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GRIEVANCE REDRESSAL MECHANISMS IN PUBLIC HEALTHCARE ESTABLISHMENTS

OVERVIEW OF THE LEGAL FRAMEWORK AND RECOMMENDATIONS FOR REFORM

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CONTENTS

I.	INTRODUCTION	1
	A. Research Methodology	3
	1. Objective	3
	2. Why public hospitals.....	5
	3. Research methods	5
II.	OVERVIEW OF THE PUBLIC HEALTHCARE SYSTEM IN INDIA	7
	A. Primary Healthcare	7
	B. Secondary Healthcare	9
	C. Tertiary Healthcare	10
III.	LEGAL FRAMEWORK GOVERNING PUBLIC HEALTHCARE ESTABLISHMENTS	11
	A. Consumer Protection Act, 1986	11
	B. The Clinical Establishments (Registration and Regulation) Act, 2010	12
	C. The Bureau of Indian Standards Act, 2016 and Bureau of Indian Standards Act, 1986 .	13
	1. The legal status of the standards	13
	2. Applicability of the existing standards to health care services.....	13
	D. National Health Mission	15
	1. Quantitative and Qualitative Health Standards under the NHM	15
	2. Enforceability of the health standards governing PHEs	20
	E. Guidelines issued by the MoHFW	22
	F. Legislation on public health.....	22
	1. National Health Bill, 2009.....	23
	2. Other public health legislation.....	25
	G. Judicial orders on grievance redressal forums in PHEs	27
	H. Other laws governing grievance redressal	28
	I. Key takeaways	29
IV.	EMPIRICAL ANALYSIS OF COMPLAINTS AT GOVERNMENT HOSPITALS.....	30
	A. Complaints with the High Courts, consumer courts and NHRC.....	30
	1. High Courts	30
	2. Consumer courts	33
	3. NHRC	36
	B. Case Studies	39
	1. Case Study I: AIIMS	39
	2. Case Study II: Mewat, Haryana	40
V.	RECOMMENDATIONS	42

A. Categorization of violations that occur in PHEs	42
B. Setting up of an authority to streamline the handling of grievances	43
1. Option 1	43
2. Option 2	44
C. Mandatory requirement of an internal grievance redressal mechanism in PHEs	45
D. Clarification on the application of the CPA to PHEs	46
ANNEXURE.....	
A. Questions posed in RTI applications to government hospitals in Delhi.....	
B. Interview questions for government officers	
C. Interview questions for civil societies	

LIST OF TABLES AND FIGURES

<i>Table 1: Sub-centres and PHCs in India</i>	7
<i>Table 2: Urban healthcare in India</i>	8
<i>Table 3: Secondary healthcare in India</i>	9
<i>Table 4: BIS standard on grievance redressal in healthcare facilities</i>	14
<i>Figure 1: Kinds of complaints against PHEs in high courts across the country</i>	31
<i>Figure 2: Nature of remedies given by the high courts across the country in complaint cases against PHEs</i>	32
<i>Figure 3: Year-wise number of complaints against PHEs in high courts across the country</i>	33
<i>Figure 4: Kinds of complaints against PHEs in consumer courts across the country</i>	34
<i>Figure 5: Nature of remedies given by the consumer courts (national and state) across the country in complaint cases against PHEs</i>	35
<i>Figure 6: Year-wise number of complaints against PHEs in consumer courts across the country</i> ...	36
<i>Figure 7: Kinds of complaints against PHEs with the NHRC</i>	37
<i>Figure 8: Nature of remedies given by the NHRC in complaint cases against PHEs</i>	38
<i>Figure 9: Year-wise number of complaints against PHEs in NHRC</i>	38
<i>Figure 10: Flowchart for Option 1</i>	44
<i>Figure 11: Flowchart for Option 2</i>	45

I. INTRODUCTION

In January, 2016, the National Human Rights Commission (“NHRC”) and the Jan Swasthya Abhiyan organised a public hearing on the right to health care for the western region in India (Maharashtra, Rajasthan, Gujarat, Goa, Daman and Diu, Dadra and Nagar Haveli). The aim of the hearing was to assess human rights violations in the public and private healthcare systems and to make recommendations to strengthen the protection of the right to health. Individuals and civil society representatives were invited to send the details of serious complaints of health rights violations to the NHRC. These complaints were then scrutinised and affected parties were invited to present their grievances.¹

As part of this public hearing, the NHRC heard 88 cases and awarded compensation for medical negligence in 5 of them.² The hearing revealed systemic failures in the delivery of health services by the public sector—it was reported that over 80 percent of the cases dealt with the unavailability of doctors, facilities and equipment at government hospitals. The hearing also invited protests from doctors’ associations who alleged that the NHRC did not have the legal authority or expertise to hear individual cases of medical negligence.³ The NHRC ultimately dismissed complaints relating to private hospitals at the hearing, recognising that its powers to investigate complaints, award compensation, and make recommendations were limited to public authorities under the Protection of Human Rights Act, 1993 (“PoHRA”).

The fact that the NHRC felt the need to hold a public hearing to address health rights violations is telling of the existing legal framework on the enforcement of the right to health. Although the Supreme Court of India (“SC”) has recognised⁴ the right to health as an integral facet of the right to life under Article 21 of the Constitution of India (“Constitution”), enforcement machineries for this right are virtually non-existent. In fact, the question of enforcement might even seem premature, given that the contours of the right to health and the corresponding duties that it imposes have not yet found legislative expression. The draft National Health Bill, 2009 (“NHB 2009”) takes important steps in this regard. It defines various components of the right to health, clearly identifies obligations for health establishments, and sets up comprehensive enforcement machinery. However, the bill

¹ More details of these hearings are available at <<http://nhrc.nic.in/JanSwasthyaAbhiyan.htm>> accessed 14 March 2017.

² ‘As public hearing ends, NHRC says condition of healthcare not satisfactory’ (*The Indian Express*, 8 January 2016) <<http://indianexpress.com/article/cities/mumbai/as-public-hearing-ends-nhrc-says-condition-of-healthcare-not-satisfactory/>> accessed 14 March 2017.

³ Somita Pal, ‘Doctors oppose NHRC ‘s public hearing on health care rights’ (*Daily News and Analysis*, 7 January 2016) <<http://www.dnaindia.com/mumbai/report-doctors-oppose-nhrc-s-public-hearing-on-health-care-rights-2162956>> accessed 14 March 2017.

⁴ *Consumer Education & Research Centre & others v. Union of India*, AIR1995 SC 42

remains in draft form and the National Health Policy, 2017 (“NHP 2017”) moves away from the idea of a rights-based approach, on the ground that threshold levels of finance and infrastructure have not yet been achieved.

The absence of uniform regulatory standards for public and private healthcare establishments also remains a barrier to the effective enforcement of the right to health. The Clinical Establishments (Registration and Regulation) Act, 2010 (“CEA”), which prescribes minimum standards for facilities at government and private hospitals is in force only in a handful of States.⁵ Failure to comply with standards attracts cancellation of the certificate of registration and the imposition of penalties. However, there is no mechanism to address individual grievances arising out of non-compliance with standards prescribed under the act.

This leaves the Consumer Protection Act, 1986 (“CPA”) as the only legal vehicle through which individual complaints regarding health rights violations can be addressed. However, the market-driven basis of this law, with its focus on the customer-service provider relationship is a far cry from the rights-based approach that is required. This is reflected in the legal uncertainty over the application of the Act to public healthcare establishments (“PHEs”) where services are provided free of cost. Patients that do not pay for services provided at such establishments might well find themselves without a remedy for health rights violations, unless they move the SC or the High Courts or make complaints to the State Human Rights Commission (“SHRC”) or the NHRC.

These are not satisfactory enforcement mechanisms. It costs time and money to approach an already overburdened higher judiciary, while the already limited powers of the human rights commissions to award compensation and make recommendations are restricted only to PHEs. In any case, the orders and directions passed by the higher courts can only constitute an *ad hoc* response to individual problems when it is clear that there are systemic issues with the delivery of health care by both public and private establishments.

Effective enforcement mechanisms are vital to the guarantee of human rights. Article 2, paragraph 1 of the International Covenant on Economic, Social and Cultural Rights (“ICESCR”) (Article 12 of which guarantees the right to the enjoyment of the highest attainable standard of physical and mental health) requires State Parties to ‘*take steps... to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.*’ General Comment No. 3 of the Committee on Economic, Social and Cultural Rights (“CESCR”),⁶ which

⁵ The CEA is in force in the states of Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim, and all Union Territories except the NCT of Delhi. Also, the States of Uttar Pradesh, Uttarakhand, Rajasthan, Bihar, Jharkhand and Assam have adopted the CEA under clause (1) of article 252 of the Constitution of India.

⁶ CESCR General Comment No. 3: The Nature of States Parties’ Obligations (Art.2, Para. 1, of the Covenant) (Adopted at the Fifth Session of the CESCR, 14 December 1990) Document E/1991/23.

interprets this provision states that ‘[a]mong the measures which might be considered appropriate, in addition to legislation, is the provision of *judicial remedies with respect to rights which may, in accordance with the national legal system, be considered justiciable.*’⁷ (emphasis supplied). Justiciable remedies for the enforcement of the right to education, food security, information, and welfare are made available in India through different statutes; the right to health, however, is on more uncertain legal footing, and as explained earlier, almost wholly reliant for its enforcement on the exercise of writ jurisdiction by the higher courts, and the grant of compensation under the CPA.

In this context, grievance redressal mechanisms at public and private healthcare establishments assume great significance, as they present an avenue for enforcing the right to health that bypasses the courts. For the purposes of this report, such mechanisms refer to internal complaint procedures that operate at individual PHEs. Especially in the context of PHEs, such mechanisms often constitute the only way in which different kinds of health rights violations—delay in treatment, denial of health care, medical negligence, poor infrastructure and facilities—may be addressed. It becomes very important, therefore, to understand the framework in which they operate, and this is the principal objective of this report.

The following section of this part of the report explains the research methodology. Part II provides an overview of the functional units of the public healthcare system in India in rural and urban areas. Part III critically analyses the legal, regulatory and policy framework concerning health rights enforcement at these units, with an emphasis on the functioning of grievance redressal mechanisms. Part IV gives a sense of the kinds of grievances and rights violations that are alleged regarding the provision of health care at PHEs. It does this through empirical information on cases brought before the High Courts, Consumer Dispute Redressal Forums and the NHRC. This is supplemented by two case studies on the working of grievance redressal mechanisms—one at the All India Institute of Medical Sciences (“AIIMS”), a tertiary referral hospital in New Delhi, and the second at a primary health centre in Mewat, Haryana. Finally, Part V makes recommendations to strengthen the enforcement mechanisms for the right to health at PHEs.

A. Research Methodology

1. Objective

There is extensive literature on the problems with public and private healthcare systems in India and the need for more effective regulation.⁸ These include studies and reports by governments, think-

⁷ *Ibid.*

⁸ Sunil Nandraj, ‘Unregulated and Unaccountable: Private Health Providers’ (2012) Vol.47 Issue 4 Economic and Political Weekly 12 <<http://www.epw.in/journal/2012/04/commentary/unregulated-and-unaccountable-private-health-providers.html>> accessed 6 March 2017 ; Vikas Bajpai, ‘The Challenges Confronting Public Hospitals in India, Their Origins and Possible Solutions’ (2014) Article ID 898502 *Advances in Public Health* <<http://dx.doi.org/10.1155/2014/898502>> accessed 6 March 2017 ; Antonio Duran et al, ‘Public Hospital

tanks, academics and civil society on a wide range of issues—declining standards of care, unethical practices, the affordability of medicines, and the lack of availability of doctors and health workers. The *legal* literature on these issues, however, is limited, confined largely to analyses of the rights-based approach that courts have adopted to address problems with the delivery of healthcare in India.⁹ One of the objectives of this report, therefore, is to address this gap in the literature and contribute to an understanding of the broader legal framework within which the delivery of health goods and services operates.

Any discussion of the legal framework inevitably brings up questions of enforcement, and as the Introduction mentions, in the context of PHEs, grievance redressal mechanisms are often the only means of enforcement that are available. However, there is limited literature on grievance redressal mechanisms in public and private hospitals,¹⁰ and where there are studies/reports,¹¹ these tend to focus only on the non-legal aspects. Thus, another objective of this report is to focus on the improvement of the healthcare system through the improvement of grievance redressal mechanisms.

This report should only be treated as a snapshot of problems with the delivery of healthcare and the enforcement of the right to health at PHEs in India. It is not an exhaustive empirical analysis of grievance redressal mechanisms at PHEs and is only intended to provide a glimpse of the kinds of complaints that are made by patients at such establishments and the legal framework within which these are addressed.

Governance in India: A Case Study on the All India Institute of Medical Sciences, New Delhi' (2015) Vol. 1 No. 1 Comparative Country Studies, Asia Pacific Observatory on Health system and Policies <http://www.wpro.who.int/asia_pacific_observatory/country_comparative_studies/ccs_public_hospitals_governance.pdf> accessed 6 March 2017; Anant Phadke, 'Regulation of Doctors and Private Hospitals in India' (2016) Vol.51 Issue 6 Economic and Political Weekly 46 <<http://www.epw.in/journal/2016/6/special-articles/regulation-doctors-and-private-hospitals-india.html>> accessed 6 March 2017; 'Report on the Working Group on Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure for the 11th Five-Year Plan' (*Planning Commission, Government of India*) <http://planningcommission.nic.in/aboutus/committee/wrkgrp11/wg11_hclinic.pdf> accessed 6 March 2017; 'Report of the National Consultative Workshop on Clinical Establishments Act' (*MoHFW, Government of India*, December 2014) accessed 6 March 2017

⁹ Shylashri Shankar and Pratap Bhanu Mehta, 'Courts and Socio-economic Rights in India' in Varun Gauri and Daniel Brinks (eds), *Courting Social Justice* (Cambridge University Press 2010); Namita Wahni and Sharanjeet Parmar, 'India: Citizens, Courts and the Right to Health: Between Promise and Progress' in Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press 2011).

¹⁰ Rama V. Baru, 'Challenges for Regulating the Private Health Services in India for Achieving Universal Health Care' (2013) 57:208-11 *Indian J Public Health* <<http://www.ijph.in/article.asp?issn=0019-557X;year=2013;volume=57;issue=4;spage=208;epage=211;aulast=Baru>> accessed 3 March 2017; Ramani KV, Mavalankar Dileep, 'Health System in India: Opportunities and Challenges for India' (2006) Vol. 20 Issue 6: 560-572 *Journal of Health Organization and Management*, IIM Ahmedabad <<http://dx.doi.org/10.1108/14777260610702307>> accessed 30 March 2017

¹¹ 'Common Review Mission Reports' (*National Health Mission, MoHFW*) <<http://nrhm.gov.in/monitoring/common-review-mission.html>> accessed 6 March 2017

2. Why public hospitals

Our decision to focus on grievance redressal mechanisms only at PHEs does not mean that there are no problems with the working of private establishments. As already mentioned, the challenges that patients face at private hospitals are well-documented in the literature.¹² However, as far as legal avenues for redressal go, it is at least clear that private healthcare establishments, unlike their public counterparts, squarely fall within the ambit of the CPA, thereby providing enforcement mechanisms to patients at such establishments. Of course, the effectiveness of the CPA in addressing these individual grievances deserves to be more thoroughly examined, but this ought to form the subject of a separate report.

We have chosen to focus on PHEs because the applicability of the CPA to such establishments is unclear (discussed in greater detail in Part III-A), making it all the more important to examine the working of their grievance redressal mechanisms.

3. Research methods

The research methods described below reflect the objectives of the report. These methods are likely to be equally useful in uncovering problems with the functioning of private healthcare establishments as well and ought to be applied as part of separate studies on the working of grievance redressal mechanisms at these establishments.

- (i) We used internet sources to access relevant laws and policies governing grievance redressal mechanisms at PHEs.
- (ii) In order to get a sense of the nature of grievances at PHEs, we analysed cases brought before the SC, all the High Courts, National Consumer Disputes Redressal Commission (“NCDRC”) and State Consumer Disputes Redressal Commissions (“SCDRC”) and the NHRC from January, 2005 to March, 2016. Cases before the SC, High Courts, NCDRC and SCDRCs were sourced from Manupatra, while cases before the NHRC were sourced from their website.
- (iii) On Manupatra, we used permutations and combinations of several search terms. These were “government hospital”, “grievance redressal”, “grievance redressal committee”, “grievance cell”, “denial of treatment”, “denied treatment”, “delay in treatment”, “late treatment”, “delayed treatment”, “improper conduct”, “conduct of doctor”, “wrong diagnosis”, “unhygienic”, “unsanitary”, “health and hygiene”, “hygiene”, “public hospital”, and “infrastructure”. We used the results to interpret the law, to obtain information on the numbers of complaints made, and to gain an overview of the kind of remedies awarded by different judicial forums in the country.

¹² Nandraj (n 8); Phadke (n 8).

- (iv) We filed applications under the Right to Information Act, 2005 (“RTI”) with 4 central government hospitals and 5 state government hospitals in New Delhi.¹³ The applications were intended to find out: a) whether grievance redressal mechanisms had been set up and were functioning at these hospitals; b) the kinds of complaints made; and c) the action usually taken in response to such complaints. The questions posed to them are set out in the Annexure to the report.
- (v) We also conducted semi-structured interviews with 5 government officers in the Ministry of Health and Family Welfare (“MoHFW”) and the National Institute of Health and Family Welfare and 3 organisations from civil society: Sehgal Foundation, Public Health Foundation of India and Centre for Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi. The questions posed to them included their views on the status of grievance redressal mechanisms in government hospitals, the desirability of giving such mechanisms statutory backing, and the need and feasibility of an overarching health regulator. The questions that we used for these interviews are also set out in the Annexure to this report.
- (vi) We made two field visits to AIIMS, New Delhi and Mewat, Haryana to gain an impression of the functioning of grievance redressal mechanisms at urban as well as rural PHEs. At AIIMS, we inspected their grievance register for two years—2013 and 2014. At Mewat, in the absence of any documentation or indeed, the existence of a functional primary health centre (“PHC”), we gained a sense of the delivery and enforcement mechanisms for healthcare through interactions with the local residents.

¹³ Central Government hospitals: AIIMS, Northern Railway Central Hospital, Ram Manohar Lohia Hospital, Safdarjung Hospital; State government hospitals: Aruna Asaf Ali Government Hospital, Deen Dayal Upadhyay Hospital, Govind Ballabh Pant Hospital, Guru Teg Bahadur Hospital, Lok Nayak Hospital

II. OVERVIEW OF THE PUBLIC HEALTHCARE SYSTEM IN INDIA

This part of the report lays down the broad structure of the public healthcare system in India. It is important to gain a sense of the various layers of authority within this structure, and therefore the different levels at which grievance redressal mechanisms may function.

The public healthcare system in India is organised into primary, secondary and tertiary levels. Each level of healthcare consists of units, which are expected to serve a specified population, depending on the geographical location, i.e. whether they are in the plains or in tribal, hilly or difficult areas.

A. Primary Healthcare

In the rural as well as urban areas, the primary healthcare infrastructure is the first point of contact between the community and the health care providers. In the rural areas, it consists of sub-centres and PHCs. A PHC is a referral unit for six sub-centres and refers cases to community health centres (“CHCs”). The PHC is the first unit at the grass root level in the Indian health care system to have a qualified doctor and a specified number of hospital beds. The activities of PHCs involve curative, preventive, promotive and family welfare services.

Table 1: Sub-centres and PHCs in India

S.No.	Unit	Population it serves	
		Plain area	Tribal, hilly or difficult areas
1.	Sub-centre ¹⁴	5000	3000
2.	PHC	30,000	20,000

In urban areas, the primary level consists of Accredited Social Health Activists (“ASHAs”), Mahila Arogya Samitis (“MAS”), Auxiliary Nurse Midwives (“ANMs”) and urban PHCs.

¹⁴ As per the Indian Public Health Standards (IPHS) applicable to sub-centres, there are two types of sub-centres - Type A and Type B, both having the recommended facilities, with the latter also having facilities for conducting child births.

Table 2: Urban healthcare in India

S.No.	Unit	Households / Population it serves	Functions
1.	MAS	50-100 households (or 250-500 population)	Its function is to build community awareness, monitor, focus on preventive and promotive healthcare, facilitate access to identified facilities, and manage funds. It will also consist of the ANM who will be in-charge of conducting outreach sessions every month.
2.	ASHA	1000-2500 beneficiaries (200-500 households)	The main function is to provide door-to-door health services, and to provide a link between the Urban PHC (U-PHC) and the urban slum population.
3.	ANM	Every 10,000 of the population	4 to 5 ANMs will be posted to each U-PHC, depending on the population. She will be in charge of organising special outreach sessions with other health professionals like doctors/ nurses/ technicians/ pharmacists, from either the government or private sphere.
4.	Urban-PHC	Every 50,000-60,000 of the population	The services provided will include OPD (consultation), basic laboratory diagnosis, and drug contraceptive dispensing, apart from distribution of health education material and counseling for all communicable and non-communicable diseases. However, it will not include in-patient care.

B. Secondary Healthcare

Secondary healthcare systems are designed to provide referral services as well as specialist services in the realm of health care for urban as well as rural populations. This level consists of CHCs, sub-district/sub-divisional hospitals and district hospitals in the rural areas.¹⁵

Table 3: Secondary healthcare in India

S.No.	Unit	Population it serves		Function
		Plain area	Tribal, hilly or difficult areas	
1.	CHC	1,20,000	80,000	It is a referral unit for four PHCs and is required to have thirty hospital beds.
2.	Sub-district hospital	5-6 lakh people and is expected to have 31-100 beds		A sub-district hospital acts as a first referral unit for the block population in which it is located, and forms an important link between the sub-centre, PHC, CHC on the one hand and district hospitals on the other hand.
3.	District Hospital	Since the area, population as well as the terrain varies, the bed strength also varies, from 75 to 500. However, on an average, for a district having a population of 10 lakh, the required number of beds would be 300.		Every district is required to have a district hospital, which is linked to the health facilities below the district level, and thus assumes the role of a secondary level referral centre. Further, district hospitals are an integral part of the District Hospital System and are fundamental for the implementation of the

¹⁵ The classification in urban areas is not clear.

			country's health policies and delivery of health care - be it curative, preventive or promotive. They also work as administrative and technical support units imparting education and training to PHCs.
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C. Tertiary Healthcare

Tertiary healthcare refers to the specialty and super-specialty hospitals that provide specialised health care, and falls in the urban health care system, though it caters to both the urban and rural populations. It also includes research institutes and medical colleges, and is at the topmost level of the referral system. Only referral cases from primary and secondary levels of healthcare are to be dealt with here; however due to the broken referral system in the country, tertiary hospitals are generally overburdened and suffer from resource deficit.¹⁶

Although the rural and urban health care systems are both divided into primary, secondary and tertiary levels, there are some differences in infrastructure. For instance, in the urban areas, the sub-centre level is absent;¹⁷ the lowest level is occupied by community workers in the form of ASHAs and MAS; and separate standards are applicable to urban PHCs.¹⁸ The governance of such services in urban areas is patchy, as the healthcare system in certain cities (Mumbai, Kolkata, Chennai) is entrusted to urban local bodies under the 74th amendment of the Constitution, whereas in cities like Delhi, it is governed jointly by local bodies as well as the state government. In cities like Patna, Ranchi, Agra etc., despite the presence of urban local bodies, primary health care still vests with the state government.¹⁹

¹⁶ 'Chapter VIII, Public Health Care System' (*Planning Commission Report*) <http://planningcommission.nic.in/aboutus/committee/strgrp/stgp_fmlywel/sgfw_ch8.pdf> accessed 28 March 2017

¹⁷ This is because distances are relatively small and transportation facilities are easily available in urban areas.

¹⁸ 'National Urban Health Mission: Framework for Implementation' (*MoHFW, Government of India, May 2013*) <http://nrhm.gov.in/images/pdf/NUHM/Implementation_Framework_NUHM.pdf> accessed 28 March 2017

¹⁹ *Ibid*

III. LEGAL FRAMEWORK GOVERNING PUBLIC HEALTHCARE ESTABLISHMENTS

This part undertakes a comprehensive analysis of existing as well as proposed laws that are relevant to the resolution of various grievances in relation to the violation of various aspects of the right to health in PHEs.

A. Consumer Protection Act, 1986

The applicability of the CPA to PHEs has been debatable due to differences in the interpretation of the terms “consumer” and “service” by various courts in the country. As the terms appear in the CPA, a consumer is someone who buys goods or avails services *for a consideration*, and services mean a variety of services including health care services, but does not include rendering services free of charge. Therefore, from a bare reading of these provisions, it appears that the monetary element is indispensable for consumers and service providers to be covered under the Act. This would appear to exclude the applicability of the CPA to PHEs, where services are generally provided free of charge. However, this assumption was dispelled by the judgment of the SC in *Indian Medical Association v V.P. Shantha* (“VP Shantha”)²⁰, which lays down principles to determine the applicability of CPA to PHEs:

- (i) services rendered at a PHE where no payment is made by the person availing the service will not be considered to be a service under the CPA. Payment of registration charges does not alter this position;
- (ii) services rendered at a PHE where payment is made by some persons availing the service and some persons availing services free of charge, brings the services for all persons under the ambit of the CPA. The rationale is not to unfairly prejudice or discriminate against persons who cannot afford to pay for health care services. For example, in a PHE, if some patients are paying for an ultrasound test, and some are availing the test free of charge, then all patients are considered to be consumers under the CPA;
- (iii) services rendered by a medical practitioner or a hospital/nursing home as a part of the conditions of service, where the employer bears the expenses of medical treatment of an employee and his dependent family members, would not be free of charge, and will be considered to be a service under the CPA.

In keeping with the SC’s pronouncement in VP Shantha, in 2004, a five-judge bench of the National Consumer Disputes Redressal Commission (‘NCDRC’) held, in *Sailesh Munjal and Anr v All India*

²⁰ AIR 1996 SC 550

*Institute of Medical Sciences and Others*²¹ that AIIMS, a tertiary government hospital in various cities in the country, is covered under the CPA. Since patients in private wards were required to pay the cost of consumables to help the hospital recover hospital charges and diagnostic charges, it held that the health care services provided were subsidised to a great extent, but were not free.

The reasoning in VP Shantha was validated by two more judgments of the NCDRC, by a two judge bench in 2010²² as well as 2012.²³ Similarly, in keeping with the third proposition laid down in VP Shantha, in *Arvind Pandey v Sulekha Saran*,²⁴ it was held that the CPA was applicable to a Maternity & Gynaecology Hospital in New Delhi, which was a PHE and covered under the Central Government Health Scheme (“CGHS”). The court held that employees covered under a CGHS scheme are consumers and the services provided by such CGHS hospitals are considered to be services covered under the CPA.

The effect of these judgments is that only PHEs where no payment whatsoever is made by any kind of patient are excluded from the scope of the CPA. Despite this, as the analysis of consumer cases in Part IV of this report indicates, there continue to be cases that are dismissed by consumer courts on the grounds that the CPA does not apply to PHEs, without first examining whether charges paid by private patients at such PHEs are subsidising the use of services by patients who cannot pay. Therefore, there continues to be some ambiguity, at least as a matter of law, regarding the application of the CPA to PHEs; the MoHFW officials whom we interviewed for this report were very clear that PHEs were covered under the CPA.

B. The Clinical Establishments (Registration and Regulation) Act, 2010

The CEA is a Central law that provides for the registration and regulation of all clinical establishments in the country (public or private), prescribes the minimum standards of facilities and services provided by them, and the fees that may be charged from patients. Non-compliance with the standards can lead to cancellation of the registration license granted under the Act and imposition of penalties provided in the Act. The CEA has not taken effect in all the states of the country, and this remains its biggest weakness i.e. that there are no minimum uniform standards for all clinical establishments across the country.

²¹ III (2004) CPJ 93 (NC)

²² *All India Institute of Medical Sciences v. Mrs. Ayesha Begum*, MANU/CF/0069/2010

²³ *S.C. Mathur v All India Institute of Medical Sciences*, II (2012) CPJ 608 (NC)

²⁴ 2012 (6) ALD(Cons.) 1 (NC)

However, even if the CEA were in force in all states, the minimum standards prescribed under it as well as the related rules²⁵ for various categories of clinical establishments do not contain provisions on grievance redressal. There is no requirement for a clinical establishment to have a grievance cell in place as a pre-requisite for obtaining either provisional or permanent registration under the Act. Neither does the application for registration require an undertaking or disclosure to this effect. The closest that the CEA comes is by requiring certain categories of hospitals²⁶ to have a patient citizen charter in place; however, even this charter does not require the creation of a grievance redressal mechanism. This demonstrates that the only central regulatory framework on clinical establishments in the country makes no provision for the enforcement of individual patient rights.

C. The Bureau of Indian Standards Act, 2016 and Bureau of Indian Standards Act, 1986

The Bureau of Indian Standards Act, 2016 (“**BIS 2016**”) was brought into force in March, 2016 and repealed the Bureau of Indian Standards Act, 1986 (“**BIS 1986**”). This act is relevant to this report as it sets out standards for goods and services, which includes healthcare services.

1. The legal status of the standards

The BIS 2016 provides for the formation of a national body, which grants licences to manufacturers or service providers for conformity with standards for goods and services that the body lays down or adopts. The BIS 1986 did not require mandatory compliance with the standards under the Act; however, under the new BIS 2016,²⁷ if the Central Government is of the opinion that it is necessary or expedient in the public interest or for the protection of human, animal or plant health, safety of the environment, or prevention of unfair trade practices, or national security, it may notify certain goods or services for which compliance with the standards laid down by the Bureau of Indian Standards is mandatory. Any contravention in terms of non-conformance with the relevant standard is punishable with compensation for the injury caused.²⁸ Till date, no such goods or services have been notified under this section.

2. Applicability of the existing standards to health care services

As per the definition of ‘Indian standards’ under the BIS 2016, it includes standards developed and adopted under BIS 1986. Therefore, though the BIS 1986 stands repealed, the standards developed

²⁵ Clinical Establishments (Central Government) Rules, 2012
<<http://clinicaestablishments.nic.in/WriteReadData/386.pdf>>

²⁶ Clinical Establishment Act Standards for Hospital (LEVEL 1A &1B): CEA/Hospital-001
<<http://clinicaestablishments.nic.in/WriteReadData/147.pdf>>

²⁷ BIS 2016, Section 16

²⁸BIS 2016, Section 31

under it continue to apply. There are several BIS standards which are applicable to health care services, twenty-one to be exact²⁹, and an overview demonstrates that they lay down standards relating to the infrastructure, services, administration etc. of hospitals. The BIS has developed standards for basic requirements for hospitals having up to 30 and 100 beds, and also standards on the classification and matrix for various categories of hospitals (30, 100, 250, 500, and 750 bedded).³⁰ A few important BIS standards, which are relevant from the perspective of grievance redressal mechanisms in PHEs are discussed below:

Table 4: BIS standard on grievance redressal in healthcare facilities

S.NO.	BIS STANDARD	RELEVANT STANDARD ON GRIEVANCE REDRESSAL IN HEALTHCARE FACILITY
1.	IS/ISO15189:2012 - Medical Laboratories - Requirements for Quality and Competence	A medical laboratory is required to have policy and procedures for the resolution of complaints or other feedback received from clinicians, patients or other parties. Records of complaints and of investigations and corrective actions taken by the laboratory are required to be maintained and it is the responsibility of the laboratory director to take action.
2.	IS15461:2004 - Performance Guidelines for Quality Assurance in Hospital Services up to 100 Bedded Hospitals	It requires complaint boxes and complaint forms to be provided, and also weekly review meetings of all heads of departments to be held to <i>inter alia</i> look into grievances / complaints. Also, a detailed complaint redressal mechanism is set out in paragraph C-6 of the standards.
3.	IS15784:2007 - Healthcare Facilities - Particular Requirements	It requires healthcare facilities of secondary and tertiary level to have grievance handling mechanisms.
4.	IS 15700:2005 - Quality Management Systems - Requirements for service quality by public service organisations	This standard is not particularly focused on health care but applies to any public service organisation. It focuses on how an organisation providing public services (which would include PHEs) should maintain quality of services: by having a realistic citizen's charter, an effective complaint handling system and service delivery requirements.

²⁹ <http://164.100.105.199:8071/php/BIS/StandardsList.php?Name=Hospital%20Planning&tech=MHD%2014>

³⁰ 'Situation Review and Analysis of Accreditation System in India' (Centre for Enquiry into Health and Allied Themes, Mumbai) <<http://www.cehat.org/go/uploads/Publications/assessingneed.pdf>> accessed 14 March 2017

5.	ISO 9001: 2008	It promotes the adoption of a process approach for developing, implementing, and improving the effectiveness of a quality management system (QMS) while enhancing customer satisfaction by meeting customer requirements.
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The standards mentioned above demonstrate that grievance redressal mechanisms are an important part of any kind of healthcare delivery establishment. However, as long as these standards remain only voluntary, or until some incentives are attached to the adoption of such standards, there is very little effect that they can have on the enforcement of patient rights.

D. National Health Mission

The National Health Mission (“NHM”) consists of two sub-missions, the National Rural Health Mission (“NRHM”) launched in the year 2005 and the National Urban Health Mission (“NUHM”)³¹ launched in the year 2013. It provides guidance to the states on achieving universal health care through the strengthening of health systems, institutions and capabilities, and all PHEs are covered under it. The aim of the missions is to develop an integrated, functional, community-owned, decentralised health care delivery system.³²

The Framework for Implementation of the NHM 2012-2017³³ (“Implementation Framework”) sets out the manner in which quality and accountability are to be assured in the delivery of healthcare services. The guiding principles of the NHM are to be achieved by enabling “*integrated facility development planning which would include infrastructure, human resources, drugs and supplies, quality assurance, and effective Rogi Kalyan Samitis (RKS)*”. The RKS, which are discussed in the next section, hold the key to providing effective grievance redressal mechanisms (at least in theory) under the Indian public healthcare delivery system.

1. Quantitative and Qualitative Health Standards under the NHM

(a) *Indian Public Health Standards (IPHS)*

³¹ The NUHM targets the urban poor population living in districts with a population of more than 50,000. The leftover urban districts are covered under the NRHM. The State Government and the Central Government enter into a memorandum of understanding for the implementation of the health missions under the NHM, fastening on the State Government the responsibility of administration of the mission, whereas substantial resources are provided by the MoHFW in contribution with the State Government.

³² ‘National Rural Health Mission’ (*National Health Mission, MoHFW*) <<http://nrhm.gov.in/nhm/nrhm.html>> accessed 3 March 2017

³³ http://nrhm.gov.in/images/pdf/NHM/NRH_Framework_for_Implementation__08-01-2014_.pdf

The IPHS have been prescribed under the NHM by a task group constituted under the Director General of Health Services.³⁴ They are a set of uniform standards or benchmarks for public health care service providers, to be used as a reference point for improving the quality of health care delivery across the country. Although the standards are not legally binding under a statutory framework, the NHM requires each sub-centre, PHC, CHC, sub-district hospital and district hospital to upgrade to these standards from their current level. The components covered under the IPHS are broadly Physical infrastructure, Services (essential and desirable), Human Resources, Equipment, Drugs and Diagnostics. These standards are in addition to the BIS standards and were developed once it was recognised that the BIS standards were not achievable because of their resource-intensive nature.³⁵ However, the IPHS are also not immune from certain shortcomings, for instance, there is no component measuring the process quality i.e. how services are organised and delivered, and thus the standards lean more towards quantitative assessment, rather than qualitative assessment. For instance, a significant measurable standard under the IPHS for almost all levels of health care delivery systems is the existence of a Rogi Kalyan Samiti. However, this does not assess the committee's qualitative functioning.

Apart from grievance redressal mechanisms, the other two requirements under the IPHS that are of relevance are:

- (i) *Citizen's Charter*: Under the IPHS for sub-centres, to ensure accountability and quality of services and patient satisfaction, it is mandated that a *citizen's charter*³⁶ be in place, *inter alia* informing patients of their right to privacy, right to access all services and most importantly, their right to grievance redressal. For PHCs and PHEs above the level of PHCs (up to the district hospital level),³⁷ this citizen's charter must provide for a grievance redressal mechanism and be put up in a public place.
- (ii) *Rogi Kalyan Samiti*: Additionally, the IPHS mandates that there should be a Rogi Kalyan Samiti or Patient Welfare Committee, sometimes also known as the Hospital Management Society. The link between an RKS and grievance redressal mechanisms is reflected in the recent detailed guidelines for RKS that were issued in 2015 ("**RKS Guidelines**"), where one of the stated objectives for RKS is to - "*Operationalize a Grievance Redressal Mechanism including a prominent display of the "Charter of Patient Rights" in the Health facility and address complaints promptly thus building confidence of people in the public health facilities.*"

³⁴ They were first conceptualised in 2005 and since then have been revised once in 2012.

³⁵ 'FAQs on IPHS' <www.nihfw.org/Doc/iphs.doc> accessed 2 April 2017

³⁶ IPHS Guidelines for sub-centres, Annexure 11 (*Directorate General of Health Services, MoHFW, Revised 2012*) <http://cghealth.nic.in/ehealth/2014/IPHC/shc_2012.pdf> accessed 19 March 2017

³⁷ 'Rogi Kalyan Samiti' (*Press Information Bureau, MoHFW, Government of India, 30 August 2013*) <<http://pib.nic.in/newsite/PrintRelease.aspx?relid=98919>> accessed 19 March 2017

For PHCs, the IPHS state that a RKS should be in place; for CHCs, having an RKS is a minimum requirement under the checklist for audit; for sub-district hospitals, the standards state that every such hospital should have an RKS; for district hospitals, the standard states that each hospital should have an RKS and *further states that a grievance redressal mechanism is an essential requirement*, unlike other requirements such as super-specialty units, post-partum units, telemedicine, counseling services etc., which are only desirable. Further, for all levels of PHEs, in the proforma used by the government / NHRM to assess the establishment's compliance with the IPHS, whether an RKS has been constituted is one of the components to be examined.³⁸

Therefore, it is evident that the RKS, of which a grievance redressal mechanism is a critical component (and essential in district hospitals), is mandatory under the IPHS.

Functioning of the RKS: The RKS is required to be registered as a society under the Societies Registration Act, 1860 and comprises a governing body and an executive committee. It functions as a non-government organization (“NGO”) and consists of members from local Panchayati Raj Institutions (“PRIs”), NGOs, local elected representatives and state Government officials. It is funded by the state government through annual maintenance grants, RKS grants and untied funds, or through money raised by it by implementing user charges or through the disposal of assets.³⁹ RKS grants of INR one lakh per PHC, CHC, Sub-divisional/Sub-district Hospital and of INR five lakh per District Hospital are required to be released to the RKS registered in various states in the country, in addition to annual maintenance grants and untied funds.⁴⁰ In fact, under the NHM, financial support by way of untied grants is provided only for those PHEs where an RKS has been constituted and registered.⁴¹

The executive body of the RKS is responsible for the establishment of the grievance redressal system in the RKS at the facility level, and for incorporating feedback to ensure that corrective action is taken to prevent the non-recurrence of grievances. The governing body reviews compliance with the citizen's charter, the effectiveness of the grievance redressal mechanism and compliance with the IPHS guidelines. The governing body is also required to send an annual audited report to the District Collector, executive body, Zila Parishad and the

³⁸ ‘IPHS Revised Guidelines, 2012’ (*National Rural Health Mission, MoHFW*) <<http://nrhm.gov.in/nhm/nrhm/guidelines/indian-public-health-standards.html>> accessed 20 March 2017

³⁹ ‘Rogi Kalyan Samitis: Framework Hospital Management Society (HMS)’ (*National Health Mission, MoHFW*) <<http://nrhm.gov.in/communitisation/rogi-kalyan-samities/framework-hospital-management-society-hms.html>> accessed 14 March 2017

⁴⁰ ‘Annual Report 2010-11’ (*MoHFW, Government of India*) <http://mohfw.nic.in/WriteReadData/l892s/3683263752ENGLISH_ANNUAL_REPORT_2010-11.pdf> accessed 13 March 2017

⁴¹ ‘Rogi Kalyan Samiti/Hospital Management Committees’ (*Press Information Bureau, MoHFW, Government of India*, 21 February 2014) <<http://pib.nic.in/newsite/PrintRelease.aspx?relid=104152>> accessed 13 March 2017

urban local body. The demarcation of powers and functions across the governing and executive bodies is unclear, and it is difficult to fix accountability on the RKS.⁴²

The overall review, monitoring and performance evaluation of RKS at the district and sub-district level is done by the District Health Society, which is the entity responsible at the district level to carry out the National Health Mission. Other RKS which are below the district and sub-district level are monitored by the Block Health Society,⁴³ or the Directorate of Health Services,⁴⁴ or any other authority designated by the State Government. Further, the Members of Parliament who are associated with RKS and District Health Societies now also head newly formed district / city level vigilance committees in each city / district to monitor the progress of the implementation of the NHM.⁴⁵ Also, in a bid to revive the RKS in government hospitals in the state of Delhi, the State Government has issued directions that local MLAs who are a part of the RKS be given office space in the hospital to facilitate the better working of the RKS.⁴⁶

(b) Quality Assurance Programme (QAP)

The 12th five-year plan also emphasizes the importance of quality delivery of health care services - *“All government and publicly financed private health care facilities would be expected to achieve and maintain Quality Standards. An in-house quality management system will be built into the design of each facility, which will regularly measure its quality achievements.”*⁴⁷ To this end, the MoHFW published ‘Operational Guidelines on Quality Assurance’ in 2013, mainly focusing on district hospitals, but with the potential to be adapted for PHEs below the level of district hospitals as well.⁴⁸

⁴² ‘6th Common Review Mission Report 2012’ (National Rural Health Mission, MoHFW) <http://www.nhm.gov.in/images/pdf/monitoring/crm/6th-crm/report/6th_CRM_Main_Report.pdf> accessed 20 March 2017

⁴³ ‘Procedure for Registration of Rogi Kalyan Samitis of different District & Sub-district Hospitals of WB’ (Department of Health & FW, Government of WB, 22 October 2013) <http://www.wbhealth.gov.in/go/reg_rks.pdf> accessed 15 March 2017

⁴⁴ <https://health.mizoram.gov.in/wp-content/uploads/2015/03/RKS-Rules-Regulation.pdf>

⁴⁵ ‘District/City Level Vigilance & Monitoring Committee (D/CLVMC)’ (National Health Mission, MoHFW) <<http://nrhm.gov.in/monitoring/district-level-vigilance-monitoring-committee.html>> accessed 15 March

⁴⁶ Astha Saxena ‘Aam Aadmi Party wants office space for MLAs in government hospitals’ (India Today, Delhi, 17 May 2015) <<http://indiatoday.intoday.in/story/aam-aadmi-party-office-space-for-mlas-delhi-government-hospitals/1/438532.html>> accessed 15 March

⁴⁷ 12th Five Year Plan, 2012-17, Volume III, Social Sectors <http://planningcommission.gov.in/plans/planrel/12thplan/pdf/12fyp_vol3.pdf> accessed 2 April 2017

⁴⁸ ‘Operational Guidelines for Quality Assurance in Public Health Facilities’ (Maternal Health Division, MoHFW, 2013) accessed 15 March 2017 <[http://www.rrcnes.gov.in/quality%20Assurance/Operational%20Guidelines%20on%20Quality%20Assurance%20\(Print\).pdf](http://www.rrcnes.gov.in/quality%20Assurance/Operational%20Guidelines%20on%20Quality%20Assurance%20(Print).pdf)> accessed 15 March 2017

In addition to these guidelines, the QAP also bolstered the idea of ‘accreditation’.⁴⁹ Accreditation originally required the meeting of certain standards set by certifying agencies such as the National Accreditation Board for Hospitals and Healthcare (“NABH”).⁵⁰ With time, however, it was felt that accreditation based on evaluation by external agencies was hard to sustain over a period of time after supervision by the external agency was withdrawn. Instead, it was likely that accreditation would be sustained better if there was an in-built system of quality management.⁵¹ This eventually led to the creation of an accreditation process under the QAP itself, without the involvement of external agencies. The Central Quality Supervisory Committee at the national level, the State Quality Assurance Committee at the state level, and District Quality Assurance Committee at the district level conduct accreditation under the QAP.

Although it was conceptualized as a new development mechanism under the NUHM, both rural and urban areas now stand to benefit from the advantages of accreditation under the NHM, as the QAP does not differentiate between health facilities at the rural or urban level in terms of eligibility for accreditation. In December 2015, the MoHFW came up with special quality assurance standards for U-PHCs, as they stand on a different footing from their rural counterparts due to various factors such as size, functions, focus on ambulatory care, limited staff and infrastructure.

The QAP highlights the new standards and approach of the NUHM, with the technical aspects of health care and patient satisfaction as its primary concern, shifting emphasis away from mere infrastructural issues. Certification also includes additional benefits such as opportunities for further funding from the State and Central Governments. One of the limitations of the QAP is that accreditation is purely voluntary.

The QAP requires the setting up of quality assurance committees and units at the national, regional and district level and a district quality team (“DQT”) at the district hospital level. The process for quality assurance requires that the DQT completes the assessment as per a check-list and invites state/district assessors for verification and guidance. The process continues till the state quality assurance committee certifies the attainment of the standards, after which the DQT has to ensure that the hospital maintains the standards. A watershed moment in the quality improvement initiative came in March 2005, when the SC, in *Ramakant Rai and Health Watch UP and Bihar v. Union of*

⁴⁹ A formal process by which an Independent and recognized body, assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Accreditation standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organizations. Accreditation is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation. <[http://www.rrcnes.gov.in/quality%20Assurance/Operational%20Guidelines%20on%20Quality%20Assurance%20\(Print\).pdf](http://www.rrcnes.gov.in/quality%20Assurance/Operational%20Guidelines%20on%20Quality%20Assurance%20(Print).pdf)> accessed 15 March 2017

⁵⁰ A constituent board of the Quality Council of India specifically for Healthcare organizations

⁵¹ ‘Operational Guidelines for Quality Assurance in Public Health Facilities’ Page 7 (*Maternal Health Division, MoHFW, 2013*), <[http://www.rrcnes.gov.in/quality%20Assurance/Operational%20Guidelines%20on%20Quality%20Assurance%20\(Print\).pdf](http://www.rrcnes.gov.in/quality%20Assurance/Operational%20Guidelines%20on%20Quality%20Assurance%20(Print).pdf)> accessed 15 March 2017

India⁵² directed all states to set up a quality assurance committee (“QAC”) for family planning surgeries at the state and district level. However, a mid-term review of Reproductive and Child health (in phase II) showed that while the QACs had been set up, they remained non-functional for the large part.

Relevant standards: Standard B of the QAP defines patient rights to include the right to all services without discrimination, right to privacy, right to informed consent etc. Under this, Standard ME B4.5 mandates the setting up of a grievance redressal mechanism. Further, the DQT consists of a ‘hospital manager’ who is responsible for the smooth administration of the non-direct patient care services, which includes grievance redressal. He is responsible for instituting an effective grievance redressal system both for the employees and the patients, ensuring cleanliness and good quality non-clinical services like security, infection control, facilitating the conduct of RKS meetings, and preparing reports of hospital progress etc.

2. Enforceability of the health standards governing PHEs

Assessing compliance with the IPHS by PHEs is done using proformas⁵³ (as mentioned before) which can be a part of internal as well as external monitoring systems. For PHCs, CHCs, sub-district hospitals and district hospitals, the external monitoring mechanisms could be the RKS or PRIs or village health sanitation and nutrition committees (“VHSNCs”) or any other community monitoring framework.

As mentioned above, the governing body of the RKS is specifically responsible for reviewing compliance with the IPHS guidelines. Additionally, for sub-district hospitals and district hospitals, the monitoring can also be done by other independent agencies or through an annual ‘jansamvad’.⁵⁴ The district monitoring committees formed under the NRHM monitor the upgrading of district hospitals to the IPHS. For CHCs, the internal monitoring is done by the District Health Authority at least once a month and for district hospitals, the findings of the internal audit are discussed with the RKS.

The RKS, therefore, has a major role to play in monitoring the working of the health care facility. To this end, the monitoring committee constituted by the governing body of the RKS is required to visit hospital wards and take patient feedback. It also submits a monthly monitoring report to the District Collector and the Chairperson of the Zila Parishad.⁵⁵

Three things emerge clearly from the above discussion:

⁵² Writ Petition (C) No 209 of 2003 (SC) (12 June 2007) (Unreported)

⁵³ ‘IPHS Revised Guidelines, 2012’ (*National Rural Health Mission, MoHFW*) <http://nrhm.gov.in/nhm/nrhm/guidelines/indian-public-health-standards.html> accessed 20 March 2017

⁵⁴ It is a form a community monitoring system under the NHM.

⁵⁵ ‘Rogi Kalyan Samitis: Framework Hospital Management Society (HMS)’ (*National Health Mission, MoHFW*) <http://nrhm.gov.in/communitisation/rogi-kalyan-samities/framework-hospital-management-society-hms.html> accessed 14 March

- (i) First, that having a functioning and effective grievance redressal mechanism, in whichever form, is a responsibility of the RKS, and having an RKS is essential under the IPHS. Additionally, having a functioning grievance redressal mechanism is also essential under the QAP.
- (ii) Second, that the RKS has an important role to play in the monitoring of PHEs at all levels.
- (iii) Third, there are a number of overlapping standards related to grievance redressal mechanisms and a corresponding number of authorities responsible for their compliance, creating an unclear chain of command.

As mentioned earlier, the IPHS guidelines, which were developed under the NRHM do not have any statutory backing. At best, they can be classified as policy guidelines, which are required to be followed under the NRHM, although a breach of these guidelines would not be punishable under the law. An attempt to give them legal backing has been made under the NHB 2009 and other state public health laws, although these are still in the draft stage.⁵⁶ The Assam Public Health Act, 2010 (“**APHA, 2010**”) requires the state government to adopt the IPHS for all kinds of PHEs; however, the language of the statute demonstrates that this is a best efforts requirement, with no penalties for non-compliance.

Similarly, pronouncements by courts in this regard have held that the IPHS are not legally enforceable. In *Al-Falah University and Ors. v. State of Haryana and Ors.*,⁵⁷ it was held that the IPHS are not mandatory and compliance with them could not be considered to be a pre-condition for the grant of an essentiality certificate to a hospital. Only the norms framed by the Medical Council of India needed to be complied with, and these norms make no reference to the establishment of grievance redressal mechanisms.

In another case,⁵⁸ the Gujarat High Court directed that all the CHCs, PHCs and civil hospitals in Gujarat should comply with the IPHS guidelines in respect of maintenance of minimum standards, without imposing any penalty for non-compliance. Observations about the IPHS were made by the Karnataka High Court in a writ petition⁵⁹ praying for a direction for the maintenance of cleanliness, providing required infrastructure and proper medicines for district hospitals in Gulbarga, Karnataka. The High Court merely noted that the process of accreditation under the aegis of the NABH is aimed at improving infrastructure in district hospitals in a phased manner, with the objective of meeting the IPHS. However, no directions were passed to enforce the IPHS.

⁵⁶ Please refer to Part III-F of this report.

⁵⁷ CWP No. 14076 of 2015 (P&H HC) (15 September 2015) (Unreported)

⁵⁸ *All India Tribal Unity and Development Council v. Superintendent Officer*, SCA No. 11467 of 2010 (Guj HC) (3 October 2013) (Unreported)

⁵⁹ *Sharan Desai v District Surgeon*, WP No.6704/2013 (GM-RES-PIL) (Kar HC) (2 September 2013) (Unreported)

The requirement of effective grievance redressal mechanisms as part of the IPHS issued under the NRHM is a classic example of soft law. As the cases in this section demonstrated, non-compliance with this requirement is not punishable under the law, nor does it present any serious consequences for hospital authorities.

E. Guidelines issued by the MoHFW

The MoHFW has in place a “hospital manual”⁶⁰ which lays down provisions for the smooth functioning of public hospitals in the areas of management, administration, various departments and wards, and includes a citizen’s charter. The manual⁶¹ envisages a grievance redressal mechanism for every public hospital, and the appendix lays down the citizen’s charter for central government hospitals. The mechanism requires a person to be designated as a grievance redressal officer in each hospital, compliant boxes to be installed and the complaints therein to be registered and regularly responded to, follow up action to be taken, a committee headed by chief of the hospital to monitor the complaints and the follow up action taken, and a nodal officer be appointed to monitor the implementation of the citizen’s charter. Responses to a few RTI applications indicated that a few government hospitals⁶² follow these MoHFW guidelines. However, like the IPHS and the QAP, this manual does not have legal backing and non-compliance with the requirement to institute grievance redressal mechanisms has no consequences.

F. Legislation on public health

Public health being a state subject, there are five states in the country that have a law, and four states that have a bill on aspects of public health. The states that have enacted legislation are Tamil Nadu (Tamil Nadu Public Health Act, 1939), Pondicherry (Pondicherry Public Health Act, 1973), Goa, Daman & Diu (The Goa, Daman and Diu Public Health Act, 1985), and Assam (APHA, 2010). The states that have public health bills pending are Kerala, Delhi, Karnataka and Gujarat. The provisions relating to grievance redressal mechanisms in some of the above-mentioned acts and bills have been discussed in the following paragraphs.

In 2009, the MoHFW task force put out a draft of the NHB 2009, which does not appear to have been finalised. The approach paper of the MoHFW⁶³ on the NHB 2009 states that the bill will serve as a

60 ‘Hospital Manual’ (Directorate General of Health Services, MoHFW) <<http://www.mohfw.nic.in/index3.php?lang=1&level=0&deptid=128>> accessed 12 March 2017

61 Chapter XIII

62 Dr Ram Manohar Lohia Hospital, Safdarjung Hospital

63 ‘Approach Paper on Public Health Act’ (Task Force on Public Health Act) <http://nhsrcindia.org/index.php?option=com_content&view=article&id=175:public-health-administration&Itemid=646> accessed 30 March 2017

model law for all states in the country, and each state will be required to adopt its own version of the bill. Only if this does not prove feasible will the bill be proposed as a central act, and not as a model law. The proposal to make it a central law is based on two approaches: either under Article 252 of the Constitution, where 2 or more states request the Parliament to legislate, or under Article 253, where the Parliament can legislate to implement an international treaty.

1. National Health Bill, 2009

The NHB 2009 is a rights-based law that specifically creates a justiciable right to health. It is a marked shift in approach from the draft Model Public Health Bill, 1987 prepared by the Central Bureau of Health Intelligence. The latter bill was not a rights-based bill; instead, it created a broad framework through which the several authorities set up under the bill were assigned responsibilities relating to water supply, drainage, sanitation and infection control in their respective local areas.

In contrast, the NHB 2009 lays down general and core obligations for the central as well as the state Governments, sets out individual and collective rights to health, creates implementation and monitoring authorities and most importantly for the purposes of this report, sets up grievance redressal mechanisms. There are two specific rights in the NHB 2009 that deal with grievance redressal:

- The first right is contained in Clause 13 and is titled the ‘right to justice’. It states that every person whose right to health is violated (whether actual or perceived) has the right to seek redressal of her grievance.
- The second right is more specific and is contained in Clause 14(18)(f). Under this provision, every user has a right to complain against the PHE where health care was received, and to have that complaint investigated, mediated or adjudicated, not only through quasi-judicial systems or through the court, but also through independent mechanisms at the institutional level within the PHE.

Chapter V of the Bill sets out two types of grievance redressal systems - (i) a community- based non-adversarial hearing and (ii) an institutionalised in-house complaint forum. It also specifies the kinds of court orders that can be passed by the district courts designated to hear health-related cases. The first mechanism is also known as the ‘*swasthya jan sunwai*’ and is intended to be an amicable dispute resolution to be conducted twice a year for PHEs at the district level and below, and once a year for those at a higher level. The hearing panel would consist of PRI and civil society representatives, while the respondents would be appropriate Government officials as well as those representatives of private healthcare establishments who volunteered to submit to such hearings. The panels would hear issues relating to denial, access, availability and quality of health care services against the appropriate government, as well as people’s suggestions for improvement and perceptions about the behaviour or attitude of health care providers. The panels would suggest follow-up actions to the issues emerging at such hearings. These recommendations would be followed up for appropriate

action, including by ‘entry in the formal service records and annual evaluation reports of the concerned service providers in Government health care establishments.’⁶⁴

Additionally, every user of health care services at an establishment with more than 10 employees has the right to get her complaint examined through an “in-house complaint forum” at such establishment. In the case of PHEs, the authority under which the PHE functions is responsible for setting up an in-house complaint forum. The Bill requires equal representation from the healthcare establishment and independent members of civil society. One full-time administrator is to be appointed as the Complaints Officer. The forum is required to decide a complaint within 7 days, and in cases of emergency, within 24 hours. The forum can take three types of action - (i) give directions to the health care establishment to rectify the violation, to take specific steps towards compliance with health rights, or to refrain from or discontinue the violation; (ii) counsel the person who has violated the health rights and require him to undergo relevant training; or (iii) recommend the initiation of disciplinary action against the violator for subsequent breaches.

The action taken in respect of the complaint is to be communicated to the complainant, published on the website and reported semi-annually to the concerned government. A user of a PHE may also make a complaint to the designated district court regarding health rights violations, such as denial of guaranteed services, sub-standard quality of guaranteed services, lack of infrastructure at the PHE, absenteeism of the staff at the PHE etc. This court may pass orders similar to the in-house complaints forums, and may additionally award compensation, damages, or order inquiries. Most importantly, the court may also direct the concerned government or PHE to make regular reports to the court regarding the implementation of its orders, especially to ensure that health rights violations are not repeated. It may additionally issue directions to concerned PHEs regarding grievances that are systemic and regular in nature.

The Bill establishes various methods of accountability⁶⁵, one of them being the ‘government monitoring system’. Under this system, all PHEs *inter alia* must prominently display information regarding the IPHS in various respects, as well as the charter of users’ rights. The overarching principle for the monitoring and accountability framework is encapsulated in sub-clause (3) which states “*The monitoring system shall be directly linked, on an ongoing basis, to corrective decision making bodies which shall be constituted by State Governments at various levels such that the information and issues emerging from monitoring are communicated to the relevant official bodies responsible for taking action (from primary health care centre to State level) so that the monitoring results in prompt, effective and accountable remedial action and is also fed into policy making and planning for future improved performance.*”

⁶⁴National Health Bill, 2009, Clause 29.

⁶⁵ National Health Bill, 2009, Clause 23

This indicates that grievance redressal mechanisms alone may not be sufficient to address violations of health rights; what is also required is a body that can take a broader view of the problems with healthcare delivery that are suggested by the individual complaints made at different in-house complaint forums. A combination of grievance redressal, monitoring and corrective action is therefore required to protect health rights effectively, and the NHB 2009 is a good example of this kind of enabling framework.

The IPHS are considered to be standards under the bill, demonstrating an attempt to give them statutory backing. The bill also provides for penalties for non-compliance with any provision of the Act or related rules, regulations or orders, which may go up to INR 10,000 or imprisonment up to 3 months or both. Penalty amounts are doubled for subsequent violations. Thus, a violation of the bill as well as the IPHS (in our case, for not having a grievance redressal mechanism) may attract the prescribed penalty. These penalties will also apply to government entities found to be violating the provisions of the Bill.

The NHB 2009 is the first legislative document (albeit in draft form) to propose comprehensive enforcement machinery for health rights. While some of its provisions might appear difficult to implement in practice, it is a good first step towards thinking holistically about addressing as well as acting on individual and systemic health rights violations.

2. Other public health legislation

(a) *Assam*

The only state to have recently passed a law on public health is Assam—APHA, 2010. However, this State legislation has adopted only parts of the NHB 2009. It does not provide for a detailed mechanism on grievance redressal but lays down that the District Public Health Board⁶⁶ shall organise an annual hearing of beneficiaries that use hospitals, with a view to improving health care services. The State Public Health Board⁶⁷ is mandated to establish and implement performance standards for services and infrastructure, which would broadly include grievance redressal as well. Apart from that, the act states that the state government shall *endeavour to adopt* IPHS (which would include grievance redressal) for all kinds of health establishments - government establishments under its control, semi-government and private, and review them to suit the needs of the state of Assam.

A government monitoring system similar to the NHB 2009 has been provided for, which is responsible for ensuring that all health care institutions and establishments prominently display *inter alia* information regarding the IPHS in various respects as well as the charter of users' rights.⁶⁸ A link between monitoring systems and corrective decision-making bodies, like the NHB 2009, has also been

⁶⁶ Assam Public Health Act, 2010, Section 15

⁶⁷ Assam Public Health Act, 2010, Section 12

⁶⁸ Assam Public Health Act, 2010 Section 17(ii)(d)

drawn.⁶⁹ However, a continuing weakness in the act is that there are no penalty provisions for non-compliance by any person or establishment.

(b) Gujarat

The Gujarat Public Health Bill, 2009 is along the lines of the APHA, 2010. It makes the state government responsible for ensuring that public health facilities are accessible and staffed as per the IPHS. Further, a government monitoring system similar to the NPHB 2009 has been provided for, which is responsible for ensuring that all PHEs prominently display *inter alia* information regarding the IPHS in various respects as well as the charter of users' rights. However, unlike the APHA 2010, there is no link to any corrective decision-making bodies, which means that the full potential of these information and monitoring systems is not realised.

For PHEs, every patient has a specific right to grievance redressal through the internal redressal system or the quasi-judicial system (the ambit of the quasi-judicial system has not been specified in the bill). For violations committed by both public and private hospitals, courts may be approached⁷⁰ on grounds specified in the bill. There are certain grounds for complaint against PHEs, which include sub-standard services, denial of services, inadequate infrastructure, malpractices, and negligence. The bill also provides for a separate right to justice, which covers grievance redressal especially through mechanisms under the bill.⁷¹

Under the Gujarat Bill, in addition to the grievance redressal mechanism as envisaged in the NHB 2009, an authority called the 'State Health Care Establishment (Registration and Regulation) Authority has been proposed, which would (i) lay down minimum standards for all health care establishments (ii) review and monitor the implementation of the act (iii) act as a grievance redressal forum regarding provisions of the act, and entertain complaints from patients or any other stakeholder. Complaints would in the first instance be dealt with by the district forums set up under the bill and then an appeal may lie to state forums. Anyone in breach of any of the provisions of the bill may be held liable to pay a fine of INR 5000⁷² and INR 50 per day for continuing default or may also be arrested by the police.⁷³

(c) Karnataka

The Karnataka Promotion of Public Health and Prevention of Diseases Bill, 2010 states that public health services shall be administered by the state and local health agencies in keeping as nearly as

⁶⁹ Assam Public Health Act, 2010 Section 18 (ii)

⁷⁰ The Gujarat Public Health Bill, 2009, Clause 50(19)(f)

⁷¹ The Gujarat Public Health Bill, 2009, Clause 40

⁷² The Gujarat Public Health Bill, 2009, Clause 67

⁷³ The Gujarat Public Health Bill, 2009, Clause 70

possible with the National Public Health Policy formulated from time to time and with the IPHS, for PHCs and CHCs. It imposes specific penalties on government public health officers as well as any other person for violation of the bill or related rules etc. in the nature of a fine up to INR 5000 or imprisonment up to one year or both. The penalty is doubled for subsequent violations. The bill also provides for civil remedies in the form of court orders directing compliance with the bill.

From an analysis of the various public health acts and bills above, it appears that steps are being taken towards giving the IPHS statutory backing and establishing statutory grievance redressal mechanisms. However, the only legislation on public health that has come into force is in Assam, which imposes only a best efforts obligation on the government to adopt the IPHS, has no penal provisions and thus lacks teeth. The other bills do provide a right to grievance redressal, a statutory grievance redressal mechanism, a provision for establishing corrective decision making bodies etc., but of course, are of no effect until they are enacted as law.

G. Judicial orders on grievance redressal forums in PHEs

The judiciary has actively taken up the cause of falling health care service standards in PHEs across the country, especially in the state of Delhi. In the case of *Baby Seema v State of Delhi*,⁷⁴ a criminal writ petition for medical negligence was treated as a matter of public importance, given the dismal condition of hospitals in Delhi. The judge directed the government to release a press notice inviting grievances faced by the general public in government as well as private hospitals, to be addressed to the Registrar of the High Court. The Secretary of the centre and state for health were directed to respond to the complaints. The judge observed that the situation demanded the intervention of the court and the court would therefore consider what remedial measures would be taken in respect of the complaints and the responses received.

In another case dated 22nd September, 2005,⁷⁵ the Division Bench recorded that grievance redressal mechanisms were required in government hospitals and gave directions for the formation of two kinds of grievance redressal forums - (i) grievance redressal committees at the centre and state level to receive complaints and suggest measures to the hospital authorities, who would be required to take appropriate steps; and (ii) all central and state government hospitals to set up grievance redressal cells which would have the option either to report to the central grievance committee or alternatively, refer complaints to the hospital authorities.

⁷⁴ MANU/DE/1456/2008, decided on 7 April 2008.

⁷⁵ *DMA Nursing Home v Union of India*, LPA No.1916/2005

In *Wahi v Burns Department of Safdarjung Hospital*,⁷⁶ the judge ordered the medical superintendent of each government hospital (centre or state) to constitute a grievance redressal committee within four weeks of the order, and to furnish responses to each complainant within eight weeks of the complaint. These two cases demonstrate that at least in the state of Delhi, the soft law requirements under the IPHS to have grievance redressal mechanisms have been converted into binding legal obligations. Through requests made under the RTI Act, we attempted to determine the extent to which these directions were complied with by hospitals in Delhi. Out of the 4 central government hospitals and 5 state government hospitals in Delhi, all central government hospitals have a grievance redressal cell; however, in case of state government hospitals, only one hospital had a proper grievance redressal cell, one hospital did not reply, two did not have a grievance redressal cell and one had set up a cell recently and had not received even a single complaint.

H. Other laws governing grievance redressal

In addition to the laws, judgments and policies discussed above, there are a few other laws under which complaints can be made against PHEs or medical professionals working in PHEs:

- (i) Under the Indian Medical Council Act, 1956, the Medical Council of India (“MCI”) has issued the Code of Ethics Regulations, 2002 (“CoER”)⁷⁷ which lays down standards for the professional conduct, etiquette and ethics for registered medical practitioners. Complaints may be registered before the appropriate Medical Council—state or the MCI. If the medical practitioner is found to be guilty of committing professional misconduct, the relevant council may award such punishment as deemed necessary or may direct the removal of the name of the medical practitioner altogether from the register or for a specified period. Such removal is publicised widely to serve as a deterrent. The violations under the code may *inter alia* include neglecting the patient, not giving priority to the interests of the patient, doing sex determination tests, soliciting of patients etc.
- (ii) The NHRC and the SHRCs have been formed under the PoHRA. The functions of the commissions include inquiring into any violation of a human right or its abetment, either *suo motu* or on a complaint, or into negligence in the prevention of such violation by a public servant; intervening in any proceeding involving any allegation of violation of human rights etc. The NHRC / SHRC is deemed to be a civil court, and thus can make any order which a civil court can.

⁷⁶ W.P.(C) 2187/1996 and WP(C) No.12896/2005, (Del HC) (6 February 2008) (Unreported)

⁷⁷ Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002 <http://www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002.aspx> accessed 23 March 2017

I. Key takeaways

The key takeaway from the above legal analysis is that the existing legal frameworks are not sufficient in terms of providing a remedy for grievances against PHES.

- (i) In terms of remedy to consumers under the CPA, the extent of applicability of the law to PHEs is unclear, leaving consumers in uncertainty about their rights.
- (ii) There are no standards requiring the establishment of a grievance redressal mechanism in the PHEs covered under the CEA, unlike the BIS. However, compliance with the BIS standards is selectively mandatory, and till date, no such mandate in the context of PHEs having a grievance redressal mechanism has been laid down.
- (iii) The IPHS under the NHM provide for setting up of grievance redressal mechanisms in district hospitals. For PHEs below the level of district hospitals, an RKS is required to be set up, which in turn is required to set up a grievance redressal mechanism. However, the IPHS or the standards under the QAP do not have statutory backing under any central law or by judicial direction.
- (iv) Certain state laws, like the APHA, 2010 requires compliance with the IPHS on a best efforts basis; other state laws, where non-compliance is punishable are in the form of a bill, and not law.
- (v) The Delhi High Court has made an attempt to mandate setting up grievance redressal mechanisms in government hospitals; however, from the information received through RTI replies, it appears that the compliance rate by state government hospitals is low.
- (vi) Other laws which could possibly be used to address grievances are the Code of Ethics under the MCI. However, this is doctor centric and not PHE centric.

The legal framework governing PHEs and grievance redressal mechanisms is at best a patchwork and does not inspire confidence. The requirement of a grievance redressal mechanism in PHEs, and that too a well-functioning one, is not a legal one, and an aggrieved person may more often than not be uncertain in respect of his rights and the avenue to exercise his rights. Although the importance of grievance redressal mechanisms is recognized through soft standards, it does not translate into legal accountability for PHEs. Stand-alone legislation like the CPA, CEA and the IMC Act may, at best, be sufficient to address individual grievances, but are clearly inadequate at tackling systemic problems with healthcare delivery in PHEs. The law as it stands today does not match up to the international standards required under the UNCESCR.

IV. EMPIRICAL ANALYSIS OF COMPLAINTS AT GOVERNMENT HOSPITALS

A. Complaints with the High Courts, consumer courts and NHRC

This section of the report seeks to provide an overview of the kinds of complaints filed or taken up against government hospitals in various forums over a period of ten years, and also the remedies awarded. We have divided these complaints into the following categories based on our analysis: (i) denial of treatment (ii) delay of treatment (iii) unhygienic facility (iv) lack of infrastructure (v) lack of doctors and other staff (vi) improper conduct of doctor (vii) improper conduct of other staff (viii) medical negligence. Further, complaints filed in the following forums have been analyzed: High courts across the country, consumer courts across the country and the NHRC, as a fair volume of complaints have been filed in these three forums.⁷⁸ The information presented in this section can be effectively utilized to design or strengthen grievance redressal mechanisms in PHEs, as it gives an idea of the kind of issues regarding which complaints are made.

1. High Courts

We analyzed complaints against PHEs made in all the High Courts across the country from the year 2005 till March 2016. Please note that the data represented below in Fig 1, Fig 2 and Fig 3 does not include cases on medical negligence as it is not the focus area of this project. Medical negligence is primarily concerned with individual medical practitioners, while our concern, through this report, has largely centered around broader failures in healthcare delivery at PHEs. The remedy for medical negligence also seems clearer in the form of the CPA, as opposed to the other kinds of complaints at PHEs that we came across.

⁷⁸ The Supreme Court has been excluded because our research for the period 2005- March, 2016 threw up only complaints relating to medical negligence.

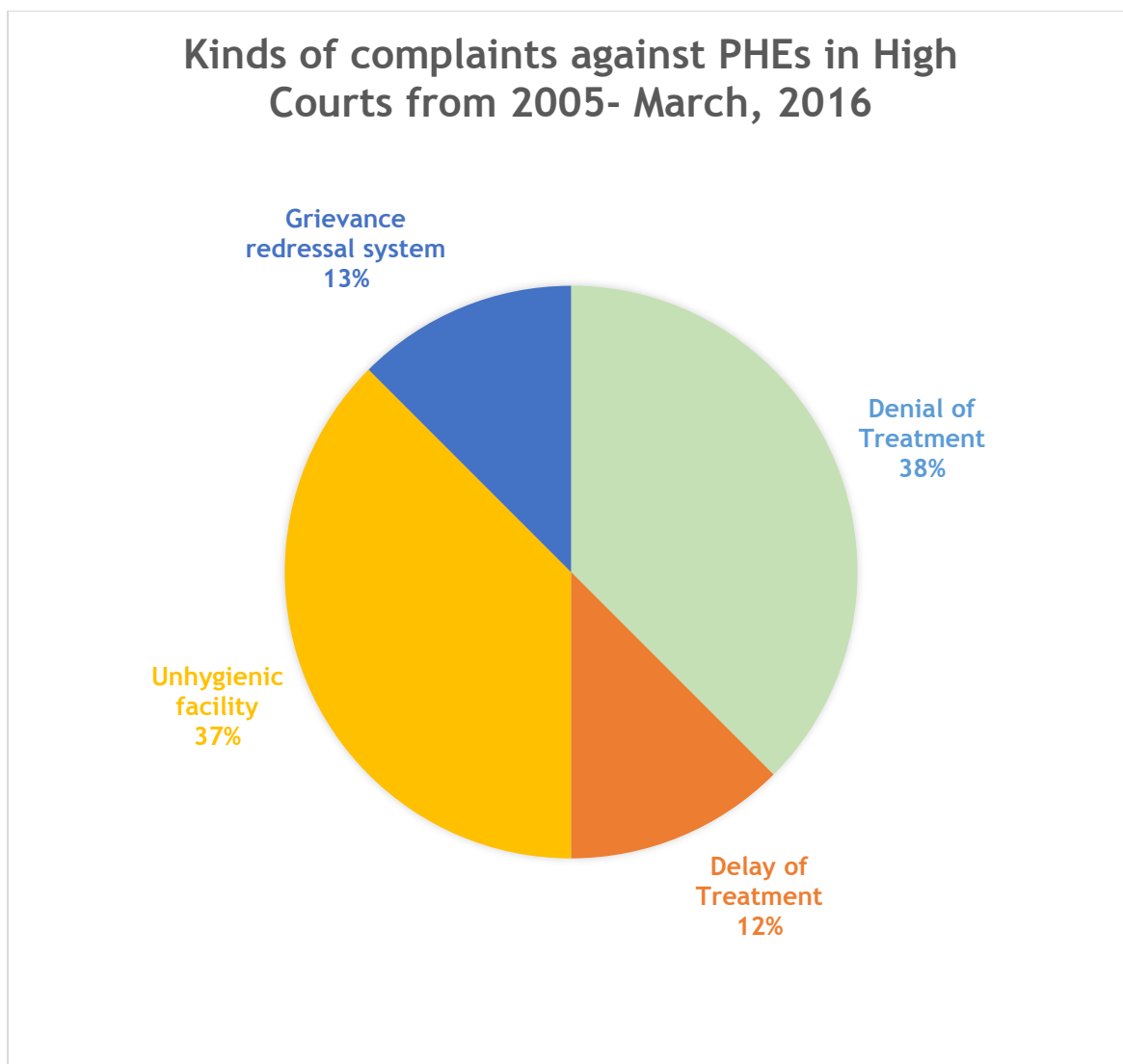


Figure 1: Kinds of complaints against PHEs in high courts across the country

A few instances of the cases that fall under the ‘denial of treatment’ category were those of HIV patients⁷⁹, acid attack victims⁸⁰ and maternity patients being denied treatment⁸¹. In the case of the HIV patient, the court ordered that the necessary operation be conducted, and in the latter two cases, compensation of INR 2,40,000 and INR 25,000 respectively was ordered. In another case⁸², a delay in treatment to a pregnant woman resulted in the death of the child, and compensation was awarded. Various cases⁸³ relating to the hygiene of hospitals were also brought or taken up *suo motu*,

⁷⁹ *Navin Kumar v. State of Bihar*, 2011 (4) PLJR 122

⁸⁰ *Ramjan v. State of Rajasthan*, 2008 (2) ILR (Raj) 705

⁸¹ *Laxmi Mandal v. Deen Dayal Harinagar Hospital*, 172 (2010) DLT 9

⁸² *S. Mary v. Union of India*, 2013(2) CTC332

⁸³ *Suo Motu v. Ahmedabad Municipal Corporation*, 2006 GLH (2) 148; *Satish Chaturvedi v. State of U.P.*, 2005 (1) AWC 50; *Ilaben v. State*, Writ Petition (PIL) No. 122 Of 2011(Guj HC) (29 December 2011) (Unreported)

with courts issuing instructions to hospitals to take clean-up action. There were two cases⁸⁴ in which the Delhi High Court directed the medical superintendent to constitute a grievance redressal cell (both of which have been discussed in detail in Part III-G of this report).

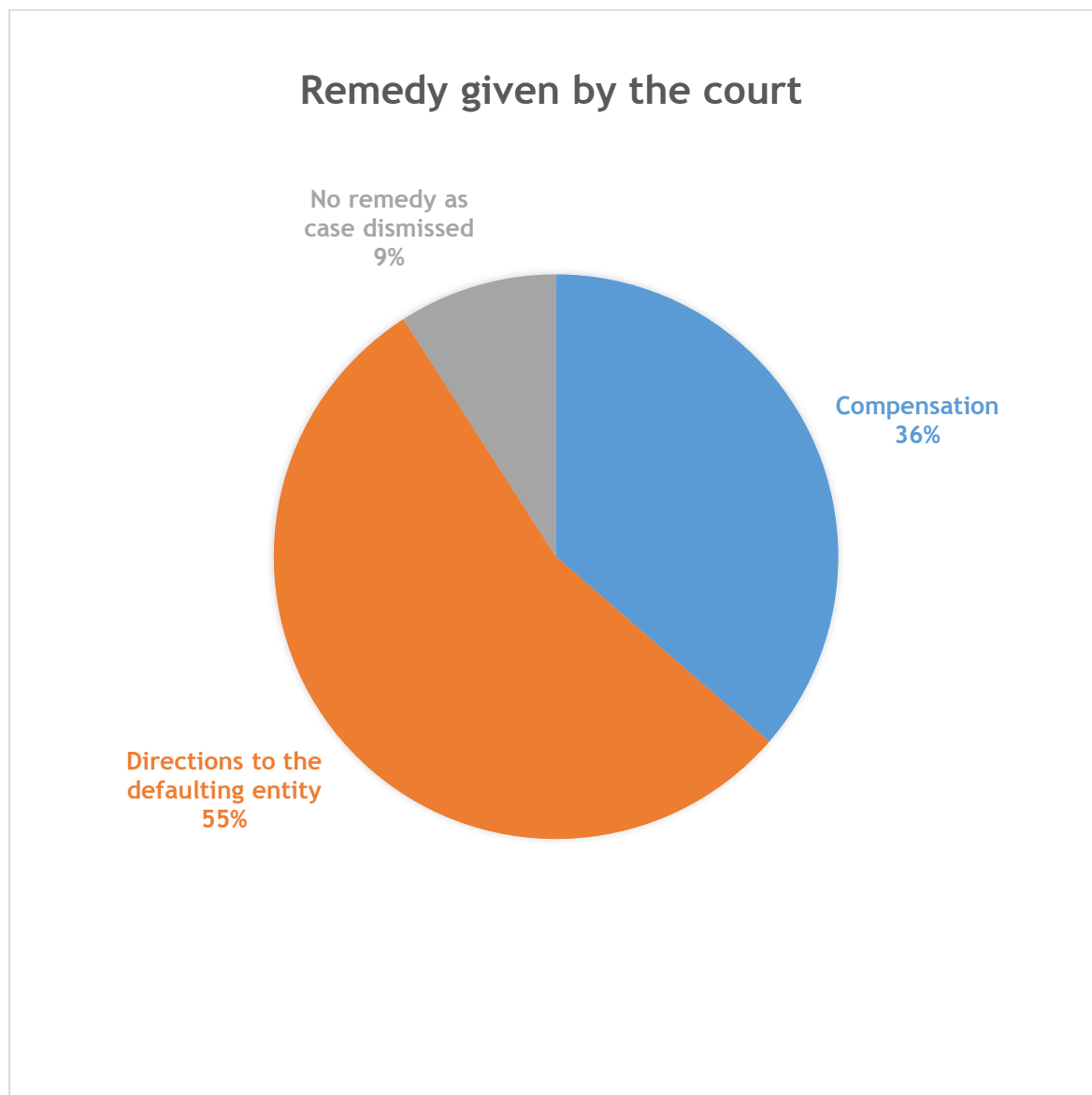


Figure 2: Nature of remedies given by the high courts across the country in complaint cases against PHEs

⁸⁴ *Lt. Col. Y.K. Wahi v. Guru Teg Bahadur Hospital*, W.P.(C) 2187/1996 and WP(C) No.12896/2005 (Del HC) (6 February 2008) (Unreported); *Delhi Medical Association v. Government of NCTD*, LPA 1916/2005

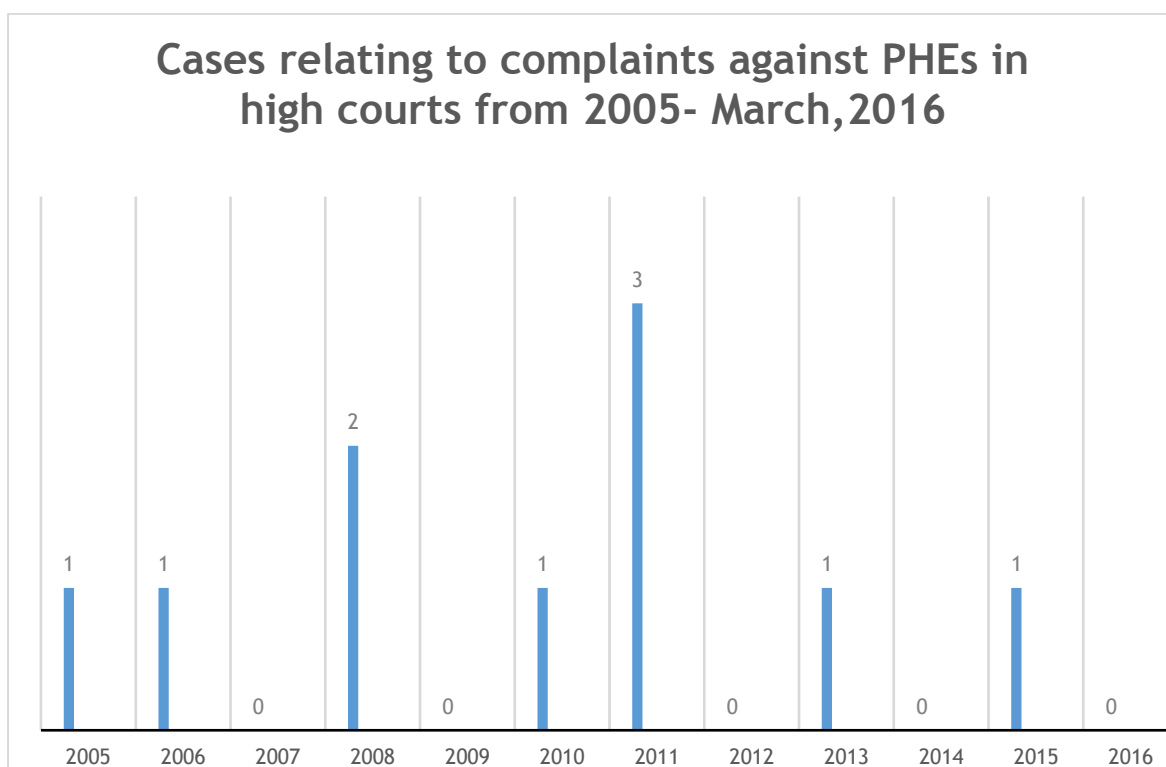


Figure 3: Year-wise number of complaints against PHEs in high courts across the country

The following conclusions can be drawn from the data -

- (i) The total number of complaints in the high courts are dismal - only 10 in almost ten years, reflecting the difficulty in approaching High Courts for issues such as those reflected in Fig 1.
- (ii) The maximum number of cases is in relation to '**denial of treatment**' and unhygienic facilities, followed by delay in treatment and the non-functioning of grievance redressal mechanisms in PHEs.
- (iii) The High Courts mostly handed out directions to defaulting entities. These ranged from directions issued to constitute grievance redressal cells, conduct operations, recruit doctors, purchase ambulances, constitute a committee to take stock of hygiene issues in the PHE and directions to maintain cleanliness.

2. Consumer courts

We analyzed complaints against PHEs made in the consumer courts, national as well as state, across the country from the year 2005 till March, 2016. Please note that although medical negligence is not one of the focus areas of this report, since CPA is the primary legislation for such cases, it was difficult to separate medical negligence cases from other cases during our research, and hence these have been included in the data represented below.

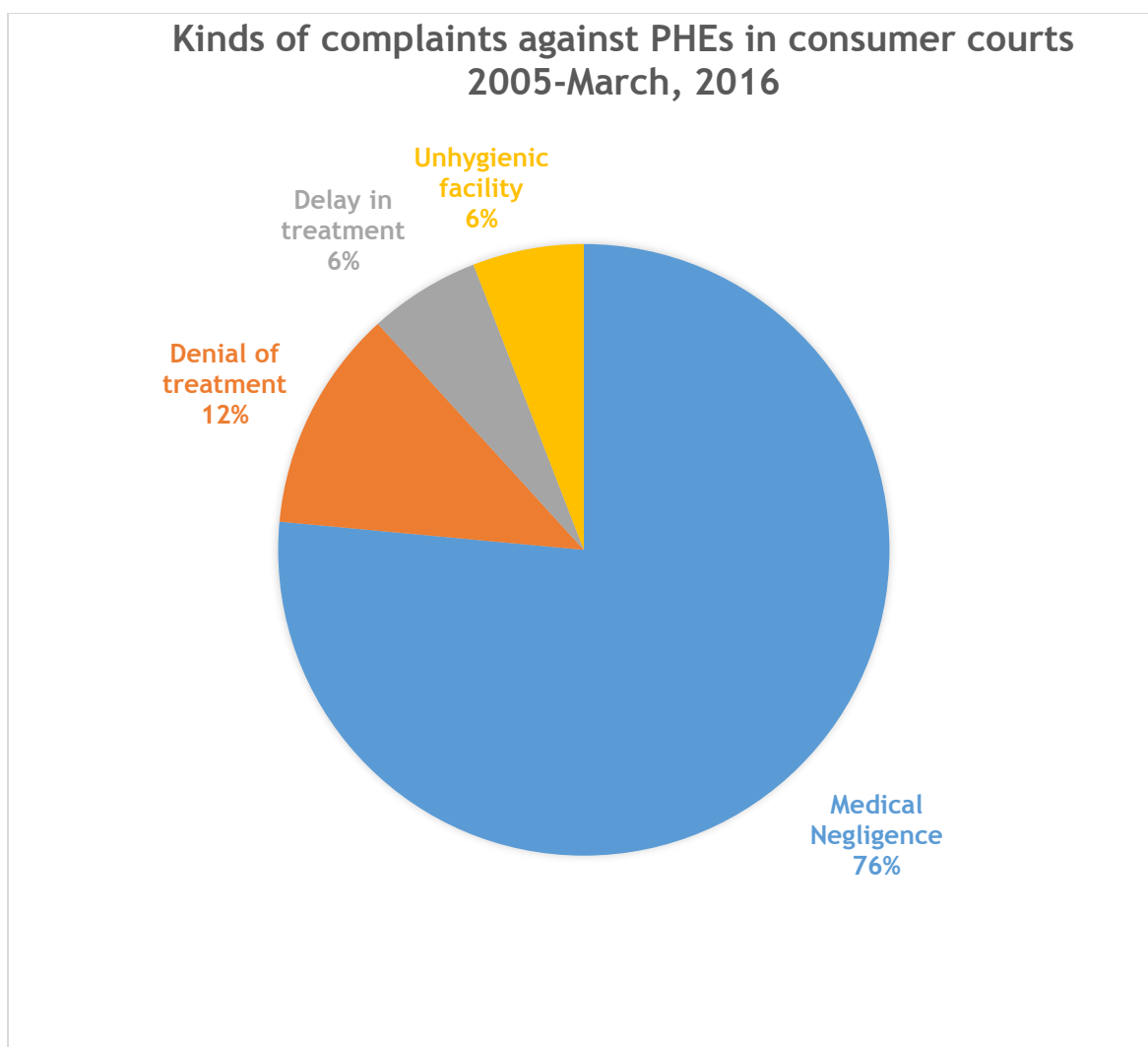


Figure 4: Kinds of complaints against PHEs in consumer courts across the country

An example of a case relating to denial of treatment is that of the non-availability of doctors at the particular PHE, as they were engaged in their private practice. A compensation order of INR 5 Lakh was imposed on all the doctors⁸⁵. Another case relating to the non-availability of blood in the blood bank was recorded. This led to delay in treatment, and compensation of INR 5 Lakh was awarded to the petitioner.⁸⁶

⁸⁵*Sayed Ali Gulam Ali v. Geeta Malu and Ors.*, III(2015)CPJ46(NC)

⁸⁶ *Arvind Pandey v Sulekha Saran*, 2012 (6) ALD(Cons.) 1 (NC)

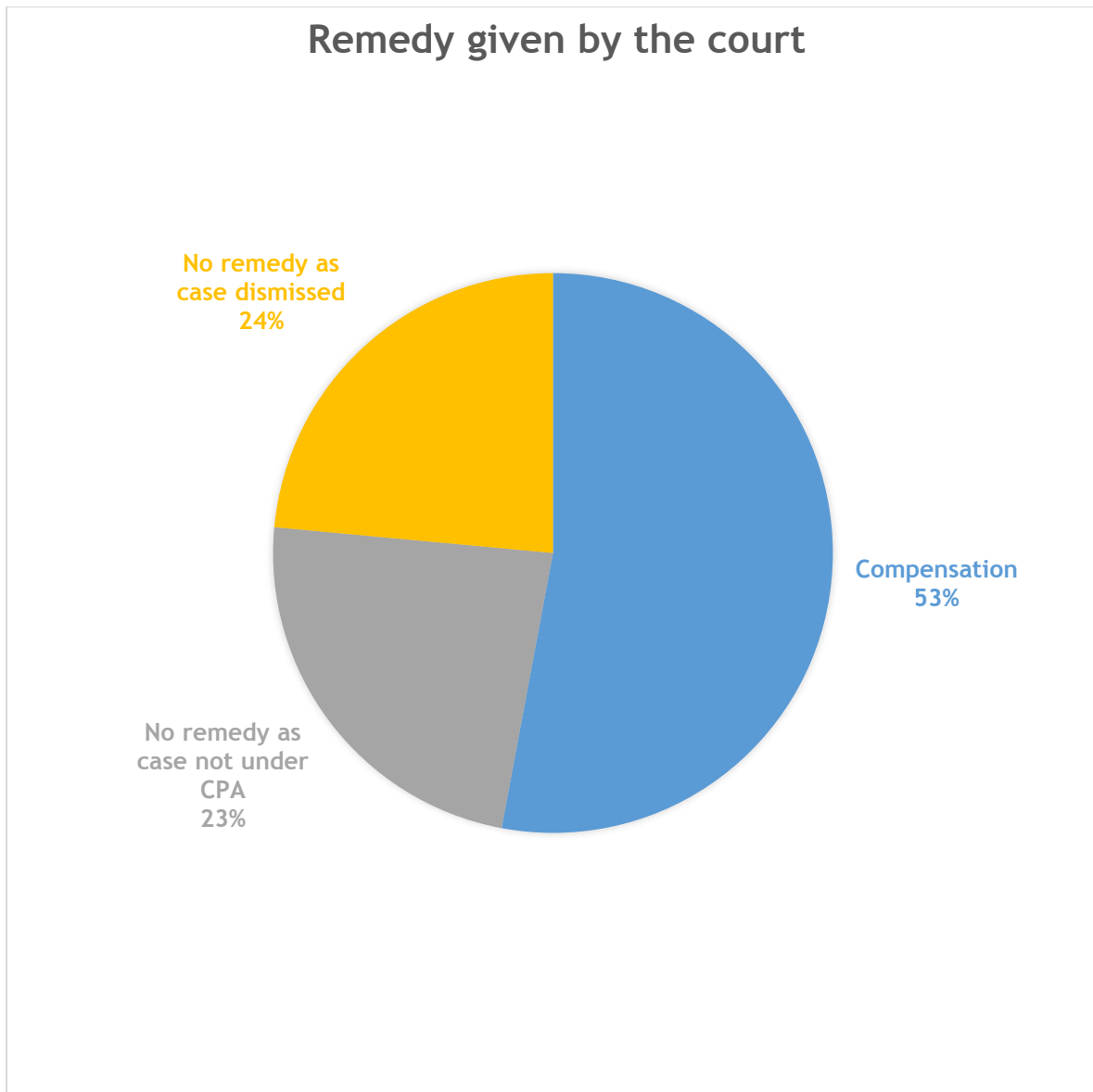


Figure 5: Nature of remedies given by the consumer courts (national and state) across the country in complaint cases against PHEs

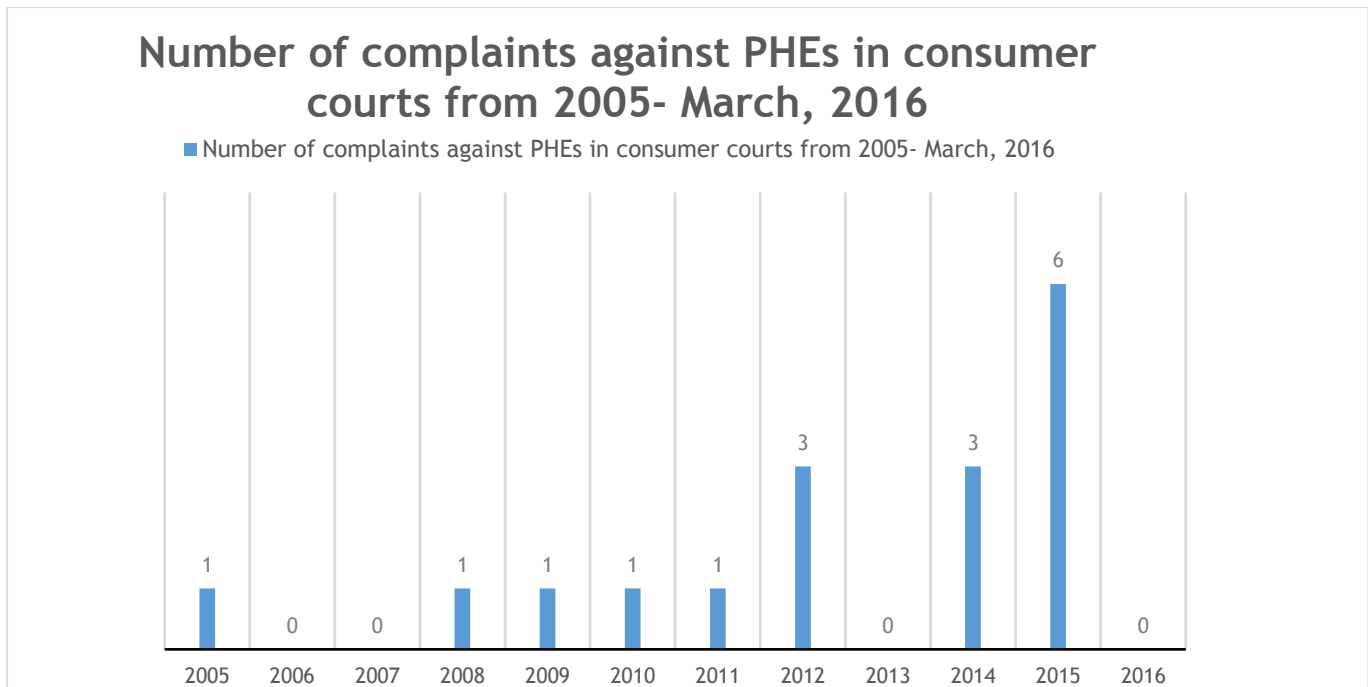


Figure 6: Year-wise number of complaints against PHEs in consumer courts across the country

The following conclusions can be drawn from the data -

- (i) The total number of cases in the consumer courts (national and state) across the country is 17, which, like the number before the High Courts, is very low. The number could be indicative of the uncertainty in the application of CPA to PHEs; it might also be due to many cases going to the district consumer courts because of the pecuniary limit.
- (ii) Other than medical negligence, the maximum number of cases are in relation to 'denial of treatment', followed by unhygienic facility and delay in treatment. This follows the pattern of complaints brought before the High Courts.
- (iii) Given the powers conferred on them by the CPA, the consumer courts mostly handed out compensation orders.

3. NHRC

We analyzed complaints against PHEs made to the NHRC from the year 2005 till March, 2016. The volume of cases filed with the NHRC or taken up by the NHRC is quite high, and therefore, undertaking a similar analysis of SHRC cases was beyond the scope of this report.

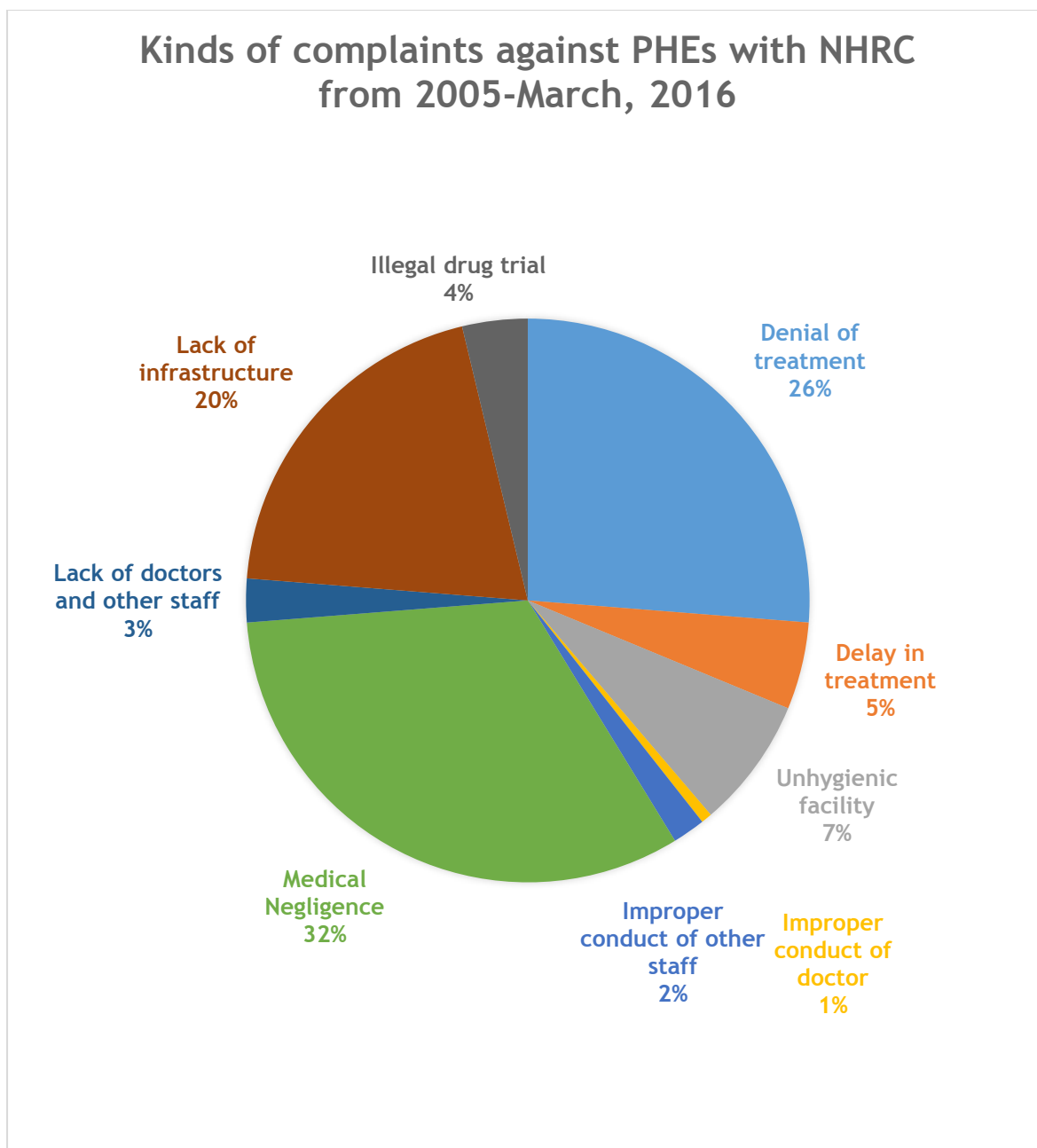


Figure 7: Kinds of complaints against PHEs with the NHRC

A variety of cases came up before the NHRC, of which the delay in treatment cases included road accident victims not being attended to in time, and the occurrence of deaths due to excessive patient load. There were also instances of women delivering while standing in queue. A few cases relating to the denial of treatment were of AIDS patients being denied treatment. Treatment was also denied due to the non-availability of beds and women being forced to deliver on the floor of the hospital. There were many cases relating to the lack of infrastructure and hygiene issues, including a case where 17 infants died due to improper disinfection; in another case, the lack of infrastructure related to a shortage of ventilators. There were several other cases where PHCs, CHCs and district hospitals were not functioning, some because of the lack of an electricity connection and others due to the lack of staff.

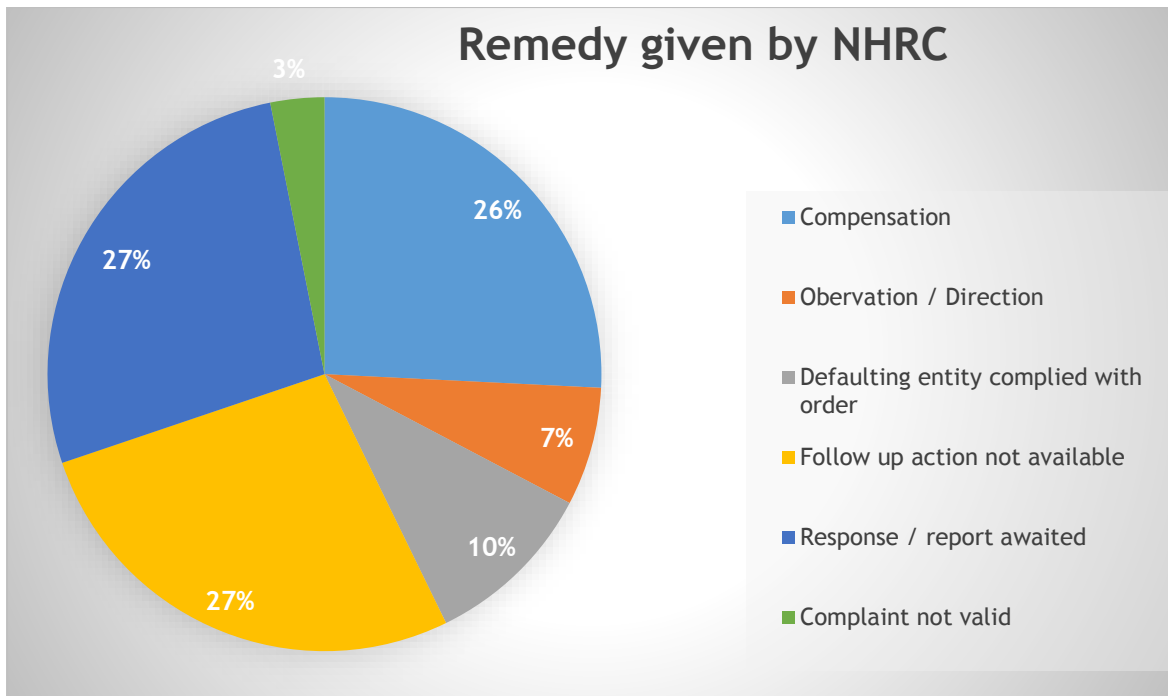


Figure 8: Nature of remedies given by the NHRC in complaint cases against PHEs

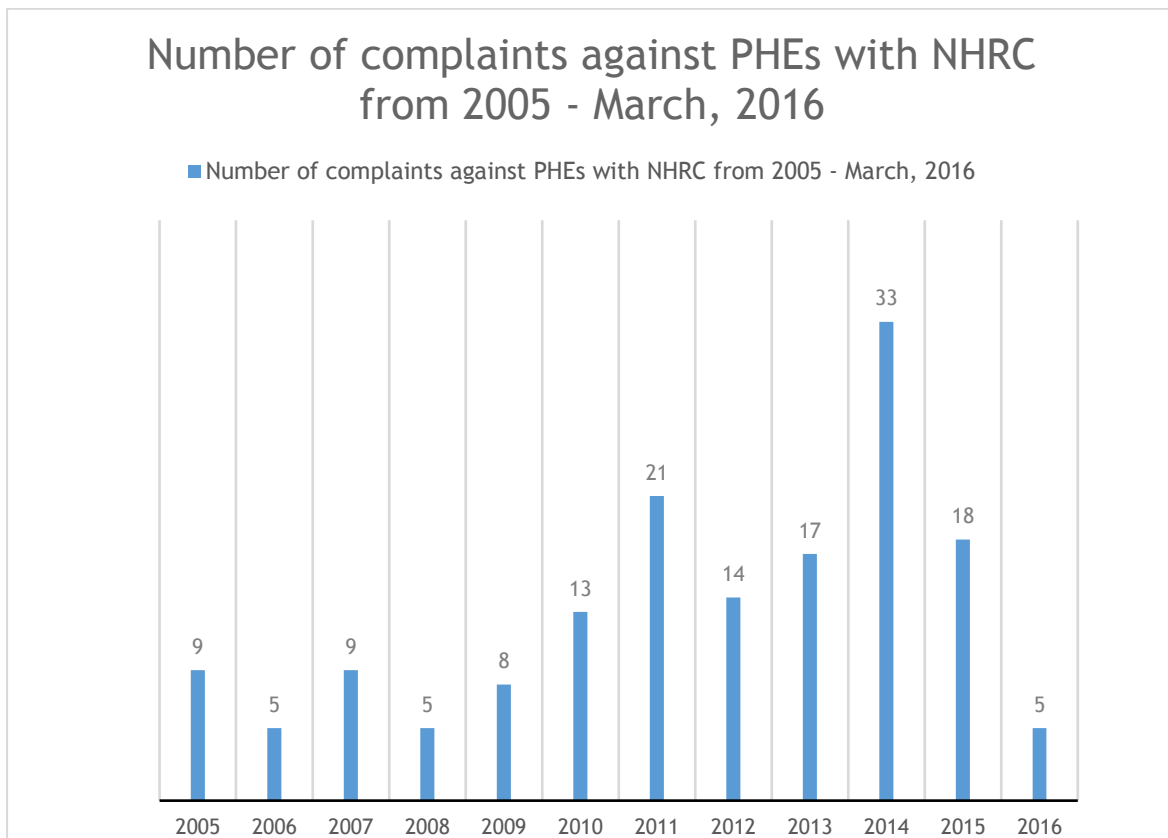


Figure 9: Year-wise number of complaints against PHEs in NHRC

The following conclusions can be drawn from the data above -

- (i) The number of complaints with the NHRC are 157 for a period of ten years, and represent the highest number of complaints made before any of the three forums analyzed in this report.
- (ii) Other than medical negligence, the maximum number of cases is in relation to ‘denial of treatment’, followed by lack of infrastructure and unhygienic facilities.
- (iii) The NHRC also mostly handed down compensation orders.

B. Case Studies

We conducted two case studies, where we studied the complaints against a tertiary government hospital in New Delhi, and complaints against a primary health centre in Mewat, Haryana. We chose two PHEs at different levels in the hierarchy, one tertiary and one primary, to detect the differences in the issues that are faced by them.

1. Case Study I: AIIMS

AIIMS is a tertiary government hospital located in various parts of the country. We conducted an inspection of the grievances filed against the hospital in New Delhi for the years 2013 and 2014.⁸⁷ A total of 100 complaints were made available to us for inspection, 75 in the year 2013 and 25 in the year 2014.

The process for making a complaint or filing a grievance with AIIMS is through the Medical Superintendent (MS). However, there were some applications that were addressed to the Chief Minister’s office as well, which are referred to the hospital. Minor complaints are handled at the MS level, and a reply is sent to the complainant. Such complaints could be related to long queues at the medicine counter, or rude behaviour by the hospital staff. However, in some very minor cases, replies are sent only if the complainant asks for a response. In most of the complaints that were inspected, the complaint was filed with the MS, forwarded to the concerned head of department, who responded to the MS, and a copy of this response was sent to the complainant.

The action taken is generally a departmental inquiry, resulting in a warning to the defaulter, counseling of the defaulter, requiring the defaulter to tender an apology, issuing of office memorandum or circular for policy changes, keeping the complaint for future references etc. There were cases that were filed with the Delhi Medical Council as well. They were usually serious cases of medical negligence dealing with individual doctors at the hospital. In very grave cases, an inquiry committee is also set up and a hearing process is undertaken. In one serious case, the matter was

⁸⁷ We picked these years because the staff at AIIMS provided the data regarding these years, and their inspection could be completed within the allotted time of 3 days. They are only intended to be representative of the kind of complaints usually made at AIIMS.

escalated to the vigilance cell and directions were given by the cell to study the functioning of AIIMS, the hygiene conditions, resources etc.

Out of the 100 applications, the grievances (other than medical negligence) that predominantly arose related to: (i) misbehaviour of the hospital staff, which includes nurses, lab technicians, compounders and doctors, and (ii) delay in treatment. Specifically, these grievances related to (including the two categories mentioned): complaining against wrong information on the hospital website regarding the timings of the medical staff, blood being drawn without the consent of patients for research, sexual harassment by hospital staff, destruction of medical records by the doctor, administration of wrong medicines, denial of treatment to an HIV patient, standing in long queues, and delay in treatment due to the absence of medical staff.

On an overview of the applications as well as the actions taken in response to them, it appears that there is an established grievance redressal mechanism in place in AIIMS which deals with minor complaints like incorrect information on the website relating to timing of doctors, to more serious cases relating to denial and delay of treatment due to lack of infrastructure and doctors. It is likely that administrative and managerial complaints can be resolved by the internal grievance redressal cell; however serious complaints, which might require compensation or other actions for the delay or denial of treatment cannot be expected to be dealt with by internal grievance redressal authorities that lack the power to award the required remedies. This demonstrates the need to have in place a more formal institutionalized process to refer serious complaints to appropriate authorities, and monitor the action taken on such complaints, especially when they require systemic changes.

2. Case Study II: Mewat, Haryana

We visited and interacted with the locals in Mewat, Haryana to assess the problems being faced by them as regards their public health care facilities. From the interaction, it emerged that the locals do not rely on the PHCs or other government healthcare facilities in Mewat, as the staff is usually absent and the doctor is also not available.

The biggest problem seemed to be that there are no facilities for doctors to stay in Mewat, which results in them making sporadic day visits, despite being paid INR 50,000 per month. The locals prefer to visit hospitals in larger towns and cities like Nuh, Alwar, Gurgaon or Delhi, or even visit local private doctors, as they have no confidence in the competence of the local government doctors who show up at the PHCs. Further, there are no female gynecologists in the area, resulting in gynecological problems remaining unaddressed unless the affected persons travel a long distance to visit a private hospital in the city. Also, the infrastructure in terms of electricity and water in the PHC is lacking.

The locals mentioned that there are monthly meetings with the district health authority, which have the potential to be used as a forum to escalate their grievances regarding the health care delivery system in Mewat. However, these meetings have a pre-decided agenda, where concerned members

of civil society are not permitted to raise the grievances of the locals. Far from a functioning grievance redressal system, there is no functioning healthcare delivery to speak of.

On being asked about the existence of RKS, it emerged that the locals were unaware of such an institution as a concept, or of its existence in the PHC and other government health care facilities in the Mewat region. The VHSNC is functioning, and the Aanganwadi worker is the minute keeper for the monthly meetings of the VHSNC. However, these committees are responsible only for vaccinations and the perception is that they cannot function as grievance redressal forums, although the NRHM policy states otherwise. (An order of the MoHFW⁸⁸ broadened the mandate of the VHSNC in July, 2011 to include it serving as a grievance redressal forum on 'health and nutrition' issues.)

From the interaction with the locals in Mewat, the stark contrast in the impact of the issues faced by a tertiary government hospital and a primary health center is evident. Both Mewat and AIIMS face the problem of a lack of doctors and staff. However, the impact of this issue makes the PHC defunct, and results in the locals turning to private health care facilities or health care facilities in nearby cities. Therefore, while at AIIMS this issue may be resolved by the internal grievance redressal cell, at the PHC level, the issue goes to the root of its functioning. In such a scenario, the best that a grievance redressal cell at a PHC might do is to be used as a tool by the patients to draw the attention of the concerned authorities in respect of the lack of doctors, staff and infrastructure.

⁸⁸ MoHFW Order No. Z 18015/8/2011-NRHM-II, dated 25th July 2011, <http://nrhm.gov.in/images/pdf/communitisation/vhsnc/order-guidelines/order_vhsnc.pdf> accessed 30 March 2017

V. RECOMMENDATIONS

PHEs in India vary vastly in terms of size, infrastructure and staff. As Part IV of this report demonstrates, problems with healthcare delivery at such establishments also range widely from matters related to hospital management to the denial of important components of the right to health—access, availability and quality. The urban or rural location of the establishment might also play a role in determining the nature of health rights violations.

What remains uniform, however, is the absence of an effective enforcement mechanism across all kinds of PHEs. The main weaknesses that this report has identified are: the uncertain applicability of the CPA to PHEs; the limited applicability of the CEA and the absence of standards on grievance redressal under the Act; the non-binding nature of the requirement to have grievance redressal mechanisms under the IPHS and QAP; the multiplicity of local authorities responsible for monitoring the delivery of health goods and services; the lack of awareness and poor functioning of RKS; and the inadequate reach and powers of institutions like the NHRC and SHRCs as well as the MCI and State Medical Councils. The only comprehensive enforcement machinery exists in the form of draft legislation. This report demonstrates that the legal and regulatory framework is clearly insufficient to meet the requirements of Article 2, paragraph 1 of the ICESCR, which recognises remedies as integral components of the rights guaranteed under the Covenant.

It appears unlikely that a legislatively guaranteed right to health will remedy this in the foreseeable future. The NHP 2017, which was approved by the Union Cabinet on 16 March, 2017 states that a rights-based approach to health may not currently be suitable, given the low levels of finance and infrastructure. As far as grievance redressal is concerned, it recommends setting up a ‘separate, empowered medical tribunal for speedy resolution to address disputes/complaints regarding standards of care, prices of services, negligence and unfair practices.’ Complaints related to the access and availability of services appear to have pointedly been excluded from the jurisdiction of this tribunal. The result is that we have a judicially recognised right to health under Article 21 of the Indian Constitution for which the only avenues of enforcement, at least as far as access and availability are concerned, lie in the form of writ petitions in the High Courts and the SC or less effectively through the recommendations of the NHRC and SHRCs. For quality-related violations, there is a patchwork of laws, regulations and non-binding standards that are of uncertain applicability and limited effectiveness.

Given these shortcomings, we suggest the following measures as a starting point to thinking strategically about addressing health rights violations in PHEs:

A. Categorization of violations that occur in PHEs

First, it might be useful to categorise the different kinds of violations that occur at PHEs, since different violations might require different remedies and correspondingly, different forums. Our

report has taken a small step in this direction, although we make no claims that the data analysed in Part IV is representative of the violations at PHEs across the country. Violations may be categorized as ‘administrative’ and ‘serious’. The former would include violations relating to the administration of the PHE, such as those which relate to the hygiene of the PHE, the behaviour or conduct of doctors and hospital staff, the attendance of hospital staff and information on the hospital website. These violations might themselves be grave, but are likely to be resolved best at the level of the internal grievance redressal forum alone, and are hence classified as administrative. Serious violations would include violations like denial of treatment, delay in treatment, lack of infrastructure, doctors and staff, medical negligence, illegal drug trials etc. There may be some overlap between these two categories of violations. For instance, if poor hygiene caused by poor administration of the PHE causes life-threatening infections, then it will be a serious violation.

B. Setting up of an authority⁸⁹ to streamline the handling of grievances

While administrative complaints may be addressed speedily through internal complaint forums, serious complaints require more stringent action than grievance redressal authorities are empowered to direct. For instance, medical negligence ought to be accompanied by the award of compensation and disciplinary action against the practitioner in question; the lack of infrastructure, doctors and staff ought to attract suspension and cancellation (for subsequent violations) of the hospital’s registration or civil penalties, at the very least. Given that grievance redressal mechanisms usually comprise members of the establishment’s own staff, and cannot therefore be independent and impartial arbiters, we suggest two mechanisms through which external monitoring and control can be introduced over the functioning of these internal authorities. The first option can be implemented using the existing framework, while the second option requires setting up a statutory authority. However, it must be noted that for any of the mechanisms to function, an internal grievance redressal system is required, and the steps to be taken to make their establishment mandatory are set out in Recommendation C below.

1. Option 1

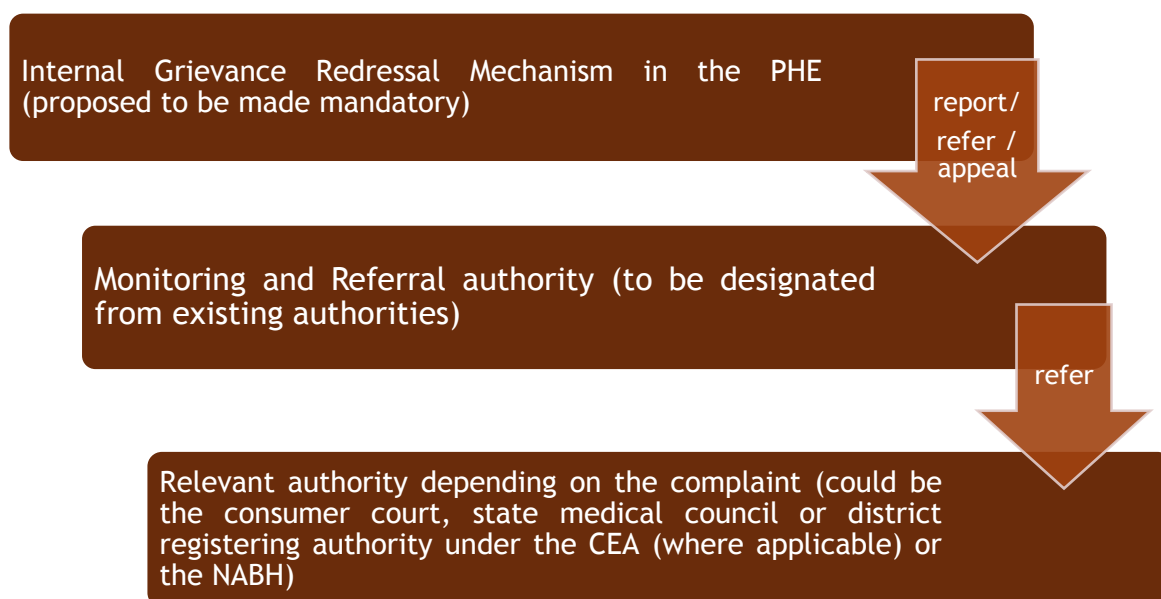
The first mechanism will require the internal grievance redressal authority to: a) compulsorily report action taken in respect of administrative complaints, and b) to compulsorily refer complaints which *prima facie* appear to be serious complaints to a ‘monitoring and referral authority’. Consider, for example, a complaint of denial of treatment brought by a patient to a PHE’s grievance redressal authority. The authority ought to make a *prima facie* determination on the merits of the complaint,

⁸⁹ The recommendations in this part of the report are intended to be in the nature of broad policy directions, and specific details regarding their operationalization, such as the composition or constitution of authorities require further consultation.

on the basis of which it may be referred to a ‘monitoring and referral authority’. Existing government departments responsible for PHEs may be designated to act as such authorities.

Such authorities could then determine the appropriate forum for the serious complaint, and refer it accordingly, for example, to the concerned District CDRC for the award of compensation, or to the State Medical Council for disciplinary action against the medical practitioner, or to the district registering authority under the CEA (where applicable) or to the NABH, where the establishment in question has received accreditation from this board. If the internal grievance redressal authority miscategorises serious complaints as administrative ones, then monitoring and referral authority could step in to correct this and refer the complaint accordingly. Given that this authority will be designated from within existing government authorities responsible for PHEs, it will also be in a position to take note of systemic issues that will be apparent from the pattern of individual grievances made before internal grievance redressal authorities. It may then recommend policy changes to tackle such issues, ensuring a feedback mechanism for individual complaints into broader health policy. The potential obstacles to the referral recommended in this option might be the lack of clarity in the application of the CPA to PHEs as well as the fact that State Medical Councils have not proved to be effective at taking action against erring medical practitioners.

Figure 10: Flowchart for Option 1



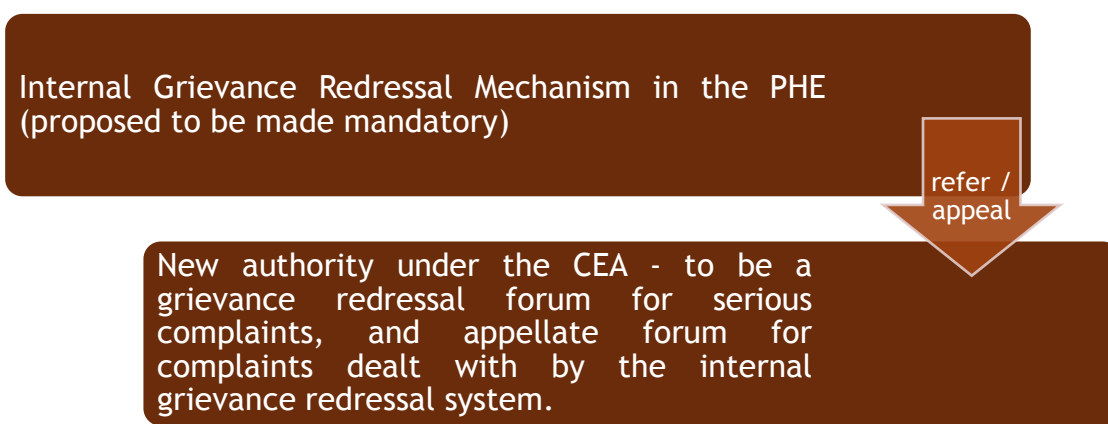
2. Option 2

Given that the NHP 2017 has recommended setting up a separate medical tribunal, it might simply be more effective to set up a new authority under the CEA. This authority could serve both as an appellate forum for patients in the case of complaints that might not have been satisfactorily addressed by internal grievance redressal authorities and as the original forum of redressal for more

serious complaints that internal grievance redressal authorities might not be capable of dealing with. It also ought to regularly communicate systemic issues with healthcare delivery, apparent from the individual complaints brought before it, to the concerned district or municipal or state authority responsible for PHEs within its jurisdiction. The objective is to ensure that grievances are fed into the health policy-making process on a regular basis.

Like the district registering authority under the CEA,⁹⁰ this proposed authority also ought to have the following powers: issuing directions to any person; holding an inquiry for not following the directions issued; imposition of a monetary penalty; causing an inspection to be made; entry and search of premises; and cancellation of registration.

Figure 11: Flowchart for Option 2



Recommendations A and B may be effected by amending the CEA. The categorisation of complaints, the requirement to compulsorily refer serious complaints to the designated monitoring and referral authority or the setting up of a new authority under the CEA, may be included through a separate chapter in the CEA.

C. Mandatory requirement of an internal grievance redressal mechanism in PHEs

As discussed above, the pre-condition for Recommendation B to work is the existence of an internal grievance redressal mechanism. The most obvious route of implementation of this requirement is through the CEA, although a concerted effort must first be made to ensure the Act's adoption and implementation by all States. The CEA empowers the Central Government to prescribe minimum standards for clinical establishments that are a requisite for obtaining permanent registration under the Act. Failure to comply with these standards may result in cancellation of the registration by the district registering authority (comprising the District Collector, District Health Officer, and three other members). One of these standards ought to relate to the constitution and functioning of

⁹⁰ Section 33, CEA

grievance redressal mechanisms, without which registration under the Act cannot be obtained. In fact, regulations under the CEA present the ideal opportunity to consolidate the existing fragmented framework of standards and guidelines on grievance redressal: standards prescribed by the BIS, IPHS, QAP and guidelines by the MoHFW. Further, standards on grievance redressal mechanisms ought to be framed under the CEA, keeping in mind the different sizes and functions of the various PHEs described in Part II. For instance, VHSNCs might be the appropriate grievance redressal authority at the level of a PHC (the NHP 2017 recommends strengthening VHSNCs in general), while an internal complaints forum might be more appropriate for larger tertiary care hospitals. These standards ought to prescribe the composition, procedure, powers and functions of grievance redressal authorities, tailored to the kind of PHE. Where such authorities are primarily composed of the staff of the PHE in question, at least one external member also ought to be included.

D. Clarification on the application of the CPA to PHEs

The CPA is an important legal tool for consumers to obtain a remedy for a deficiency in any service provided by a service provider. As this report has discussed, health care services fall within the ambit of the CPA only if they are provided for a consideration. As can be seen from Fig 5, 23% of the cases filed between 2005 and 2016 were dismissed by consumer courts as they did not fall within the CPA, and many of these were based on a doubtful interpretation of the CPA in respect of what constitutes consideration in respect of PHEs. Therefore, it is recommended that the CPA be amended to clarify and settle the meaning of ‘consideration’ in relation to PHEs, such that there is no ambiguity in the application of the CPA to PHEs.

The statutory recognition of a right to health would have made it easier to craft corresponding enforcement machinery. Since the NHP 2017 has shelved this proposal for the moment, other regulatory avenues must instead be found to ensure that health rights violations are addressed speedily and effectively. Next steps must include more comprehensive studies on the working of existing institutions like consumer courts, State Medical Councils, accreditation boards, and local authorities responsible for the delivery of healthcare services. Only a holistic understanding of existing authorities will help design an accountable system of grievance redressal, specific to the needs of different kinds of PHEs.

ANNEXURE

A. Questions posed in RTI applications to government hospitals in Delhi

- (i) Is there a grievance redressal cell in AIIMS? If yes, when was it first constituted?
- (ii) Is the functioning of the grievance redressal cell governed by any internal guidelines or rules or regulations? If yes, please provide the latest copy of the same.
- (iii) What is the composition of the grievance redressal cell?
- (iv) Does the grievance redressal cell have regular meetings to deal with the complaints filed? How often does the cell meet?
- (v) Is there information, such as a charter or guidelines, that guides patients at the hospitals regarding the procedure for filing complaints with the grievance redressal cell of AIIMS? If yes, please provide the latest copy of the same.
- (vi) Please provide complete data on the number of complaints that have been filed with the grievance redressal cell or otherwise with the hospital from the year 2005 till date, in relation to the health care provided by the hospital.
- (vii) Please provide complete data from the year 2005 till date on the number of complaints filed with the hospital that relate to -
 - a) Delay in treatment in the hospital;
 - b) Denial of treatment in the hospital;
 - c) Hygiene of the hospital;
 - d) Medical negligence by doctors, nurses and other staff of the hospital;
 - e) Behaviour / conduct of the hospital staff including doctors, nurses etc.;
 - f) Unsatisfactory functioning or non-responsiveness of the grievance redressal cell of the hospital;
 - g) Any other issue relating to the healthcare facilities provided by the hospital.
- (viii) Is a record of the complaints filed against the hospital maintained? If yes, for how many years is the record retained?
- (ix) Are the records relating to the complaints filed against the hospital publicly available?
- (x) Do the records of the complaints include the decision or action or recommendation by the grievance redressal cell, in relation to such complaints? If yes, please provide data from the year 2005 till date.

B. Interview questions for government officers

- (i) Is there a difference in the kind of problems faced by PHEs depending on the tier of the PHE or the location (urban / rural) of the PHE?
- (ii) How are the problems in PHEs dealt with?
- a) What are the existing mechanisms for handling complaints by consumers in PHEs? Are they governed by any law, rules or regulations? How are they monitored, and who do the concerned persons report to?
 - b) Do PHEs take up issues / complaints suo motu?
 - c) Do PHEs have a Rogi Kalyan Samiti? Are they functioning? If yes, how do they function and do they follow the guidelines prescribed by the MoHFW under the NHM?
 - d) Who monitors the RKS at different tiers, and what is their accountability?
 - e) What is the preferred mode and mechanism used by consumers to sort out complaints?
 - f) What is the preferred mode and mechanism used by the hospital administration for sorting out complaints? Do you think it is effective or any changes need to be made to make it work better?
 - g) What would be the design of the ideal redressal mechanism?
 - h) Is the hospital grievance redressal system or RKS adequate for addressing their reliefs, or the consumers have to approach the courts in any case? If the latter, what is the actual role of the grievance redressal cells?
 - i) In NHRC cases, when notices are sent to them, how are they responded to? Is any follow up action taken?
 - j) Is there any budgetary allocation to hospitals for grievance redressal mechanisms?
 - k) Are you aware or has there been any follow up on the Delhi High Court orders (2008) which required medical superintendent to set up grievance redressal cells in public hospitals?
 - l) The centre and state secretary were directed by the Delhi high court to constitute committees to hold public hearings and suggest remedial actions to the court OR redressal measures to the concerned functionary of the hospitals in the year 2005 - was this done? What was the outcome?
- (iii) What are the outcomes of consumer complaints against PHEs?
- a) What are the follow up actions that are taken by hospital authorities in response to complaints received by them, in respect of improvement of health care services?
 - b) What is the process for formulating the health policies for improvement?
 - c) Are the follow up actions documented or publicised?
 - d) Are they effective in improvement of the health care delivery services in hospitals etc.?
 - e) How is the improvement (or the absence of it) measured?

C. Interview questions for civil societies

- (i) What are the kinds of problems faced by PHEs in general?
 - a) How do PHEs keep a tab on the problems being faced by them?
 - b) Is there a difference in the kind of problems faced by public hospitals depending on the tier of the hospital or the location (urban / rural) of the hospital?

- (ii) How are the problems in PHEs dealt with?
 - a) What are the existing mechanisms for handling complaints by consumers in PHEs? Are they governed by any law, rules or regulations? How are they monitored, and who do the concerned persons report to?
 - b) Do PHEs take up issues / complaints suo motu?
 - c) Do PHEs have a Rogi Kalyan Samiti? Are they functioning and do they follow the guidelines prescribed by the MoHFW under the national health mission?
 - d) What is the preferred mode and mechanism used by consumers to sort out complaints?
 - e) What is the preferred mode and mechanism used by the hospital administration for sorting out complaints? Do you think it is effective or any changes need to be made to make it work better?
 - f) What would be the design of the ideal redressal mechanism?
 - g) What are the kinds of reliefs that the consumers ask for in their complaints to public hospitals?
 - h) Is the hospital grievance redressal system or RKS adequate for addressing their reliefs, or the consumers have to approach the courts in any case? If the latter, what is the actual role of the grievance redressal cells?

- (iii) What are the outcomes of consumer complaints against PHEs?
 - a) What are the follow up actions that are taken by hospital authorities in response to complaints received by them, in respect of improvement of health care services?
 - b) What is the process for formulating the health policies for improvement?
 - c) Are the follow up actions documented or publicised?
 - d) Have such actions contributed in the improvement of the health care delivery services in the hospital?
 - e) How is the improvement (or the absence of it) measured?

- (iv) Experience of the civil society
 - a) What actions have been take up by you in respect of the problems faced by PHEs?
 - b) How has the government responded to their efforts?
 - c) How successful do you think the NHRC has been in highlighting the problems of PHEs? Do you think they can play a greater role?
 - d) What are the challenges faced by patients / consumers when filing for complaints?

e) Do you think a public interest litigation in this regard would be helpful?



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BETTER LAWS. BETTER GOVERNANCE

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