The Rajasthan Right to Health Act, 2022: Proposed Draft Rules

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Acknowledgements

The proposed rules have been framed through an independent process of research, analysis, and drafting. We are grateful to other researchers, lawyers, activists, and professionals mentioned below, whose inputs have helped us shape this document.

To know more about the process followed and the contributors, please visit the following link: https://vidhilegalpolicy.in/research/proposed-draft-rules-to-the-rajasthan-right-to-health-act-2022/

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December 2023

Proposed Draft Rules - Rajasthan Right to Health Act, 2022

Proposed Draft Rules under the Right to Health Act, 2022 ('**Act**' or '**RTH Act**'), along with Explanatory Notes

Draft Rules and Explanatory Notes on the Rights to Health, Responsibilities, and Obligations [In Exercise of the Powers under Sections 3, 4, 5, And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
Who is an 'ordinary resident'? [Section 2(w)]		
1.	**Resident or ordinary resident** (1) 'Resident', or an 'ordinary resident of the state of Rajasthan' as understood in the Act and these Rules, shall include all such persons as mentioned below: (i) persons who have migrated to the state of Rajasthan for any purpose including work for any period of time; (ii) homeless persons living in Rajasthan; (iii) members of denotified, nomadic, and semi-nomadic tribes living in Rajasthan; (iv) workers in the informal economy living in Rajasthan; (v) refugees from other states within India, or from other countries, living in Rajasthan;	In an ideal right to health framework, rights should not be limited to just 'residents' or 'citizens', but to all users. Some exceptions may be made to entitle only the residents of the state to health insurance coverage provided by the state government. However, Section 3 read with Section 2(w) of the RTH Act, as it stands now, restricts the application of rights to 'ordinary residents of the state'. In order to enable the most inclusive understanding of the application of health rights, we have tried to clarify that 'resident' covers within its scope persons for whom providing documentary or other forms of evidence of residence may be difficult or impossible - at the time of seeking health care or in general.

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	(vi) any other person who is living in Rajasthan but does not have adequate documentation or proof relating to their identity, citizenship, residential, or domicile status owing to adverse socio-economic factors. (2) At the time of seeking or availing health care, whether at a health care establishment or otherwise, proof of residential / domicile status may be produced by a resident through documents or supporting information including but not limited to- (i) [List of cards/ documents held under different schemes/ laws in the state of Rajasthan may be added here] (ii) Any other document or supporting information as may be deemed appropriate. The SHA shall publish a regularly updated non-exhaustive, illustrative list of cards / documents / kinds of supporting information that may be used for this purpose. This list must include - at the very least - the cards / documents / kinds of supporting information referred to in this Rule, or suitable equivalents. (3) Non-availability of documentation or proof relating to identity, citizenship, residential, or domicile status of a patient shall not be a ground for denial of or delay in provision of health care under the Act and these Rules.	

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	(4) Delays in furnishing documents or proof of residence / domicile by a resident shall not be a ground to charge costs for health care which residents are entitled to free-of-cost under the Act and these Rules.	
Who is a patient? [Section 4]		
2.	**Definition of patient** Any person seeking, availing, or being provided health care as defined in the Act - (i) at any health care establishment to which the Act applies (ii) as part of non-institutional or community health care (iii) at any other location including sites of research Explanation - (i) In the Act and these Rules, 'patient(s)' or 'all patients' would be deemed to include residents and non-residents, unless otherwise mentioned. (ii) The rights to health of patients under the Act and Rules, and the obligations that are due to them, shall correspondingly be exercised by, and owed to, the next friends or representative of such patients, unless expressly stated otherwise.	This clarification has been added so that 'healthcare' is perceived not just through the lens of health care establishments, but to also include community health care and health research sites - in applicable contexts. Justiciability and meaningful operationalisation of the right to health ('**RTH**') would be difficult unless representatives and next friends are included in the ambit of rights holders.

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Who is a 'next friend'? [Section 3 & 4]		
3.	**Definition of next friend** 'Next friend', in relation to a patient, means any of the following persons: (a) Any person appointed by the patient through a medical power of attorney or otherwise chosen by the patient; (b) Spouse or de facto spouse or a partner with whom the patient has a relationship in the nature of marriage or a friend of long standing who attends to the patient in the healthcare establishment; (c) Adult children; (d) Parents; (e) Adult Siblings; Any other lineal ascendant or descendant of the patient who is present at the healthcare establishment.	There is no single definition of 'next of kin' or 'guardian' recognised in Indian law. The term 'next friend' is used in order to adopt an inclusive approach to those who may be authorised to represent or take decisions on behalf of a patient. It also includes persons appointed through advance directives, as recognised under The Mental Healthcare Act, 2017, and more recently, through the Supreme Court judgement on end-of-life care in *Common Cause v Union of India* [Miscellaneous Application No. 1699 of 2019 in Writ Petition (Civil) No. 215 OF 2005].
Rights of patients who are not residents [Section 4]		
3.	**Rights of non-resident patients** (1) All patients, who are not 'residents' as understood in the Act and these Rules, shall have the health rights set out for residents under Section 3 of the Act, including the right to be heard and seek redressal in case of any grievance.	The proviso to this rule has been added to address the concern regarding the possible reluctance of the state government to make services and facilities mentioned in the following provisions free for non-residents,

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	Provided that patients who are not residents may be subject to charges for the health care mentioned in Sections 3(b), 3(d) and 3(s) of the Act. (2) Non-availability of documentation or proof relating to identity, citizenship, residential, or domicile status of a patient, shall not be a ground for denial of or delay in health care services or facilities under the Act and these Rules.	owing to fear of unfair and excessive financial burden on the state - *Section 3(b) - to avail free OPD services, IPD services consultation, drugs, diagnostics, emergency transport, procedure, and emergency care as provided by all public health institutions accordantly to their level of health care as may be prescribed by rules made under this Act* *Section 3(d) - to have the right to avail free health care services from public health institution, health care establishment and designated health care centres in the prescribed manner and subject to be terms and conditions specified in the rules* *Section 3(s) - to avail free transportation, free treatment and free insurance coverage against road accidents at all health care establishments accordantly to their level of health care available in the health care institution for emergency care, first aid or stabilize and transfer as per guidelines with appropriate financial provisions by State Government in the prescribed manner and*

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		subject to the terms and conditions specified in the rules.
Rights of health care providers [Section 4]		
4.	**Rights of health care providers** (1) Health care providers shall have the right against discrimination - based upon factors including illness or conditions (including HIV status or other health condition), religion, bodily ability, race, caste, sex, gender, age, sexual orientation, or place of birth - at health care establishments. (2) Health care providers shall have the right to refuse health care to patients who sexually harass them, or are physically or verbally abusive towards them. (3) Health care providers shall have all other rights in accordance with relevant service laws and rules; The Rajasthan Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2008; The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013; and other applicable laws and policies.	Section 4 of the Act contemplates, among other things, rights of healthcare providers (**HCP/s**) vis-a-vis patients. This draft rule aims to protect HCPs against discrimination in their right to work, as well as in their physical interactions with patients, and to empower them to exercise these rights.

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Responsibilities and Duties of Health Care Providers and Health Care Establishments towards Patients [Sections 3 and 4]		
5.	**Obligations of Health Care Providers and Health Care Establishments towards Patients** All health care providers and health care establishments have an obligation to respect and fulfil the rights to health of all patients as set out in section 3 of the Act and as prescribed in the Rules.	Section 3 of the Act extends the right to health only to residents. However, section 4(2) of the Act states that health care providers and health care establishments have rights and responsibilities towards patients as prescribed in the Rules. Since it is appropriate that all the rights in section 3 are extended to patients and not just residents, we have suggested using the power under section 4(2) of the Act to state that health care providers and health care establishments have obligations towards patients to fulfil the rights set out in section 3. The specific details of these obligations will be prescribed in the Rules.
6.	**Responsibilities regarding providing adequate relevant information [Section 3(a)]** Health care providers- (1) Health care providers must inform patients of -	*Section 3(a) - [Right] to have adequate relevant information about the nature, cause of illness, proposed investigations and care, expected results of treatment, possible complications and expected costs.*

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	(i) The patient's health status except in circumstances where there is substantial evidence to suggest that the disclosure of health status would jeopardise or cause significant adverse impacts to the physical or psychological health of the patient or their unborn child. (ii) The range of diagnostic procedures and treatment options generally available to the patient (iii) The nature of each option, what would be involved, and the desired outcome (iv) The benefits, risks, costs, uncertainties about and likelihood of success for each option, and consequences generally associated with each option; and (v) The patient's right to refuse health services and an explanation of the implications, risks, and obligations of such refusal. (2) When recommending an option for treatment or care to a patient, the health care provider must explain their reasons for doing so, and share information about reasonable alternatives, including the option to take no action. (3) The health care provider must provide information as set out in this rule, in a simple manner that is understandable to a lay person, and in a language that is known to the patient (or their next friend or representative, as the case may be) as far as possible. Respectful and inclusive etiquette should be maintained during such conversation. Explanation - The information required to be provided to a patient under this rule, shall be shared with the next friend or representative of the patient in the following circumstances -	The law must protect the rights of patients to be properly informed of the details of their conditions, and to have all the information they need to be able to make informed decisions regarding their care. This is an essential precondition for patients to be able to give informed consent to any treatment or course of action in regard to their health, and to protect the autonomy and agency of patients in the healthcare context. This draft rule explains the types of information that are required to be actively disclosed to patients, and the records and facilities that healthcare establishments (**HCE/s**) must make available to facilitate patient-information processes.

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	(i) the patient expressly consents to sharing of information. (ii) the patient does not have the capacity to receive, process, make decisions on, or act upon such information at the relevant time. (4) For the purposes of these Rules, "informed consent" means the express consent of a patient to receiving a particular form of health care, after fully understanding the nature of such health care and its benefits and risks of harm as well as the benefits and risks of harm of not receiving such health care and of alternative health care. <u>Health care establishments</u> - Health care establishments must ensure adequate human resources, physical space, set procedure, sensitisation, and training to enable health care providers and other workers in the establishment to carry out the responsibilities set out in this Rule.	
7.	**Responsibilities regarding patient records [Section 3(e)]** <u>Health care providers</u>- Health care providers shall comply with any requests to provide patients with access to up-to-date versions of their own patient files and records, regardless of whether the patient is receiving or seeking health care from the health care provider in question at the time of such request. <u>Health care establishments</u>- (1) All health care establishments must ensure that each patient has a file that contains	The objective of this draft rule is to ensure that healthcare providers and establishments are obligated to maintain proper patient records, as well as issue transparent bills in respect of healthcare services availed of by the patient. It also elucidates the right of patients to access these records at any time, as contemplated under the parent provision [Section 3(e) of the Act] which provides as follows:

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	up-to-date information about: (i) all consultations that the patient or next friend or representative has with any healthcare provider at the establishment and a record of the outcomes of such consultations; (ii) all diagnostic or investigative tests of procedures recommended by any healthcare provider at the establishment; (iii) all prescriptions; (iv) all patient charts; (v) all copies of informed consent forms that are signed by the patient, their next friend or representative; (2) The up-to-date patient file described in clause (1) shall be available at all times to the patient. (3) The next friend or representative of the patient may access the patient file only upon: (i) the death of the patient; (ii) the lack of decision-making capacity of the patient, Explanation: “decision-making capacity”, in the context of health care, means a person's ability, determined without regard to their age, to understand and appreciate the nature and consequences of proposed health care recommendations and other options, and to make an informed decision concerning such health care, at the relevant time. (iii) the express authorisation of the patient, whether through a medical power of	*Section 3(e) - [Right] to have access to patient records, investigation reports and detailed itemized bills of treatment*

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	attorney or otherwise. Explanation-Medical power of attorney includes an advance medical directive or any other document appointing a surrogate to take decisions regarding medical treatment on behalf of the person executing the medical power of attorney when such person loses healthcare decision-making capacity (4) Access to patient records shall not be denied on any or all of the following grounds: (i) Non-payment of bills; (ii) Discharge against medical advice; (iii) Desire to obtain treatment from another healthcare provider or healthcare establishment; (iv) Inability to provide a personal health identifier or health id or other unique identity required to access health care, by whatever name called; (v) Non-participation in a digital health record system. (5) At the request of the patient or their next friend or representative, as the case may be, the healthcare establishment shall share all or any part of the patient's file with another healthcare provider or another healthcare establishment. (6) Patient records may be maintained in digital form in such form as may be specified by the SHA for treatment protocols, but a physical copy of such records shall always be provided to the patient, or their next friend or representative, as the case may be, upon their request.	

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	(7) The health care establishment shall ensure that it has protocols in place to maintain patient records in the manner required in these Rules, and that its health care providers, health care workers, and administrative staff are appropriately trained to comply with the obligations in these Rules.	
8.	**Responsibilities regarding informed consent [Section 3(g)]** <u>Health care providers</u>- (1) Health care providers shall obtain informed consent from every patient before commencing the delivery of any health care. (2) If a health care provider considers it necessary to make changes to a treatment plan, or testing requirements, or other components of health care to be provided to the patient, at any time after having obtained informed consent from the patient, the health care provider shall inform the patient of such changes, and obtain informed consent again from the patient before providing such health care. Provided that, in cases requiring immediate action by the health care provider in order to prevent any significant adverse impact on the patient's health, the health care provider may take steps necessary to prevent such impact without seeking informed consent if: (i) the patient in question is unable to exercise decision-making capacity; and (ii) if the next friend or representative of the patient is unavailable.	The Act safeguards the patient's right not to be subjected to tests or treatment without explicit informed consent, as follows: *Section 3(g) - [Right] to informed consent prior to specific tests or treatment (e.g. surgery, chemotherapy etc.) from all health care establishments* Pursuant to Section 3(g), this draft rule sets out a process for the realisation of the right to informed consent - by requiring healthcare providers and establishments to follow certain steps in order to obtain informed consent, from patients, within the meaning contemplated under the Act.

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	After taking such immediate steps, the health care provider shall either wait for the patient to regain decision-making capacity or until a next friend or representative of the patient is available to provide consent on their behalf, before providing any further health care. <u>Health care establishments</u>- (1) The health care establishment must ensure that all health care providers are properly instructed, trained, and sensitised to seek informed consent. (2) The health care establishment must ensure that there are protocols in place to seek informed consent from patients, their next friends, or representatives. (3) The health care establishment must also ensure that adequate human resources and procedural safeguards are present at the establishment to enable a meaningful implementation of obligations pertaining to patients' right to information and informed consent. (4) The SHA for treatment protocols, in consultation with health care professionals and patient rights groups, and in reference to best practices within the country and the world, may create an appropriate policy concerning informed consent for adoption at different levels of health care establishments. The policy must have reference to existing statutory obligations, ethical codes, and global standards regarding informed consent. It should contain specific guidance on decision-	

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	making capacity, medical directives, emergent situations, exceptions, situations in which next friends or representatives may consent on behalf of the patient, etc. It should also include illustrative examples to guide health care providers regarding recommended approaches in complex or ambiguous real-life situations pertaining to informed consent.	
9.	**Responsibilities pertaining to confidentiality [Section 3(h)]** (1) All personal health data concerning a patient, is confidential data, and shall be safeguarded as such, in accordance with these Rules. (2) Confidential personal health data shall not be disclosed to anyone unless - (i) the patient consents to such disclosure in writing; (ii) a court order or any law requires such disclosure; or (iii) non-disclosure of the data represents a serious threat to public health, including a serious and identified risk to a specific person and / or community. Personal health data means "data about or relating to the health status of a person who is directly or indirectly identifiable and that can be used to distinguish such person from another"	The Act provides for the right of the patient to privacy in the healthcare context and confidentiality in regard to health-related information and records, as follows: *Section 3(h) - [Right] to confidentiality human dignity and privacy during treatment at all health care establishments* This draft rule, accordingly, delineates what constitutes confidential health data and sets out various restrictions and guidelines regarding its disclosure, management, and use.

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	Obligations of health care establishments to protect the personal health data of patients- (1) All health care establishments shall ensure that they have protocols, processes, systems, and control measures in place, safeguarding the rights of patients in respect of their personal health data and its processing, in accordance with the following guiding principles, and subject always to the other confidentiality and privacy requirements under these Rules (a) Consent: There must be express prior consent by a patient for the collection and use of their personal health data. (b) Data minimisation: Only such personal health data may be collected by the health care establishment that is necessary for the purpose of delivering health care, and efforts must be made to minimise the amount of personal health data collected. (c) Purpose and Use limitation: The patient, at the point of collection of data, should be informed about the purposes for which the personal health data is going to be used. The personal health data should not be used for any purposes other than those intimated to the patient. (d) Retention limitation: The personal health data should be stored for only as long as is necessary for the purposes for which such data is collected. Once such purpose has been fulfilled, personal data may be deleted or retained in an anonymised form only. (e) Disclosure of personal data: The personal health data collected may not be disclosed to any third party without the consent of the patient. Where consent	

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	is granted, the patient should be informed about the sharing of data with third parties and the purposes for which such data will be shared or disclosed. (2) No personal health data shall be published, displayed, or posted publicly by any health care establishment.	
10.	**Responsibilities pertaining to presence of female person during physical examination of a female patient by a male practitioner [Section 3(i)]** Health care providers- If a male practitioner is of the opinion that a physical examination of a female patient is necessary for diagnosis or treatment, he shall inform the patient of this, and of their right to have a female person present during such physical examination. Health care establishments- All health care establishments shall ensure that there is an appropriate number of trained female health care providers, workers or other staff that are available at the establishment to ensure that female persons can be present during the physical examination of female patients by male health care practitioners.	This draft rule seeks to outline the protocol to be ensured by HCPs and HCEs during physical examinations of female patients. It imposes a human resource requirement on establishments in this regard. This draft rule aims to give effect to Section 3(i) of the Act, which reads as follows: *Section 3(i) - [Right] to the presence of female person, during physical examination of a female patients by a male practitioner*

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11.	**Responsibilities pertaining to non-discrimination [Section 3(k)]** (1) No health care establishment, health care provider, or other worker in a health care establishment, shall discriminate against any patient, their next friend, representative, or any other person accompanying the patient, based upon factors including illness or conditions, including HIV status or other health condition, religion, disability, race, caste, sex, gender, age, sexual orientation, or place of birth. Explanation - Discrimination means any distinction, exclusion, or restriction made through action, words, behaviour, physical segregation, or in any other manner, on the basis of the mentioned grounds, which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of rights under this Act and these Rules. Such actions, words, behaviours, physical segregation, etc. need not lead to denial of or delay in the provision of health care in order to be considered as discrimination under the Act and these Rules. (2) The health care establishment must conduct regular sensitisation and training on diversity, inclusion, accessibility, and non-discrimination for all workers including health care providers. (3) The health care establishment must initiate disciplinary proceedings against offending health care providers and other workers, as per relevant laws, regulations, administrative procedure, institutional policy, etc. (4) Chief Medical Officers must conduct regular sensitisation and training on diversity, inclusion, accessibility, and non-discrimination for all workers, including community and front-line workers who are responsible for providing health care outside health care establishments.	This draft rule gives effect to Section 3(k) of the Act which reads as follows: *Section 3(k) - [Right] to have treatment without any discrimination based upon illness or conditions, including HIV status or other health condition, religion, race, caste, sex, age, sexual orientation or place of birth of any of them at all health care establishments* The purpose of this draft rule is to prohibit discrimination in the healthcare context, in furtherance of Section 3(k), and to explain the meaning of non-discrimination in practice. The rule requires HCEs and local public health officers (i.e. Chief Medical Officers) to take steps to build capacity among healthcare providers, and imposes an obligation on HCEs to take action against personnel who act in violation of these provisions.

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12.	**Responsibilities pertaining to right to choose source of obtaining medicines or tests [Section 3(m)]** No healthcare provider or healthcare establishment shall require or pressure patients to source medication or diagnostic procedures from any specific vendors, pharmacists, or facilities, as the case may be.	*Section 3(m) - [Right] to choose source of obtaining medicines or tests at all health care establishments* This draft rule aims to ensure that patients are not forced into availing of testing services or purchasing pharmaceuticals at any particular facility or shop.
13.	**Responsibilities pertaining to treatment summary [Section 3(q)]** <u>Health care providers</u>- (1) A health care provider must provide a patient (or their next friend or representative as the case may be) with a treatment summary at the time of the discharge or referral of the patient from a health care establishment. (2) The treatment summary must contain all relevant information regarding: (i)the nature of the health care rendered; (ii) the prognosis for the patient; (iii) the need for follow-up treatment, and recommendations if any; (iv) relevant details regarding patient history, allergies, and other information that may be critical to the line of treatment followed; and (v) such other details as are deemed relevant by the health care provider. (3) A patient leaving a health care establishment against medical advice, or seeking a second opinion, cannot be a ground for denying treatment summary, or denying referral services that are recognised as a right under the Act.	This draft rule aims to ensure that, pursuant to Section 3(q) of the Act, patients choosing to leave a particular HCE are not deprived of their medical records, thus protecting their right to be provided with a complete record of their treatment at such establishment, whether they are leaving to seek healthcare elsewhere, or leaving against medical advice. *Section 3(q) - [Right] to have treatment summary in case of a patient leaving health care establishment against the medical advice*

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	Health care establishments- Health care establishments must cooperate with health care providers, patients (or their next friend or representative as the case may be), and enable health care providers to carry out their responsibilities pertaining to providing treatment summary.	
14.	**Responsibilities pertaining to the right to grievance redressal [Section 3(r)]** (1) The health care establishment must ensure the provision of adequate physical space, human resources including support staff, comprehensive and periodic training of such human resources, and such other resources and facilities that are important for the setting up and sustained functioning of in-house grievance redressal mechanism(s) envisaged under the Act and these Rules. (2) The health care establishment and health care provider must cooperate with all levels of grievance redressal mechanism(s) set up under the Act and these Rules, and enable their meaningful functioning.	*Section 3(r) - [Right] to be heard and seek redressal in case of any grievance occurred during and after availing health care services* This draft rule aims to facilitate the creation of appropriate infrastructure at HCEs to host functioning grievance redressal systems, as well as requiring HCEs and healthcare providers to play meaningful roles in grievance redressal.

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The Rajasthan Model of Public Health [Section 5(a)]		
15.	**Principles and considerations guiding the Rajasthan Model of Public Health** The Rajasthan Model of Public Health shall be formulated and prescribed by the government of Rajasthan on the basis of principles and considerations including and not limited to the following- (1) All efforts must be made towards meaningful and comprehensive adherence of the public health care system in Rajasthan to the Availability, Accessibility, Acceptability and Quality framework of health care. (2) Principles of diversity, inclusion, responsiveness, transparency, accountability, and evidence-based flexibility shall guide all levels of the health care system in Rajasthan. (3) Patients and residents shall be viewed not as passive recipients of health care, but as active participants in the health care system and decision-making (regarding their own health as well as regarding the health care system) - with their own agency, preferences, and humanity. (4) The frameworks for health regulation and grievance redressal on health in Rajasthan must be guided by the principles of independence, impartiality, proportionality, flexibility, clarity, efficiency, and transparency.	*Section 5 - The Government shall have the following general obligations, by enhancing the quantum of the resources in time bound realization of health and well-being of every resident in the State:-* *(a) to formulate and prescribe a model of public health known as "Rajasthan Model of Public Health"* These points have been added to the proposed draft rules as guiding principles to the model of RTH and public health to be followed in Rajasthan.

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	(5) Latest scientific evidence shall inform health care systems, and health research shall be promoted in the state. (6) Coordination of the health sector with functionaries and stakeholders in allied areas such as water, sanitation, housing, environment and climate change, and rights of disadvantaged or marginalised communities, shall be prioritised. (7) Active participation and inclusion of local communities, civil society organisations, health experts, and other members of the public shall be enabled at all levels of discourse and decision-making on health and allied areas. (8) Reporting and accountability systems under the Act, these Rules, or any regulation or executive order issued on the basis of the Act or Rules, must be designed in such a manner that functionaries, health care providers, administrators, workers, residents, and patients are encouraged to be honest and transparent. Performance evaluation metrics should be evolved in a manner that builds a culture incentivising sharing of errors, defaults, authentic data on health indicators, and other such details - with the object of seeking cooperation, feedback, and financial or advisory assistance. The focus should be on consistent improvement of the health care system in Rajasthan and support for all its stakeholders.	

Draft Rules and Explanatory Notes on the Rights to Health, Responsibilities, and Obligations [In Exercise of the Powers under Sections 3, 4, 5, And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
	(9) An appropriate, holistic model shall be formulated for science-based, rights-based, proportionate, and flexible management of public health emergencies, with meaningful inclusion of local governments and local communities. To this end, the government and the authorities under the Act shall include inputs and guidance from experts on public health, legal policy, disaster management, administration, and other areas. (10) Appropriate and sufficient budgetary allocation should be made with objectives including increased quality and accessibility of health care, and fair pay / benefits for health care providers and other workers (including frontline workers and support staff).	
Responsibilities towards awareness and education about the Act [Section 5]		
16.	**Responsibilities towards awareness and education about the Act** (1) The state government, local governments, and local administrations (including district administrations and municipal bodies) must take all possible and necessary steps for the education and awareness of residents, patients, health care providers, other workers including front line workers, hospital administrators, functionaries identified in the Act and these Rules in diverse capacities, as well as other functionaries in allied roles/ sectors, regarding - (i) the rights and responsibilities set out in the Act and these rules;	Section 17(l) requires the government "*to take appropriate measures to inform, educate and empower people about health issues*" This draft rule gives effect to the above provision, by explicitly requiring the different levels of government within the state to take the necessary steps to educate stakeholders, including patients and healthcare workers, regarding their rights and responsibilities

Draft Rules and Explanatory Notes on the Rights to Health, Responsibilities, and Obligations [In Exercise of the Powers under Sections 3, 4, 5, And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
	(ii) the authorities and systems and governance structures set up under the Act and these Rules; (iii) details of any guidance or regulations issued by the SHA or the DHA; (iv) relevant processes and procedure set out in the Act and these rules; and (v) details of any regulations or executive orders arising out of or pertinent to the Act and these Rules. (2) The following considerations must guide efforts taken towards awareness and education pertaining to the above - (i) Simple, effective, and inclusive language must be used (ii) Targeted sessions must be conducted for various stakeholders (iii) Persons from marginalised groups should be included both as educators and participants (iv) Local languages, cultural practices, and lifestyles should be taken into account to design these efforts (v) Sessions should be scheduled keeping in mind the daily lifestyles and preferences of the local community (vi) Diverse media including posters, banners, videos, etc. must be used for effective dissemination of information, keeping in mind varying levels of digital access. Such media should be accessible to persons with diverse disabilities. (vii) Innovative modes of education and awareness generation, such as skits, cultural programmes, art, etc. which actively engage diverse participants, should be encouraged at different levels.	under the Act, as well as regulations, processes, and orders issued under the Act. It emphasises on the need for accessible, and inclusive language, and wide reach of such awareness and education.

Draft Rules and Explanatory Notes on the Rights to Health, Responsibilities, and Obligations [In Exercise of the Powers under Sections 3, 4, 5, And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
	(viii) Civil society organisations, community leaders, health rights organisations, public health experts, and diverse members of the local community must be actively involved in education and awareness generation.	

Draft Rules and Explanatory Notes on Grievance Redressal Mechanisms [In Exercise of the Powers under Sections 5(D), 11, 12, 13, 14 And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
At the outset, Vidhi reiterates concerns about the lack of neutrality, feasibility, competence, propriety, and patient-centrality in the GRM envisaged in the parent Act. They are explained in greater detail in reference to relevant provisions in our note containing analysis and recommendations pertaining to the RTH Act, 2022. *An optimal rights-based GRM in the area of healthcare would consist of independent, trained, accessible, responsive, and inclusive systems and personnel at different levels of healthcare and administration. However, in case suitable amendments to the Act are not feasible, at least in the foreseeable future, Vidhi has attempted to counterbalance the GRM structure which is currently skewed against patients/ users. Within the constraints and contours of the parent Act, we have suggested the introduction of rules that will hopefully increase the accessibility and impartiality of the mechanisms.* *Further, we invite comments on suitable provisions for public hearings of grievances, social audits, and other larger transparent provisions, especially in relation to their applicability to private establishments.*		
Definitions of 'grievance', 'complaint', and 'complainant' [Section 11]		
1.	**Definition of grievance** "grievance" means "any discontent, dissatisfaction, displeasure, or disapproval regarding the delivery of health care including, but not limited to: (i) the non-provision of health care, in contravention of the provisions of this Act; (ii) deficiency in the health care provided; or (iii) violation of the rights of patients and residents under the Act and Rules. "deficiency" in relation to health care, shall have the same meaning as 'deficiency' under clause (11) of section 2 of the Consumer Protection Act, 2019.	The phrase 'discontent, dissatisfaction, displeasure or disapproval' has been borrowed from the South African National Complaints Management Protocol for the Public Health Sector, with the objective of capturing the widest range of circumstances that may give rise to a complaint in the healthcare context, as contemplated under this grievance redressal mechanism.

Draft Rules and Explanatory Notes on Grievance Redressal Mechanisms [In Exercise of the Powers under Sections 5(D), 11, 12, 13, 14 And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
	Definition of complaint "complaint" means the expression of a grievance submitted for resolution, in any form prescribed by these Rules. **Definition of complainant** "complainant" means any person who may make a complaint in accordance with these Rules.	The definition of deficiency in section 2(11) of the Consumer Protection Act is reproduced below: *"deficiency" means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service and includes—* *(i) any act of negligence or omission or commission by such person which causes loss or injury to the consumer; and* *(ii) deliberate withholding of relevant information by such person to the consumer.*
Right to make a complaint [Sections 3, 4, and 11]		
2.	**Who may make a complaint** Complaints may be made by patients, their next friends or their representatives.	This provision is intended to ensure that a patient's attendants or representatives may raise a grievance on their behalf, especially where a patient is not in a position to do so themselves, thus avoiding unnecessary obstacles or delays.

Draft Rules and Explanatory Notes on Grievance Redressal Mechanisms [In Exercise of the Powers under Sections 5(D), 11, 12, 13, 14 And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
Establishment and functioning of In-house grievance facilitation cells at healthcare establishments [Section 11]		
3.	**In-house grievance facilitation cell** (1) An in-house grievance facilitation cell ("**GFC**") must be instituted at every health care establishment to which the Act applies. This must be done within one (1) calendar month from the date of coming into force of these Rules. (2) A grievance facilitator must be posted at the in-house GFC to facilitate the receipt of complaints and the resolution of grievances raised through such complaints. (3) The complainant shall be assisted by a representative of the local community or a civil society organisation, selected or nominated in accordance with these Rules. Such a community representative at a GFC shall be referred to as '**mareez mitra**' or '**patient ally'**. (4) The GFC may also have such other office staff members including facilitators and computer operators as may be deemed necessary to carry out its functions in an efficient and effective manner. (5) The GFC must be located in a prominent area of the health care establishment, with appropriate signage to direct patients or complainants to its location. The physical location of the GRC as well as signages mentioned in this provision must adhere to prevailing accessibility guidelines for persons with disabilities, e.g. those issued by the	This obligation is intended to apply to both public and private health care establishments, including designated health care centres. It remains to be ascertained whether primary health centres would be in a position to nominate 'mareez mitras' or 'patient allies'. They have currently been included in the scope of this Rule. The decision to include or exclude this may be taken based on capacity at the level of these centres.

Draft Rules and Explanatory Notes on Grievance Redressal Mechanisms [In Exercise of the Powers under Sections 5(D), 11, 12, 13, 14 And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
	Ministry of Health & Family Welfare. Regional language(s) and Braille must be used in addition to English and Hindi. (6) The health care establishment shall display information about the mareez mitra / patient ally, including their role and the manner in which they can be contacted, in a prominent and accessible manner. Explanation: The grievance facilitator may have other functions/ roles in the health care establishment, as long as they are available in the capacity of grievance facilitator throughout the working hours of the establishment. Grievance facilitators may also be staffed at the GFC on a shift-basis, to enable full-time functioning of the GFC. Provided that health sub-centres and primary health centres set up by the state government or under the National Health Mission may be exempted from selection or nomination of mareez mitra / patient ally, in case the procedure or the availability of such representative is deemed to be unfeasible by the state government owing to limited capacity of such establishments.	
4.	**Functions of the grievance facilitator** The grievance facilitator shall have the following functions at the GFC: (1) Receiving verbal, written, or online complaints from patients, their next friend, or their representative - and recording them in digital and / or physical modes in a standard format.	This rule outlines the role of the grievance facilitator (who forms part of the grievance redressal mechanism and is to be appointed at every GFC). This person is responsible for giving effect to the grievance redressal mechanism within the health facility. This includes receiving and recording complaints from patients, inquiring into complaints,

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	(2) Conducting an inquiry into the complaints received in accordance with these Rules; (3) Coordinating with the administrator / in-charge of the establishment, health care provider(s), or other worker(s) to resolve the grievance at the level of the establishment. (4) Ensuring compliance with the procedure and timelines prescribed in these Rules. (5) Updating details of action taken on the complaint at every stage, in the manner and format prescribed in these Rules. These details would include minutes of discussions and / or hearings, records reviewed, and other steps taken to resolve the grievance. (6) Coordinating with the mareez mitra / patient ally amicably to enable meaningful resolution of grievances. (7) Maintaining anonymity and confidentiality of the complainant, as required under these Rules.	coordinating with the HCE administration to resolve complaints, and ensuring compliance with the grievance redressal process.
Patient Facilitator / '*Mitra*' [Sections 3, 4, and 11]		
5.	**Selection or nomination of Mareez Mitra / Patient Ally** A mareez mitra / patient ally, who is a member of the local community or civil society organisation, shall be selected or nominated in the following manner:	The mareez mitra / patient ally is intended to assist patients in navigating the health care establishment and the grievance redressal mechanism. Given that power is already skewed towards health care establishments

Draft Rules and Explanatory Notes on Grievance Redressal Mechanisms [In Exercise of the Powers under Sections 5(D), 11, 12, 13, 14 And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
	(1) The Chief Medical Officer ("**CMO**") of every district shall issue a public call inviting applications for the position of mareez mitra / patient ally at: (i) public health care establishments which are required to have a mareez mitra / patient ally. (ii) private health care establishments located within the district to which this Act applies. (2) The following criteria shall be important to examine in the selection of the patient ally: (i) membership in a civil society organisation working in the area of health or allied rights (ii) being a member of the local community (iii) knowledge of healthcare systems in Rajasthan (iv) familiarity with the local community and culture(s). (3) Laws and rules pertaining to public calls prevalent in the state shall dictate the manner, timelines, and procedure to be followed for the purpose of the selection process prescribed in this Rule. (4) Members of marginalised gender, caste, linguistic, and other socio-economic groups, including persons with disabilities - or members of organisations working with marginalised communities - should be encouraged to respond to the public calls, and prioritised for selection. (5) In case the selection process does not result in successful selection, the CMO shall nominate mareez mitras / patient allies in consultation with civil society organisations,	with their in-house grievance facilitation cell, the mareez mitra / patient ally is intended to balance this to the extent possible.

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	medical officers in-charge, block development officers, and circle officers working within their district. The nomination process shall be initiated following the exhaustion of selection procedure mentioned in applicable laws or rules. (6) Mareez mitras / patient allies should be selected or nominated within three (3) calendar months from the date of coming into force of the Rules. Explanation 1: The mareez mitra / patient ally shall not be deemed to be a public servant or employee of the government or health care establishment. Explanation 2: More than one patient ally may be selected or nominated at a health care establishment.	
6.	**Role of the Mareez Mitra / Patient Ally** The mareez mitra / patient ally shall play a role in enabling the complainant to have a more efficient, safe, and fair hearing and resolution of their complaint at the institutional level. (1) The complainant may request the mareez mitra / patient ally to accompany them while their complaint is being received and recorded physically at the GFC, or to register the complaint on their behalf. (2) The mareez mitra / patient ally shall try to create a safe and empowered environment for the complainant to explain their grievances and demands, and exercise their choice regarding anonymity, confidentiality or seeking a public hearing.	This draft rule sets out the process to be followed by the mareez mitra / patient ally during the complaint filing and grievance redressal process, including helping the patient express their concerns, accompanying the patient through the filing and processing of the complaint, and advising the patient regarding their rights in the context of the grievance redressal process and under other applicable laws.

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	(3) The mareez mitra / patient ally may also counsel the complainant regarding other grievance redressal mechanisms or fora that may be explored. This could include suitable mechanisms under criminal, consumer, or other civil laws as well as regulations governing health care establishments and health care providers. (4) On the complainant's request, the mareez mitra / patient ally shall accompany and assist the complainant through the grievance resolution process, including conversations held by the grievance facilitator with the complainant, administrator, health care provider(s), other worker(s), etc. (5) The mareez mitra / patient ally shall try to assist the complainant in navigating any hostility, discrimination, intimidation, or discouragement faced at the time of filing the complaint or during any stage of in-house resolution of the complaint (including the stage of corroboration of resolution of grievance by the complainant). (6) The patient ally may report incidents of hostility or discrimination faced by the complainant to the DHA in case they are not appropriately addressed at the institutional level. Explanation: The mareez mitra / patient ally may not be present at all times at the health care establishment. In case a complainant prefers to file an anonymous complaint while the mareez mitra / patient ally is not present, they may raise their grievance through the helpline. Further, the complainant may prefer the mareez mitra / patient ally to be present at any stage during or after filing their complaint. In that case, they may request the presence and assistance of the patient ally at the earliest possible time, either through the GFC or the helpline.	

Draft Rules and Explanatory Notes on Grievance Redressal Mechanisms [In Exercise of the Powers under Sections 5(D), 11, 12, 13, 14 And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
	Grievance Redressal Officers and Invitees at DHA and SHA [Sections 11 and 12]	
7.	**Appointment of grievance redressal officers at the district and state level** The state government shall appoint grievance redressal officers (**GRO/s**) at the district and state levels to assist the DHA and the SHA in resolving grievances. (1) The state government shall issue a public call inviting applications for the position of GRO at the district and state levels. (2) A GRO should be selected on the basis of the following criteria: (i) experience in public health, health administration, dispute resolution, or allied fields (ii) knowledge of the healthcare system in Rajasthan (iii) knowledge of and sensitivity to rights and concerns of stakeholders including patients (iv) familiarity with the local community and culture(s) (v) The GRO shall not have any financial or other interest in a health care establishment (3) Laws and rules pertaining to public calls and government appointments prevalent in the state shall dictate the manner, timelines, and procedure to be followed for the purpose of such appointment. (4) The state government and the district administration may also appoint adequate office staff and support staff to assist the GROs, the DHAs, and the SHAs in efficient execution of their roles and responsibilities.	SHA, as used in these Rules, refers to the SHA for logistical grievances under the Act. This draft rule provides for the appointment of a Grievance Redressal Officer who is intended to be an independent person appointed at the levels of the DHA and the SHA to counter the potential lack of neutrality of both these offices in redressing grievances. One of the selection criteria suggested, i.e. the GRO shall not have any financial or other interest in a health care establishment, is intended to avoid any conflict of interest or bias in resolving grievances. While it would be ideal for the GRO to be a completely independent office, with fixed tenure and a guarantee that terms of appointment cannot be varied to their disadvantage, this is not explicitly contemplated within the scheme of the existing Act.

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Sr. No.	**Draft Rule**	**Comments**
8.	**Power to appoint invitees to the SHA and DHA** The SHA and DHAs may appoint invitees to the authority to assist them in deciding upon complaints, appeals, and other matters. Such invitees should have experience in public health, patient rights, and such other relevant subject matters. Invitees may be appointed long-term or on a case-by-case basis depending on the subject matter of the specific matters before the DHA/ SHA.	This draft rule provides for people with expertise in the subject matter of the complaint before the district or state authority (DHA or SHA) to shed light on the specific issue and facilitate an informed, effective resolution.
Registering Complaints [Section 11]		
9.	**Registering a complaint** (1) Complaints may be made before the GFC verbally or in a written form. Verbal complaints may include complaints made through a helpline, while written complaints may include any complaint submitted in a physical or digital form, through a drop-box or otherwise. (2) The SHA may specify any other modes in which a complaint may be made. (3) Complaints may be registered for the complainant by the mareez mitra / patient ally. (4) The GFC shall record all complaints received in a standard format, whether physical or digital.	A standard format in which complaints can be recorded will have to be prescribed. This draft rule sets out the process for the registration of complaints, ensuring that they may be made in writing or verbally or may even be filed through the mareez mitra / patient ally, for ease of filing, and to ensure that any (temporary) indisposition of the patient does not prevent them from being able to file a complaint.

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	Provided that in cases where the health care establishment is closed or has no staff present during official working hours, or has no functional GFC, complaints may be filed directly before the DHA which has jurisdiction over the establishment in question.	
In-house Grievance Redressal Processes [Section 11]		
10.	**Handling Complaints at GFC level** (1) The grievance facilitator shall receive and record complaints in digital and / or physical modes in a standard format. (2) Upon receipt of a complaint, the grievance facilitator may conduct an inquiry into the complaint received, which may include any or all of the following steps- (i) referring to relevant records; (ii) assessing the site of grievance; (iii) speaking with the complainant to understand the details of their grievance; (iv) speaking with the administrator / in-charge of the establishment, health care provider (s), or other worker (s) who may be involved in the grievance or situation in any capacity. (3) The grievance facilitator shall coordinate with the administrator / in-charge of the establishment, health care provider(s), or other worker(s) to resolve the grievance at the level of the establishment.	This draft rule contemplates the processing of grievances at the level of the GFC, with the grievance facilitator taking on the main function of handling complaints, in coordination with all interested parties. Since this is an in-house grievance facilitation cell (in line with the contours laid down by the parent Act), we expect it to resolve grievances at the level of the institution rather than perform adjudicatory functions and impose penalties. It is intended as a first step in the grievance redressal process.

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	(4) The grievance facilitator shall coordinate with the mareez mitra / patient ally amicably to enable meaningful resolution of grievances.	
11.	**Timelines** The GFC shall ensure that all complaints are resolved within 3 (three) days of the complaint being made. Provided that - Where a grievance relates to the provision of emergency care, emergency obstetric care, first aid, or any other health care such that a failure to resolve the grievance immediately would: (i) result in a loss of life; (ii) place the health of a pregnant person or their unborn child in serious jeopardy; (iii) cause serious impairment to bodily functions; (iv) result in serious dysfunction of any organ or part of a body; (v) result in loss of liberty or irreparable harm to the privacy and dignity of an individual; (vi) otherwise render the grievance redressal process infructuous; the GFC shall resolve such grievance immediately and in any case, not later than 2 (two) hours from the time of making the complaint. ***Illustrations of grievances requiring immediate resolution.*** *The victim of a road traffic accident is brought to a Community Health Centre. She is stabilised but requires emergency transport to the district hospital. There is no ambulance service*	A short timeline for resolution of complaints is set out under this draft rule, in keeping with the aforesaid resolution-focus of grievance redressal as envisioned at the GFC level. Grievances involving life-threatening or other critical emergencies (as defined in the draft rule) are required to be resolved on the spot, within 2 (two) hours of the complaint being made.

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	available. The In-House Grievance Cell at the Community Health Centre must make arrangements for such transport immediately. *A private health care institution refuses to release the body of a patient to his family, alleging the non-payment of bills. The In-House Grievance Cell must ensure that the body is released immediately.* *The HIV status of a patient is displayed prominently on their patient chart in a public ward. The In-House Grievance Cell must act immediately to protect the patient's privacy and ensure that this information can be viewed only by healthcare workers and providers involved in the care of the patient.*	
Grievance Redressal Processes at District and State Levels [Sections 11 and 12]		
12.	**Procedure of grievance redressal at the district and state level** The SHA and DHAs shall be assisted by a GRO in inquiring into and resolving matters taken up *suo moto*, grievances raised through an original/ forwarded complaint or appeal, or issues raised by patient allies. (1) A GRO shall have the following powers while inquiring into and resolving a matter, a complaint, an issue, or an appeal - (i) call all records necessary and relevant to verify the allegations in the complaint/ appeal; (ii) inspect the site of grievance if required;	The inclusion of a GRO in the process is intended to make the redressal process relatively more neutral or unbiased. A dedicated and trained officer would also be able to assist in timely and informed resolution. Vidhi believes that ideally, the grievance redress process should be completely independent and optimally empowered. However, in keeping with the contours of the Act, in these Rules, the decision/opinion of the GRO has been

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	(iii) summon the complainant, the relevant mareez mitra / patient ally, health care provider(s), hospital administrator, other workers, or any other person that may be relevant to the grievance (iv) conduct mediation or conciliation processes as appropriate, including holding meetings with the complainant and the concerned health care provider or health care establishment, as the case may be Provided that the GRO shall not have the power to summon the complainant in case they have chosen to remain anonymous. (2) At any point during the process of mediation or conciliation before the GRO, if the parties reach a settlement, the GRO shall prepare a written record of the settlement to be signed by the parties, and provide an original of such record to each party. (3) In case no resolution is reached within twenty (20) days of receiving a matter/ complaint/ appeal, the GRO shall send a recommendation in writing to the SHA or the DHA (as the case may be), explaining their opinion as well as suggested individual and systemic remedies, if any. (4) The corresponding DHA or SHA may reject the recommendation only with reasons in writing, and such rejection shall be part of public record. (5) In case of non-rejection or non-response from the corresponding DHA or SHA, the recommendation of the GRO shall be deemed to be the order of the DHA or SHA. (6) In case of reasoned rejection of the GRO's recommendation, the DHA or the SHA (as the case may be), shall convene one or more meeting(s) of its members, along with the	phrased as a 'recommendation' and not an 'order', and the DHA/SHA shall have the power to ultimately decide the matter. A timeline of 20 (twenty) days is provided for resolution of the matter by the GRO, and it is also provided that if the DHA / SHA does not take action or communicate its decision upon a complaint being forwarded to them - then the GRO's order becomes final. This is to ensure that matters do not drag on indefinitely, and that a resolution may be reached within a reasonable timeframe. The DHA and SHA are given similar powers of inquiry as given to the GRO, to enable them to process complaints / appeals. Further details of proceedings of the SHA and DHA are to be determined by regulations issued by them.

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	GRO and special invitee(s) if any to determine appropriate action to be taken on the complaint. The SHA or DHA shall issue directions accordingly. (7) The decision of the DHA arrived at through the above-mentioned process shall be subject to appeal before the SHA as per the provisions of the Act. An appeal before the SHA or a complaint forwarded to the SHA shall be governed by the same process as set out in this Rule. Explanation: The DHA and the SHA shall have the same powers of inquiry as set out for the GRO mentioned in this rule, apart from other powers including those mentioned in Section 12 of the Act.	
Processing, Tracking, and Resolution of Complaints [Section 11]		
13.	**Tracking and automatic forwarding of complaints** (1) At the time of making a complaint, it shall be assigned a unique number, and the complainant shall be provided with a token, counterfoil, extract from a register or any other means that enables them to track the status of their complaint, in digital and / or physical modes. (2) An automatic digital system shall be set up by the state government for the purposes of tracking and forwarding complaints, and intimating complainants about the status of their complaint and action taken on their complaint.	This draft rule envisions a streamlined filing and processing structure that allows complainants to keep track of their complaints as they make their way through the grievance redressal system. This would ideally be an automated system to reduce administrative bottlenecks.

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14.	**Anonymity / Confidentiality of Complaints** The GFC, DHA, or SHA (as the case may be) shall ensure that no identifying information or personal health information of complainants is disclosed except to such persons or to such extent as is necessary for the resolution of the complaint. Provided that where a complainant has opted to pursue an anonymous complaint process, no details other than anonymised details of the complaint shall be shared with anyone without the express written consent of the complainant.	This draft rule aims to ensure patient / complainant privacy by requiring the authorities to maintain strict confidentiality (with regard to personal health information) throughout the grievance redressal process, and, at the option of the complainant, anonymity as well.
15.	**Resolution of Complaints** (1) A complaint shall be said to have been resolved, when the complainant confirms in writing that: (i) the grievance has been resolved to their satisfaction, or (ii) they have chosen to pursue alternative modes of resolution. (2) Written confirmation issued by the complainant, under clause (1) of this Rule, must bear their signature or thumb impression, and be delivered to the GFC or GRO of the DHA or SHA, as the case may be.	This draft rule sets out the criteria to determine when a complaint has been finally resolved, and a protocol to be followed to officially close the matter. The proposed process requires confirmation from the complainant - to safeguard against unauthorised or arbitrary closure of grievances.

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Sr. No.	**Draft Rule**	**Comments**
Directions and Remedies [Sections 11, 14, and 18]		
16.	**Directions that may be passed by the DHA or the SHA** (1) To resolve a grievance, the DHA or the SHA may, on the recommendation of the GRO, or of its own motion, recommend appropriate action to provide a remedy to the individual complainant as well as to direct a health care provider or health care establishment to take systemic remedial action. These may include directions to: (i) issue an apology to the complainant; (ii) conduct an internal inquiry into the grievance and submit a report on the action proposed to be taken to prevent its recurrence; (iii) train or sensitise its healthcare providers and other workers; (iv) undergo an audit of its internal operating policies, procedures or protocols, by an agency or body approved by the DHA or the SHA; (v) pay compensation to the complainant; (vi) take any other specific action to resolve the grievance (2) The DHA or the SHA shall require the health care establishment to submit an action taken report within 15 days of passing the directions under clause (1) This timeline may be extended where the health care establishment is directed to take long-term, systemic action. (3) The DHA and the SHA shall each publish a quarterly report containing the following information: (i) the number of complaints forwarded, appeals preferred, and matters taken up of its own motion;	In order to have an effective grievance redressal mechanism, it is necessary that the authorities are empowered to award appropriate remedies as part of the resolution process. This draft rule provides for the types of directions that may be passed and remedies that may be awarded by the DHA / SHA - these include individual remedies as well as directions aimed at infrastructural and systemic reform. The draft rule also requires the DHA and SHA to publish data on the functioning of the grievance redressal system before it, on a quarterly basis - including the number of complaints and appeals received / preferred, grievances resolved, action taken, and a list of HCEs that have been complained against. It is stipulated that these reports must protect the privacy and confidentiality of patients and complainants.

Draft Rules and Explanatory Notes on Grievance Redressal Mechanisms [In Exercise of the Powers under Sections 5(D), 11, 12, 13, 14 And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
	(ii) the number of grievances resolved; (iii) the list of health care establishments against which complaints are made; (iv) the action taken reports submitted by all health care establishments with respect to resolution processes. (4) The DHA and SHA shall ensure that their quarterly reports do not contain any information through which patients or complainants can be identified.	We welcome comments regarding the DHA or SHA's powers to direct the payment of compensation of their own accord, or only as part of the conciliation/mediation process.
17.	**Imposition of Civil Penalties** (1) The DHA or the SHA may, on the recommendation of the GRO, or of its own motion, impose a penalty on a healthcare establishment for failure to comply with the provisions of the Act or these Rules. (2) A penalty may be imposed only after: (i) the conduct of an inquiry by the DHA, SHA, or any other officer nominated in this behalf by the DHA or SHA; and (ii) giving the health care establishment or healthcare provider concerned the opportunity of being heard. (3) In determining the quantum of the penalty, the DHA or SHA shall have regard to the following factors: (i) the nature, gravity, and duration of the non-compliance; (ii) the number of persons affected and the nature of harm suffered by them;	This draft rule provides for civil penalties to be imposed by the DHA / SHA in order to penalise an HCE or a healthcare provider where the mere resolution of the grievance (as contemplated under the preceding rule) is judged to be inadequate. It also sets out the process to be followed when imposing such penalties, and lists the criteria to be considered when determining the amount of the civil penalty. HCEs / HCPs may appeal to a competent civil court, against civil penalties imposed by DHAs / SHAs under these rules.

Draft Rules and Explanatory Notes on Grievance Redressal Mechanisms [In Exercise of the Powers under Sections 5(D), 11, 12, 13, 14 And 17 of the Act]		
Sr. No.	**Draft Rule**	**Comments**
	(iii) the negligent nature of the non-compliance; (iv) the repetitive nature of the non-compliance; (v) any other aggravating or mitigating factors relevant to the circumstances of the case. (4) Any health care institution aggrieved by the order of the DHA or the SHA imposing a civil penalty may prefer an appeal to a civil court of competent jurisdiction.	
18.	**Action under other legislation** (1) When the DHA or SHA is of the opinion that a complaint brought before it warrants disciplinary, penal or other regulatory action under any other law in force in the State, the DHA or the SHA may, in addition to issuing directions, bring the complaint to the notice of the appropriate authority. (2) At the time of bringing the complaint to the notice of the appropriate authority, the DHA or SHA shall also forward the recommendations of the GRO, if any, as well as the findings of any inquiry that may have been conducted by it.	Section 18 of the Act provides that the Act (and consequently these Rules) are intended to be implemented alongside other laws regulating healthcare services in the state, and are not intended to interfere with or duplicate the operation of existing laws. This draft rule aims to leverage existing mechanisms under other healthcare regulatory laws, and to facilitate the functioning of the grievance redressal system under these rules, in tandem with other laws and mechanisms, by empowering DHAs and SHAs to refer matters to appropriate authorities under other laws (along with the GRO's recommendations, and the authority's findings, as appropriate).

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