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RESEARCH ARTICLE

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#RollBackRTH: Tactics, strategies and framing in the Right to Health Care Act 2022 debate in Rajasthan, India

Simran Pachar[a], Veena Sriram[a], Vikash Ranjan Keshri[b] and Arima Mishra[c]

[a]School of Public Policy and Global Affairs, University of British Columbia, Vancouver, BC, USA; [b]Jindal School of Public Health and Human Development, O. P. Jindal Global University, Sonipat, Haryana, India; [c]School of Development, Azim Premji University, Bengaluru, Karnataka, India

ABSTRACT

The role and influence of interest groups in the healthcare sector, such as the hospital industry, insurers or physicians, are critical aspects of understanding health politics. Yet, scholarship examining the interests and actions of these actors has been surprisingly limited in health politics scholarship on Global South contexts. In India, national- and sub-national health sector reform debates have gained traction. The country's vast, underregulated and powerful private healthcare sector plays a decisive role in shaping policy outcomes. This study explores the public-facing strategies, tactics and frames used by policy actors in the debate surrounding the Right to Health Care Act 2022 in the state of Rajasthan. We describe a policy conflict in which private healthcare sector coalitions representing diverse constituencies united rapidly to effectively execute their opposition strategy. The opposing coalition deployed multiple approaches concurrently, pairing indirect and direct strategies and tactics and using diverse framing choices to "win" the public narrative and secure a dominant role in the policy process, placing supporting policy actors in a defensive position. Our findings contribute to a growing body of scholarship on domestic health politics in Global South contexts that expands our understanding of interest groups into different institutional and ideational spaces.

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Introduction

The actions and politics of sub-national and national-level policy actors in healthcare, such as interest groups representing the hospital industry, insurers or physicians, are crucial to understanding the pathways of health sector reform. The role of these actors has gained particular salience in health policy analysis in recent years, due to contestations around the appropriate direction for universal health coverage (UHC) within countries. As with all health and social policy processes, debates regarding health sector reform at the national level are intensely political, resulting in clashes of interests, ideas and ideology within institutional frameworks, that shape the nature and distribution of service and financing coverage (Fox & Reich, 2015; Ho et al., 2022). For example, debates pertaining to pooled health financing mechanisms in public and private sectors, payment mechanisms, quality improvement, performance monitoring and health rights have accelerated, within countries and globally (Ho et al., 2022; Novignon et al., 2021; Sundararaman & Murugan, 2023).

In India, national- and sub-national discussions regarding equitable access to health services have gained urgency. Policy actors have geared up to advocate for their interests within those debates, including, but not limited to, the country's vast, largely unregulated and powerful private healthcare sector, civil society and political parties (Chakravarthi et al., 2023). Despite accounting for more than two-thirds of health service delivery in India (Selvaraj et al., 2022) the private healthcare sector in India remains enormously

CONTACT Veena Sriram veena.sriram@ubc.ca School of Public Policy and Global Affairs, University of British Columbia, Vancouver, BC, USA

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heterogenous and poorly regulated. Numerous attempts at national and state-level regulation have run into fierce opposition from interest groups representing the private hospital industry and medical professionals (Mishra et al., 2021; Nandraj, 2015; Peters & Muraleedharan, 2008; Putturaj et al., 2021).

In recent years, major debates have animated health sector reform processes in India. Civil society actors have sought to institutionalise the right to health nationally (Duggal, 2013), as well as the state level (Sundararaman & Murugan, 2023), where much of the authority for health service delivery is concentrated. Alongside these debates, the Government of India, has introduced and expanded one of the world's largest UHC programmes, Ayushman Bharat (Press Information Bureau, 2018). The nature of federalism in India has meant that these policy debates are occurring at multiple yet deeply interconnected levels, as evidenced in the western state of Rajasthan. The Right to Health Care Act was first tabled in the Rajasthan State Assembly in September 2022. The Act aimed to enhance the overall public healthcare system (Government of Rajasthan, 2022), including through the expansion of free treatment, medication, diagnostics and emergency transport, at public health facilities. Additionally, in emergencies, the Act sought to grant residents the right to receive prompt treatment in private healthcare establishments as well, without waiting for prepayment or police clearance.

This specific provision—mandating treatment at no cost in the case of emergencies—faced major resistance from key interest groups within the private healthcare sector in Rajasthan, particularly those representing private medical practitioners and the heterogeneous hospital industry. These include representatives of the Indian Medical Association (IMA) Rajasthan, Private Hospital and Nursing Home Society (PHNHS), and United Private Clinics and Hospitals of Rajasthan (UPCHAR). After a 17-day protest by tens of thousands of medical practitioners that garnered national and international headlines (Biswas, 2023), the State government reached an eight-point agreement, one of which excluded 98% of the private hospitals from the emergency provision (Khan, 2023). However, the strategies, tactics and frames used by these groups to advance their objectives appeared to go far beyond technical policy concerns and into a range of professional, ethical and political realms.

This study of public-facing strategies, tactics and frames used in this specific policy debate in Rajasthan, India offers valuable insight into the tension between private healthcare actors and policy reforms around universal health coverage through the right to health. As health service delivery and financing in healthcare sectors rapidly evolve in an effort to meet global targets, it is crucial to develop deeper insights into the motivations, perspectives, framing tools and strategies used by interest groups to influence policy outcomes (Koon et al., 2016; Shiffman & Shawar, 2022). The stakes of these debates are high, not only for understanding their impact on health rights and equitable access to care, but for understanding the process by which these decisions are taken and the voices that are privileged within those processes. From an Indian context, there is an urgent need to generate evidence and analyse the factors that impede or facilitate health sector reform, both for emerging legislation such as similar Right to Health legislation in other states and for existing legislation such as the Clinical Establishments Act, which has experienced continued roadblocks in implementation (Nandi et al., 2016). Understanding the role of domestic interest groups has gained further salience with growing corporatization within the Indian healthcare sector (Hooda, 2015; Hunter et al., 2025). This shift raises significant public policy concerns, including hidden influences on policymaking, subversion of public interest, and challenges to accountability (Fuse Brown 2025).

Currently, there is a dearth of literature on the influence of interest groups in healthcare governance in India, with some important exceptions (Baru, 2003; Chakravarthi et al., 2023; Hunter et al., 2022). This lacuna reflects a broader gap in scholarship on the politics of domestic healthcare reform in similar contexts. In particular, the specific strategies and tactics used in domestic policy debates by actors such as the hospital industry and physician associations demand greater focus (Ameso & Prince, 2022; Lacy-Nichols et al., 2023; Novignon et al., 2021), as does a deeper exploration into professional politics of physicians in LMICs (Brophy & Sriram, 2021; Koon et al., 2016; Yılmaz, 2017). Available scholarship from India has noted that doctors, through their associations, strategically draw on a particular mix of carefully cultivated relationships with the State and their large, fluid membership base that extends into associations that represent clinician-entrepreneurs representing hospital and clinic owners to advance their goals. In many cases, successfully (Mishra et al., 2021; Putturaj et al., 2021; Wood, 2013). As Wood notes in a study of occupational groups in Varanasi, Uttar Pradesh, doctors receive "extraordinarily privileged access to the state" that facilitate more

responsiveness to their concerns than other occupational groups; however, protests and strikes were still used as a form of agitation "to force responsiveness and accountability" (Wood, 2013).

We thus conducted the study to generate knowledge around the following questions: What public facing strategies and tactics were used by key stakeholders in debates pertaining to RTH policy in Rajasthan? How did policy actors frame their arguments and positions? And, how did these approaches potentially shape policy outcomes in this case? We draw on concepts focused on strategies, tactics and framing as part of broader policy process frameworks in order to better understand the role and power of domestic policy actors, such as physician associations and the hospital industry, in shaping major health sector reform.

Theoretical background

The role and influence of policy actors are key dimensions of several policy process frameworks. Many frameworks approach policy actors in terms of institutional positioning, networks, relational power and available resources. The specific *actions* of these actors, i.e. their strategies, tactics and choices in framing, and their impact on policy outcomes are however often less explicitly articulated in theorisations of the policy process, with some exceptions. The actions of policy actors, such as interest groups, are particularly crucial to understanding the ways in which actors operationalise and direct their power and resources to shape episodes within policy processes in their favour. For example, Weible & Heikkila (2017) in their Policy Conflict Framework, elevate the actions of policy actors in policy conflicts by examining their cognitive and behavioural characteristics, such as policy positions, perceived threats, political strategies, and tactics within a conflict. Such an approach allows us to both "zoom in" and understand how interest groups shape the outcomes of policy debates that ultimately have major implications for outcomes, including in this instance, population health.

Understanding the types of interest groups involved in the policy process provides a foundation for examining their strategies, tactics and framing choices. Binderkrantz defines interest groups "as membership organisations working to obtain political influence" (Binderkrantz, 2008). Interest groups can be broadly categorised into three types—those with corporative resources drawing on their representation of specific groups in public or private sectors, public interest groups that focus on collective interest that will not provide material benefits to the membership, and other groups who have varying levels of corporative resources and public interest groups (Binderkrantz, 2008).

Strategies and tactics are those efforts taken by actors to influence outputs and outcomes directly or indirectly. Strategies refer to longer-term approaches aimed at achieving a particular outcome, while tactics refer to specific activities that operationalise those strategies. Two broad categories of actions have been identified in interest group theory—direct and indirect (A. Binderkrantz, 2008), building on other theories that examine strategies through the lens of insider or outsider approaches (Beyers & De Bruycker, 2018; Weiler & Brändli, 2015). Direct strategies include individual- or group-level interactions with decision-makers, such as meetings, telephone conversations or participation in expert committees (Beyers & De Bruycker, 2018). Indirect approaches often include activities aimed at mobilising constituencies or generating public attention, such as press conferences, social media campaigns or protests. The choice of strategies and tactics is strongly influenced by interest group type. In the European context, corporatist groups tend to use direct approaches, while public interest groups use indirect approaches. However, strategies and tactics are also influenced by institutional, political and social contexts. The nature of strategies and tactics has also evolved considerably with the advent of newer forms of digital communication, such as WhatsApp, Facebook and X/Twitter, among others (van der Graaf et al., 2016).

Framing is a form of operationalising strategies and tactics by shaping perception on policy choices, and has been the focus of more rigorous scholarship in health policy analysis in Global South contexts (Koon et al., 2016). One aspect of framing scholarship—contestation—examines the framing contests that are at the heart of policy debates between policy actors (Dodge & Metze, 2024). In this approach, explorations into framing are centred on "the power to use language to convince others to support or oppose a cause, to draw attention to some aspect of the issue over others, and to arouse fears or allay fears" (Yordy et al., 2019, *p*. 740). Framing processes also engage with broader social discourses in a bidirectional way; choices in framing are informed by context, but also shape the context. Framing contests are also increasing

occurring simultaneously through multi-modal actions; in the press, in direct communications (e.g. press conferences) and in digital spaces (e.g. social media), although the impact of multi-modal approaches is yet to be rigorously investigated.

As observed in all aspects of the policy process, power is also latent in the choice of strategies, tactics and framing. Interest groups with specific advantages, such as large membership bases, networks or financial resources, will accordingly select specific strategies and tactics that most effectively drive their agenda forward (Binderkrantz & Krøyer, 2012). Framing processes are similarly produced within power relations, in that "people located in powerful positions and institutions have greater resources to articulate frames and win framing debates" (Dodge & Metze, 2024).

Methods

We utilised qualitative data, specifically publicly available documents and other audio-visual materials. We primarily analysed public-facing policy documents, media appearances and social media activity from official accounts from organisations and/or leaders from January, 1 st 2022 to April 30th, 2023, after a memorandum of understanding was signed between parties to call off the protests. The weeks between February 2023 and April 2023 were a pivotal time for the RTH Act in Rajasthan, with heightened protests - both online and in public spaces, as well as public analysis and debate, and therefore, a considerable amount of data from this period is included in this study. The analysis also considers initial discussions around RTH legislation in 2018, and recent discussions following a change in government in November 2023.

Our team comprised of public health and public policy researchers based in Canada and India.

We drew upon sources in both English, Hindi and Rajasthani/Marwari. Drawing on the READ approach (Dalglish et al., 2020), the data was managed and catalogued using Google Sheets with date, author, type of document and analytical notes. The tweets also included links to YouTube videos and Instagram posts, which were summarised in the form of notes coded separately. The content from these different mediums was compiled in Microsoft Word documents with translations in English. Further, video sources were transcribed in English.

A total of 163 publicly available materials were used in this study (Appendix 1). We searched for and examined publicly available documents on the Right to Health Care Act 2022 in Rajasthan:

- Election manifestos of political parties in the state that include the Right to Health for constituents.
- Draft of Bill tabled in the Rajasthan State Assembly.
- Select Committee recommendations on the RTH Bill tabled in the Assembly, included in the RTH Act.
- Documents on consultations and recommendations by stakeholders on the issue.

To examine the stance of private healthcare providers, government representatives and stakeholder organisations on the issue, we examined the following:

- A review of media appearances, press conferences, and podcast appearances of key stakeholder representatives on both national and regional media channels.
- A review of opinion pieces and advertisements published by the government and other stakeholders in the regional print media.
- Review of social media campaigns around the RTH Act employed by key stakeholders on X (formerly Twitter), Instagram and YouTube from official social media handles. Organisations included the Indian Medical Association, United Private Clinics' & Hospitals' Association of Rajasthan, civil society organisations, other interest groups (See Appendix 2 and 3 for hashtags).

Ethics

We used publicly available information for this study, including publicly available information from public figures (i.e. official accounts) and therefore did not require clearance form an ethics review board (Panel on Research Ethics, 2023).

Analysis

We analysed data using NVivo V. 14. An inductive approach was used to understand the following three categories of data: 1) Framing; 2) Advocacy strategies and tactics; 3) Process. The first iteration of the codebook was developed by one analyst after a primary analysis of an initial list of documents. After discussions with the research team, a more concise codebook was developed and reapplied to the full set of materials using NVivo (see supplemental information). Following the coding process, a random sample of 20% of the material was blind coded by two other researchers in both Hindi and English, to check for any differences in the interpretation of the data and ensure consensus. We abstracted codes up to create aggregate categories that formed the basis for further analysis.

Results

Box 1. List of Stakeholders.

Government Actors

- **State Chief Minister**
- **State Health Minister**

Opposing Coalition:

- **Indian Medical Association:** the largest doctors' organisation in India with 350,000 members spread across 1700 branches (IMA)
- **United Private Clinics' & Hospitals' Association of Rajasthan:** an organisation for private clinical establishments in Rajasthan. UPCHAR allows for any hospital, maternity home, nursing home, dispensary, clinic, diagnostic centre, laboratory, or sanatorium to be a part of the organisation.
- **Private Hospitals and Nursing Homes Society:** an organisation to represents the rights of private healthcare establishments in the state. (PHNHS)

Key Civil Society Actors:

- **Prayas Chittor:** a voluntary organization working in social policy development in the Chittorgarh district of Rajasthan.
- **Jan Swasthya Abhiyan:** a national platform that coordinates activities on healthcare and forms the Indian regional circle of the global People's Health Movement (PHM).

Other Actors:

- **Civil society activists** including Anand Grover, Chhaya Pachauli, Dr Dhvani Mehta, Dr Himanshu Bhushan, Kavita Srivastava, Khushboo Sharma, Kim D'Souza, Dr Mohankumar S., Dr Narendra Gupta, Nikhil Dey, Nikita Puri, Pallavi Gupta, Dr Pavitra Mohan, Prem Kumar, Priyam Lizmary Cherian, Dr Rajendra Bhalavat, Rakshita Swamy, Dr Sharad Iyengar, Shreyashi Ray, Dr Tej Prakash Sinha, Dr Varinder Jain and others.
- **Civil Society Organizations and Think Tanks** like Lawyers Collective, Vidhi Centre for Legal Policy, National Health Systems Resource Centre (NHSRC), People's Union for Civil Liberties (PUCL), Institute of Development Studies (IDS) Jaipur, Vidhi Centre for Legal Policy, IDS Jaipur, Mazdoor Kisan Shakti Sangathan (MKSS), Health Systems Transformation Platform (HSTP), Basic HealthCare Services, Social Accountability Forum for Action and Research (SAFAR), Action Research and Training for Health (ARTH), All India Institute of Medical Sciences (AIIMS) Delhi, Association of Healthcare Providers India (AHPI), NATHEALTH and others.

Overview of the Right to Health Act in Rajasthan

Rajasthan has a population of 68 million, which accounts for almost 5.6% of India's total population according to the 2011 Census of India (Ministry of Home Affairs, 2011). The Rajasthan Right to Health Care Act, 2022 is meant to address longstanding inequities in access to and quality of health services in the state, and outlines responsibilities for the state government to provide each resident with the 'highest attainable standard of physical, mental, intellectual and social well-being and state of health, which is conducive to living a life in dignity' (Government of Rajasthan, 2022), aligned with the definition of Right to Life under Article 21 of the Indian Constitution (Article 21. Protection of Life and Personal Liberty, 1950). The Act includes several obligations for the state government in the area of health systems and patient rights.

Under the rights granted to residents, clause [3 (c)] included an emergency clause which included provisions for them to receive prompt treatment in all healthcare facilities including private establishments, without waiting for prepayment or policy clearance. The Act also included provisions to establish a State Health Authority to handle logistical grievances and treatment protocols for all healthcare establishments (Figure 1).

Overview of the policy process

The policy process in Rajasthan can be traced back to 2018, when it was included in the state election manifesto of the Indian National Congress (INC) as the first point in the healthcare section (Indian National Congress, 2018). The document also provides other commitments around free treatment and medicines, improved access to facilities, and the establishment of a 'regulatory authority' to oversee the quality of services provided by private healthcare institutions and prevent hospitals from pressuring patients to pay exorbitant fees. After the incumbent BJP government in the state was defeated in 2018, the INC-led government presumably began working on the draft bill. The first draft of the RTH Bill from the political executive of the state reportedly drew inspiration from a draft law that was submitted by the Jan Swasthya Abhiyan (JSA), a network of civil society organisations that focus on healthcare policies and advocacy (Pachauli, 2023). A committee was constituted by the government to modify the draft law, which included civil society members and health officials. This momentum was reportedly slowed by the COVID–19 pandemic (Gupta & Pachauli, 2023).

There appears to be no public, widespread voices of opposition from the coalition group before the first draft was presented by the government for public consultation in March 2022. After the publication of the first draft, a coalition representing private doctors, clinics and hospitals raised questions in the media (Saini, 2022). Eventually, this coalition included the largest doctors' association in the country, the Indian Medical Association (IMA), as well as groups representing resident doctors. The IMA primarily represents doctors working in the private sector, including clinician-entrepreneurs, hence a significant overlap with the interests of particular hospital industry interest groups. Other organisations involved are listed in Box 1.

Limited information is available regarding the events between March and September 2022. During this time, consultations with various groups continued, including those representing physicians and private hospitals. The state government tabled a modified version of the earlier bill, titled the 'Rajasthan Right to Health Bill', on September 21, 2022. This action appears to have sparked calls for protests from the coalition (Parihar, 2023). Doctors' organisations started to stage protests stating their demands had not been met (Gupta & Pachauli, 2023) and demanded that the Bill be debated thoroughly (Parihar, 2023). The bill was then referred to a 16-member Select Committee chaired by the Health Minister (Gupta & Pachauli, 2023). There was a series of consultations between the state government and stakeholders from the medical community and civil society organisations (Mascarenhas, 2023). Amendments made by the Select

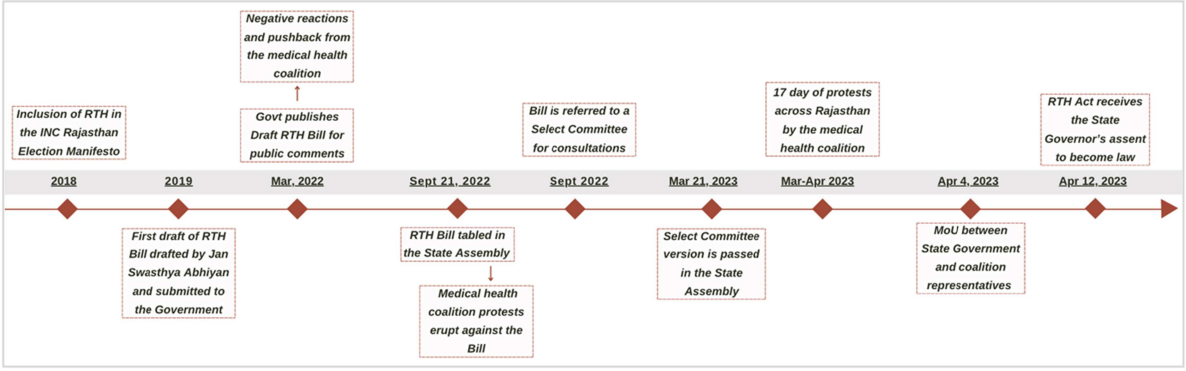

Figure 1. Timeline of the Right to Health Legislation in Rajasthan.

Committee were incorporated in the final version that was tabled and passed in the State Assembly on March 21, 2023 (Saini, 2023).

Despite the amendments, the protests in the state continued to grow, with calls for a complete withdrawal of the RTH Act. This phase reached its zenith with a 17-day-long protest, which led to a complete shutdown of private healthcare institutions in the state (Biswas, 2023). The coalition deployed an 'all hands on deck' approach during this intense agitation and used a variety of strategies, tactics and framing devices to appeal to wider audiences, gain public sympathy and persuade policymakers.

On April 4, 2023, after the 17-day protests, the state government and the three major organisations that represented the opposition coalition—IMA Rajasthan, PHNHS and UPCHAR—reached a Memorandum of Understanding. The protests were called off, and medical services resumed; on the condition that the Act would be amended as per the demands of the protestors. The final MoU between the groups included exemptions for private hospitals with fewer than 50 beds and for those operating without taking state subsidies ("Private Doctors Call off Strike in Rajasthan," 2023). These stipulations exempted almost 98% of private hospitals in the state (Khan, 2023). The MoU also directed the state to withdraw any criminal charges against any protester filed during the agitation. As a future safeguard, it included a clause that any changes in the RTH Act in the future would require consultation with IMA representatives (Misra, 2023).

On April 12, 2023, the Rajasthan Right to Health Act was given the Governor's assent and came into law. While consultations on the Rules under the Act were held, finalisation of these rules was not completed (Mehta et al., 2023). Rajasthan underwent state elections in November 2023, with the incumbent government losing to the opposition party at the time (Indian Express, 2023). It is unclear at the time of this writing whether the schemes enacted by the former ruling party, including the Right to Health Act, will be continued or terminated. Civil society organisations, led by Jan Swasthya Abhiyan, have urged the new government to expedite the implementation process, including draughting rules for the Act (Times of India, 2023b).

Strategies, tactics and framing from the opposing coalition

Strategies and tactics

Coordinated messaging across the protest

Despite the opposing coalition including a large number of interest groups across medicine and the hospital sector, a coordinated strategy was employed. There was a publicly cohesive and united front where coalition members put forth a variety of arguments and buzzwords—across physical spaces, traditional media platforms and social media—to convey their message and sway public opinion.

Strategic use of social media and mass media platforms

Members of the coalition leveraged social media platforms (X *[formerly Twitter]*, Instagram, Facebook, YouTube) to mobilise support albeit with a few dissimilarities: organisations such as the IMA and its members used formal and respectful language to register their protest against the Act, whereas state-level organisations like UPCHAR (United Private Clinics' & Hospitals' Association of Rajasthan) and PHNHS (Private Hospitals & Nursing Homes Society) appeared to be using more confrontational language in their posts, such as threats of boycotting public insurance schemes, leaving the state to practice medicine elsewhere, and switching professions. Members from the coalition also utilised mass media, including print media to put forth their arguments (op-eds, full page ads), and made appearances in national and state news media channels and engaged in panel debates to communicate their viewpoints on the policy. The opposing coalition also prepared distinctive posters and graphics that amplified their message.

On-ground mobilisation and protests

The protests against the RTH Act were marked by dramatic scenes with large crowds gathered in the state capital Jaipur. Tweets from IMA suggest the number to be 50,000 including doctors, medical staff, ancillary service professionals, families of these groups etc; however, these numbers could not be independently

verified through news sources. The agitation saw rallies in the city centre, including the shutting down of medical services (Times of India, 2023a). Social media handles of coalition groups also urged more members of the medical community to join the protests from other parts. Photos and videos of doctors and medical staff locking their clinics and hiring buses to reach the state capital were posted as a way to encourage others to join. Notably, digital campaigns—such as the coordinated wearing of black bands—played an integral role in sustaining momentum and creating a sense of collective identity. While coalition groups were mobilising on the ground in Rajasthan, other doctors and groups from across India were also posting their 'black bands of solidarity' photos on X to show support.

#JaipurChalo Doctors, paramedics, pharmacists, lab staff, hospital employees, medical reps, chemists and all others affiliated to healthcare industry from all over Rajasthan and neighbouring states are urged to attend #MahaRally on 4th April 2023 to force @ashokgehlot to #RollbackRTH. [Jaipur Chalo translates to Let's go to Jaipur (state capital)]

Generating sympathy through children and families

The protests on the ground and online saw many children of doctors (and medical professionals) and family members including the elderly with posters stating emotional appeals against the RTH Act. Online, videos and skits with similar messaging were circulated where toddlers and young children were acting out skits of scenarios of how the RTH Act could be misused by entitled patients in the future.

Access to decision-makers

IMA social media handles published various images of their members meeting with politicians and bureaucrats in Rajasthan and across India to put forth their demands against the legislation. Other avenues for engaging publicly with decision-makers included formal communication through letters, which were also posted on social media. As the leading national-level organisation in this debate, IMA leveraged its influence with national and state politicians and posted about these interactions on social media along with photographs.

Framing

Victimisation of the medical profession

The initial reactions were framed as scepticism and a sense of mistrust with the Government stemming from the private sector's past experiences with other healthcare policies and framed private medical professionals as victims. The Private Hospitals & Nursing Homes Society (PHNHS) Secretary remarked in an interview with the media in January 2022 when the first draft of the Bill was circulated for public consultations, *"All government schemes seem to be good as they are for the welfare of people but the government should also look after the interests of hospitals. Already, the public sentiments are against doctors and the medical fraternity is facing problems. Any new policy should not affect our work."* (Saini, 2022). However, from March 2023 onwards, when the protests were beginning to grow, the victimisation framing became more pronounced in the messaging. Advertisements and social media posts framed doctors as victims of government policies. For instance, a March 2023 ad in a local Hindi daily newspaper declared, "*When there were no private hospitals, patients used to cry. Now, after building private hospitals, doctors are crying. It is only the government that laughs*," explicitly portraying doctors as suffering under government legislation.

Use of buzzwords

Calling 'RTH' a 'black bill': Prior to and during the lead-up to the ground demonstrations, there was frequent use of the words 'black bill', '*kaala kanoon'* (black law in Hindi) and 'draconian bill' to refer to the RTH Act. These buzzwords were repeated by different coalition members and in different mediums (tweets, videos, press conferences, op-eds etc). One social media campaign involved IMA members across India wearing black bands with captions such as "Say No to #RTHBill".

Fear-based approaches

Coalition members largely used fear-based wording and framing strategies to protest against the RTH Act. This comes in a three-fold argument: The first, inciting fear among doctors that this legislation would lead to an erosion of their professional rights, autonomy and monetary loss. Videos of skits/performances based around the idea of doctors (and medical staff) leaving the medical profession due to monetary loss and instead working in other jobs were widely circulated. Fear was incited by the threat of increased bureaucratic control and 'red-tapism' over the private healthcare system, called as the "Inspector-Raj" on one TV news debate. X posts with videos showcased doctors and medical staff taking up 'alternative' careers, including one video posted by UPCHAR, where private hospital staff pretended to take up farming.

The second part of this fear-based strategy extends towards the larger public, where, it was continuously reiterated how the RTH policy will lead to an increased burden on the healthcare system, forcing doctors to leave the profession and in the end, hurt the public. Some made comparisons to the National Health Service in the United Kingdom, as well as other "socialist" countries such as Venezuela. Further, the notion that private healthcare facilities would succumb to the 'bad quality level' of public healthcare facilities was also used to induce fear in the public against RTH.

The third part of the strategy focused on concerns that this Bill would lead to similiar legislation in other parts of the country, and therefore needed to be stopped in Rajasthan before it became a threat to other state chapters of IMA and other state-level hospital groups.

Policy design, framing and potential misinformation over RTH provisions

The opposing coalition was concerned about the design of the policy itself, concerns that were echoed in commentary by health policy analysts (Barnagarwala, 2023; Mascarenhas, 2023; Phadke, 2023). Examples of concerns included the specifics of reimbursement (i.e. the mechanisms by which the government would reimburse private providers) and the exact definitions of emergencies, emergency care and healthcare facilities.

Despite these objective concerns about the language, alleged misinformation emerged during the agitation regarding the provisions of the Act, arising out of the earlier (pre-Select Committee recommendations) version of the Bill. There could be two reasons behind this large amount of misinformation: either, it arose out of ignorance or confusion where the protesting doctors did not read the provisions of the amended Act, or, due to a more manipulative intent. Consequently, civil society activists pointed to opposing coalition representatives misinforming the protesting doctors on the ground and using fear-based framing to persuade them to continue their protest against the RTH Act (ETHealthWorld, 2023).

Patient-entitlement framing

Another frame used by the opposing faction was the idea of entitled patients who would irrationally demand treatment under the Emergency clause of the RTH Act. The idea was an oft-repeated talking point to how the vague definition under the Emergency clause would cause patients to demand free treatment for non-emergency situations, to demand ambulance services unnecessarily and to be a burden on the private healthcare system. A particular example of this came in the form of a YouTube skit titled "RTH: Right to Hangover" posted by UPCHAR which depicted a scenario of patients in a private hospital misusing services by quoting the RTH Act provisions. The doctors in this skit are portrayed as helpless under the threat of state action and succumb to the pressure of providing alcohol to these entitled patients, thus, terming the right to health as a right to hangover.

Other forms of framing as noted in Table 1 and in Appendix 4 covered a range of other issues, such as evoking constitutional protections for trades, alignment with other social movements such as the protests to protect farmers' rights, catering to election-related populist demands and noting the need to address other social determinants of health in order to achieve the right to health.

The coalition claimed 'victory' and lauded the efforts of its members in interviews and social media posts which congratulated the 'medical fraternity' for standing united against the RTH Act. It claimed that the protests had forced the government to agree to all of its demands as a result of the intense agitation of the

Table 1. Selected framing approaches used by the opposing coalition.

Framing approaches used by the opposing coalition	Sample quotes
Victimisation of the medical profession	*A doctor speaking to the press:* Why are we being forced to provide free treatment when we do not get any other services for free? Doctors will give free treatment if they get every other service including school for their children, rent, electricity and other services for free.
Limitations of existing healthcare policies	*Doctor on a news debate:* Already existing healthcare schemes in the state like RGHS and CHIS both have outdated rates from 2013 and 2016 which have financially impacted the hospitals already.
Flawed policy design	*Doctor on a news debate:* The Emergency clause in the RTH Bill is much wider than required. Will a general physician or a specialised doctor like a gynaecologist be available in the hospital 24 hours, so that they can treat all emergency cases, or risk facing fines?
Bureaucratic control framing	*Doctor on a news debate*:It imposes "Inspector-Raj" on the doctors and private hospitals. Hospitals can't go against the [court orders], against the orders of the DHA, which can inspect and seize private hospitals arbitrarily.
Framing the RTH Act as 'draconian'	*IMA National President in an interview to the press*:RTH Bill is draconian, populist and anti-poor bill. It is the responsibility of the government to provide RTH to all but is now forcing the private sector to shoulder the entire burden. All private healthcare facilities will leave the state if this Bill is allowed in.
Patient entitlement narrative	*Skit videos circulating on social media:*RTH (Right to Health) is deemed as a "Right to hangover" where alcoholic patients misuse the ambulance services and emergency provisions to go and get alcohol for themselves.
Fear-based framing	IMA letter to the Governor of Rajasthan against RTH:Apart from the moral depravity such a legislation would end up in creating mayhem in the casualties and be an incitement to violence. The financial burden on the fragile institutions is likely to end in the collapse of the private health care delivery system.

coalition members. The official IMA X handle posted *"Landmark Victory for #IMA. Private Sector exempted from RTH Act. We congratulate IMA Rajasthan & all branches. Salutes to Medical Unity."*

Strategies, tactics and framing from supporters

Strategy and tactics

Supporters of the Act included a group of health policy activists, primarily from Jan Swasthya Abhiyan (JSA) and spokespersons from the ruling party. In the public debate, however, there was the appearance of a 'David v. Goliath' contest, given the overwhelming volume and coordination of the opposition's messaging and the defensive positioning that supporters found themselves taking. The main platform for Act supporters was televised news debates, where a small number of activists and some political spokespersons represented the pro-RTH Act perspective. Supporters also commented regularly in newspapers, participated in podcasts and wrote op-eds in multiple languages. The opposition did, however, have a more visible and voluble presence across physical and digital spaces. Supporters also used social media platforms like X to c ounter some misleading claims, but their reach was limited compared to the opposition, who used videos, skits, and eye-catching posters. On the ground, media coverage favoured the protesting doctors, especially during high-visibility events such as hunger strikes and marches.

On the other hand, actors from the Rajasthan government, including the Chief Minister and party spokespersons, issued public statements and attempted to signal their willingness to negotiate with protest leaders, in an effort to call off the protests, through media statements. Despite these efforts, the counter-arguments of the pro-RTH faction were eclipsed by the opposing doctors' highly visible and coordinated actions.

Framing

Policy actors, including government officials, politicians from the ruling political party, and civil society activists, also used specific framing techniques to counter the arguments of the protesting groups. Unlike the opposition, which seemed highly organised and cohesive, the supporters' framing was less defined and more fragmented. Their messages often appeared reactive, as they sought to address the rapidly evolving and multifaceted arguments put forward by the protesting private sector doctors.

Merits of the policy: These arguments included raising awareness about the design of the RTH policy and its benefits, and publicly supporting the Act. For instance, a health rights activist participated in several news debates and stated on a podcast, "The Act has clauses beneficial to the public. And if the public healthcare system is strengthened by this Act, it also works in favour of medical professionals." Similar points were made in print media, including in op-eds, noting that "The quality of care and transparency in health systems would be augmented, there would be better working conditions and growth prospects for medical practitioners and healthcare workers in the public sector and it would also bring relief to them from undue pressures." (Pachauli & Gupta, 2023).

The government also funded ads appeared in local dailies addressed to the protesting doctors, with messages from the Chief Minister. One such ad, formatted as a letter, highlighted the Act's intent: "The Right to Health Act contains provisions that will effectively provide the public with timely and quality health services. The Act aims to ensure that citizens receive relief without causing any hardship to the medical community. To address doctors' concerns about certain ambiguities and to improve the Act, it was sent to a Select Committee at their request. After resolving all their concerns, the Bill was brought before the Legislative Assembly and passed unanimously by members of both the ruling party and the opposition."

Combatting alleged misinformation: The issue of misinformation around the provisions of the Act was raised by its supporters and efforts were made to clarify the 'controversial' clause of emergency care and reimbursement. An INC representative reaffirmed on a news panel debate, "It has been clarified in the State Assembly by the Health Minister, that both the emergency clause and the reimbursement clause will be clarified in detail when the Rules are developed (after the Bill passes the Assembly)."

A civil society activist used social media to call out perceived misleading claims made by some actors from the opposing coalition, as seen in an X post: "Doctors opposing #Rajasthan's #RightToHealthBill came up with this utterly deceptive ad in today's @DainikBhaskar declaring the Bill as useless for the patients! I hope the govt. takes note of this as in how the masses r being misled by a powerful lobby for its own interest."

Motives of the opposing coalition: Supporters of the Act highlighted motives of the protesting faction. As stated by a spokesperson of the ruling party:

Doctors have already been consulted within each stage of the policy process, but are now opposing the Bill just for the sake of opposing it. They are opposing the will of 80 million people of Rajasthan. It has been clarified in the State Assembly by the Health Minister, that both the emergency clause and the reimbursement clause will be clarified in detail when the Rules are developed (after the Bill passes the Assembly).

The supporters of RTH stated on several occasions that requested changes had been made in revised versions of the Bill and reiterated numerous times that the remaining concerns of the opposing faction would be addressed when the Rules were draughted. In another government-funded ad, the Chief Minister addressed the issue: "It is beyond comprehension why the medical community is protesting against such a welfare-focused legislation, which has been prepared with the consent of doctors. It is unfair that some elements are spreading confusion about this Act. Medical personnel should keep in mind that medicine is the most noble profession and thus they should end their boycott and return to work with the spirit of public service".

The use of these frames was therefore largely defensive and not platformed as extensively across physical and digital spaces. In the aftermath of signing the MoU and the Governor's assent to the Bill on April 12th, the supporters of the RTH Act – primarily health rights activists – expressed their excitement on social media. Government representatives expressed relief that the medical services in the state had resumed. As progress on implementation of the Act stalled, civil society organisations urged – before and after state elections – to expedite the implementation process, with no success.

Discussion

In the pursuit of global health goals around universal health coverage, national and sub-national governments across the Global South are pursuing large-scale health sector reform pertaining to health service delivery and financing (Agartan, 2025). At the heart of many of these debates are profound questions regarding access, affordability and the right to health (Greer & Méndez, 2015; Nygren-Krug, 2019; Rizvi et al.,

2020). The role of, and competition between, interest groups at the domestic level in negotiating these policy processes has not received sufficient scholarly attention, including the strategies and tactics by which different policy actors pursue their goals and the dynamics of framing contestation in shaping policy outcomes (Sriram et al., 2024). The role of domestic actors has gained additional salience due to growing health sector privatisation and corporatisation in lower and middle-income countries such as India (Bustamante & Méndez, 2014; Chakravarthi et al., 2023). Using careful, coordinated, and strategic framing, these actors legitimise their positions, influence policy decisions, and contain opposing views from civil society actors.

This research contributes to a small but growing body of research that examines the dynamics of health policy contestation, such as those pertaining to UHC and the right to health, at the national and sub-national level in Global South contexts. In the face of a consequential health sector reform in Rajasthan, the Right to Healthcare Act, we find that private healthcare sector coalitions representing diverse interests and constituencies, in this case in Rajasthan, united rapidly and effectively to execute a multi-modal strategy in physical and digital landscapes to oppose the Act. The agitation against the legislation is another example of the ability for an extremely heterogeneous Indian private healthcare sector to unite rapidly and effectively, as also observed in Karnataka, India (Mishra et al., 2021; Putturaj et al., 2021). The coalition deployed multiple approaches concurrently, pairing indirect and direct strategies and tactics and using diverse framing choices to "win" the public narrative and secure a dominant role in the policy process. The power resources of the actors involved—most notably the Indian Medical Association bolstered by an effective coalition with state-level associations representing small hospitals—made the utilisation of these various strategies, tactics and framing more effective in the policy conflict, building on Wood's observations of the robust, flexible political strategy of doctors in Uttar Pradesh (Wood, 2013). Conversely, the supporting coalition, despite its inclusion of the ruling party, were unable to overcome the sheer volume and scale of the opposing coalition's approach and found themselves in a defensive position through much of the debate.

Our study highlights the confluence of professional power and commercial interests in the selection of strategy, tactics and framing choices. A wide variety of frame modalities—concerns regarding "draconian" overreach of government, fears for the medical profession, concerns around patient entitlements—were simultaneously deployed in physical spaces and in traditional and digital media landscapes. The utilisation of diverse frames by the opposing coalition was seemingly successful in galvanising doctors and potentially other health workers to their cause, as evidenced by the large turnout for the 17-day protests. In particular, the use of emotive framing, such as victimisation and fear, and its amplification during heightened phases in the debate, appears to be particularly salient to this analysis. The "narrative of victimisation" of the medical profession has been used in other policy debates by the Indian Medical Association and other doctors' groups, as noted by Samant et al in their study of newspaper accounts of violence against doctors (Samant et al., 2024). The opposing coalition also connected this framing of victimisation of the medical profession to other social movements (e.g. the 2020–2021 farmers' protests in India) and linking themselves to broader cultural themes (Dodge & Metze, 2024), regardless of the underlying fact that physicians as a collective hold immense privilege in South Asian society relative to other occupational groups (Kumbhar, 2023). The frames did have conflicting ideological standpoints that drew on different symbolic representations of physicians, such as the framing of the charitable nature of doctors and health facilities juxtaposed with concerns around giving "free" services to the population, similar to countries with state-financed and delivered healthcare. Ultimately, due to the 'flood the zone' approach taken by the opposing coalition, they were effective in their ability to yoke their frustrations as medical professionals to issues around the private hospital industry (i.e. framing concerns about professional autonomy rather than the role of business and industry in healthcare) and could paper over any dissonance across the frames. The role of medical and professional power in this case is significant, as other health worker constituencies, such as community health workers, have engaged in extensive mobilisation for their demands with limited successes (John, 2023).

The use of diverse strategies and tactics, the ways in which these strategies were utilised by interest groups across different time points and how this in turn reflects actor power is an important area for reflection. The opposing coalition in this case provides a useful example of interest groups strategically phasing direct and indirect strategies in physical and digital spaces to secure their position in the

policymaking space. For example, the pervasive presence of opposing coalition members on traditional media (television debates, newspaper advertisements, etc), the more aggressive and savvy tone taken by smaller hospital-based organisations on social media, and the utilisation of IMA's extensive membership base for on-ground protests, helped create a groundswell of support that ultimately appeared to have placed substantial pressure on the government and stalled meaningful progress of the Act. This dynamic may also be an indication of the difference in the level of influence that these supporters had on accessing media sources and amplifying their messaging. The opposing coalition appeared to test the limits of what is acceptable, for example, the use of children in advocacy that was called out by the Rajasthan State Commission for Protection of Child Rights (The Times of India 2023). The role of misinformation in this case is also a key theme of how strategies, tactics and framing choices fuelled contestation. For example, supporters of the Act repeatedly noted that specific clauses were being purposefully misinterpreted, but were constrained in countering the spread of misinformation. The role of mis/dis-information in framing contestations in health policy requires further scholarship, given its growing role in shaping public policy debates.

The practical implications of this research are twofold. One, the challenges faced by supporters of rights-based approaches to health policy in Global South contexts require further research and attention. In this case, the opposing coalition created a deluge in the public debate, leaving supporters, which included the ruling party and civil society organisations, on the backfoot. Learning across contexts, particularly from social movements, can help generate potential strategies to address these patterns. For example, debates pertaining to single-payer health financing in the United States can provide useful insights on the need for supporters of progressive health reform to diversify framing approaches (Geyman, 2005) and also strategies and tactics by a broader set of policy actors (Quadagno & Lanford, 2019). Two, governance processes pertaining to high-stakes health policy reform, such as UHC and the right to health, require closer attention from national- and global-level policy communities. Greer and Méndez argue that "[without] support in domestic politics, a redistributive policy such as UHC is unlikely to happen", and that governance structures and processes are crucial to understanding policy design and/or implementation, and ultimately, their success or failure (Greer & Méndez, 2015). The findings of this study support this argument and provide further evidence around the costs of neglecting governance as a crucial and indispensable aspect of these processes.

Finally, the ability for the opposing coalition through its strategies, tactics and framing to destabilise medium- to long-term outcomes in this case warrants further attention, including from an institutional perspective. IMA secured some major wins in the process, such as demanding input into Rules formulation, which provided ample opportunities to prevent the policy from being implemented, as has been the case in other contexts in India (Muraleedharan & Nandraj, 2003). From a longer-term perspective, the ability for the IMA and other actors to immediately frame the outcome as a victory arguably helped IMA garner more trust from its members, including in other states. These patterns have major implications for health sector governance, in that, absent rigorous governance platforms to debate, discuss and adapt health legislation, meaningful reform will continue to stall, and inequities in access to healthcare, including during emergencies, will persist.

This study has several limitations. First, we did not set out to conduct a study of the merits of the legislation. Various policy analysts have commented on its strengths and weaknesses in scientific journals and in the media. Our objective was instead narrowly focused on the *actions* taken by policy actors and their implications on policy outcomes, rather than providing an interpretation of the strengths and weaknesses of the policy itself. Second, we drew on publicly available information that was available in the digital space, such as online newspapers, videos, policy reports and on social media. A more robust analysis would have included interviews or observation that would help us explore actor motivations, relationships and resources. However, we believe that the narrative portrayed by public debate warrants its own investigation and therefore justifies the use of these data. We encourage further research on these policy cases using data such as interviews, focus groups and observation. Finally, while we drew upon a wide variety of sources in multiple languages and across multiple platforms, it is possible that we excluded particular data points that would have strengthened the analysis.

Conclusion

In this paper, we have sought to unpack debates regarding a highly consequential piece of health legislation at the sub-national level in India, the Rajasthan Right to Health Care Act, and examine the various strategies, tactics and framings taken by domestic healthcare sector policy actors, specifically physicians and the hospital industry, within this debate, in an effort to unpack—in an exploratory manner—the linkages between actor power, policy contestation and policy outcomes in healthcare reform. We find that private healthcare sector coalitions in this case used multi-modal strategies and tactics and diverse framing that resulted in "flooding the zone" with their objections, capturing the public narrative and securing a dominant role in the policy process. Conversely, the supporting coalition, despite its inclusion of the ruling party, was unable to overcome the sheer volume, scale and power resources of the opposing coalition's approach and found themselves in a defensive position for much of the debate. Policy learnings include the need for health activists and supporters of progressive health reform to diversify their strategies, tactics and framing in policy debates, and for policy communities to prioritise inclusive systems of health governance. As policy debates around UHC and the right to health accelerate in many countries, unpacking the politics of these actors is crucial to building a comprehensive understanding of reform processes.

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Appendix

Appendix 1. Included documents.

Policy documents	
Legislations (Draft, Act)	2
Memorandum of Understanding between Government and Opposing Coalition	1
News Media	
Op-eds, Newspaper articles	34
TV News Panel debates	4
Podcast	1
Social Media	
Tweets (with photos and videos)	88
YouTube Videos	4
Instagram Posts	5
Miscellaneous	
PSA Ads *(Ads published in local dailies as letters to the public by different actors)*	15
Letter by Indian Medical Association	1
Letter of support issued by other groups (caste-based alliances)	2
Chief Minister's Budget Speech	1
Election Manifestos	4
Policy reports, peer reviewed literature (e.g. Vidhi Centre for Legal Policy)	2

Appendix 2. Hashtags used during the online 'protest' campaign by opposing coalition.

1. Medical unity	#medicalunity #jaimedicos (hail medicos)
2. RollBackRTH	#NoToRTH #RollbackRTH #काला_क़ानून_वापस_लो (take back the black bill) #जयपुर_चलो (lets go to Jaipur) #MahaRally (Massive rally) #SayNoToRTH #RTH झूठकापुलदिा (RTH is a lie) #RTH_गलत_है (RTH is wrong)
3. Aggressive wording	#झुकेगा_नहीं_साला (will not bend down - expletive) #ना_झुके_हैं_ना_झुकेंगे (will not bend down)
4. To appreciate doctors during the protests	#unsungheroes
5. To frame the state Chief minister as insensitive	#Insensitive_Gehlot (Name of the Chief Minister)

Appendix 3. Hashtags used during the online 'protest' campaign by supporters of the RTH Act.

Supporting the RTH Act	#SayYesToRTH #राइट_टू_हेल्थ_संजीवनी_है (RTH is a boon) #YesToRTH #Rajasthan_Support_RTH

Appendix 4. Framing approaches used by the opposing coalition.

Framing approaches used by the opposing coalition	Description	Sample quotes
Limitation of existing healthcare policies	Negative impacts of existing healthcare system and health-related schemes	*Doctor on a news debate:*Already existing healthcare schemes in the state like RGHS and CHIS both have outdated rates from 2013 and 2016 which have financially impacted the hospitals already.
Flawed policy design	Concerns regarding the design of the policy itself (e.g. weak definitions of emergencies)	*Doctor on a news debate:*The Emergency clause in the RTH Bill is much wider than required. Will a general physician or a specialised doctor like a gynaecologist be available in the hospital 24 hours, so that they can treat all emergency cases, or risk facing fines?
Constitutional principles	Constitutional principles guaranteeing the right to practise any trade/ profession without state interference.	MHC members published print media ads as public service announcements in the local newspapers and cited articles from the Constitution that prohibit forced labour and exploitative working conditions *(Art 23: Rights against exploitation and forced labour)*
Bureaucratic control framing	RTH Act as a tool for the state administrators to interfere with the private healthcare system negatively.	*Doctor on a news debate:*It imposes "Inspector-Raj" on the doctors and private hospitals. Hospitals can't go against the [court orders], against the orders of the DHA, which can inspect and seize private hospitals arbitrarily.
Portraying the RTH Act as a populist electoral strategy	RTH Act as a 'populist' scheme to garner votes from the incumbent government for the upcoming elections.	*Doctor on a news debate:*This Bill was brought because RTH was included in the election manifesto of the current government, and they wanted to fulfil this just before the upcoming elections and use it get votes. The government wants to confuse the public and that's why it passed this bill.
Framing the RTH Act as 'draconian'	The RTH Act was framed as 'draconian' and 'dictatorial' for not including the perspectives of the MHC.	IMA National President: RTH Bill is draconian, populist and anti-poor bill. it is the responsibility of the government to provide RTH to all but is now forcing the private sector to shoulder the entire burden. All private healthcare facilities will leave the state if this Bill is allowed in.
Patient entitlement narrative	Bill provides undue power to the patients and make them feel entitled to the best quality treatment even for non-emergency ailments, which would negatively impact the medical practitioners.	Skit videos circulating on social media: *RTH (Right to Health) is deemed as a "Right to hangover" where alcoholic patients misuse the ambulance services and emergency provisions to go and get alcohol for themselves.*
Characterising medical establishments as charitable entities	MHC insisted that the private healthcare system is already charitable and fulfils its moral obligations towards emergency care patients.	*Doctor on a news debate:*We have always been treating emergency patients, taking in medico-legal cases, and providing all services, so why was there a need to bring in this bill?
Calling attention to the possibility of RTH across India	Medical professionals across India urged to protest against the Rajasthan RTH Act by calling attention to the threat of similar Acts being implemented across the country	*(DR Sharda Jain of New Delhi, urging in an X video for doctors across India - to join the RTH Act protests to ensure that similar legislation is not passed in other states)*
Other determinants of health framing	Right to health concept is broader than just regulating private healthcare facilities. They insisted that it should also include provisions for clean air, clean water, no sale of alcohol etc	The current Act mainly ensures the Right to Healthcare; to move towards a comprehensive Right to Health, further concrete steps are needed by the state to ensure entitlements to determinants of health (such as food security and nutrition, water supply and sanitation, healthy environmental conditions etc). (ET HealthWorld, 2023)
Contrasting with different jurisdictions	Examples from welfare and socialist programmes of countries like the UK (National Health Service), to argue that these systems hurt patients, and would cause longer wait times and hurt investment opportunities in the state.	A full-page ad was printed in all local editions of a newspaper daily (Rajasthan Patrika) that listed the grievances that doctors had against the RTH Act (Rajasthan Patrika ePaper 2023).
Fear-mongering framing	RTH Act clause for providing free medical care in emergencies as a threat to a medical professional's rights.	IMA letter to the Governor against RTH: Apart from the moral depravity such a legislation would end up in creating mayhem in the casualties and be an incitement to violence. The financial burden on the fragile institutions is likely to end in the collapse of the private health care delivery system.
Connection to other social movements	Doctors organisations also urged allied healthcare professionals to lend their support to the protests against the RTH Act. These included pharmacists, pathology lab technicians, hospital staff etc.	#JaipurChalo Doctors, paramedics, pharmacists, lab staff, hospital employees, medical reps, chemists and all others affiliated to healthcare industry from all over Rajasthan and neighbouring states are urged to attend #MahaRally on 4th April 2023 to force @ ashokgehlot to to #RollbackRTH (Tweet from UPCHAR).