCs, they were all very new names. We had never heard of them and they were not familiar with the rural areas at all. And they were all there to run these PHCs, which are very strange.

Interestingly, the government wanted to hand over a far larger number of PHCs to private agencies, than they were actually able to. It gradually happened that there were not really too many takers among the private bodies to take up these PHCs to run on PPP mode. And I guess the sheer reason for this was because they didn't see much of a profit in running these PHCs. So while the government had called for tenders for far more number of PHCs, around 250 or something. It was able to find takers only for somewhere around 100 of these rural PHCs. And then subsequently they also came out with a tender for running urban PHCs in PPP. Subsequently, these PHCs were handed over, but studies and assessments of these PHCs showed and very clearly there were evidence of it, that these PHCs were not doing any better than any of the bad performing PHCs which were directly being run by the government. So many of these PHCs were found to have under-qualified staff. The doctor's availability wasn't regular. There were also complaints by the staff of these PHCs that they were underpaid. And even the local community around those PHCs, they were not really satisfied and happy with the kind of services they were getting. There was a lack of monitoring at the hands of the government of these PHCs and things were happening in a very erratic manner, the functioning of the PHCs haven't really improved. There was no improvement or no change in terms of quality of care or the delivery of services or improvement in health indicators.

So we did put a lot of pressure on the government to withdraw these PHCs from PPP mode. We had even filed PILs for that. And then there were these reports and studies which further convinced even the government that the entire policy had not really brought about any result, as was expected. Subsequently, all these PHCs have now been withdrawn from PPP mode. So right now in Rajasthan, we don't have any healthcare facilities directly being run by private entities in PPP mode. But then there are some services in public healthcare facilities like the CT scans or the MRIs, which are delivered to the patients in partnership with private diagnostics or lab. But no absolute handing over of public health institutes as of now. But we never know, you know. If government has now changed in this state, then they might like to experiment with it again.

Vivek Divan:

That's an interesting experience because I think the PPP model is being suggested across the Ayushman Bharat program also. So I think much to be learned probably from

Rajasthan's experience. So when you mentioned that there are diagnostics provided in public hospitals by the private sector, would those diagnostic facilities be covered by that free medicine scheme?

Chhaya Pachauli:

They are all covered. The patients are not supposed to pay for those services, including diagnostics like MRIs, which are quite expensive. Government pays to the diagnostic labs on behalf of the patients. Patients get it completely free. But only if you are a resident of Rajasthan and if you have a Jan Aadhaar card to prove that, yes.

Vivek Divan:

And it does not require any proof of income or anything, anyone in any income bracket?

Chhaya Pachauli:

Yes, anyone who is a resident of Rajasthan.

Vivek Divan:

Okay, this is very very interesting and a lot of what you have described today, Chhaya, is unique, I think to Rajasthan in a way in which I think we must really deliberate on what we can learn from these experiences that states are experimenting with or have tried and where there are gaps, where there are successes and what can be improved on. Certainly, there are lessons to be learned elsewhere.

I do want to touch on a couple of other things. You mentioned it in the past, of course, the health insurance scheme. You mentioned the Chiranjeevi scheme. I know that there is a Mukhya Mantri Ayushman Arogya Yojana also and there has been a significant uptake in Rajasthan on health insurance. Has it come to the aid of people? Could you describe a little bit about that?

Chhaya Pachauli:

Yeah, so the health insurance scheme in Rajasthan Vivek, comes with all those flaws and gaps that any public funded health insurance scheme in India has. Since it's something which is implemented in partnership with private hospitals, a large part of services which are delivered within health insurance schemes are through private providers. So the scheme in a way transfers a lot of power into the hands of these private hospitals. We have come across several, several instances wherein the private hospitals have tried to make profits beyond the health insurance coverage and there have been instances where patients have been charged beyond the amount in the packages or voluntary to irrational treatment, unrequired surgeries, or denial of care at times. So these things have been very rampant in Rajasthan.

There have also been these administrative challenges in running the entire scheme. And there has been this pull and push all the time between the government and the private

hospitals with regard to reimbursement of claims and especially timely reimbursement of claims. And then there have been pressures by the private hospitals on the government to increase the premium or to increase the package rates and those kinds of things. So this push and pull and this tension has always existed.

And there had been times when the private hospitals have abruptly stopped providing patient services under the scheme on the grounds that their claims haven't been reimbursed. And until and unless the government reimburses those claims, they wouldn't be providing services to the patients. And the patients had to bear the brunt of it, usually. So these things have been there. But having said that, one of the positive aspects of Rajasthan's health insurance scheme, which earlier was Chiranjeevi Swasthya Bima Yoshana and now has been renamed to MAA (Mukhyamantri Ayushman Aarogya) Yojana. The positive thing is that universal nature, as I had also mentioned. So it's not limited to a particular population now. So anyone can enrol themselves into the scheme. It's only that people who don't meet the criteria of being in the NFSA category or the economic survey category. They just have to pay half the premium of 850 rupees and they too can get benefit of this health insurance scheme.

So, I think this huge dependence on health insurance schemes is something that we should be concerned about. The idea should be and the approach of the government should be that there should be minimal reliance on the private hospitals for any kind of service delivery. As much as possible people should be getting quality healthcare services from public healthcare facilities for free, rather than tying up with private hospitals and leaving the patients on their mercy. Especially in our country where private healthcare sector is hardly regulated, we do not have any systems of monitoring or regulation of private healthcare systems. So we don't really know what's happening with the patients who are going there. So until unless we have a system of regulation of some kind of monitoring, I think it's a very risky approach to delivering healthcare services through health insurance schemes. We would need very robust systems to be put into place if we really want health insurance schemes to succeed.

There has also been this observation that health insurance schemes in India haven't really helped bring down out-of-pocket expenditure much, because they are very selective in nature, very selective packages. They don't cover OPD. However, in Rajasthan, in this scheme now they are planning to add some daycare packages as well. But still, I think the larger focus should be on how do we divert as much as budget into strengthening the primary, secondary healthcare services within the public healthcare system.

Vivek Divan:

Thanks for bringing that issue of accountability up, Chhaya, I think repeatedly one years of this in the context of healthcare, generally speaking, and giving power to a sector to actually enter into the fray and actually provide services without any modality through which they are governed is a real problem. Like you even mentioned earlier, I think the Clinical Establishments Act, if at all, has been taken up reluctantly in only a few states. Similarly, you described the Right to Healthcare Act and its attempt in Rajasthan to legislate and that is also met with resistance. You raise a very, very important point around also the privatization

of insurance and what sort of governance and oversight there would be of a system which if it begins to fail people.

I want to end on a positive note and go back to the point you mentioned which is a really unique and successful story in Rajasthan, the abolition of user charges from public health facilities at all levels. I think it would be great to tell our listeners a little bit about what that system was and how its abolition has actually led to an increase in access.

Chhaya Pachauli:

Yeah, so like any other state, Rajasthan also had this system of OPD and IPD charges for patients. So any patient who would go to a public healthcare facility will have to get this parchi (slip) of 10 rupees or 20 rupees for OPD or a larger amount, say 30 rupees or 50 rupees for IPD. So this is something which has now been eliminated at all levels of public healthcare facilities in Rajasthan. And this happened in the year 2022. And I guess the idea was to move as far as possible towards the universal healthcare where the public healthcare facilities, public healthcare services are entirely free and nobody has to incur any out of pocket expenditure for facilities received from public healthcare institutions. So this was the whole idea and this has also been a long standing demand of civil society organizations, that public healthcare services ought to be absolutely free. There should be no user charges.

During the last government, they came up with this whole scheme called Mukhya Mantri Nishulk Nirogi Rajasthan Yojana, which ensures that no kind of user charges, no OPD, IPD charges and all the medicines and diagnostics would be provided free to anyone who accesses care from public healthcare facilities. I guess one of the reasons for how this happened was also Vivek, that it was just before the elections were approaching. So I guess the timing of it, the elections in Rajasthan were in 2023 and this came about in the year 2022. Probably that was something on the minds of the political leaders who were trying to at that time, devise schemes and programs or announce schemes and programs which would be considered pro-people and pro-welfare, fetch them political mileage during the election. So that could have been one of the reasons, but I'm not sure. But whatever it was, this whole policy was very much welcomed by us and by people as well. And this would certainly lead to more uptake of public healthcare facilities.

However, again, there's this caution that only announcing schemes and programs wouldn't help. If you want the healthcare services to be taken up by the people, they should be available at the public health facilities. If there's a scheme saying that everything is free but then there are no services, at the point of delivery, it doesn't really make sense. So until and unless we strengthen services at the primary level, at the PHC level, and at the CHC (Community Health Centre) level, people wouldn't really be able to take optimum benefit of this policy, which in itself is extremely applaudable, I guess, to eliminate all kinds of user charges from public healthcare system. And this is something I guess other states should also be doing. But the thing that it's limited only to the residents of Rajasthan is something that we don't see as a very good public health policy. We think that they shouldn't have put any such criteria. We hope that in the time to come, the government would withdraw that particular criteria which is there,that only the residents of Rajasthan can have free services and others will have to pay.

Vivek Divan:

Chhaya, you've given us a really broad and widespread picture of the various issues around healthcare and health in Rajasthan, the state of it. I think one of the things you repeatedly said is the concern around a lot of these benefits accruing only to residents who can prove and therefore leaving out so many so many people from marginalized contexts. I completely appreciate that.

As you also reminded us, user charge being removed is only useful to the extent that some of those levels at which healthcare is accessed are strengthened. Like the PHC level and the secondary level have not been given the attention that they are due and which has caused a pressure on the tertiary level hospitals. But I think there's also a lot of hope to take from the work that you have done with allies and others, and certainly credit should be given to governments which have actually brought the force, if not fully implemented, some of the welfare measures taken in the context of health. Thanks for such an eye-opening conversation and more strength to you in your work.

Chhaya Pachauli:

Thank you, Vivek. It was a pleasure.

Vivek Divan:

Thanks for joining us for this episode of Status of States. Stay tuned for more such conversations. This is your host, Vivek Diwan, signing off.