WWW.IJRPR.COM

International Journal of Research Publication and Reviews

Journal homepage: www.ijrpr.com ISSN 2582-7421

From Directive Principles to Legal Rights: The Evolution of Health Rights in Rajasthan

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ABSTRACT :

The right to health, recognized internationally as a core human right, has seen varied levels of realization across nations. In India, this right has historically been rooted in the non-justiciable Directive Principles of State Policy, with the judiciary gradually interpreting it as part of the fundamental right to life under Article 21. Despite such interpretations, healthcare access remains deeply unequal, especially in under-resourced states like Rajasthan. This paper traces the evolution of the right to health from a constitutional aspiration to a legally enforceable right in Rajasthan through the enactment of the Rajasthan Right to Health Act, 2022. It also analyzes the role of the Mukhyamantri Ayshman Arogya Yojna in operationalizing health entitlements and expanding financial protection.

Using a combination of doctrinal legal analysis, policy review, and secondary empirical data, the research evaluates the impact of these interventions on health access and equity. The study identifies both opportunities and bottlenecks in translating legal commitments into accessible healthcare services, particularly in the context of private sector resistance and administrative challenges. By situating Rajasthan's policy shift within broader national and global frameworks, the paper contributes to the discourse on rights-based health governance in India

Keywords: Human Rights, DPSP, Mukhyamantri Ayushman Arogya Yojna, Right to Health Bill 2023

INTRODUCTION

Access to healthcare is widely recognized as a fundamental human right essential for a life of dignity and well-being. Global frameworks such as the Universal Declaration of Human Rights (1948) and the International Covenant on Economic, Social and Cultural Rights (1966) have firmly established the right to health as a core component of human development. While several nations have progressively legislated this right, India's constitutional design locates health within the Directive Principles of State Policy (Articles 39(e), 41, and 47), rendering it aspirational rather than enforceable. Although the Indian judiciary has interpreted Article 21—the Right to Life—to encompass the right to health, the absence of an explicit, justifiable legal mandate has left much of healthcare policy fragmented and uneven in implementation across states.

Rajasthan presents a unique case in this context. Historically marked by low health indicators, high out-of-pocket expenditure, and rural-urban disparities, the state has taken a landmark step by enacting the Rajasthan Right to Health Act, 2022—the first legislation in India to provide a legally enforceable right to free and accessible healthcare. Complementing this legal framework is the Mukhyamantri Ayshman Arogya Yojana, a state-sponsored health insurance scheme that offers financial protection to families across income groups. Together, these initiatives signal a shift from policy intent to legal entitlement in the realm of public health.

This research aims to trace the evolution of the right to health in India with a focus on Rajasthan, analyze the legal and policy framework of the Right to Health Act, and evaluate the effectiveness of the Mukhyamantri Ayushman Arogtya Yojana in operationalizing this right. The study employs a doctrinal legal method to examine constitutional provisions, legislative texts, and judicial interpretations, while also adopting policy analysis and secondary empirical methods to assess health outcomes and scheme performance. Through this multidimensional approach, the research seeks to contribute to a deeper understanding of rights-based health governance in India and assess whether Rajasthan's legislative experiment represents a sustainable model for other states.

Constitutional Foundations and Policy Pathways: Tracing the Pre-Legislative Evolution of the Right to Health in Rajasthan

P.P. Rao (1994) emphasizes that the Directive Principles, though non-justiciable, are not merely moral guidelines but constitutional instructions that the state is duty-bound to implement progressively. He argues that Article 47, which directs the state to improve public health, must be read in conjunction with Article 21 to expand the scope of fundamental rights.

M.P. Jain (2008), in his seminal work Indian Constitutional Law, analyses how the judiciary has played a central role in inferring socio-economic rights from Article 21. He particularly highlights cases where courts directed the government to provide emergency treatment and public health services. Jain critiques the inconsistency in implementation but acknowledges that judicial innovation has made the right to health a de facto constitutional right.
B. Shiva Rao's The Framing of India's Constitution (1968) offers insight into the Constituent

Assembly's deliberations, showing that socio-economic rights were deliberately placed in Part IV due to concerns about state capacity. However, he notes that framers envisioned these principles as essential for achieving the goals of justice and equality. Rao's historical account is often cited to argue that the DPSPs were intended to be progressively transformed into justiciable rights.
Rajeev Dhavan (2009) offers a critical view, arguing that while the judiciary's role in expanding Article 21 is commendable, it can lead to "judicial populism" if not matched by legislative clarity and resource allocation. He warns against courts overstepping into policy domains, stressing that real constitutionalization of health must occur through parliamentary enactments and robust public health infrastructure.
A.S. Anand, former Chief Justice of India, in various public lectures and writings, maintained that the right to health is inseparable from the right to life and must be protected not just in emergencies but as an everyday entitlement. His contributions have influenced a wave of judicial pronouncements reinforcing the state's duty to provide basic health service.
Baru and Nundy (2008) discuss the evolution of state-level health initiatives in India, noting that Rajasthan's early efforts were heavily focused on maternal and child health through centrally sponsored schemes. They highlight how the state gradually experimented with public-private partnerships (PPPs) under the National Rural Health Mission (NRHM), setting the stage for later insurance-based models. Their analysis points to an increasing reliance on outsourcing and service contracts that shaped the state's institutional orientation before legislative intervention.
The NHSRC Evaluation Report (2018) on the Bhamashah Swasthya Bima Yojana (BSBY) provides detailed insights into the challenges Rajasthan faced in implementing a universal insurance model. It revealed issues such as poor awareness among beneficiaries, delays in claims processing, and private hospital resistance. The findings underscore the administrative groundwork and limitations that informed the push toward a more rights-based and accountable system like the Right to Health Act.
Jan Swasthya Abhiyan Rajasthan (2019, 2021) documented grassroots mobilizations and public hearings that influenced the framing of the Right to Health discourse. Their advocacy emphasized community experiences of denial of care and high out-of-pocket expenditure, especially in rural and tribal areas. These participatory assessments played a crucial role in shaping political momentum and formulating pre-legislative drafts that foregrounded equity, accessibility, and public provisioning.
Kumar (2022), in his paper "From Insurance to Entitlement: Health Policy Shifts in Rajasthan," traces the ideological shift from welfare provisioning through schemes to rights-

based guarantees. He argues that policy instruments like the Chiranjeevi Yojana were not merely administrative reforms but pre-legislative testing grounds that exposed the structural gaps in health access. His study suggests that these schemes built the empirical and political case for codifying health as a legal right.
Oxfam India's Health Equity Report (2020) highlights that despite multiple policy interventions, Rajasthan ranked among the lowest in terms of equitable access to healthcare prior to the Act. The report critiques the state's dependence on vertical programs and insurance models that neglected systemic investment in public infrastructure. These findings served as an indirect but powerful critique that encouraged the move toward a statutory right.
The People's Union for Civil Liberties (PUCL) Rajasthan chapter published working papers and policy briefs from 2015 to 2021 that document citizen grievances and legal gaps in healthcare provisioning. They emphasize how the absence of grievance redressal mechanisms and enforceable standards in pre-legislative frameworks created demand for statutory reforms.

The Rajasthan Right to Health Act, 2023 and Insurance-Based Implementation

The Rajasthan Right to Health Act, 2023 marks a transformative legal development, asserting that every resident of the state is entitled to free outpatient and inpatient care services at all public health institutions and selected private healthcare providers. The Act emerged in response to growing public demand for accountability in healthcare delivery, especially in rural and under-served areas. It mandates emergency care without prepayment, prohibits denial of treatment, and sets up grievance redressal mechanisms. However, it has been met with resistance from private hospitals, many of which protested the obligations imposed without corresponding guarantees of timely reimbursement (The Hindu, 2023).
On the policy side, the Mukhyamantri Ayushman Arogya Yojana, launched in 2021, laid the groundwork for this legal shift. Offering insurance coverage up to ₹25 lakh per family per year, the scheme expanded access to secondary and tertiary care. It replaced earlier schemes like Bhamashah Swasthya Bima Yojana and included a wider base of beneficiaries, including gig workers and small farmers. While the scheme showed promise in reducing out-of-pocket expenditures and broadening coverage (Government of Rajasthan, 2022), several implementation gaps remain.
Ground-level realities complicate the impact of these initiatives. Studies by Jan Swasthya Abhiyan (2023) reveal that many patients remain unaware of their entitlements under the Act or the insurance scheme. Bureaucratic hurdles in empanelment and claim processing further delay service access, undermining the potential of the right to health as a lived reality. Despite these challenges, the Act and insurance schemes have begun to institutionalize a rights-based approach to healthcare. There is greater public discourse around health entitlements, and digital tools under the MAA scheme (like e-cards and hospital dashboards) are improving transparency. However, the success of this legal-policy integration depends heavily on political will, adequate budgetary support, sustained community engagement and resolution of tensions between the state and private healthcare providers.
This section thus highlights the importance of implementation pathways in realizing constitutional ideals. Rajasthan's model provides a valuable case study in transitioning from policy to enforceable rights, though its success will ultimately rest on bridging the gap between legal text and health system practice. The Chiranjeevi Yojana, while broad in its scope, risks becoming another bureaucratic instrument if its integration with the legal framework is

not systematically reinforced. The dual mechanism—legal rights through the Act and financial coverage through insurance—creates potential for confusion among beneficiaries, particularly where access depends on hospital compliance and digital documentation. The scheme's promise of high-value insurance coverage is often diluted in practice due to limited empanelled hospital participation in remote areas.

This critical reflection reveals that while Rajasthan has taken a pioneering step, the sustainability and replicability of its model depend on dynamic institutional reform, budget prioritization, and continuous feedback from frontline stakeholders. The challenge is not only to legislate rights but to cultivate a healthcare ecosystem where these rights are systematically upheld and socially embedded.

Conclusion

The journey from Directive Principles to enforceable legal rights is a complex one, particularly in the context of public health. Rajasthan's experiment with the Right to Health Act, 2023 and the Mukhyamantri Ayushman Arogya Yojana exemplifies a bold attempt to bridge this gap. It brings healthcare into the domain of rights rather than charity or welfare, reasserting the constitutional promise of equity and dignity. However, the efficacy of such legislation depends on more than legal text—it requires administrative robustness, intersectoral collaboration, financial commitment, and widespread awareness.

The Act and accompanying insurance scheme reflect an innovative blend of rights-based and welfare-based approaches, but their success is contingent on how well implementation challenges are addressed. In sum, while Rajasthan has taken a laudable lead in institutionalizing the right to health, the real test lies in its ability to translate legal entitlement into accessible, acceptable, and quality healthcare for all its citizens.

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