Comments on the Rajasthan Right to Health Care Bill, 2022

Submissions to the Government of Rajasthan

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Executive Summary

The Rajasthan Right to Health Care Bill, 2022 ("Bill") recognises health rights of residents and health care providers, sets out corresponding obligations for the state government, and lays out administrative and grievance redressal mechanisms for the realisation and implementation of such rights and obligations. In response to the call for public comments on the Bill from the Government of Rajasthan, the Vidhi Centre for Legal Policy has submitted the following observations and recommendations on the draft from a legal and policy perspective:

Need for a distinction between Public health and Healthcare: Public health laws aim to prevent the outbreak of diseases, tackle public health emergencies, and ensure the overall health and well-being of a population. Healthcare laws aim to provide citizens with the best possible standards of medical diagnosis and treatment. The Bill conflates the two. In the interests of clarity, ease and efficiency of administration, and enforceability of the rights and duties, we have recommended that the Bill be divided into two clear Parts, one on public health (including public health emergencies) and the other on healthcare.

Need for prior compatibility review: Several laws relating to public health and healthcare are already in force in Rajasthan. The Bill potentially contradicts certain provisions in these laws. To address this, the Bill imposes a loosely-worded obligation on the State Government to conduct a compatibility review in the future. Instead of conducting this after the enactment of the Bill, we have recommended that a rigorous compatibility review be undertaken before the Bill is passed. The manner in which the Bill is to interact with existing laws should be clearly set out directly in the text of the Bill.

Need for stronger and clearer rights: While the Bill attempts to provide residents of the state with certain general healthcare rights, we have pointed out the need for clarity on the specific rights of patients (both individual and collective). Next, public health rights (sanitation, drinking water etc., are wholly absent, and we have recommended that these be added to the Bill. Given the recent experience with the pandemic, we have pointed out that rights of frontline workers should also be explicitly included.

Need for re-examination of duties: The Bill places certain duties on residents and healthcare providers. We have demonstrated that these are potentially onerous and restrictive, and also in potential conflict with certain rights provided under the Bill. We have recommended that the need to include such duties in this Bill should be carefully re-examined, and the use of other strategies, like information, education, and awareness, to encourage appropriate patient behaviour, should be considered.

Need for clearer and enforceable obligations of the State Government: The Bill has a laudable chapter which places a host of obligations on the State Government. However, we have highlighted that the provisions are broad and vaguely worded, and there is no mechanism for accountability or enforcement. To ensure that this chapter achieves its purpose, we have recommended that these issues be resolved by redrafting this chapter. An accountability and grievance redressal mechanism should be set up as envisaged in point 7 of this summary.

Need for an independent, dedicated health authority: Having shown that the administrative set-up under the Bill suffers from certain key drawbacks, we have recommended that the authorities under the Bill be restructured keeping in mind the following design principles: functional independence from the State Government, full-time executive members, stratified composition with clearly delineated roles, and representation from third-tier bodies.

Need for a best-in-class grievance redressal mechanism: We have pointed out that in the absence of a robust monitoring and accountability mechanism, the aims of the Bill cannot be realised. As such, we have explained the need to set up independent ombudspersons at the block/ taluka level, with appellate ombudspersons at the district and state levels. The Bill also imposes a wholly unnecessary blanket bar on jurisdiction of civil courts. We have questioned the propriety of this provision, given the absence of any alternative mechanism for adjudication under the Bill. In addition to setting up a grievance redressal mechanism to redress other individual complaints, a distinct and independent monitoring mechanism - consisting of sectoral experts - should be established for ensuring accountability of the State Government and the authorities.

Introduction

- On 8 March, 2022, the Rajasthan State Government released a draft of the Rajasthan Right to Healthcare Bill, 2022 ("Bill") and invited public comments on the same.
- The Vidhi Centre for Legal Policy ("Vidhi") is submitting this Note in response to this call.
- This Note is divided into two parts:

I. Comments on Drafting and Definitions

II. Comments on Substantive Aspects of the Bill

A. *The Need for a distinction between Public Health & Healthcare, and addition of a separate chapter on Public Health Emergencies*

B. *Interface of the Bill with existing laws*

C. *Rights & Duties of stakeholders*

D. *Obligations of the State Government*

E. *Regulatory Architecture and Administration*

F. *Grievance Redressal Mechanisms*

III. Details that Require Clarity through Rules

PART I: COMMENTS ON DRAFTING AND DEFINITIONS

This Part examines whether the language of the Bill lends itself to clear and unambiguous implementation and enforceability. Specific instances of drafting errors have been enlisted and explained below.

- Preliminarily, it may be noted that the section on definitions is traditionally not seen as a substantive provision of a law. Unless the defined term has been used in a substantive provision, it has no enforceability. This is the case with several terms defined in Clause 2 of this Bill.
- As such, these terms may be linked to substantive provisions to ensure that they can be enforced.
- For example, the term 'capacity to consent' has been defined in Clause 2(e) of the Bill, but has not been employed anywhere else in the Bill. To ensure that its intended implication is realised and its significance is clearly understood, this term may be linked to the provision which gives persons the right to informed consent (Clause 3 of the Bill).

A. Drafting errors

Provision	Error
Long title	Long title of the Bill is absent.
Enacting formula	Enacting formula of the Bill is absent.
Preamble	The Preamble seems incomplete and ends abruptly. The last sentence is "The Constitution of India incorporates provisions Article 21 of the constitution guarantees protection of life and personal liberty to every citizen" – This is incomplete.
Clause 1(c) - Short Title, extent and commencement	This clause states that the Act "shall come into force on such date as the government may, by notification in the official Gazette." There seems to be a missing word here, leading to the lack of clarity. As per the general norm, this clause should read as follows: "It shall come into force on such date as the government may, by notification in the official Gazette **appoint**."
Clause 2 - Definitions	The numbering format (alphabets) used for the sub-clauses under this clause hampers the readability of the text. Instead, a numerical pattern should be used.
Clauses 2(o)(I) and 2(o)(II)	A mistaken repetition of the same clause.
Clause 8(b)(VI) - Constitution and Duties of State Health Authority	The clause does not mention the procedure for the appointment of the three persons from the Government Medical Teachers of the state. Adding the phrase "nominated by the state government" or any other qualification would address this.
Clause 11(c)(III) - Constitution and Duties of District Health Authority	There is no clarity with respect to the way in which the quotation marks have been placed when mentioning a potential outbreak. It seems as though the intention was to put the phrase 'potential outbreak' in quotes, which suggests that the drafters meant to use it in a specific sense. If this is the case, 'potential outbreak' should be explicitly defined in Clause 2 of the Bill.

B. Ambiguous Drafting

Provision	Issue
Clause 2(a) - Definition of 'affordable'	This clause defines 'catastrophic household healthcare expenditure' as health expenditure exceeding 10% of its total monthly consumption expenditure or 40% of its monthly non-food consumption expenditure. This may be reconsidered as the WHO defines expenditure as being catastrophic if a household's financial contributions to the health system

Provision	Issue
	exceed 40% of income remaining after subsistence needs (not just food) have been met.
Clauses 2(b) and 2(d) – Definition of 'basic primary healthcare services' and 'comprehensive primary healthcare services'	These clauses provide the definitions for the phrases 'Basic Primary Healthcare Services' and 'Comprehensive Primary Healthcare Services'. In defining these terms, the wording used is 'as defined from time to time'. However, the Bill does not state how specific services that fall under either of these definitions will be defined or who will define them.
Clause 2(e) - Definition of 'capacity to consent'	Uses archaic language such as the phrase "mentally challenged". Instead, it is advised to either try and list out the specific disabilities that are intended to be covered, or provide a more acceptable phrasing. For guidance, the UK government's guide on inclusive language (here) can be referred to. This term should be linked to the right to informed consent in Clause 3 of the Bill.
Clause 2(jj) - Definition of 'public health'	The draft defines public health as the health of the population, as a whole, specially as monitored, regulated and promoted by the Government. This definition is at odds with the generally accepted, more comprehensive definition of public health - Public health is defined as "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society" (Acheson, 1988; WHO).
Clause 2(k) - Definition of primary healthcare services'	The word 'disaster' is loosely defined, and seems to be an incomplete version of the definition provided in Clause 2(d) of the National Disaster Management Act. The complete definition from the National Disaster Management Act should be adopted.
Clauses 2(i), (j), and 2(l) - Definition of 'decontamination', 'deratting', and 'disinfection'	These terms do not find further mention in the Bill, although these are important public health functions. In defining 'Decontamination' and 'Disinfection'', the Bill mentions 'health measures' without defining the same. Considering the broad scope of this phrase, a clear outline of what such measures can include should be provided.
Clause 2(o) - Definition of 'essential public health functions'	This clause specifies that monitoring and evaluating health status to identify community health problems and taking measures to solve them are one of the essential public health functions. However, the procedure for this should be outlined in the chapter which lays out the obligations of the relevant authorities under the Bill. The various sub-clauses under this provision seem to use the phrases 'health problems' and 'health issues' interchangeably, without outlining the scope of either of these.
Clause 2(t) - Definition of 'healthcare provider'	The definition of 'healthcare provider' is vague. In the interest of clarity, an illustrative and inclusive list of healthcare providers should be set out in this provision (for e.g., registered medical practitioners, nurses, ANMs, ASHA workers etc.).
Clauses 2(w) - Identifiable health information; and 2(dd) - non-identifiable health information	While the intent behind this provision is commendable, the terms have not been employed in any of the substantive provisions of the Bill.
Clause 2(y) - Definition of 'Informed consent'	Suggestion to use gender-neutral language instead of phrases like 'himself/herself'.
Clause 2(kk) - Definition of 'public health institution'	The term 'health services' should be defined with reference to the definition of 'health care' set out in Clause 2(r) of the Bill.
Clause 2(ll)(II) – Definition of 'public health emergency'	Given that the definition uses broad phrases like 'large number' and 'widespread exposure' which are subjective, the substantive provisions of the Bill must provide a more detailed method for determining these thresholds.

Provision	Issue
Clause 2(oo) – Definition of 'public health surveillance'	Surveillance powers granted in respect of collecting 'health-related' data. To ensure that the broad phrasing carries does not give rise to the possibility of potential misuse, reasonable safeguards should be introduced in the substantive provision, i.e., Clause 8(d)(IX).
Clause 2(ww) - Definition of 'Secondary Health Care Services' and 2(xx) - Definition of 'Tertiary Health Care Services'	Including some examples or illustrations may be useful here, to make the definitions more holistic/ comprehensive.
Clause 3 (Rights of Residents) and Clause 5 (Rights of Health Care provider)	There should be a uniformity in the drafting language. For instance, some of the sub-clauses of Clause 3, relating to rights of residents start with 'Residents will have a Right to', whereas some start with 'Right to—'
Clause 3(a)	'Residents have the right to collect information to make themselves healthy' - This is drafted in a vague manner and would be difficult to operationalise.
Clauses 3(g), 3(h), 3(j) and 3(m)	These clauses use the term 'health care establishment' in different ways. For instance, while in some sub-clauses it is used in conjunction with the terms like 'be it public or private', in other ones it is used broadly ('every health care establishment'). This creates an unexplained inconsistency. The terms 'be it public or private' need not be used if health care establishment itself has been defined in the Definitions section to include both public and private establishments.
Clause 3(k)	'Right to take treatment summary in case of patient, leaving against the medical advice' - The language used to draft this is unclear and the meaning, responsibility, and implication are vague. Instead, this should be broadened to provide a general right of patients to access medical records at all times, irrespective of whether they are discharged against medical advice.
Clause 2 (e) - Capacity to consent, Clause 3 (dd) - non-identifiable health information	The terms defined here do not find specific references in the act. The act does not utilize the terms defined in these clauses later in the draft, making the implications of such definitions ambiguous.
Clause 7(a) under Obligations of the government	Vague mention of 'appropriate state budget' without outlining what is intended by the use of the word 'appropriate' or which body will determine whether it is appropriate or not.
Clause 7(i)	It should be made clear that the standard to be followed in determining the threshold of 'nutritionally adequate and safe food' should be clarified in the rules framed under the Bill.
Clause 7(j)	Broad phrasing like 'effective measures' used which can potentially vest excess power in the government to impose restrictions in this regard. A clearer outline of the kind of measures that can be taken under the mandate of the Bill should be provided. The Bill should contain a distinct chapter on public health emergencies, given that they will require special measures over and above the performance of essential public health functions and the delivery of health care services.
Clause 9(d)(V) under Constitution and Duties of State Executive Committee	The acceptable procedures that can be used to monitor health status should be outlined to avoid the risk of legitimizing excessive surveillance. Moreover, a definition of what parameters fall within the umbrella of 'health status' should be provided.
Clause 11(b)(IV) under Constitution and Duties of District Health Authority	The number of senior-most officers that the Bill seeks to include in the District Health Authority from each of the 7 departments mentioned must be clarified.
Clause 11(c)(VI)	This clause discusses the creation of tools for monitoring as one of the functions of the District Health Authority. It also discusses the collection of data. It must be clarified what the extent and scope of the usage of these tools would be. Additionally, clear rules must be laid down for what kind of data will be collected, whether it will be stored or not, etc.

Provision	Issue
Clause 12 - Powers of the State Health Authority and District Health Authority	In this clause, there is an absence of proportionality requirements that would be in keeping with the rights-based nature of the Bill. For instance, the references to carrying out inquiries (Clause 12(a)), entering a building (Clause 12(c)), etc. should all reflect the principle that only such measures should be taken as are necessary, proportionate and least restrictive of the rights of those concerned.

PART II: COMMENTS ON SUBSTANTIVE ASPECTS OF THE BILL

A. The Need for a distinction between Public Health & Healthcare, and addition of a separate chapter on Public Health Emergencies

1. Current Position under the Bill

Although the instant Bill is titled as the 'Right to *Healthcare* Bill' (emphasis supplied), it regulates both public health as well as healthcare without any clear demarcation between the two. For example, it includes prevention, treatment, and control of epidemics as an obligation of the government [Clause 7(j)]. However, the rights and duties of stakeholders, obligations of the Government, regulatory architecture, grievance redressal mechanisms etc. are have not been separated from each other, thus creating scope for confusion.[1] At the same time, the public health aspects of the bill are inadequate and require more careful articulation and implementation mechanisms.

2. Vidhi's Comments

The field of health law has traditionally recognised a distinction between public health and healthcare. This distinction is generally captured in the following terms:

> "*[public health]* is *a collective ("public") responsibility, geared toward improving the health and well-being of an entire community—or state, or country—as opposed to diagnosing or treating particular individuals. In addition, public health addresses the "conditions to be healthy," meaning that it is focused on "the prevention of disease and the promotion of health" … as opposed to medical care for those who are already ill…Public health studies the causes and distribution of disease and injury in populations. This is one of the defining differences between public health and healthcare*."[2]

Further, the World Health Organisation has defined 'public health law' in the following terms:

> "*Public health law refers to the formal set of laws – and to the legal processes for implementing and enforcing them – that seek to ensure the conditions for people to live healthy lives. Apart from laws pertaining directly and palpably to health infrastructure and health regulation, a robust public health system uses a combination of laws, regulations, public awareness, public trust, and public participation mechanisms – under an umbrella of recognized human/ health rights – to promote community and individual health (physical, mental, social, etc.) in the society. Such mechanisms include focus on larger social, economic, and political factors that promote or discourage health behaviours*."[3]

Thus, laws relating to public health generally aim to prevent the potential outbreak of diseases, tackle public health emergencies, and generally ensure the overall health and well-being of a population. On the other hand, laws relating to healthcare aim to provide citizens with the best possible standards of medical diagnosis and treatment by, *inter alia*, regulating clinical establishments.

[1] See comments on Chapters II & III of the Bill.

The aims being distinct, the rights and duties as well as regulatory approach which is adopted to secure them are also different. As such, India (as well as other jurisdictions) has traditionally enacted separate legislations to address each aspect. For example, the state of Rajasthan itself addresses public health through third-tier legislations such as the Rajasthan Municipalities Act, 2009 and the Rajasthan Panchayati Raj Act, 1994, or through specific laws such as the Rajasthan Vaccination Act, 1957, while healthcare is addressed through laws such as the Rajasthan Medical Act, 1952 and the Clinical Establishments Act, 2010.

In the interests of clarity, ease and efficiency of administration, and enforceability of the rights and duties, the Bill should be divided into two clear Parts. The Part which addresses public health may contain, *inter alia*, provisions relating to the public health functions of the State Government and third tier bodies, rights and duties of citizens, etc. while the Part relating to healthcare may contain, *inter alia*, provisions relating to the rights of patients, duties of clinical establishments etc. A common authority with oversight over both may be retained, provided that its functions and powers in relation to public health and healthcare are clearly delineated. The Part dealing with public health should have a chapter solely dedicated to public health emergencies, given the powers required to be exercised in order to tackle them, and the special duties and responsibilities which arise in such conditions.

[2] Scott Burris et al, 'The New Public Health Law: A Transdisciplinary Approach to Practice and Advocacy' (Oxford University Press, 2018), pp.4-5.

[3] WHO, 'Advancing the right to health: The Vital Role of Law', 2017.

B. Interface of the Bill with Existing Laws

1. Current Position under the Bill

The Bill attempts to harmonise its provisions with existing laws relating to healthcare and public health in Rajasthan.[4] This is sought to be achieved in the following manner:

- Generally speaking, the Bill is to be applied in uniformity with, and not in derogation of, any other laws in force in Rajasthan which deal with the same subject matter.[5]
- However, in the event of a conflict between this Bill and other laws, the provisions of this Bill are to prevail over the other laws to the limited extent of the conflict.[6]

Moreover, the State Government is obligated to undertake comprehensive reviews of the existing laws on health within one year of this law coming into force, to ensure the compatibility of those other laws with this Bill.

2. Vidhi's Comments

Instead of laying down a set of general rules governing the interaction between existing laws and the Bill, the potentially conflicting laws should first be identified. The conflicts should then be explicitly addressed in the text of the Bill.

The Rajasthan State Government has already enacted the following legislations which, among others, touch upon various aspects of public health and healthcare:

- Clinical Establishments (Registration and Regulation) Act, 2010: this Act enables the registration and provides for the regulation of clinical establishments.
- The Rajasthan Para-Medical Council Act, 2008: this Act provides for the constitution of a Para-Medical Council, regulation of Para-Medical profession, and recognition of institutions imparting education or training in Para-Medical subjects in the State and for related matters.
- The Rajasthan Medical Act, 1952: this Act provides for the registration of Medical Practitioners in Rajasthan.
- The Rajasthan Vaccination Act, 1957: this Act makes the vaccination of children compulsory.
- The Rajasthan Panchayati Raj Act, 1994: this Act obligates the Panchayati Raj institutions to perform certain public health functions.
- The Rajasthan Municipalities Act, 2009: this Act obligates the urban local bodies to perform certain public health functions.

A careful mapping of the provisions of these laws must first be undertaken and potential conflicts must be identified. After decisions have been made on how these conflicts are to be addressed, appropriate provisions may be placed in the body of the Bill explaining its interface with these existing laws.

For instance, there must be clarity on the mechanisms that will be used to fix prices for healthcare services at healthcare establishments. Currently, the Central Government exercises this power under the Clinical Establishments Act, 2010. The power of price fixation for services in clinical establishments in the state of Rajasthan already exists under rule 9(ii) of the Clinical Establishments Rules, 2012, read with section 52 of the Clinical Establishments Act, 2010. This power is currently exercised by the Central Government in consultation with the concerned State Government. If this power is now proposed to be exercised under the proposed law, any overlap with the Clinical Establishments Act must be appropriately clarified.

[4] Rajasthan Right to Health Care Bill, 2022, s.18.

[5] Rajasthan Right to Health Care Bill, 2022, s.18(b)

[6] Rajasthan Right to Health Care Bill, 2022, s.18(c).

In the same vein, the Clinical Establishments Act, under which standards for healthcare establishments are set must also ensure that such standards meet the rights of accessibility, affordability, and quality guaranteed under the proposed law.

For all future laws/rules/regulations/notifications/other instruments dealing with public health or healthcare, the State Government should ensure that these are fully compatible with the provisions of the Bill.

C. Rights and Duties of Stakeholders

1. Current position under the Bill

Chapter-II of the Bill provides for the rights and duties of residents and health care providers.

Residents have been defined as persons who are bona fide residents of Rajasthan or are currently residing in Rajasthan. These residents have been given a range of rights and duties only in the domain of healthcare.

Rights of Residents

According to Clause 3, Residents have the right to:

- collect information to make themselves healthy
- free consultation, drugs, diagnostics, emergency transport and emergency care at all public health institutions
- free/affordable care for surgeries at all public hospitals
- avail free services the empanelled hospitals, if they are covered under insurance scheme through
- avail free services from the private hospitals established through land allocation on concession rates as per the terms and conditions mentioned at the time of the allotment of the land
- receive information, records and reports of self from the health care establishment, be it public or private
- informed consent at all health care establishments, be it public or private
- confidentiality at all health care establishments
- safe and quality care according to standards prescribed for different levels of health care establishments run or managed by Government or private institutions.
- proper referral transport by all health care establishments be it public or private
- take treatment summary in case of patient, leaving against the medical advice
- be heard and seek redressal from health care establishment if any grievance occurred after availing services
- receive the dead body of the deceased person, to be exercised by the family member/authorized person, irrespective of payment due status from every health care establishment

Duties of Residents

According to Clause 4, Residents must:

- Avail of tertiary healthcare services only after following referral from primary or secondary level institutions or service providers
- Provide healthcare providers with relevant and accurate information

- Comply with the prescribed healthcare
- Sign a discharge certificate or release of liability if they refuse to accept or continue the recommended treatment
- Not pollute the premises where the treatment is being provided
- Refrain from misconduct and misbehaviour with healthcare providers, and treat them with respect and dignity
- Refrain from physical assault on healthcare personnel or damage to property
- Report illegal or unethical behaviour
- Permit post-mortem to be done in case of unnatural death

Healthcare providers ("HCP"s) have been defined as persons who are authorised by the Government to engage in identifying, preventing, and/or treatment of illness and/or disability.

Rights of healthcare provider

According to Clause 5, healthcare providers have the right to:

- protection from complaints relating to adverse consequences on providing services of any kind as long as the provider has acted bonafide to the best of their professional capability through application of standard treatment procedure and judgment, and in the best interests of the residents and exercised all reasonable care
- be treated with respect and dignity by the patients and attendants.
- decent working conditions and training.
- right of physical safety and security at the workplace.
- availability of protective measures for any accidental exposure to harm.

Duties of healthcare provider

According to Clause 6, healthcare providers must:

- Follow the standard treatment guidelines and protocols as notified from time to time, and using the clinical judgement in the best interest of the resident.
- Maintain confidentiality, privacy, dignity of residents, and treat them with respect.
- Respect the rights of residents to take a decision to get a lab investigation or to purchase medicines from a vendor of their choice.
- Ensure informed consent is taken before every procedure.
- Regularly explain and inform either patient or relatives regarding the severity of the disease, progression, treatment and prognosis.

2. *Vidhi's Comments*

Rights of residents

- It is commendable that 'residents' has not been defined in a restrictive way that requires proof of domicile, citizenship, etc. However, there should be a differentiation between rights of residents and users. While certain rights like state health insurance may be reserved for residents of the state, certain rights such as emergency health care, information, quality of care, etc. should be applicable to any user or patient.

- The chapter mentions 'Collective' rights, but most of these rights are individual rights, and community health rights have been left out of the draft. There is scope here for the inclusion of rights of marginalised communities, rights of participation in decision-making and representation, articulation of broader public health rights, etc.

- In the same vein, some rights such as right to confidentiality, treatment summary, receive dead body, etc. should be part of 'user rights' as opposed to 'rights of residents'.

- In 2018, the Ministry of Health and Family Welfare ("MoHFW"), Government of India, adopted a Charter of Patient Rights, on the basis of a list prepared by the National Human Rights Commission. It has since been updated and approved by the National Council for Clinical Establishments.[7] As per this charter, a patient/ user and their representative has the following rights with respect to a clinical establishment:

    - *To adequate relevant information about the nature, cause of illness, proposed investigations and care, expected results of treatment, possible complications and expected costs*

    - *To information on the Rates charged for each type of service provided and facilities available. Clinical Establishment shall display the same at a conspicuous place in the local as well as in English language.*

    - *To access a copy of the case papers, patient records, investigation reports and detailed bill (itemized).*

    - *To informed consent prior to specific tests/treatment (e.g. surgery, chemotherapy etc.)*

    - *To seek second opinion from an appropriate clinician of patients' choice, with records and information being provided by the treating hospital.*

    - *To confidentiality, human dignity and privacy during treatment.*

    - *To have ensured presence of a female person, during physical examination of a female patient by a male practitioner.*

    - *To non-discrimination about treatment and behaviour on the basis of HIV status*

    - *To choose alternative treatment if options are available*

    - *Release of dead body of a patient cannot be denied for any reason by the hospitals.*

    - *It was recommended that patient seeking transfer to another hospital/discharge from a hospital will have the responsibility to "settle the agreed upon payment".*

[7] 'Charter of Patients' Rights and Responsibilities', <http://clinicalestablishments.gov.in/WriteReadData/3181.pdf>.

- *It may be specified in the charter that no discrimination in treatment based upon his or his illness or conditions, including HIV status or other health condition, religion ethnicity, gender (including transgender), age, sexual orientation, linguistic or geographical/social origins.*
- *Informed consent of patient should be taken before digitization of medical records Right to care according to prescribed rates wherever relevant.*
- *Right to choose source for obtaining medicines or tests*
- *Right to protection and compensation for patients involved in clinical trials, as per Drugs and Cosmetics Act and other Government Guidelines.*
- *Right to protection and compensation for participants involved in biomedical and health research as per ICMR and other Government Guidelines.*
- *Right to Patient Education*
- *Right to be heard and seek redressal: Every Hospital shall have/establish a time bound Grievance redressal mechanism to address the grievances of the patients. A Grievance redressal officer will be identified by the hospital and his name and contact details will be displayed at a conspicuous place in local language and in English. The records of grievances received and remedial action taken will be maintained. The name and contact details of the district registering authority will also be displayed who may be contacted in case of non-redressal of the grievance of patients to their satisfaction*
- *Right to proper referral and transfer, which is free from perverse commercial influences*
    - *In case of referral by the hospital, the referring hospital will provide proper referral transport facility in the most appropriate vehicle/ambulance for transfer of patient to the nearest possible hospital where facilities for appropriate and timely management of the condition of the patient, are available.*
    - *Such transfer of patient will not be refused even if not referred by the treating hospital and even if the patient is leaving against medical advice (LAMA). The applicable reasonable charges may be levied by the Clinical Establishments for such transfers. However, in case of an emergency situation, such referral transport will be provided free of cost as far as possible and will not be refused for want of any payment.*
    - *State/UT Government may consider to define various charges for different types of ambulance for compliance by the hospitals and other clinical establishments. The Clinical Establishments will be required to display the rates of charges of ambulance(s)*
    - *The referring hospital shall provide a qualified and trained person to monitor and manage the condition of the patient enroute till the patient is received by the referee hospital*

Since the state government is empowered by the Constitution to implement such rights through state-level laws, MoHFW had written to the states to do the same in 2019. Although the draft of this Bill mentions some of these rights under Clause 3, a more comprehensive articulation of all the rights articulated in the Charter of Patient Rights is crucial under 'user rights' in healthcare establishments.

- The 'right to collect information to make themselves healthy' is vaguely worded and therefore difficult to operationalise. A more detailed public awareness and information right, with specific allocation of duties, would be more useful here.

- Although the title of the Act mentions that it is a Right to Health Care Bill and not a public health law, certain public health provisions (such as inclusion of public health emergencies) have been included in the draft. In that context, public health rights should be included in the bill, and there should be separate sections/ clauses dealing with public health and healthcare rights. Separate sections on these two categories of rights would help in appropriate allocation of responsibilities for their implementation.

- There is no mention of allied rights which pertain to underlying determinants of health – such as food, water, sanitation, housing, etc.

- While availability, accessibility, and quality of health care services have been guaranteed, there has been no mention of acceptability (which refers to cultural suitability and approachability of the health system).

Rights of Health Care Providers

- There should be a section on rights of HCP vis-à-vis the government, and appropriate modifications may be made in other health-related laws in the state (which currently lack a rights-based approach for HCP). Apart from registered medical practitioners, other healthcare workers and frontline workers involved in public health functions (ASHA workers, sanitation workers, ANMs, etc.) should be included within the ambit of such rights. Apart from working conditions, safety, pay, dignity, etc. health insurance mechanisms (especially in situations of public health emergencies) may be envisaged here.

- The right to be treated with respect and dignity by patients and attendants is vague. Since the violation of any right under this law is a ground for grievance redressal (as per Clause 13), the rights should be worded more carefully and specifically.

- Rights to decent working conditions, physical safety, security, etc. should be drafted in clearer and more detailed ways. There are two ways of doing this – (a) Mention the components of these rights in the body of the Bill, (b) Refer to appropriate labour or service laws.

Duties of residents and HCP

Ideally, duties of residents and HCP should not be part of state-level legislation. By not only including duties in the legislation but also placing rights and duties in the same chapter, the draft fails to highlight the justiciability of rights over duties.

- Some of these provisions (such as providing accurate information to HCPs, complying with prescribed healthcare, etc.) are better suited to be part of service rules, patient charters, HCP training programmes, public awareness programmes, etc. – as opposed to being legislated. Imposing legally enforceable duties on all residents and HCPs will make them susceptible to disproportionate and unfair legal claims/ procedure under this Bill, and infringement of their other rights.

- More appropriate and efficient alternative mechanisms are already in use in case of some of these duties. For grave violations such as physical assault of HCPs by residents and medical negligence by HCPs, criminal law provisions and criminal court procedure are used. In case of littering or pollution of premises, fines may be imposed at the institutional level.

- Some of these duties (e.g. availing tertiary healthcare only after obtaining referral, signing a discharge certificate or release of liability if they refuse to accept or continue recommended treatment, etc.) are excessive and restrictive. Legislating them within this Bill is likely to result in harassment of users and infringements of their rights to healthcare and health services. The practise of 'discharge against medical advice' is often a result of a breakdown of trust between HCPs and patients/relatives/next friends. To address this, more emphasis is needed on training HCPs in a process of shared decision-making, rather than on imposing a potentially legally enforceable duty on patients.

- Some of the duties, such as the duty to report illegal or unethical behaviour, refrain from misconduct or misbehaviour, etc. are worded in vague and undefined terms. Since the grievance redressal mechanisms do not clarify grounds for complaint or appeal, and any violation pertaining to the Bill may be brought within the ambit of a grievance, such vague articulation is likely to be harmful to users. Instead, there should be an easily accessible mechanism that allows users to report grievances against HCPs or healthcare establishments.

- Duties of HCPs pertaining to obtaining informed consent, maintaining confidentiality, respecting the right to take a decision to get a lab investigation or to purchase medicines from a vendor of their choice, informing patients regarding severity of the disease, progression, treatment and prognosis, etc. would be better framed under 'rights of users'.

Some specific comments on Clauses 4 and 6

- Traditional public health duties, such as duty to self-report symptoms of a contagious disease, or operating an established community reporting or surveillance system for the same, are missing from this draft. These may be included in the proposed chapter on Public Health Emergencies, with specific reference to the contours and limits of the duties, the powers of the government vis-à-vis the enforcement of such duties, and their overall implications.

- It is not clear as to what an HCP should do if a user does not possess the capacity to consent under this law. The capacity to consent has been defined in Clause 2 of the Bill, but does not find any use in the rest of the Bill.

- The duty to inform patients or relatives – there should be careful consideration of the patient's right to privacy and confidentiality when informing relatives.

D. Obligations of the State Government

1. Current Position under the Bill

Chapter-III of the Bill (Section 7) lays down the general obligations of the government under this law. It includes obligations ranging from resource optimization and budgetary allocation, alignment of services and schemes towards a robust health system in the state, notification of safety and quality standards, setting up coordination mechanisms, and education and empowerment of people regarding health issues.

2. Vidhi's Comments

- 'Appropriate state budget should be provided' is a vague obligation that cannot be operationalized in the absence of clearly laid down procedural, output-based, and/ or impact-based obligations
- The chapter mentions arbitrary timelines for implementing and developing a Human Resource Policy, without describing the vision, components, or intended impact of the same.
- Six months have been provided for setting up social audit and grievance redressal mechanisms under this Bill. Please refer to Chapter II. E of this document for more details on the issues with the mechanisms envisaged therein.
- Clause 7(d) mentions that the state government should 'align all health services and schemes' within one year of enactment of this Bill. Please refer to Chapter II. B of this document for more details regarding this.
- Safety and quality standards are better suited to the Clinical Establishments Act of respective states. Therefore, such functions should be performed under the suitable legislation instead of creating multiple overlapping laws, while ensuring that such standards meet the rights-based guarantees under this Bill.
- Certain provisions, such as consideration of criteria such as distance, geographical area, population density, etc. for allocation of health services – are better dealt with by existing programmes under the National Health Mission ("NHM") or existing standards such as the Indian Public Health Standards ("IPHS"). Partial duplication of the same in this Bill may cause unnecessary confusion.
- The chapter includes the obligation to set up coordination mechanisms among relevant government departments to facilitate other determinants of health such as food, drinking water, and sanitation. The mechanism envisaged under this Bill in Chapter IV (the State and District Health Authority), which includes representation from diverse departments pertaining to various components of public health, is better suited for such coordination function, rather than the governance, executive, and grievance redressal functions assigned to these authorities under this Bill.

E. Regulatory Architecture/Administration

1. Current Position under the Bill

The Bill sets up regulators at two tiers: state (State Health Authority and State Executive Committee) and district (District Health Authorities).

State-level: State Health Authority & State Executive Committee

The State Health Authority ('SHA') is the primary regulator/administrator under the Bill.

The composition of the SHA is as follows:[8]

- Chief Secretary of the State Government of Rajasthan – Chairperson.
- Secretary in charge of the Medical, Health and Family Welfare Department – Co-Chairperson.
- Director of Health Services (Public Health) – Member-Secretary.
- Secretaries in charge of a range of relevant departments:
  1. Medical Education
  2. Public Health Engineering
  3. Women & Child Development
  4. Panchayati Raj and Rural Development
  5. Social Justice and Empowerment
  6. Tribal Area Development
  7. Urban Development
  8. Finance
  9. Information and Public Relations
  10. Revenue
  11. Ayurveda, Yoga, Naturopathy, Unnai, Siddha, and Homeopathy
  12. Education
  13. Relief
  14. Rehabilitation
- Three members of the Legislative Assembly to be nominated by the State Government.
- Three persons from the Government Medical Teachers, especially from clinical specialties.
- Four non-official persons from the following classes:
  1. Public health experts to be nominated by the Chairperson.
  2. Representatives of health associations to be nominated by the Chairperson.
  3. Civil society organisations to be nominated by the Chairperson.
  4. One member from a reputed NGO, preferably working in Rajasthan, to be nominated by the Chairperson.
- A Representative of the Chairman of the State Pollution Control Board.
- Three representatives from patient groups, to be nominated by the Chairperson.

The SHA is expected to perform 5 broad kinds of functions:

1. **Advise** the Government on all matters concerning public health.[9]
2. **Formulate** the health goals of the State and get these included in the mandate of the Panchayati Raj institutions and urban local bodies,[10] formulate the state-level strategic plans for implementation of

[8] Rajasthan Right to Health Care Bill, 2022, s.8(b).

[9] Rajasthan Right to Health Care Bill, 2022, s.8(d)(I).

[10] Rajasthan Right to Health Care Bill, 2022, s.8(d)(II).

the Act including action on the determinants of health, viz., food, water, and sanitation,[11] and formulate a comprehensive policy/plan to prevent, track, mitigate, and control a public health emergency.[12]

3. **Monitor** the preparedness of the State to manage public health emergencies,[13] and develop mechanisms for regular medical, clinical, and social audits to ensure quality healthcare at all levels.[14]
4. **Involve the community** as active co-facilitators, help them in identifying key indicators, and create tools for monitoring, providing feedback, and validating any data that is collected as a result of such feedback or monitoring.[15]
5. **Delegate** its functions by constituting committees/scientific panels/technical panels,[16] and **associate** with institutions, experts, NGOs etc. to ensure that its functions are efficiently discharged.[17]

To enable efficient discharge of functions, SHA has been given the following powers:

- It may require any person to furnish information by resorting to sections 176 and 177 of the Indian Penal Code, 1860 ('IPC').[18]
- It may enter any building or place if they have reason to believe that any document relating to the subject matter of an enquiry may be found there. It may proceed to seize such documents, subject to section 100 of the IPC.[19]
- It may fix responsibilities and hold to account private institutions, facilities, buildings or places, which provide inpatient or outpatient services.[20]
- The Government may regulate prices for packages and ensure that rates for the packages are displayed in the public domain.[21]
- During a pandemic or during any other public health emergency, the Government may take-over buildings, facilities, services, and duties of human resources from private institutions, and also prescribe rates for treatment provided by private institutions.[22]

State Executive Committee

The State Executive Committee ('SEC') is an independent body under the Bill, to be set up by the SHA.[23] It essentially appears to be the executive arm of the SHA, as its functions are to implement the plans/policies/strategies formulated by the SHA.

The composition of the SEC is as follows:

- Secretary in charge of Medical, Health, and Family Welfare Department – Chairperson.
- Secretaries in charge of a range of relevant departments:
    1. Medical Education
    2. Women & Child Development
    3. Panchayati Raj and Rural Development

[11] Rajasthan Right to Health Care Bill, 2022, s.8(d)(III).
[12] Rajasthan Right to Health Care Bill, 2022, s.8(d)(IV).
[13] Rajasthan Right to Health Care Bill, 2022, s.8(d)(V).
[14] Rajasthan Right to Health Care Bill, 2022, s.8(d)(VI).
[15] Rajasthan Right to Health Care Bill, 2022, s.8(d)(IX).
[16] Rajasthan Right to Health Care Bill, 2022, s.8(d)(VII).
[17] Rajasthan Right to Health Care Bill, 2022, s.8(d)(VIII).
[18] Rajasthan Right to Health Care Bill, 2022, s.12(b).
[19] Rajasthan Right to Health Care Bill, 2022, s.12(c).
[20] Rajasthan Right to Health Care Bill, 2022, s.12(c).
[21] Rajasthan Right to Health Care Bill, 2022, s.12(d).
[22] Rajasthan Right to Health Care Bill, 2022, s.12(d)(I).
[23] Rajasthan Right to Health Care Bill, 2022, s.9(a).

    4. Ayurveda, Yoga, Naturopathy, Unnai, Siddha, and Homeopathy
    5. Elementary education
- Mission Director (National Health Mission), Rajasthan.
- Director of Medical and Health Services (Public Health).
- Additional Director (Hospital/Administrator), Rajasthan.
- Nodal officer (under this Act), Rajasthan.
- Three persons from the Government Medical Teachers, especially from clinical specialties.
- Four non-official persons from the following classes:
    1. Public health experts to be nominated by the Chairperson.
    2. Representatives of health associations to be nominated by the Chairperson.
    3. Civil society organisations to be nominated by the Chairperson.
    4. One member from a reputed NGO, preferably working in Rajasthan, to be nominated by the Chairperson.
- A Representative of the Chairman of the State Pollution Control Board.

The SEC is expected to perform 5 broad kinds of functions:

1. **Implement** the state-level strategic plans formulated by the SHA for implementation of the Act including action on the determinants of health, viz., food, water, and sanitation,[24] **implement** the comprehensive policy/plan formulated by the SHA to prevent, track, mitigate, and control a public health emergency, as well as situations of outbreaks or potential outbreaks in the state.[25]
2. **Ensure** that the State Government is prepared for the management of public health emergencies.[26]
3. **Ensure** that there are mechanisms for regular medical, clinical, and social audits to ensure quality healthcare at all levels.[27]
4. **Monitor** the health status of the population to identify and solve community health problems.[28]

District-level: District Health Authority

The District Health Authorities ('DHAs') are the federated units of the SHA at the district level. Their primary function is to implement the plans/policies/strategies of the SHA and coordinate between departments and agencies of the State Government to ensure that the interests of the districts are adequately safeguarded.

The composition of the DHAs is as follows:
- District Collector – Chairperson
- CEO of the Zila Parishad – Co-chairperson
- Chief Medical & Health Officer (CMHO) – Member Secretary
- Senior most officers from the following departments in the district:
    1. Public Health Engineering
    2. Social Justice and Empowerment
    3. Integrated Child Development Services (ICDS)
    4. Women Empowerment
    5. Local Body
    6. Education
    7. Ayurveda, Yoga, Naturopathy, Unnai, Siddha, and Homeopathy

[24] Rajasthan Right to Health Care Bill, 2022, s.9(d)(I).

[25] Rajasthan Right to Health Care Bill, 2022, s.9(d)(II).

[26] Rajasthan Right to Health Care Bill, 2022, s.9(d)(III): it may be noted that this is Vidhi's understanding of the clause. The text itself reads: "to ensure the State for management of public health emergencies".

[27] Rajasthan Right to Health Care Bill, 2022, s.8(d)(IV).

[28] Rajasthan Right to Health Care Bill, 2022, s.8(d)(V).

- Pramukh, Zila Parishad of the district and three Pradhans' of the Panchayat Samitis in rotation.
- Four non-official members:
    1. Public health experts to be nominated by the Chairperson.
    2. Representatives of health associations to be nominated by the Chairperson.
    3. Civil society organisations to be nominated by the Chairperson.
    4. One member from a reputed NGO, preferably working in Rajasthan, to be nominated by the Chairperson.

The DHA is expected to perform the following broad kinds of functions:

- **Implement** the policies, recommendations, and directions of the SHA.[29]
- **Formulate** and **implement** strategies and plans of action for the determinants of health, viz., food, water, sanitation, and environment.[30]
- **Formulate** a comprehensive policy/plan to prevent, track, mitigate, and control a public health emergency, as well as situations of outbreak or potential outbreak based on the state plan.[31]
- **Coordinate** with government departments and agencies to ensure availability of and access to safe food, water and sanitation throughout the district.[32]
- **Organise hearings** for beneficiaries coming to hospitals to improve healthcare services.[33]
- **Involve the community** as active co-facilitators, help them in identifying key indicators, and create tools for monitoring, providing feedback, and validating any data that is collected as a result of such feedback or monitoring.[34]

2. Vidhi's Comments

The composition of the SHA and the DHAs should include full-time executive members

- Every member of the SHA and DHAs are ex-officio appointees. As a result, they are all 'multi-hatting', i.e., their regular occupation is entirely different, and they are administering these authorities only as an additional obligation. In order for a body of this nature to function effectively and efficiently, it requires a class of full-time executive functionaries (a CEO, a CFO, directors, and officers, and employees.) as is the case with a majority of statutory regulators. In its present form, the SHA and DHAs are functionally not regulators or authorities, but mere platforms for coordination.
- The following regulators at the central level have full-time executive members:
    - Agricultural and Processed Food Products Export Development Authority: Consists of a full-time Chairman shall be appointed by the Central Government and is to be the CEO of the Authority.
    - Airports Authority of India: Consists of a full-time Chairperson who is to be appointed by the Central Government. The other members of the Authority may be appointed as full-time or part-time members as the Central Government may think fit.
    - Airports Economic Regulatory Authority of India: All three members of the Authority are to be full-time members. These are the Chairperson (who is also the CEO of the Authority) and two other members.
    - Atomic Energy Regulatory Board: Currently, the Board consists of a full-time Chairman, an ex-officio Member, four part-time Members and a Secretary.
    - Central Electricity Regulatory Commission: Consists of a full-time Chairperson who is also to be the CEO of the Commission, and three other full-time members.
    - Central Pollution Control Board: Consists of a full-time Chairman and a full-time member secretary.

[29] Rajasthan Right to Health Care Bill, 2022, s.11(c)(I).
[30] Rajasthan Right to Health Care Bill, 2022, s.11(c)(II).
[31] Rajasthan Right to Health Care Bill, 2022, s.11(c)(III).
[32] Rajasthan Right to Health Care Bill, 2022, s.11(c)(IV).
[33] Rajasthan Right to Health Care Bill, 2022, s.11(c)(V).
[34] Rajasthan Right to Health Care Bill, 2022, s.11(c)(VI).

- Coal Regulatory Authority of India: Consists of a full-time Chairperson and four other full-time members with expertise in legal, financial, technical and consumer interest.
- Coffee Board: consists of full-time executive functionaries (a CEO, a CFO, directors, and officers, and employees.)
- Competition Commission of India: The Chairperson and all other members of the CCI are whole-time members.
- Food Safety and Standards Authority of India: Full-time Chairperson and other part-time members.
- Inland Waterways Authority of India: Consists of a Chairman, a Vice-Chairman, not more than three full-time members and not more than three part-time members.
- Insurance Regulatory and Development Authority of India: Consists of a full-time Chairperson, not more than five whole-time members and not more than four part-time members.
- Pension Fund Regulatory and Development Authority: Consists of a full-time Chairperson, three whole-time members and three part-time members.
- Petroleum and Natural Gas Regulatory Board: Consists of the following full-time members: Chairperson, a Member (Legal) and three other members to be appointed by the Central Government.
- Reserve Bank of India: Full-time Governor and Deputy Governors.
- Rubber Board: consists of full-time executive functionaries (a CEO, a CFO, directors, and officers, and employees.)
- Securities and Exchange Board of India: Currently, it consists of a full-time Chairperson, two full-time members and four part-time members.
- Spices Board: consists of full-time executive functionaries (a CEO, a CFO, directors, and officers, and employees.)
- Tea Board: consists of full-time executive functionaries (a CEO, a CFO, directors, and officers, and employees.)
- Telecom Regulatory Authority of India: Consists of a Chairperson (full-time), not more than two full-time members, and not more than two part-time members to be appointed by the Central Government.
- Tobacco Board: consists of full-time executive functionaries (a CEO, a CFO, directors, and officers, and employees.)

- At the state-level in Rajasthan, the Rajasthan Electricity Regulatory Commission consists of a full-time Chairperson who is also to be the CEO of the Commission, and three other full-time members.
- Specifically, in relation to regulators in the field of health, the Governing Board of the National Health Authority consists of one full-time member, that is the CEO of the NHA.

The composition of the SHA should include representation from third-tier bodies

- The SHA has no members from Urban Local Bodies or Panchayati Raj institutions. This may pose a problem with coordination and overlap in jurisdiction/functions, as it is these entities which are obligated to perform public health actions at the granular level under the third-tier laws.
- If the concern is that owing to the large number of these bodies, it may be difficult to distribute membership in an equitable manner, representatives from these bodies can be made rotating members with fixed metrics for rotation (for e.g., at least one representative from municipalities which have consistently performed poorly in public health metrics).

The composition of the SHA & DHAs should be stratified, with a clear delineation of functions

- Although both the SHA and the DHAs are composed of different classes of members (for e.g., secretaries of government departments, MLAs, representatives of patient groups, etc.) there is no stratification of these classes. As a result, the functions of each class have not been separately identified and delineated. This reduces clarity in the roles to be played by each member, leading to a potential loss of efficiency.

- The SHA and DHAs may consist of three distinct classes of members: non-executive supervisory members such as the Chairperson and Vice-Chairperson (MLAs, Chief Secretary etc.), an advisory board (directors of relevant departments of the State Government, public health and healthcare professionals etc.) and the full-time executive members (CEO & CFO of the SHA, officers, directors, and employees).
- For an example of this kind of structure, one may refer to the National Institute for Health and Care Excellence, United Kingdom ('NICE') is an independent, standard-setting body constituted under the Health and Social Care Act, 2012, which is responsible for providing National Health Service staff with clear and robust advice on quality of care. The composition of NICE is stratified in nature. It is composed of the Board and the Senior Management. The former sets out strategic priorities and policies, and determines the broad framework, while the latter is responsible for day-to-day decision-making and implementation in general. The organization is further split into six directorates for performance of its functions. The CEO of the Senior Management team is also a member of NICE's Board. The Board is composed of experienced health and social care professionals with wide experience in management, trusteeship and administration. The Senior Management is composed of technical experts from the areas of medicine, health technology, health policy etc. and is responsible for NICE's day to day functioning.

The number of members of the SHA should be reduced

- The 31-member SHA is large and unwieldy, and is required to meet only twice a year. Decision-making is likely to be a laborious process, with the SHA being unable to fulfil all its functions through bi-annual meetings.
- While all the members may be obligated to convene on a bi-annual basis, the full-time executive members should dedicate the entirety of their time to the administration of the SHA or the DHAs, as the case may be.

The powers of the SHA should not be conflated with those of the State Government & reasonable safeguards should be introduced to prevent potential abuse/misuse of powers

- The provision which deals with general powers of the Authorities is not the ideal place to house the power of the Government to regulate prices for healthcare in private institutions. The power may either be transferred to the SHA, or a separate section may be framed to enable the Government to exercise this power.
- It may be noted that as it stands, the power of price fixation for services in clinical establishments in the state of Rajasthan already exists under rule 9(ii) of the Clinical Establishments Rules, 2012, read with section 52 of the Clinical Establishments Act, 2010. This power is currently exercised by the Central Government in consultation with the concerned State Government. If a new power to fix prices is to be given under the Bill, a rigorous compatibility review will thus be necessary.
- The provision which deals with general powers of the Authorities is not the ideal place to house the power of the Government during a pandemic or a public health emergency. A separate Chapter should be framed for this purpose. Further, given the extraordinary nature of the powers which have been granted to the Government, certain minimum safeguards should be put in place to prevent the possibility of misuse or regulatory overreach.

The SEC should not be a separate body

- Having an executive arm for the SHA is a sound proposition. However, no purpose is served by making this an independent body, as its sole function is to execute the plans/strategies prepared by the SHA. There is no scope for disagreement/difference in opinion.

- In any case, there is significant overlap between both the composition and the functions of the SHA and the SEC which leads to redundancy and may present problems with coordination.
- Moreover, representatives from the CSOs and NGOs should ideally be members of the supervisory body, and not the executive arm, as they cannot be expected to dedicate all their time to undertaking the activities of the SHA.
- The aim of creating a separate executive arm can be better achieved by designating certain members of the SHA as full-time executive members. This is the standard model followed by the majority of statutory regulators in India, as has been explained in the comments above.

F. Grievance Redressal Mechanisms

1. Current Position under the Bill

The Rajasthan Right to Health Care Act 2022 (The Healthcare Act) has laid down a provision for setting up a grievance redressal mechanism through its Clause 13. The said act, has laid down time-sensitive obligations for the state to set up a complaint forum. The Healthcare Act:

- Obligates the Government to frame rules on issues pertaining to denial of services and infringement of rights under the Healthcare Act
- Envisages setting up of a web-portal and a user-friendly helpline
- Lays down specific timelines within which the concerned officers should resolve the complaint
- Lays down timeframes for each level of grievance redressal to redress the complaint within a stipulated timeframe. Its failure to do so will result in escalation of the complaint to a higher authority.

2. Vidhi's Comments

Lack of mechanisms to ensure accountability of the State Government and the authorities set up under the Bill

There are several issues in the manner with which the Healthcare Act approaches grievance redressal. Firstly, the act only considers the need for grievance redressal when a service is denied or rights under the healthcare act are infringed upon. While it has not been specifically mentioned, it may be presumed that only complaints against healthcare providers are being considered under the ambit of Chapter V. The larger question regarding the accountability of the State Health Authority and District Health Authorities set up under the act should be considered while drafting the chapter on grievance redressal.

In addition to setting up a grievance redressal mechanism to redress complaints against healthcare establishments, a distinct and independent monitoring mechanism for ensuring accountability of the State Government and the authorities should be established. This body should ideally consist of sectoral experts that will specifically consider the performance of obligations by the State Government set out in Clause 7 of the Bill.

For instance, The National Health Bill, 2009 imagines a monitoring and accountability mechanism that comprises the establishment of a health information system, governmental mechanisms through establishment of committees, and community-based monitoring framework. Further, the National Rural Health Mission envisaged an accountability framework through the following mechanisms: community-based monitoring, external surveys, and stringent internal monitoring. *Rogi Kalyan Samitis* are facility-level community-based committees to monitor the performance of health facilities and health outcomes at such facilities.[35] These may be considered in devising an independent monitoring mechanism under the proposed law.

Obligations pertaining to Web based portal/user-friendly helpline

According to the Act, a resident can file a complaint at a specified web-portal or a customer friendly helpline number. The accessibility of these measures to the common user should be considered while designing them.

[35]Guidelines for establishing grievance redressal and health helpline, National Health Mission, <http://nhm.gov.in/images/pdf/programmes/Grievance_Redressal_System/Guidelines_for_Establishing_Grievance_Redressal_and%20_Health_Helpline.pdf>.

Further, the reader of the act faces an ambiguity in terms of understanding where such mechanisms are stationed, and who has the obligation of maintaining them.

The Healthcare Act should clearly mention the body/institution/establishment in charge of setting up of the web-based portal/ user-helpline and the kinds of complaints or grievances that may be lodged.

Accountability of Grievance Redressal Bodies

Under Clause 13 of the Bill, if the concerned officer does not respond to a complaint within 30 days, the complaint may be forwarded to the District Health Authority and then elevated to the State Health Authority if required. However, it is not clear under the Act whether there will be any legal consequences, in the nature of penalties, for the failure of the concerned officers or authorities to resolve the complaint.

Non-performance of duties to redress complaints within the timeframe stipulated in the act should have a performance-related disincentive for the concerned officer.

Unclear/ Inappopriate Appellate Mechanisms to redress grievances

In the Bill, the failure of the concerned officer to redress a complaint escalates it to the higher authority [Clause 13(b)(IV)]. Clause 15 provides the right of a complainant to appeal in cases where they do not find the redressal satisfactory, but the grounds and process are unclear. This is especially problematic, as the act further bars the jurisdiction of civil courts in matters pertaining to this law. Moreover, the appellate authority mentioned here is the DHA, thus raising questions regarding its independence and neutrality in grievances pertaining to non-fulfilment of obligations by the government.

Lack of independence of the grievance redressal bodies

Under the Healthcare Act, District Health Authority and State Health Authority, both of which are functionaries under this act, have been recognized as grievance redressal bodies. From a reading of this act, the relationship between the proposed in-house complaints' redressal forum that the government is required to constitute under Clause 13, and the District Health Authority, and the State Health Authority is unclear.

Conflicts of interest would arise if District Health Authorities and the State Health Authority play the role of administrators and adjudicators at the same time. We suggest that instead of making District Health Authorities and State Health Authorities function as grievance redressal mechanisms, independent ombudsperson offices be set up at various levels, through this Bill.

The concept of an ombudsperson in facilitating healthcare delivery, and as a means to resolve grievances in healthcare delivery, is not new. In Brazil, Municipal Health Ombudspersons are appointed. For instance; in the State of Minas Girais, the Municipal Health Ombudsperson was observed to have been acting as an "instrument of power and access to the rights of 'Brazilian Unified Health System users.'[36] 'The Role of such an ombudsperson is said to have been to listen and to clarify issues regarding Brazilian Unified Health Systems Operations and procedure, and to support resolution of health problems.

In the UK, the Health Service Ombudsperson for England draws his powers almost wholly from the Health Service Commissioners Act 1993.[37] The general remit of the powers of such an ombudsperson is to act on

[36] Rita de Cássia Costa da Silva et al, 'Ombudsmen in health care: case study of a municipal health ombudsman', 48 (1) Rev Saude Publica 2014, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4206117/#fn03>.

[37] Health Service Commissioners Act, 1993.

complaints made in relation to failure in a service by a service provider, failure of a body to provide a service, and maladministration in provision of services.

In Rajasthan, we can look at ombudsperson as a body that either facilitates resolution of grievances at the local level, or resolves them in a more formalistic manner, if resolution at the local level is not possible. Here, there is a possibility of gradation in the kind of disputes, infringement of rights, non-fulfilment of obligations etc. regarding which a local ombudsperson at the block level can be approached, and grievances for which the complainant may have to go to ombudspersons at a higher level (i.e., at the district and then the state level), were such resolution at local level unsuccessful or dissatisfactory.

The Bill also must provide examples of the kinds of grievances or complaints that can be brought to local ombudspersons. For instance, these will broadly include the denial of healthcare services and the infringement of user rights. Whether these occur at private or public healthcare establishments, the ombudsperson will have the power to take action to resolve them. On the other hand, the Bill must also clarify the kinds of issues that the ombudsperson will not be able to adjudicate on, i.e. awarding damages or compensation, or cancelling the licence of healthcare establishments. Their role should largely deal with investigation of grievances, ordering inquiries, directing healthcare establishments to issue apologies or conduct internal audits to prevent such complaints from recurring, etc.

Bar of jurisdiction of civil courts

Ombudspersons (or other grievance redressal mechanisms envisaged under this Bill) would not possess the ability, resources, or authority to adjudicate on legal claims that may result in awarding damages or compensation, or cancelling the license of healthcare establishments. Given that it will not be practicable or appropriate for them to adequately address all infarctions, infringements, disputes, claims etc., jurisdiction of civil courts should not be barred through a blanket provision such as Clause 16. In any case, it may be noted that owing to the current position of law, writ petitions before the jurisdictional High Court or the Supreme Court cannot be barred.

PART III: DETAILS THAT REQUIRE CLARITY THROUGH RULES

Implementation of any law requires delegated legislation or rules that clarify components, constituents, and procedure under the umbrella of the parent law. In order to reduce ambiguity and ensure that the vision of the law is realised to the fullest extent, careful and detailed drafting of rules – with adequate scope for flexibility and modification where necessary – is important.

In particular, the following aspects of the Bill require clarity through rules:

- Detailed components of each right (of residents, users, and HCPs) envisaged in Chapter II of the Bill. This could be in the form followed by the general comments on the Articles of the International Covenant on Economic, Social and Cultural Rights (ICESCR).
- The following provisions under Clause 7 of the Bill (Obligations of the Government) require clarity through Rules:
    - The process and timelines for budget allocation for health in the state, through a comprehensive analysis of various funds (under the NHM, state's own funds, funds under diverse schemes, state health insurance, corporate social responsibility or CSR plans, etc.). Appropriate flexibilities for decentralised fund planning and use at the district and lower levels, as well as during emergent situations, should be provided here.
    - Details of the Human Resource Policy envisaged here should be thoroughly planned and in line with diverse schemes and programmes pertaining to the same. A common portal which takes into account district and institutional flexibilities, and details of deputation, may be created.
    - The availability, quality, and affordability norms provided here should be detailed in line with existing standards under the Clinical Establishments Acts and Rules at the central and state levels, NHM, IPHS, etc.
    - Composition, powers, functions, accountability structures, and procedure pertaining to the coordination mechanism envisaged under Clause 7 (i)
- Components, procedure, timelines, and circumstances pertaining to health impact assessment [Clause 2(v)] and social audit [Clauses 2(vv) and 7(c)] - as well as the details and limits of powers, duties, and functions of the authorities assigned to plan and implement the same.
- Components, procedure, timelines, and circumstances pertaining to the proposed chapter on public health emergencies - as well as the details and limits of powers, duties, and functions of the authorities assigned to plan and implement the same.
- Apart from incorporating recommendations provided in Chapter II. E of this document, details of the composition, appointment/ transfer/ resignation/ termination/ dismissal of functionaries, procedural norms, etc. pertaining to regulatory architecture and administration.
- Apart from incorporating recommendations provided in Chapter II. F of this document, details of the composition, appointment/ transfer/ resignation/ termination/ dismissal of functionaries, procedural norms, formats for complaint and appeal, etc. pertaining to grievance redressal mechanisms.
- Contours, process, responsibility, and accountability pertaining to compatibility review and other processes envisaged under Clause 18.

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