FIRST WORKING DRAFT
Bill No. of 2021

THE RIGHT TO HEALTH AND HEALTHCARE BILL, 2021

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ARRANGEMENT OF CLAUSES

Bill No. of 2021

THE RIGHT TO HEALTH AND HEALTHCARE BILL, 2021

A

BILL

to provide for the right to health and healthcare for all individuals residing within the territory of India, the rights of healthcare workers, and all matters connected therewith and incidental thereto.

WHEREAS the right to health is a constitutional right in India, which shall be realised by the Central Government, the State Governments, local authorities, communities and individuals without discrimination on the basis of an individual's caste, indigeneity, race, religion, gender identity, gender expression, sexual orientation, sex characteristics, disability, age, health status or condition, financial ability, occupation, marital status, criminal antecedents, language, place of birth, geographical location, nationality or citizenship, or any other social, economic, cultural or political characteristics.

STATEMENT OF OBJECTS AND REASONS

Article 21 of the Constitution provides that no individual shall be denied the right to life or personal liberty.

1. The fulfilment of the right to the highest attainable standard of health and its underlying determinants is a fundamental right of every individual residing within the territory of India. The fulfilment of the right to health includes, but is not limited to, the realisation of the right to free, accessible and quality healthcare, access to the determinants of health such as food, water, housing, sanitation, and a clean environment, access to information and education regarding health, and regulation of the determinants of health.

2. In *Francis Coralie Mullin v. Administrator, Union Territory of Delhi*, the Supreme Court of India held that Article 21 mandates the provision of the bare necessities required for living a life with human dignity. Articles 14, 15, 16 and 17 bar the State from discriminating among individuals, including on the grounds of their religion, race, caste, sex or place of birth. Further, the State is permitted to enact special measures for the upliftment of marginalised individuals and groups such as, but not limited to, Dalit, Adivasi and indigenous individuals, transgender and gender diverse individuals, intersex individuals, and women and children.

3. Article 23 prohibits human trafficking and forced labour, and Article 24 prohibits the employment of children in any hazardous occupation. Article 38 of the Directive Principles of State Policy urges the State to minimise inequalities and to secure a just social order. Under Article 39, the State should strive to secure a sufficient means of livelihood, distribute the ownership and control of resources to serve the common good, ensure equal pay for equal work, secure the health and strength of all workers, protect children from abuse and abandonment, and promote the healthy development of children and adolescents. Every individual should have the equal opportunity to secure a fair trial and redressal of the violations of their rights under Article 39-A. Article 41 urges the State to secure the right to work, and public assistance in case of unemployment, old age, sickness or disability. Under Article 42, the State shall endeavour to secure just and humane conditions of work, including maternity relief. The provision of care to infants and children is a Directive Principle under Article 45 and Article 47 encourages the State to strive for the improvement of public health, including by raising the level of nutrition and standard of living. Article 48A urges the State to strive to improve and safeguard the natural environment.

4. The Supreme Court of India has upheld the right to health in a plethora of judgments. In *C.E.S.C. Limited v. Subhash Chandra Bose*, the Supreme Court of India stated that the right of health means the fulfilment of complete physical, social and intellectual wellbeing, and merely the absence of sickness. In *State of Punjab v. Ram Lubhaya Bagga* and *Devika Biswas v. Union of India*, this right has been recognised as a fundamental right for all individuals under Article 21, which mandates the State to take actions such as opening Government-run hospitals, reducing waiting times and providing all such healthcare services as would be available in other hospitals. It was also made independently justiciable in the 1996 case of *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, wherein emergency care was placed at the core of the fundamental right to health. Further, the fundamental right to health, as per the decision in *Navtej Singh Johar v. Union of India*, necessitates the right of the individual to control their health and body, be free from interference and access a system of healthcare that provides equal opportunity to attain the highest level of health.

5. The State has a duty to ensure, to all individuals within its territory, the right to health, and the underlying determinants of health as per Article 3 and 25 of the Universal Declaration of Human Rights, Article 12 of the International Covenant on Economic, Social and Cultural Rights, Article 6 of the International Covenant on Civil and Political Rights, Article 24 of the Convention on the Rights of the Child, Article 12 of the Convention on the Elimination of all of Discrimination Against Women, Article 25 of the United Nations Convention on Rights of Persons with Disabilities, the Declaration of Alma-Ata 1978, the Programme for Action of the International Conference on Population and Development, Cairo 1994, the International Health Regulations, 58th World Health Assembly 2005, and other such international conventions. The State's duty to realise this right, *de jure* and *de facto*, cannot be avoided merely due to financial constraints. Most recently, during the COVID-19 pandemic, the Supreme Court of India has stated that the right to health is a fundamental right under Article 21 and includes the right to affordable treatment. The

Supreme Court of India also urged the Central Government to augment the protections afforded to healthcare workers.

6. Therefore, this Bill seeks to operationalise the responsibility, obligation and duty of the State to all individuals residing within the territory of India. In realising the right to health and healthcare within a rights-based and welfare framework, the State shall be guided by the principles of dignity, equality, availability, accessibility, acceptability and quality (AAAQ), affordability, inclusivity, non-discrimination, cultural sensitivity, timeliness, privacy, accountability, fairness and justice, and federalism and decentralisation. These principles cannot be realised without providing additional protections for marginalised individuals and groups and recognising the rights of contractual, non-contractual, voluntary and all other healthcare workers who are the mainstay of public and private healthcare systems.

CHAPTER I
PRELIMINARY

Clause 1: Short Title, Extent and Commencement

(1) This Bill may be called the Right to Health and Healthcare Bill, 2021.
(2) It shall extend to the whole of India.
(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

Clause 2: Definitions

(1) In this Bill, unless the context otherwise requires:
   (a) "AAAQ" means available, accessible, acceptable and quality.
   (b) "Acceptable" means goods, services and facilities that are respectful of medical ethics and individual preferences, culturally appropriate to individuals, communities and groups, particularly marginalised individuals/groups, and designed to respect confidentiality and improve the health status of every individual within the territory of India.
   (c) "Accessible" means goods, services and facilities that are accessible and free to every individual within the territory of India, including those belonging to marginalised groups, without discrimination for individuals with physical, intellectual and/or mental disabilities and/or historical, cultural and/or socio-economic conditions.
   (d) "Adolescent" shall mean an individual who has completed their fourteenth year of age but has not completed their eighteenth year of age.
   (e) "Affordable" means free, to the extent possible, and that which can be secured by every individual without reducing that individual's capacity to acquire other essential goods, services and facilities.
   (f) "Available" means the supply of quality goods, services and facilities that are available in sufficient quantities and with sufficient number of healthcare workers who have the competencies and skills to match local health needs, including those of marginalised individuals/groups.

(g) "Biomedical and health research" means research including research on:
  (i) basic, applied and operational research or clinical research, designed primarily to increase scientific knowledge about diseases and conditions (physical, intellectual, mental or socio-behavioural);
  (ii) detection and causes of diseases, including neglected tropical diseases and rare diseases, and conditions (physical, intellectual, mental or socio-behavioural); and
  (iii) evolving strategies for promotion of health and/or prevention, or amelioration of disease and rehabilitation but does not include clinical trial as defined in clause 2(j).

(h) "Caregiver" means any individual including a family member, next of kin, guardian, friend or any individual of the healthcare user's choice, who provides care, support or assistance to the healthcare user with or without payment.

(i) "Catastrophic health expenses" means 5% or more of an individual's total disposable monthly income or wages, as applicable.
For the purposes of this definition, "total disposable income" shall mean the total monthly income of an individual after their expenditure on essential goods, services and facilities and shall not be subject to the provision of an individual's return under the Income-tax Act, 1961 (Act No 43 of 1961).

(j) "Clinical trial" means any research that contributes to the knowledge of:
  (i) biological, clinical, psychological or social processes in human beings;
  (ii) methods for the provision of healthcare services;
  (iii) human pathology, causes of diseases and effects of the environment on the human body;
  (iv) development or new application of pharmaceuticals medicines; or
  (v) development of new applications of health technology.

(k) "Community participation" means the process by which members of a community, either individually or collectively and with varying levels of commitment, develop the capability to assume greater responsibility for assessing their health needs and problems, which may include further planning, monitoring and governance of the implementation of these programs, creating and maintaining organisations in support of these efforts, and evaluating the effects and thereby adjusting goals and programmes on an ongoing basis.

(l) "Conversion practice" means any practice or treatment that attempts to change, repress or eliminate an individual's sexual orientation, gender identity and/or gender expression,
Provided that conversion practice does not include any counselling related to affirming one's sexual orientation, gender identity and/or gender expression.

(m) "Counselling" means the skilled, principled and non-judgmental use of relationship characterised by the application of one or more psychological theories and/or a recognised set of communication skills, modified by experience, intuition and the healthcare user's values, personal resources and capacity for self-determination to facilitate self-knowledge, emotional acceptance, growth and optimal development of personal resources, including but not limited mental healthcare under the Mental Healthcare Act 2017 (Act No 10 of 2017) and pre-operative and post-operative interventions.

(n) "Essential goods, services and facilities" means goods, services and facilities the delivery of which is intrinsic to the fulfilment of rights under this Bill, including but not limited to:
   (i) health and healthcare services;
   (ii) the public transportation of individuals or the transportation of freight within the territory of India or internationally, including ambulance and other patient transport services;
   (iii) the supply and distribution of determinants of health and any other related service in accordance with clause 10;
   (iv) the production, supply or distribution of adequate pharmaceutical medicines;
   (v) garbage, sanitary, cleaning and sewerage services within a healthcare establishment;
   (vi) the production, supply or distribution of any form of energy, power or fuel or of energy, power or fuel resources;
   (vii) fire-fighting services;
   (viii) the public distribution system for food grains management and delivery;
   (ix) the functioning of prisons, welfare, childcare institutions and other establishments housing incarcerated persons; and
   (x) any other goods, service and facilities declared to be essential by order or notification of the Central Government and State Governments.

(o) "Free" means at no out-of-pocket expense or user charges to an individual or their caregiver(s).

(p) "Healthcare establishment" means the whole, or part thereof, of a public or private institution, facility, building or place, whether for profit or not-for-profit, that provides, or is operated or designed to provide, inpatient and/or outpatient healthcare services.

(q) "Healthcare services/healthcare treatment" means any testing, examination, treatment, care, counselling, procedure or other intervention or service towards a therapeutic, nursing, rehabilitative, palliative, convalescent, preventative, diagnostic, research, information dissemination or any other health-related purpose, or any combination thereof, irrespective of whether the intervention or service takes place at a healthcare establishment or any other place whatsoever.

(r) "Healthcare worker" means every individual, by whatever professional designation they may be referred to, who provides healthcare services/healthcare treatment as defined in clause 2(q) irrespective of whether they are employed on a salaried-basis, contractual basis, temporary basis, voluntary basis, under any incentive-based employment or are unpaid, including but not limited to ambulance drivers, Accredited Social Health Activists and Anganwadi workers, autopsy personnel, auxiliary nurse midwives, contractual staff not employed by the healthcare establishment, crematorium workers, dental healthcare professionals, emergency healthcare service providers, healthcare professionals, laboratory and diagnostics personnel, mental health professionals, midwives, mortuary workers, nurses, nursing assistants, optometrists, paramedical professionals, pharmacists, physicians, physiotherapists, practitioners of alternative medicine, sanitation workers, social workers, or other appropriately trained and qualified individuals with specific skills relevant to healthcare, nursing, rehabilitative, palliative, convalescent, preventative

or other healthcare services, students, trainees, interns and residents, technicians and voluntary personnel.

(s) "Healthcare user" means an individual and their caregiver(s) that seeks, accesses or uses the services of a healthcare worker, including individuals requiring medical care or treatment as an outpatient or inpatient from any healthcare establishment or any place whatsoever.

(t) "Incarcerated persons" means individuals that have been confined and/or detained, including under any law, forcefully or otherwise, in such a manner as to materially affect the realisation of their right to health and healthcare under this Bill, including but not limited to individuals in prisons, jails or detention centres, undertrial prisoners, detainees, convicted individuals and individuals in police or judicial custody, individuals in childcare institutions, as defined under the Juvenile Justice (Care and Protection of Children) Act 2016 (Act No. 2 of 2016), individuals in custodial institutions, individuals residing in remand homes, individuals residing in mental health establishments, individuals in rehabilitation centres, individuals in shelter homes and marginalised individuals and groups that have been forcefully confined and/or detained by a family member, guardian or any other individual.

(u) "Marginalised individuals/groups" means individuals or groups who require special protections due to their social, cultural, economic and/or political status, historical, traditional and/or present exclusion from political power, representation and/or resources or physiological or mental health conditions, including but not limited to women, infants, children, adolescents, elderly individuals, individuals with disabilities, individuals with stigmatised communicable diseases, individuals who use drugs, Dalit individuals (including but not limited to individuals from Scheduled Castes), Adivasi (including but not limited to individuals from Scheduled Tribes, wherever such categories exist de-notified tribes and nomadic tribes) and other indigenous individuals, individuals who have been discriminated based on their gender identity, gender expression, sexual orientation or sex characteristics, trafficked individuals, sex workers, inter-state, intra-state and international migrants, individuals in conflict situations, refugees, individuals fleeing abusive households, homeless individuals, individuals with rare diseases and individuals participating in clinical trials.

Explanation: For the removal of doubt, marginalised individuals/groups include but are not limited to those provided additional protections under the Scheduled Caste and Scheduled Tribe (Prevention of Atrocities) Act 1989 (Act No. 33 of 1989), the Transgender Persons (Protection of Rights) Act 2019 (Act No. 40 of 2019), the Maintenance and Welfare of Parents and Senior Citizens Act 2007 (Act No. 56 of 2007), the Rights of Persons with Disabilities Act 2016 (Act No. 49 of 2016), the Prisons Act 1894 (Act No. 9 of 1894), the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act 2017 (Act. No 16 of 2017), the Mental Healthcare Act, 2017 (Act. No 10 of 2017), and as defined thereunder.

(v) "Neglected tropical disease" means a disease that is indigenous to, or occurs principally in, tropical or subtropical areas of the world including but not limited to dengue, rabies, blinding trachoma, Buruli ulcer, endemic treponematoses, leprosy, Chagas disease, human African trypanosomiasis, leishmaniasis, cysticercosis,

dracunculiasis, echinococcosis, foodborne trematode infections, lymphatic filariasis, onchocerciasis, schistosomiasis and soil-transmitted helminthiases.

(w) "Out-of-pocket expenses" means expenses that are not borne by a healthcare establishment, the State or any other entity, including but not limited to an insurance company, and are therefore required to be paid by a healthcare user or their caregiver(s).

Explanation 1: Out of pocket expenses includes expenses which are not covered under any government scheme, insurance scheme or employment benefits for access to healthcare related goods, services or facilities.

Explanation 2: Out of pocket expenses may include those borne out of cost sharing, self-medication and other expenses incurred for the fulfilment for the rights under this Bill.

(x) "Prescribed" means prescribed by rules made by the Central Government or the State Government, as the case may be.

(y) "Public health emergency" means any potential, imminent or current occurrence that can endanger the lives, health and safety of individuals within the territory of India and whose scale, timing, or unpredictability threatens to overwhelm routine capabilities, including:

(i) occurrence of an international, national, state or local level crisis including calamitous epidemic disease, pandemic diseases and fatal infection agent;

(ii) crisis that poses a substantial risk of human fatalities or permanent or long-term disabilities or health impact requiring immediate action for its prevention, control and management.

(z) "Rare disease" means any disease that affects less than 5,00,000 individuals within the territory of India at any given point for which no cure or treatment currently exists but may be managed with various techniques, including but not limited to medical interventions.

(aa) "Sensitive information" means, for the purposes of this Bill, such personal information that includes but is not limited to age, biometric information, caste, criminal antecedents, disability, financial ability, financial information or other payment instrument details, gender identity or gender expression, geographical location or residence, indigeneity, language, level of education, marital status, medical history and records, nationality or citizenship, occupation, passwords, place of birth, race, religion, sexual orientation, sex characteristics and/or any other social, economic, cultural or political characteristics.

(bb) "Quality" means goods, services and facilities that are safe, effective, patient-centric, timely, efficient, equitable, and ensure rationality of care.

Explanation: For the purposes of this definition, "quality" shall be assessed in accordance with existing standards including but not limited to the IPHS Guidelines for Sub-Centres, PHC, CHC, Sub-District and District Hospitals and those under Clinical Establishments (Registration and Regulation) Act, 2010 (Act No. 23 of 2010) and the Clinical Establishment (Central Government) Rules, 2012.

(cc) "State" means the Central Government, the Parliament of India, the Governments and the Legislatures of each of the States, all local or other authorities and all instrumentalities of the Central Government or the State Governments within the territory of India.

CHAPTER II
RIGHTS OF INDIVIDUALS AND GROUPS WITH RESPECT TO HEALTH AND HEALTHCARE

Clause 3: Right to Health

Every individual shall have a right to the highest attainable standard of complete physical, intellectual, mental and social well-being, irrespective of any pre-existing conditions.
Explanation: The highest attainable standard of well-being is more than merely the absence of disease or infirmity.

Clause 4: Right to Healthcare

Every individual shall have a right to access healthcare services that are free or affordable and AAAQ-compliant, at any healthcare establishment within the territory of India.

Clause 5: Right to Non-Discrimination

Every individual shall have the right to health and healthcare under Clauses 3 and 4 respectively without direct or indirect discrimination in any form, including but not limited to, discrimination on the basis of their age, caste, criminal antecedents, disability, financial status, gender identity or gender expression, geographical location or residence, health status or condition, indigeneity, language, level of education, marital status, nationality or citizenship, occupation, place of birth, race, religion, sexual orientation, sex characteristics and/or any other social, economic, cultural or political characteristics.

Clause 6: Right to Live with Dignity

Every individual shall have the inalienable right to live a dignified life, including enjoyment of the right to health and healthcare free from discrimination regardless of their ability to pay for healthcare services.

Clause 7: Right to Sexual and Reproductive Healthcare Goods, Services and Facilities

Every individual shall have the right to access, and delivery of, comprehensive and free or affordable sexual and reproductive healthcare goods, services, facilities and information, including but not limited to:

(1) obstetric and gynaecological healthcare services;
(2) menstrual health goods, services and facilities in a clean, sanitary and comfortable manner throughout their menstrual cycle,
Provided that the right to access menstrual health resources, goods and services shall include the right to access facilities for safe and sanitary disposal;
(3) safe and effective methods of contraception, including the right to receive information and services regarding the range of contraception methods and counselling for the method that is medically best suited for them;

Provided that no individual shall be subject to sterilisation through coercion or force or association with financial or non-financial incentives and disincentives and in the absence of their explicit, autonomous and informed consent;

Explanation: Access to sterilisation as a method of contraception shall include preoperative and postoperative examinations, counselling and care to ensure full recovery;

(4) safe medical termination of pregnancy services, including post-abortion care;
(5) testing for any sexually-transmitted infections;
(6) counselling and effective treatment for sexual and reproductive health-related conditions, including contraception, sterilisations, sexually-transmitted infections; and
(7) maternal and child care, which includes prenatal care, neonatal care and postnatal care.

Explanation 1: The right to access free or affordable sexual and reproductive healthcare goods, services and facilities by all individuals, including minors as defined under the Protection of Children from Sexual Offences Act 2012 (Act No. 32 of 2012) and the Indian Penal Code 1860 (Act No. 45 of 1860), shall not be subject to provision of a police clearance or report in a medicolegal case.

Explanation 2: The rights under this clause include safe transportation to and from healthcare establishments.

Clause 8: Right to Life Saving, Emergency Medical Care and Healthcare Services

Every individual shall have the right to emergency or life-saving healthcare services without delay, compromising quality of care, compromising the safety of the individual, payment of any prior charge, fee, or other financial or non-financial compensation and/or the provision of a police clearance or report in a medico-legal case.

Clause 9: Right to Receive Essential Pharmaceutical Medicines, Devices and Implants

Every individual shall have the right to:

(1) receive free or affordable and AAAQ compliant access to essential pharmaceutical medicines, vaccines, devices and implants, including for the management or treatment for pre-existing conditions.
(2) choose amongst the available alternative essential pharmaceutical medicines, vaccines, devices and implants and from a source most suitable to them.
(3) access any medicines, devices and implants that are not readily available in India in accordance with the procedure prescribed.

Clause 10: Right to Determinants of Health

(1) Every person shall have the right to receive food that is sufficient according to the needs of each person shall including preferences for dietary and culturally sensitive food.

Explanation: Person as used in this Bill shall have the same meaning as in the National Food Security Act 2013 (Act No 20 of 2013).

(2) Every person shall have the right to access free or affordable, sufficient, safe, acceptable and physically accessible water for personal and domestic uses and for maintaining personal hygiene.

(3) Every person shall have the right to affordable housing where they can live:
  (a) in safety, including from human interference or environmental factors, and under healthy conditions;
  (b) with dignity, including with access to basic facilities;
  (c) with privacy;
  (d) in peace, including protection from forced eviction, harassment or other such threats.

(4) Every person shall have the right to sanitation, which includes:
  (a) privacy, safety and protection of dignity in accessing sanitation facilities;
  (b) access to affordable toilets and other excreta disposal facilities that can effectively prevent human, animal and insect contact with excreta;
  (c) access to sewerage channels to remove wastewater and excreta and safe disposal or treatment thereof; and
  (d) effective enforcement of the Prohibition of Employment as Manual Scavengers and their Rehabilitation Act 2013 (Act No 25 of 2013).

(5) Every person shall have the right to a healthy environment, which includes:
  (a) timely, effective and sufficient mitigation of the effects of climate change;
  (b) protection from the effects of air, water, sound and other forms of pollution; and
  (c) effective and sufficient enforcement of the Wildlife (Protection) Act, 1972 (Act No 53 of 1972), the Water (Prevention and Control of Pollution) Act, 1974 (Act No 6 of 1974), the Forest (Conservation) Act, 1980 (Act No 69 of 1980), the Air (Prevention and Control of Pollution) Act, 1981 (Act No 14 of 1981), the Environment (Protection) Act, 1986 (Act No 29 of 1986) and the Biological Diversity Act, 2002 (Act No 18 of 2003).

Clause 11: Right to Confidentiality

Every individual shall have the right to confidentiality with regard to their sensitive information and any other information shared with their healthcare worker or the healthcare establishment.
Explanation: The confidentiality of the individual shall be maintained at all times, including after their discharge and after their death.

Clause 12: Right to Privacy and Data Protection

Every individual shall have the right to privacy with respect to their sensitive information that is stored by every healthcare establishment and within the knowledge of every healthcare worker.

Clause 13: Right to Information and Education

(1) Every individual shall have the right to receive information regarding:
  (a) their right to health, right to healthcare and other associated rights under this Bill;
  (b) their rights and entitlements relating to health under any other statute, rule, policy or regulation;
  (c) the healthcare goods, services and facilities available at every healthcare establishment, and any such other information as is necessary for accessing the goods, services and facilities; and

(d) the processes, procedures and any other relevant information necessary for redressing any violation of their rights under this Bill,

in a manner that is accessible with minimum use of unfamiliar or complicated technical terminology, available in two regional languages and presented orally in case of limited reading proficiency.

Provided that the information must be communicated in a manner consistent with the definition of the term "communication" as provided under Section 2(f) of the Rights of Persons with Disabilities (Act No. 49 of 2016).

Provided further that such information programmes shall be regularly updated and communicated to reflect the latest developments in the law and the best available scientific knowledge.

Provided further that such information shall be clearly displayed in a prominent manner at every healthcare establishment.

(2) Every individual shall have the right to be informed with respect to:

(a) health concerns prevalent in the community, including methods of prevention, control and treatment;

(b) healthy and active lifestyle; and

(c) sexual and reproductive health,

in a manner that is accessible with minimum use of unfamiliar or complicated technical terminology, available in two regional languages and presented orally in case of limited reading proficiency.

Provided that the information must be communicated in a manner consistent with the definition of the term "communication" as provided under Section 2(f) of the Rights of Persons with Disabilities (Act No. 49 of 2016).

Provided further that such information programmes shall be regularly updated and communicated to reflect the latest developments in the law and the most recent scientific knowledge.

Provided further that such information shall be clearly displayed in a prominent manner at every healthcare establishment.

Provided further that children and adolescents shall have the right to receive such information as part of their school curriculum, which shall include sensitised and scientifically accurate information.

<u>Clause 14: Right to Explicit, Autonomous and Informed Consent</u>

(1) Every individual shall have the right to provide their explicit, autonomous and informed consent before accessing any healthcare service.

Provided that, in the case of emergency or life-saving healthcare services, a caregiver's consent shall be taken and in the absence of a caregiver's consent an individual's consent may be presumed.

Provided further that there shall be no presumption of consent where the individual has previously made an explicit declaration to the contrary or otherwise.

(2) Every adolescent shall have the right to:

(a) participate in the decision-making process regarding the provision of any healthcare service; and

(b) to receive all the necessary and relevant information regarding the healthcare service in a manner appropriate to their capacity for understanding.

Provided that the guardian of the adolescent shall give due consideration to the opinion of the adolescent while providing or withholding consent for any healthcare service.

Provided further that every adolescent shall have the right to receive sexual and reproductive healthcare services irrespective of their guardian's beliefs.

(3) Every individual with a physical, mental or intellectual disability of a temporary or permanent nature shall have the right to:
   (a) provide their explicit, autonomous and informed consent before undergoing any healthcare service;
   (b) not have their decision substituted by that of any other individual; and
   (c) receive all the necessary and relevant information regarding the healthcare service in a manner appropriate to their capacity for understanding.

(4) In addition to the right in Clause 14(1), every elderly individual shall have the right to:
   (a) fully participate in the decision-making process regarding the provision of any healthcare service; and
   (b) receive all the necessary and relevant information regarding the healthcare service in a manner appropriate to their capacity for understanding,

   Provided that such right shall also extend to elderly individuals that are unable to consent due to medical reasons and/or are dependent on their caregiver.

Clause 15: Right to Refuse Healthcare Services

Subject to sub-clause (2) and (3) of clause 14, every individual shall have the right to refuse healthcare services, and no individual shall be subject to any healthcare service without their explicit, informed and autonomous consent.

Provided that the refusal to undergo a healthcare service, or any part thereof, shall not in any manner prevent the individual from undergoing any other healthcare service or receive part of any ongoing healthcare service.

Provided further that no individual shall refuse healthcare services from any healthcare worker belonging to a marginalised individual/group solely on the basis of their marginalised identity under clause 2(u).

Clause 16: Right against Denial of Healthcare Services

Every individual shall have the right to seek and receive healthcare services without any harassment, denial or barriers.

Explanation: No individual shall be denied any healthcare services on the basis of their pre-existing conditions irrespective of their current condition, identity, nationality or lack of documentary proof including proof of Indian citizenship.

Clause 17: Right to Die with Dignity

Every individual shall have the right to die with dignity, including but not limited to:

(1) receiving free or affordable and AAAQ compliant palliative healthcare services and other long-term healthcare services and assisted services;

(2) refusing healthcare services, including the provision of emergency or life saving healthcare services;
(3) receiving a dignified funeral in accordance with their chosen rites and practices, and without discrimination on the basis of the characteristics under clause 33; and
(4) die at a place of preference including at a healthcare establishment or their home.

Clause 18: Right to be included in Health Planning, Programmes and Policies

Every individual shall have the right to be included in decision-making and public consultations regarding the formulation of health plans, programmes and policies.
Explanation: Efforts will be made to ensure participation of marginalised individuals/groups.

Clause 19 Right to Redressal

Every individual shall have the right to receive fair and speedy redressal of their rights violations under this Bill as enunciated under Chapter IX.
Provided that the right to fair and speedy redressal shall include the right to receive timely and free legal assistance from legal professionals wherever necessary.

Clause 20: Rights of participants in Clinical Trial, Biomedical and Health Research

In addition to, and alongside the rights of all individuals under this Bill, the Drugs and Cosmetics (Act No. 23 of 1940) and Drugs and Cosmetics Rules (1945), Ethical Guidelines of the Indian Council of Medical Research (2006), Indian Good Clinical Practice Guideline (2001) and ICMR's National Ethics Guidelines for Biomedical and Health Research involving Human Participants, 2017**,** every individual participating in a clinical trial, biomedical and health research shall have the right to:

(1) voluntary informed consent as a pre requisite for their participation in clinical trials or research, and such consent shall be prior and fully informed consent without any influence, duress, coercion, undue incentives or persuasion by healthcare workers or pharmaceutical companies;
(2) be informed about the name of the drug that is undergoing trial or research, along with the dates, doses and duration of such administration, potential side effects and other risks associated with such administration;
(3) withdraw their participation at any time during the clinical trial or biomedical and health research;
(4) privacy and confidentiality before, during and after the conclusion of the clinical trial or research, including the non-disclosure of any data, including but not limited to sensitive information to a third-party without the explicit, autonomous, and informed consent of the individual;
(5) free and AAAQ compliant healthcare services for treating or managing any adverse health impact as a consequence of the clinical trial or research, during or after the conclusion of the clinical trial or biomedical and health research;
(6) receive free ancillary healthcare services for ongoing treatment of any medical condition or pre-existing condition during the duration of their participation in the clinical trial or biomedical and health research; and

(7) receive financial compensation in case of injury or death as a consequence of their participation in the clinical trial or biomedical and health research.

Explanation 1: In case of death of the participant due their participation in clinical trial or biomedical and health research, the next-to kin shall receive the financial compensation.

Explanation 2: A healthcare user shall only be provided healthcare services for experimental or bio-medical and health research or a clinical trial as per the guidelines laid down in the law and will be given prior information regarding the experimental nature of the bio-medical and health research or a clinical trial, as applicable, in the prescribed manner.

Explanation 3: In order to participate in any clinical trial or bio-medical and health research, each participant must read and sign an informed consent form before any receiving treatment or testing related to the trial or research commences. The consent form shall be made available in regional languages and presented orally in case of limited reading proficiency or physical, intellectual or mental disability.

CHAPTER III
RIGHTS OF HEALTHCARE USER

Clause 21: Right to be Informed

(1) Every healthcare user shall have the right to be provided with the latest and complete information regarding:
   (a) their health status;
   (b) their diagnosis or prognosis, as the case may be;
   (c) ongoing and proposed healthcare service(s), including but not limited to risks, benefits and consequences thereof;
   (d) estimated out of pocket expenses and other expenses;
   (e) their healthcare records including but not limited to medical examination reports and discharge summary; and
   (f) any other such information as may be requested by the healthcare user.

(2) This information shall be provided by the relevant and qualifying healthcare workers at every stage of treatment and in a manner appropriate to their capacity for the healthcare user's understanding and in a language that is most appropriate for the healthcare user.

Provided that any such information shall be made available to a caregiver, while preserving the rights of confidentiality, express, autonomous and informed consent and privacy of the healthcare user.

Clause 22: Right to Choose between Available Treatments

(1) Every healthcare user shall have the right to choose between alternative treatments available for their diagnosed condition.

Explanation: No healthcare worker shall administer any alternative treatment with the knowledge that such treatment is likely to harm or negatively impact the healthcare user.

(2) Every healthcare user shall have the right to receive correct and accurate information as per Clauses 13 and 14 in order to make an informed decision with respect to their choice of treatment.

Clause 23: Right to Choose a Source for Medical Diagnostics

(1) No healthcare user or their caregiver shall be forced to use a particular healthcare establishment for diagnostic procedures.
(2) Every healthcare user shall have the right to receive information with respect to alternate establishments for obtaining diagnostic procedures.
Provided that such establishments must comply with standards prescribed under this Bill and any other law and shall be accredited by the National Accreditation Board of Testing and Calibration Laboratories and any other authority established by the State for this purpose.
(3) Every healthcare user shall have the right to choose between alternative sources for diagnostic procedures as recommended by their healthcare workers to the best of their knowledge and as per updated scientific evidence-based data.

Clause 24: Right to Information on Healthcare Worker

Every healthcare user shall have the right to information on the healthcare worker who is providing them with healthcare services including but not limited to the educational qualifications of the healthcare worker and wherever applicable, their employee identification number and the department of the healthcare establishment in which the healthcare worker is working.
Explanation: Where applicable, the healthcare worker shall wear an identification card or badge that clearly and succinctly displays their name and identification number.
Provided that such information shall not be used in a prejudicial manner to discriminate against the healthcare worker as per Clause 2(u)

Clause 25: Right to Continuity of Care

(1) Every healthcare user shall have the right to continuity of care with respect to the provision or delivery of healthcare goods, services and facilities, including:
(a) relationship continuity, that is, the ongoing relationship between a healthcare user and their preferred healthcare worker(s);
(b) management continuity, that is, the coordinated delivery of healthcare goods, services and facilities by healthcare workers belonging to different departments of a healthcare establishment; and
(c) where and if necessary, at the explicit, autonomous and informed request of the healthcare user only, the transition to a different healthcare worker or healthcare establishment at any geographical location.
Explanation: Every healthcare user shall have the right to uninterrupted healthcare goods, services and facilities irrespective of a temporary or permanent change in their geographical location.
(2) Every healthcare user shall have the right to continuity of care with respect to the referrals and transfer to other healthcare establishments and such referral and transfer must take place keeping in mind the best interest of the healthcare user.
Provided that no referral or transfer shall take place without taking into consideration the provisions of this clause.

Clause 26: Right to be Discharged with Dignity

(1) Every healthcare user shall have the right to be discharged from the healthcare establishment where they are receiving healthcare services.
(2) Every healthcare user shall have the right to request and receive a copy of all their sensitive information, or part thereof, stored by the healthcare establishment, including upon discharge.
Provided that a healthcare worker or healthcare establishment may be entitled to prevent the discharge of a healthcare user for necessary medical reasons or to comply with their legal obligations.
Explanation: No healthcare user shall be denied discharge or a copy of their sensitive information, or part thereof, due to any reason whatsoever.

Clause 27: Right to a Second Medical Opinion

(1) Every healthcare user shall have the right to receive a second medical opinion from another healthcare worker or healthcare establishment of their choosing.
(2) Where the healthcare user seeks a second medical opinion from a healthcare worker at a different healthcare establishment, the former healthcare establishment shall facilitate the transfer of required information within 24 hours, and any additional information within 12 hours, subject to the provisions of this Bill.

Clause 28: Right before Referral and Transfer

No individual shall be referred and transferred to another healthcare establishment unless:
(1) the referring healthcare establishment does not have the capacity, resources or expertise to fulfil the healthcare user's right to healthcare;
(2) the transfer is in the best interests of the healthcare user, and is unlikely to cause any injury or death;
(3) the referring healthcare establishment has provided the healthcare user or their caregiver with a written explanation for referral and transfer;
(4) the referring healthcare establishment has arranged, in a timely manner, free or affordable and quality transportation the healthcare user.
Provided that until the healthcare user is transported to and received by the receiving healthcare establishment, the referring healthcare establishment shall bear the sole responsibility for the health, safety and wellbeing of the healthcare user.

Clause 29: Right to Receive Body of Deceased Individual

Every caregiver of a deceased individual shall have the right to receive the body of the deceased individual and receive a copy of all the sensitive information, or part thereof, stored with respect to the deceased individual by the healthcare establishment.
Explanation: No caregiver shall be refused receipt of the body of the deceased individual or a copy of their sensitive information, or part thereof, due to any reason whatsoever, other

than for necessary medical reasons, to comply with their legal obligations or in case of a public health emergency.

Clause 30: Right to a Habitable, Clean and Safe Environment

Every healthcare user shall have the right to a habitable, clean and safe environment in every healthcare establishment in accordance with the provisions of this Bill.
Explanation: For the purposes of this clause, the right to a safe environment shall include protection against misdemeanour and physical, emotional and mental abuse.

Clause 31: Right to Access Caregivers and Caregiving Services

(1) Every healthcare user shall have the right to access at least one caregiver of their choice.
(2) In the absence of a caregiver and/or wherever necessary, a qualified healthcare worker shall be provided by the healthcare establishment to deliver caregiving services either within the healthcare establishment or elsewhere.

CHAPTER IV
RIGHT TO HEALTH AND ADDITIONAL PROTECTIONS AGAINST DISCRIMINATION

Clause 32: Right to Sensitive Healthcare Workers and Counselling

Every individual shall have the right to:
(a) receive healthcare services from a healthcare worker trained in, and sensitised towards, their difficulties and health-related concerns;
(b) access free or affordable and AAAQ counselling services for dealing with their specific difficulties and health-related concerns.

Explanation: The right to receive healthcare services from a qualified, trained and sensitised healthcare worker shall include the right to receive healthcare services from a healthcare worker belonging to their community.

Clause 33: Right to Protection of Cultural, Traditional and Community-Based Practices

In addition to, and alongside the rights of all individuals under this Bill, every individual belonging to a marginalised group shall have the right to:
(a) have their religious, social, cultural and spiritual beliefs protected while accessing any healthcare service; and
(b) be treated by a healthcare worker trained in community-based healthcare services, including traditional medicinal and healing practices.

Clause 34: Right to Accessible Healthcare Services

In addition to, and alongside the rights of all individuals under this Bill and the Rights of Persons with Disabilities Act 2016 (Act No 49 of 2016), persons with disabilities shall have the right to accessible healthcare goods, services, facilities including but not limited to visual, motor and auditory accessibility at a healthcare establishment.

Clause 35: Right of Protection Against Discrimination on the Basis of Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics

In addition to, and alongside the rights of all persons under this Bill and the Transgender Persons (Protection of Rights) Act, 2019 (Act No. 40 of 2019) every marginalised individual or individual belonging to a marginalised group shall have the right to:

(a) access free or affordable and AAAQ compliant gender affirming procedures, including gender affirmation surgery, hormone therapy and other related services necessary for affirming one's self-determined gender identity;
(b) acquire legal or other documents, including but not limited to those relating to their identity and education, issued by the State or a private entity that mention their chosen name, gender identity and photograph;
(c) refuse psychiatric or physical examinations, unwanted procedures and surgeries, and discriminatory medical classifications;
(d) choose a ward of their preference in every healthcare establishment,
Provided that in a situation where the individual is unable to choose their ward due to medical reasons, they shall be placed in a ward that is consistent with their self-determined gender identity;
Provided further that the individual's ward will be consistent with their self-determined gender identity and not dependent on the provision of identification documents; and
(e) not be subject to any coerced and unscientific treatments and practices, including but not limited to conversion practices, designed and performed to alter the individual's sexual orientation and/or self-determined gender identity or gender expression;
(f) not be subject to any coerced and unscientific treatments and practices, including but not limited to conversion practice, designed and performed to alter an individual's sexual orientation and/or self-determined gender identity or expression; and
(g) access community-owned healthcare services that focus on prevention, treatment, care and diagnosis.

Clause 36: Rights of Infants and Children

In addition to, and alongside the rights of all individuals under this Bill, every infant and child shall have the right to:

(1) access free or affordable and AAAQ compliant pediatric subspecialty services for receiving comprehensive and coordinated healthcare services that are conducive to their overall growth and development;
(2) receive emergency or life saving healthcare services, irrespective of their parent or legal guardian's beliefs
Explanation: Emergency or life saving healthcare services shall be provided to all infants and children unless denial of such care is based on the opinion of the healthcare worker, which is grounded in the best interests of the infant or child, and updated evidence-based scientific knowledge; and
(3) not be subject to any forced or otherwise coerced treatments, practices or medical procedures that are related to religious, traditional, cultural or other societal norms.

Clause 37: Rights of Elderly Persons

In addition to, and alongside the rights of all individuals under this Bill and Maintenance and Welfare of Parents and Senior Citizens Act 2007 (Act No 56 of 2007), every elderly person shall have the:

(a) right to receive emergency or life saving healthcare services, irrespective of their caregiver's beliefs,
Explanation: The provision of emergency or life saving healthcare services for elderly individuals shall not be compromised unless such a decision is based on the opinion of the healthcare worker, which is grounded in the best interests of the individual and updated evidence-based scientific knowledge; and
(b) right to be free from physical, mental or emotional abuse at their personal residence, a healthcare establishment, an old age home or assisted living facility, and any other place whatsoever.

Clause 38: Rights of Incarcerated Persons

In addition to, and alongside the rights of all persons under this Bill, the Prisons Act, 1894 (Act No 9 of 1894) and the Juvenile Justice (Care and Protection of Children) Act, 2015 (Act No 2 of 2016), every incarcerated person shall have the right to:

(a) a habitable, clean and safe environment, including but not limited to an environment that is devoid of inhumane conditions and overcrowding that might lead to the spread of infections, or other pathogens detrimental to the health of the incarcerated person;
(b) physical, mental and social well-being;
(c) receive adequate provisioning of basic goods, services and facilities necessary for complete realisation of the right to health and right to healthcare under this Bill;
Explanation: the sufficient provisioning of basic goods, services and facilities shall include but is not limited to the right to access free or affordable and AAAQ sexual and reproductive healthcare goods, services and facilities under clause 7;
(d) refuse healthcare services, including but not limited to forced or coerced physical or mental examinations; and
(e) seek redressal for violation of any rights under the provisions of this Bill as per Chapter VIII.

Clause 39: Rights of Persons with Rare Diseases

In addition to, and alongside the rights of all persons under this Bill, every person, including persons with rare diseases shall have the right to:

(a) timely and accurate diagnosis and prognosis of the rare disease, irrespective of the availability of cure or treatment for the same;
(b) access latest, factually accurate, and medically and scientifically sound information on the relevant rare disease; and
(c) access adequate mitigation, disease management and care techniques including but not limited to physiotherapy and palliative care for the complete realisation of rights under this Bill.

CHAPTER V
RIGHTS OF HEALTHCARE WORKERS

Clause 40: Right to Equitable, Just and Fair Benefits

Each healthcare worker shall be entitled to equitable, just and fair benefits, including financial and non-financial benefits without any discrimination.

Clause 41: Right to a Habitable, Safe, Clean and Humane Work Environment

Every healthcare worker shall have the right to work in a habitable, clean, safe and humane environment, which is appropriate to the full realisation of their right to health and wellbeing at the workplace.

Explanation: A humane work environment shall include but is not limited to:

(a) dignity at the workplace;
(b) mitigation of hazardous working conditions; and
(c) freedom from coercion to perform any identity based occupation, including but not limited to caste-based occupation or labour practices relating to the provision of healthcare services.

Clause 42: Right to Receive Protective Equipment

(1) Every healthcare worker shall have the right to receive free, appropriate, safe, sufficient, ergonomic and quality personal protective equipment as prescribed.
(2) In the absence of the provision of appropriate, safe, sufficient and quality personal protective equipment, every healthcare worker shall have the right to refuse to perform the duties associated with their employment without suffering any consequence, financial or non-financial, whatsoever.

Clause 43: Right to be Free from Violence, Coercion, Abuse or Sexual Harassment

(1) Every healthcare worker shall have the right to work in an environment that is free from physical, mental, emotional or sexual violence, coercion, abuse and harassment, including threats of such violence, coercion, abuse and harassment.
(2) In addition to the protection afforded under sub-clause (1), every healthcare worker shall have the right to effective enforcement of the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act 2013 (Act No 13 of 2013) and any other law.

Clause 44: Right to Training and Capacity Building

(1) Every healthcare worker shall have the right to receiving regular training on:
    (a) recognising and responding to the needs of marginalised individuals/groups;
    (b) prevention of physical, mental, emotional and sexual violence, coercion, abuse and harassment at the workplace, including specific concerns arising at healthcare establishments;
    (c) the use of personal protective equipment;

(d) the safe use, handling and storage of healthcare equipment;
(e) prevention of health and safety risks at the healthcare establishment; and
(f) any other concern as the need arises.

(2) Every healthcare worker shall have the right to receive regular short-term and long-term training for continuing their professional development.

Clause 45: Right to Mental Health Counselling

Every healthcare worker shall have the right to free or affordable and AAAQ compliant mental health counselling services at their workplace.

Clause 46: Right to be Involved in Decision-making

Every healthcare worker shall have the right to be included in decision-making and public consultations regarding the formulation of health plans, programmes and policies.
Explanation: Efforts will be made to ensure participation of marginalised individuals/groups.

Clause 47: Right to Compensation

Every healthcare worker shall have the right to receive financial compensation in case of injury or death during the course of their employment.
Explanation 1: Such compensation shall, at minimum, be commensurate with the loss of current and future income caused by the physical or mental injury, and any financial liabilities incurred pursuant to the treatment of such physical or mental injury.
Explanation 2: In case of death of a healthcare worker, the next-to kin shall receive the financial compensation.

CHAPTER VI
RIGHTS DURING A PUBLIC HEALTH EMERGENCY

Clause 48: Non-obstante Clause

Notwithstanding anything contained in any law, including but not limited to the Epidemic Diseases Act, 1897 (Act No 3 of 1897) and the Disaster Management Act, 2005 (Act No 53 of 2005), every law, rule, regulation, policy or other measure enacted during, or with respect to, a public health emergency shall be subject to the provisions of this chapter.

Clause 49: Prevention of Carceral Measures

(1) Every individual shall be allowed full enjoyment of all their rights under this Bill during a public health emergency, notwithstanding any provision under any other law.
(2) The State shall not enact or take recourse to any carceral or penal laws or repressive measures during a public health emergency, including measures under any law, which violates or has an otherwise detrimental impact on the rights of individuals under this Bill and the complete realisation of highest attainable standard of health.

Clause 50: Access to Goods, Services and Facilities

Every individual shall have the right to access:
(1) essential goods, services and facilities without any restrictions whatsoever, reasonable or otherwise; and
(2) non-essential goods, services and facilities with reasonable restrictions, during a public health emergency.

Clause 51: Right to Information during a Public Health Emergency

(1) In addition to the rights under the provisions of this Bill, every individual shall have the right to:
    (a) access the updated, factually accurate, and medically and scientifically sound information during a public health emergency
    Explanation: Such information shall include prevention, management, diagnosis and treatment for the cause of the public health emergency; and
    (b) receive information on preventive measures curated by the State based on accurate and real-time rate of infection, recovery and mortality at the local, state and national levels,
    Provided that the provision of such information shall be dispersed without compromising the anonymity, privacy and confidentiality of any individuals.
(2) Every individual shall have the right to receive information that is not related to the public health emergency without any disruption or interference whatsoever.

Clause 52: Right to Refuse Healthcare Services, Examinations and Vaccinations

In addition to the rights under the provisions of this Bill, every individual shall have the right to:
(1) access free or affordable and AAAQ compliant healthcare services for the diagnosis, treatment and management of the cause of the public health emergency;
(2) not be forced or otherwise coerced to undergo any examination or testing; and
(3) not be forced or otherwise coerced to receive any pharmaceutical medicines or vaccination.

Clause 53: Right to Access Transport Services

Every individual shall have the right to access and not be denied use of public or private transport services during a public health emergency.
Provided that if the cause of the public health emergency is connected to a contagious pathogen, the State shall ensure that any restriction placed on the movement of individuals is minimal, lawful, necessary, proportionate, and based on updated evidence-based scientific knowledge.
Provided further that access to essential healthcare services are made available through alternative means.

Clause 54: Right to not be Traced without Consent

No individual shall be traced or otherwise subject to any surveillance without their explicit, autonomous and informed consent.

CHAPTER VII
MONITORING AND PARTICIPATORY GOVERNANCE MECHANISMS

Clause 55: Monitoring and Participatory Governance Mechanisms

(1) The Central Government, State Governments and local authorities shall, within 180 days of coming into force of this Bill, establish accountability and governance frameworks as per the provisions under this Bill.
Provided that any monitoring and participatory governance mechanism shall be operationalised in accordance with the provisions of this Bill.
Provided further that any monitoring and participatory governance mechanism established under this Bill shall ensure communities' and individual ownership in their respective local bodies based on health information systems as established under Clause 71 of this Bill.
Provided further that any change in health programming on monitoring shall include local communities as active co-facilitators articulating their needs, identifying key indicators and creating tools for monitoring and evaluation, providing feedback and validating the data that is collected.

(2) The State Government shall ensure an integrated and rights-based approach to monitoring as per the following:
    (a) any sensitive information shall be shared based on the explicit, autonomous and informed consent of each individual;
    (b) for non-personal data:
        (i). effective and safe sharing of related information amongst state institutions at all levels, the public and non-government institutions;
        (ii). multi-sectoral analyses of available data and information;
        (iii). comprehensive interpretation and analysis of available data from a rights-based perspective; and
        (iv). broad dissemination of monitoring outputs among institutions and within civil society organisations.

Provided that any measure under this clause shall be undertaken in compliance with the right to privacy under Clause 12.

Clause 56: Community-based Monitoring Mechanism and Framework

(1) Notwithstanding anything contained in any law, the State shall ensure community participation while formulating health programs, while carrying out monitoring, evaluation, planning and governance activities for all healthcare establishments and healthcare workers within the territory of India.
(2) The Central Government and the State Governments shall establish a community-based health monitoring, evaluation, governance and planning body called Health Council at each of the village, block and district levels.
(3) The Central Government or State Governments shall constitute Health Councils in the respective urban areas/cities at the ward level and at the Municipality/Municipal

Corporation/Notified Area/Borough /Town Panchayat levels for effective monitoring and governance of health systems within the territory of India.

(4) The State Governments shall establish community-based health monitoring, evaluation, governance and planning bodies called State Health Councils at the State level.

(5) The Central Government shall establish a community-based health monitoring, evaluation, governance and planning body called National Health Council at the national level.

Clause 57: Constitution and Composition of Village Health Councils

(1) The Village Health Councils established under this Bill shall consist of one member from each of the following groups:
   (a) Gram Panchayat members from the village(s);
   (b) ASHA, Anganwadi Sevika, ANM; and
   (c) SHG leader, the PTA/MTA Secretary, village representative of any community-based organisation working in the village(s), user group representative.

(2) The chairperson of the Village Health Council shall be the member of panchayat(s) who shall preferably be a marginalised individual or an individual belonging to a marginalised group.

(3) The Convenor of the Village Health Council shall be the ASHA/Anganwadi Sevika of the village(s).

Clause 58: Constitution and Composition of Block Health Councils

(1) The Block Health Councils established under this Bill shall comprise:
   (a) 30% members who are representatives of the Block Panchayat Samiti (or members of the Block Panchayat samiti) with at least one woman or a transgender person;
   (b) 20% members who are non-official representatives from the Village Health Councils, coming from villages under the jurisdiction of the block, with annual rotation to enable representation from all the villages;
   (c) 20% members who are representatives from community-based organisations, Civil Society Organisations, people's organizations or individuals working on community health and health rights in the area covered under the block;
   (d) 20% members who are representatives of the healthcare workers, including the Medical Officer – Primary Health Centre and at least one ASHA/ANM working in the block area; and
   (e) 10% members who are representatives of the CHC level Rogi Kalyan Samiti.
   Provided that the total membership strength of the Block Health Councils shall be prescribed keeping in mind the demographic composition of the respective block.

(2) The chairperson of the Block Health Council shall be one of the Block Panchayat Samiti representatives, preferably a Panchayat Samiti member belonging to the block coverage area.

(3) The executive chairperson of the Block Health Council shall be the Block Medical officer or the Medical Officer of a PHC within the Block area.

(4) The secretary of the Block Health Council shall be one of the representatives from community-based organisations, Civil Society Organisations, people's organisations or individuals working in health rights within the Block.

Clause 59: Constitution and Composition of District Health Councils

(1) The District Health Councils established under this Bill shall consist of the following persons:
   (a) 30% members who are representatives of the Zilla Parishad (including the convenor and members of its Zilla Parishad Health Committee) with at least one woman, one transgender person and one member from the SC/ST community;
   (b) 15% members who are district health officials, including the District Health Officer / Chief Medical Officer and Civil Surgeon or officials of parallel designation, along with representatives of the District Health planning team which might include the Medical Superintendent or any officer of a parallel designation;
   (c) 15% members who are non-official representatives of Block Health Councils, with annual rotation to enable successive representation from all blocks;
   (d) 20% members who are representatives from community-based organisations, Civil Society Organisations, people's organizations or individuals working on health rights and regularly involved in facilitating and community-based monitoring at subordinate levels (Village/Block) in the District;
   (e) 10% members who are representatives of the healthcare workers, including the Medical Officer – Primary Health Centre and at least 2 ASHA/ANM working in the district; and
   (f) 10% members who are representatives of Rogi Kalyan Samiti in the District.
   Provided that the total membership strength of the District Health Councils shall be prescribed keeping in mind the demographic composition of the respective district.
(2) The chairperson of the District Health Council shall be one of the Zilla Parishad representatives, preferably convener or member of the Zilla Parishad Health Committee.
(3) The executive chairperson of the District Health Council shall be the CMO / CMHO / DHO or officer of equivalent designation.
(4) The secretary of the District Health Council would be one of community-based organisations, Civil Society Organisations, people's organizations or individuals working on health rights within the District.

Provided that Health Councils in urban areas/cities at the ward and Municipality/Municipal Corporation/Notified Area/Borough/Town Panchayat level shall be comprised of such members as prescribed from time to time.

Clause 60: Functions of the Village, Block and District Health Councils

The Health Councils established under Clause 56(2) shall carry out the following functions:

(1) ensure regular monitoring of health and healthcare services within their respective jurisdictions and strict adherence to the health programs;
(2) facilitate and organise periodic public hearings and dialogues to ensure and strengthen the direct accountability of the health system to the community and beneficiaries through various methods that shall include:
   (a) the preparation of quarterly public reports on health at each level; and

(b) undertake periodic, external, household, and facility surveys that track the effectiveness of the various activities to ensure rigorous monitoring of the health care system.

(3) ensure that their respective healthcare establishments acts in accordance with provisions of this Bill to ensure complete realisation of the right to health of each individual;
(4) facilitate conditions that enable individuals to realise the highest attainable standard of health;
(5) ensure that public expenditure on health to carry out their respective functions is consistent with the provisions of this Bill;
(6) review coverage norms and mechanisms every two years on the basis of updated evidence-based scientific knowledge, and experience of past norms and mechanisms;
(7) carry out clinical and medical audits of expenditure on issues concerning public health;
(8) institute systems of confidential inquiries into deaths to identify and analyse the failures of the healthcare system with a view to ensure systemic improvements;
(9) develop mechanisms for creating and empowering the decentralised implementing subordinate bodies and seeking their feedback in a structured manner on a regular basis; and
(10) any other function necessary to fulfil rights and obligations as enunciated under this Bill.

Provided that Health Councils in urban areas/cities at the ward and Municipality/Municipal Corporation/Notified Area/Borough /Town Panchayat level shall be responsible for carrying out same functions as enunciated under this provision.

Clause 61: Constitution and Composition of State Health Councils

(1) State Health Councils established under this Bill shall have the following members:
   (a) 30% of total members who are elected representatives, belonging to the State legislative body (MLAs/MLCs) or convenors of Health Committees of Zilla Parishads of selected districts (from different regions of the state) by rotation;
   (b) 15% who are non-official members of District Councils, by rotation from various districts belonging to different regions of the state;
   (c) 20% members who are representatives from community-based organisations, Civil Society Organisations, people's organizations or individuals working on health rights involved in facilitating community based monitoring in the state;
   (d) 15% members who are State Health Department: Secretary Health and Family Welfare, Commissioner Health, relevant officials from Directorate of Health Services (including the NRHM Mission Director) along with technical experts from the State Health System Resource Centre / Planning cell;
   (e) 10% members with each with experience of at least 10 years of working in the field of public health and health rights; and
   (f) 10% members who are officials belonging to other related departments and programmes such as Women and Child Development, Water and Sanitation, Rural development.

   Provided that the total membership strength of the State Health Councils shall be prescribed keeping in mind the demographic composition of the respective state.
(2) The Chairperson of the State Health Council shall be one of the elected members (MLAs).

(3) The Co-chairperson of the State Health Council shall be one of the members with experience of at least 10 years of working in the field of public health and health rights.
(4) The Executive chairperson of the State Health Council shall be the Secretary, Health and Family Welfare for the state.
(5) The Secretary of the State Health Council shall be one of the representatives of community-based organisations, Civil Society Organisations, people's organizations, or individuals working on health rights within the state.
(6) The State Health Council shall also employ such other additional officers and employees as the Chairperson determines in consultation with the executive Chairperson and Co-chairperson.

Clause 62: Functions of the State Health Councils

The State Health Councils shall enjoy the following functions:
(1) facilitating and organising periodic public hearings and dialogues to ensure and strengthen direct accountability of the health system to the community and beneficiaries through various methods that shall include the preparation of bi-annual public reports on health and the state of healthcare at the state level;
(2) overseeing the functioning of Village, Block and District Health Councils;
(3) formulating, negotiating and adopting a new state programs, polices, strategies, guidelines within 180 days of its constitution, on the basis of updated evidence-based scientific knowledge and assessment of success and limitations of prior policies;
    Provided that the state policy on health shall be revised at least every three years on the basis of updated evidence-based scientific knowledge and experience of past norms and mechanisms;
(4) establishing performance standards with quality measures, capacities, and process for health care infrastructure, service providers, quality or performance improvement that are required for achieving the objectives under this Bill;
(5) monitoring and regulating quality of standards in health establishments;
(6) establishing specific, time-bound and verifiable benchmarks, and indicators for each of the obligations under the right to health;
(7) developing coverage norms and mechanisms to ensure equitable distribution of public health systems;
(8) reviewing coverage norms and mechanisms every five years on the basis of updated evidence-based scientific knowledge, and experience of past norms and mechanisms;
(9) promoting access to primary, secondary and tertiary healthcare, including but not limited to:
    (a) acute and episodic healthcare services;
    (b) adolescent healthcare services;
    (c) child and adult immunisation;
    (d) chronic disease prevention;
    (e) dental healthcare services;
    (f) geriatric healthcare services;
    (g) health education and promotion;
    (h) infant and child healthcare services;

(i) maternal healthcare services;
(j) non-coercive family planning;
(k) nutrition and food safety;
(l) occupational healthcare services;
(m) ophthalmological healthcare services;
(n) other health promotion services;
(o) palliative healthcare services;
(p) prenatal, postnatal and neonatal healthcare services;
(q) preventive healthcare services and other public health services;
(r) school healthcare services;
(s) sexual and reproductive healthcare services;
(t) testing and screening; and
(u) any other service necessary to fulfil rights and obligations under this Bill and as prescribed from time to time.

(10) planning State health programmes for identifying, preventing and addressing conditions of public health importance, including but not limited to:
(a) epidemics, pandemics and outbreaks;
(b) epidemiological tracking, programme evaluation and monitoring;
(c) testing and screening programmes;
(d) diverse treatments;
(e) mitigation of hazardous substances and activities;
(f) administrative inspections; and
(g) any other method as prescribed from time to time.

(11) instituting systems of confidential inquiries into deaths to identify and analyse the failures of the healthcare system with a view to ensure systemic improvements;

(12) establishing and implementing performance standards, measures, capacities, and processes for healthcare establishments through quality or performance improvement that are accessible, affordable and non-punitive;

(13) ensuring that the medicines listed in the National List of Essential Medicines and the latest Model List of Essential Drugs of the World Health Organisation are available at all levels of healthcare establishments, and ensuring rational drug use;

(14) developing public health information, education and communication infrastructure and programmes for mass public health campaigns and activities with institutionalised involvement of educational institutions, non-governmental organisations, community-based organisations, associations of medical providers, traditional healthcare practitioners, mass media (including privately owned mass media), and all other stakeholders in promotion of public health;

(15) formulating human resource development plans for health to ensure availability, efficiency and regular capacity building of healthcare workers, commensurate with the public health needs of the state with the purpose of delivery of continuous quality care to every individual;

(16) developing and implementing capacity building plans for all the Health Councils under this Bill;

(17) establishing formal or informal networks between allopathic, homeopathy, Ayurveda, Unani, Siddha and all other indigenous systems of medicine within the public health system, and ensure their regulation as per other laws in force;

(18) developing policies for appointment of technical experts and administrative and technical staff, and formulating compensation packages for such experts and staff to be recruited from the open calls on a deputation basis;

(19) developing mechanisms for initiating public-private partnership for implementation of public health programmes that ensure equity and quality of healthcare services;

(20) developing mechanisms for creating and empowering the decentralised monitoring committees at all levels, rural and urban, and seeking their feedback in a structured manner on a regular basis;

(21) undertaking compatibility review of the existing laws and policies of the State Government that are related to health, to determine compliance with the provisions of this Bill and make recommendations for reform, amendment or repeal where such laws and policies are inconsistent with the provisions of this Bill;

(22) appointment, dissolution or removal of committees and subcommittees to address technical aspects of specific areas with respect to the Council's functions, or any other public health mandate of the State Government, on such terms as it may deem fit; and

(23) any other function necessary to fulfil rights and obligations as enunciated under this Bill.

Clause 63: Constitution and Composition of the National Health Council

(1) The National Health Council established under this Bill shall have the following members:

(a) the Secretary, Ministry of Health and Family Welfare, who shall be the Chairperson;

(b) the Director General of Health Services, who shall be the first Co-chairperson;

(c) one nominated non-official member with an experience of at least 15 years of working in the field of public health and health rights, who shall be the second Co-chairperson;

(d) one representative from the National Directorate of Health Services;

(e) one representative from each State Health Councils preferably the chairperson/Executive Chairperson or the Convenor;

(f) one representative of recognised professional associations and statutory councils relating to health at the national level;

(g) two nominated non-official members possessing ten years of experience as public health experts and those have been employed with Civil Society Organisations who have expertise in public health and special knowledge in any related field for at least ten years; and

(h) two nominated representatives from marginalized groups/individuals.

Provided that for the selection of the members under sub-clauses (g) and (h), the Central Government shall call for nominations from people through widespread advertisement within 15 days of this Bill coming into force and where reasonable time of at least 45 days shall be provided for responses from interested individuals.

Provided further that the final selection from the list of nominees shall be made on the principle that they represent the interests of all classes of individuals and have demonstrated experience in the field of public health and health rights.

Provided further that all nominated members shall enjoy equal powers as that of official members.

(2) The National Health Council shall also employ such other additional officers and employees as the Chairperson determines in consultation with the Co-chairpersons.

Clause 64: Functions of the National Health Councils

In addition to the functions enumerated under clause 62, the National Health Council shall enjoy the following functions:

(1) facilitating and organising periodic public hearings and dialogues to ensure and strengthen the direct accountability of the health system to the community and beneficiaries through various methods that shall include the preparation of bi-annual public reports on health at the national level;
(2) overseeing the functioning of State Health Councils;
(3) formulating, negotiating and adopting a new programs, polices, strategies, guidelines on the national level and decide on priorities within 180 days of its constitution, on the basis of updated evidence-based scientific knowledge;
(4) formulating and reviewing, every three years, minimum standards, protocols, norms and guidelines of public and private (for profit and not-for-profit) healthcare establishments towards:
    (i). access to healthcare services, including equitable coverage norms and minimum service guarantees;
    (ii). basic quality and safety assurance systems to cover all the performance parameters, including financial, physical, human power-based, and processes-based performance parameters; and
    (iii). regulation of clinical trials and health technology assessment;
(5) establishing a subordinate national-level healthcare service regulatory body to ensure compliance with the standards, protocols, norms and guidelines.
(6) formulating policies relating to the functioning, functions and membership of national-level healthcare service regulatory body established under sub-clause (5);
(7) establishing of performance standards with quality measures, capacities, and process for health care infrastructure, service providers, quality or performance improvement that are required for achieving the objectives under this Bill;
(8) monitoring and regulating quality of standards in healthcare establishments.
(9) reviewing, every three years, the regulations, standards, and protocols as laid down by the Council for fulfilment of rights under this Bill;
(10) designing and adopting national health information systems as per the provisions of Clause 71;
(11) planning of national healthcare campaigns, and the dissemination of information, education and communication programmes;
(12) supervising and verifying compliance with such matters as the Central Government may, from time to time, refer to, in order to ensure accountability;
(13) undertaking compatibility review of the existing laws, and policies of the Central Government that are related to health, to determine compliance with this Bill, and make recommendations for reform, amendment or repeal where such laws and policies are inconsistent with the provisions of this Bill;

(14) appointing, temporary or permanent, advisory committees on technical aspects of the aforementioned matters, or any other health matter for which the Central Government is responsible;

(15) appointing any monitoring committees as may be needed to monitor the progress of the implementation of this Bill, or any part thereof; and

(16) any other function necessary to fulfil rights and obligations as enunciated under this Bill.

Provided that every function of the National Health Council shall be carried within a decentralisation framework, such that the states and local bodies are empowered to their fullest without interreference in their public health functions.

Provided further that the National Health Council shall ensure effective coordination and national-level uniformity in designing of, and compliance with, standards, norms and prioritisation, equitable distribution and utilisation of resources, and shall provide financial, technical and human resource assistance, wherever needed for effective planning and implementation of the healthcare plans and programmes of the state governments.

Clause 65: Remuneration, Term and Removal of the all Members of Health Councils

(1) All members of Village, Block, District, State and National Health Councils shall be entitled to remuneration by the State as may be prescribed from time to time.

(2) All members of Village, Block, District, State and National Health Councils shall be appointed and removed as may be prescribed from time to time.

Clause 66: Constitution and Composition of the Committee for Realisation of Health in Prisons

(1) Each State Health Council shall, within 90 days of its constitution, establish a Committee for Realisation of Health in Prisons that is responsible for ensuring the enforcement of the provisions under this Bill with respect to the prisons within its jurisdiction.

Provided that no Committee shall be responsible for overseeing more than fifteen prisons within its jurisdiction, and the relevant State Health Council shall, in such cases, constitute more than one Committee for Realisation of Health in Prisons.

(2) The Committee shall consist of:

(a) one full-time Chairperson who shall have equivalent qualifications to a Judicial Member of the District Mediation and Conciliation Committee under Clause 83(2); and

(b) one member from civil society organisations who have a demonstrated experience in the field of public health, preferably with a focus on the health of incarcerated persons or other marginalised groups/individuals.

Provided that for the selection of the members under subclauses (a) and (b), the relevant State Health Council shall call for nominations from people through widespread advertisement within 15 days of this Bill coming into force.

Provided further that, from the nominations that have been received from the public, the final selection shall be made on the principle that they represent the interests of all classes of individuals to the best extent possible and have demonstrated experience as per the requirements of this sub-clause.

(3) The members of the Committee for Realisation of Health in Prisons shall be entitled to such remuneration by the healthcare establishment as may be prescribed from time to time.

Clause 67: Functions of the Committee for Realisation of Health in Prisons

The Committee for Realisation of Health in Prisons shall perform such functions as may be prescribed from time to time including but not limited to:

(1) meet at least once in three months, and no less than four times in one calendar year.
Provided that the Committee shall have its first meeting within 30 days of it being established.
Provided further that, during a public health emergency, the Committee shall meet at least once every month.

(2) act in accordance with, and ensure the full implementation of, the provisions of this Bill, and latest Manual for Realisation of Health in Prisons published by the Central Government;

(3) establish an independent mechanism for receiving complaints regarding the violation of their rights under this Bill, directly from the incarcerated persons in prisons within its jurisdiction;
Provided that the Committee shall establish a mechanism that protects the privacy and confidentiality of the incarcerated person's identity.

(4) anonymize the complainant and forward the complaints received from the incarcerated persons to the Committee, along with the latest report submitted on the public health conditions and infrastructure in the respective prison;

(5) conduct at least one survey visit every three months to each prison within its jurisdiction, and submit a report detailing its compliance with the provisions of this Bill and latest Manual for Realisation of Health in Prisons to the Committee at its next meeting;
Provided that, during a public health emergency, such visits shall be conducted at least once every 45 days; and

(6) establish a mandatory sensitisation and training programme for all prisons within its jurisdiction, with the purpose of acquainting all individuals living or working within the premises of the prison with the rights of incarcerated persons under this Bill and publishing the best public health practices as per the latest Manual for Realisation of Health in Prisons.

Clause 68: Publication of Manual for the Realisation of Health in Prisons

The National Health Council, within 90 days of this Bill coming into force, publish a Manual for the Realisation of Health in Prisons, in accordance with the United Nations Standard Minimum Rules for the Treatment of Prisoners, the provisions of this Bill, and the best available scientific knowledge relating to the medical needs of incarcerated persons in prison.
Provided that the National Health Council shall publish a revised and updated version of the Manual for the Realisation of Health in Prisons within two years from the publication of the previous edition, in accordance with the best available legal, public health, and medical guidelines.

Provided further that, in case of any conflict between the Manual for Realisation of Health in Prisons and the provisions of this Bill, the latter shall prevail in guiding the actions of the Committee and every prison within the territory of India.

Clause 69: Social Audit in Health Network Sector Planning

A community-based social audit mechanism for health networks and planning shall be established at every Village, Block and District Health Council, by the Central and State Governments, as prescribed.

Clause 70: Implementation of Health Policies and Programmes

(1) Notwithstanding any provisions of any law, all health plans and programmes that are planned, prepared and implemented at the national, state and local levels shall, in all circumstances, be subject to the provisions of this Bill.
(2) All existing implementing bodies and authorities at the national, state and local levels shall be accountable and shall report to their respective Health Councils, in such manner and within such time as may be prescribed.
(3) The functioning and tenure of the Health Councils and its members at the national, state and local levels shall be prescribed by the Central Government and State Governments.

Clause 71: Health Information Systems

(1) The Central Government shall facilitate, and coordinate the establishment, implementation and maintenance of health information systems in compliance with the provisions of this Bill, and to ensure the complete realisation of right to health, including but not limited to accessibility and quality of care at the:
    (a) national level;
    (b) state level, including at the sublevels of the:
        (i) state;
        (ii) district;
        (iii) block; and
        (iv) village.
    (c) healthcare establishments from the private healthcare sector, including non-≥ governmental organisations, charitable and missionary hospitals, and healthcare establishments.
(2) All data collected for the purposes of this clause shall be subject to the rights to privacy under clause 12.

CHAPTER VIII
REDRESSAL MECHANISMS

Clause 72: Constitution and Composition of the Office of Internal Complaints

(1) In addition to any internal redressal mechanisms required by any law, every healthcare establishment shall, within 90 days of this Bill coming into force, constitute the Office of

Internal Complaints, which shall be an independent authority located within the premises of the healthcare establishment.

Provided that where a healthcare establishment operates at more than one location, each such location shall have its own Office of Internal Complaints.

(2) The Office of Internal Complaints shall comprise of at least two Internal Complaints Officers and there shall be at least one Internal Complaints Officer present within the premises of the healthcare establishment at any given time.

Clause 73: Qualifications and Tenure of the Internal Complaints Officer

(1) An Internal Complaints Officer shall be an individual who:
    (a) is not employed by the healthcare establishment as a healthcare worker; and
    (b) has demonstrated experience in the field of public health; and
    (c) shall possess any other such qualifications as may be prescribed.

(2) An Internal Complaints Officer shall hold office for such a period, not exceeding four years, from the date of their nomination as may be specified by the healthcare establishment at the time of appointment.

Provided that the term of an Internal Complaints Officer may not be extended beyond a period exceeding two years by the healthcare establishment.

Clause 74: Jurisdiction of the Internal Complaints Officer

(1) The Internal Complaints Officer shall settle all complaints regarding:
    (a) the failure by a healthcare establishment to respect, protect and fulfil:
        (i). any individual's right to health and healthcare, as enumerated below:
            1) the right to sexual and reproductive healthcare goods, services and facilities;
            2) the right to life saving and emergency medical care and services;
            3) the right to essential pharmaceutical medicines, vaccines, devices and implants;
            4) the right to determinants of health within the healthcare establishment;
            5) the right to data protection;
            6) the right to confidentiality and privacy;
            7) the right to information and education;
            8) the right to explicit, autonomous and informed consent;
            9) the right to refuse healthcare services;
            10) the right to seek, enjoy and not be denied healthcare services;
            11) the right to die in dignity; and
            12) the right to refuse healthcare services, examinations and vaccinations during a public health emergency;
        (ii). any healthcare worker's rights under the provisions of this Bill.
    (b) a breach by the healthcare establishment of its contractual obligations under a contract with its healthcare workers or healthcare users.

Clause 75: Functions of the Internal Complaints Officer

The Internal Complaints Officers of every healthcare establishment shall:

(1) establish procedures for:
    (a) the investigation and settlement of all complaints;
    (b) lodging and recording all details of complaints;
    (c) categorising all complaints as either urgent or normal;
    (d) resolving urgent complaints within 24 hours; and
    (e) consulting the Medical Superintendent or any other healthcare worker of the healthcare establishment in case of complaints that require the input of a medical professional;
(2) establish an easily accessible mechanism by which all individuals seeking redress can contact an Internal Complaints Officer;
(3) display the name and contact details of the Internal Complaints Officers and the procedure for filing a complaint in a manner that is clearly visible to any individual entering the healthcare establishment;
(4) inquire into complaints in an objective, independent, efficient and comprehensive manner; and
(5) inquire into and mediate the issue arising out of a complaint between the parties to the complaint within five days.

    Provided that in the interest of justice, an Internal Complaints Officer may, if necessary for the provision of emergency or life-saving healthcare services, take such steps as may be necessary to ensure access to healthcare services on a complaint by a healthcare user or their caregiver without awaiting a response from the healthcare establishment.

Clause 76: Resignation or Removal of Internal Complaints Officers

(1) An Internal Complaints Officer may submit their resignation with reasons in writing to the healthcare establishment.
(2) In accordance with the other conditions of this provision, the Internal Complaints Officer shall serve a notice period of at least 30 days and ensure a smooth transition of work to the new Internal Complaints Officer such that there is no lapse in the right of any individual to seek redressal for violations of the provisions of the Bill.
(3) In accordance with the other conditions of this provision, , the Internal Complaints Officer shall conclude proceedings ongoing in the case of any pending investigations and complaints to ensure that there is no lapse in the right of any individual to seek redressal for violations of the provisions of the Bill.
(4) If any Internal Complaints Officer:
    (a) is convicted for an offence, or an inquiry into an offence under any law is pending against them;
    (b) is found guilty in any disciplinary proceedings, or a disciplinary proceeding is pending against them;
    (c) acquires such financial or other interests likely to prejudicially affect the performance of their functions; or
    (d) abuses their position so as to render their continuance in office prejudicial to public interest,

    such individual shall be terminated from their position as an Internal Complaints Officer by the healthcare establishment.

(5) In the event of resignation of an Internal Complaints Officer, the healthcare establishment will appoint a new Internal Complaints Officer with effect from seven days prior to expiry of the notice period of the resigning Internal Complaints Officer.
(6) In the event of termination of an Internal Complaints Officer, the healthcare establishment shall appoint a new Internal Complaints Officer within two days of such termination.

Clause 77: Training of Internal Complaints Officers

The healthcare establishment shall:
(1) within two days of appointment, provide training to a newly appointed Internal Complaints Officer under the provisions of this Bill;
(2) on an annual basis, organise sensitisation and capacity building workshops and awareness programmes for its Internal Complaints Officer;
Provided that such sensitisation and capacity building workshops and awareness programmes shall include marginalised individuals/groups.
(3) make available such information as any Internal Complaints Officer may require in deciding a complaint.

Clause 78: Remuneration of the Internal Complaints Officers

An Internal Complaints Officer shall be entitled to such remuneration by the healthcare establishment as may be prescribed from time to time.

Clause 79: Power of Office of Internal Complaints to Grant Relief

Where, an Internal Complaints Officer is satisfied that any act amounts to a violation of any provision under this Bill, they shall have the power to grant relief including but not limited to:
(1) settling dispute between parties to the complaint through the process of mediation and conciliation;
(2) issuing any such directions for compliance by the healthcare establishment and make such other recommendations as may be necessary for the complete realisation of the rights enumerated under this Bill; and
(3) awarding such just and fair compensation where an Internal Complaints Officer is satisfied that a complaint arises out of a situation where there is a *prima facie* violation under the provisions of this Bill.

Clause 80: Officers of the Office of the Internal Complaints

(1) The Office of the Internal Complaints shall be provided with officers and employees for the effective and timely execution of their duties.
(2) The appointment, conditions of service and remuneration of the officers and employees of the Office of the Internal Complaints shall be determined by the Internal Complaints Officers in consultation with the healthcare establishment.

Clause 81: Compliance with the Orders of an Internal Complaints Officer

(1) The directions issued by the Internal Complaints Officer shall be enforced by the healthcare establishment within 30 days.
Provided that in case of complaints categorised as urgent by an Internal Complaints Officer, the healthcare establishment shall comply with the directions of the Internal Complaints Officer within 24 hours.
(2) The healthcare establishment shall submit a report detailing the measures undertaken to comply with the directions of the Internal Complaints Officer within a period of 30 days from the date of receipt of directions.
Provided that in the event that the healthcare establishment fails to submit its compliance report to the Office of Internal Complaints upon the expiry of 30 days, the Office of Internal Complaints shall refer the complaint to the District Mediation and Conciliation Committee.
(3) In case an Internal Complaints Officer is of the opinion that the healthcare establishment has not fully complied with their directions issued under clause 79(2), they shall issue additional directions that shall be complied with by the healthcare establishment within seven days, and a failure to do so will result in referral to the District Mediation and Conciliation Committee.

Clause 82: Jurisdiction of the District Mediation and Conciliation Committee

A District Mediation and Conciliation Committee is empowered to inquire into and settle any violation of the provisions of this Bill that arise from:
(1) an original complaint filed by a Complainant (or in case of the Complainant's death, their caregiver) that has accessed the services of a healthcare establishment within its jurisdiction that does not have an Internal Complaints Officer;
(2) an original complaint filed by a Complainant (or in case of the Complainant's death, their caregiver) against the conduct of any Office of Internal Complaints within its jurisdiction;
(3) a referral by an Internal Complaints Officer within its jurisdiction, in accordance with the provisions of this Bill, including referrals arising from non-compliance of a direction by the healthcare establishment in which the Internal Complaints Officer is employed;
(4) a referral by parties to a complaint before an Internal Complaints Officer, where either party is dissatisfied with the settlement or directions issued by such officer;
(5) a *suo moto* cognisance of any systematic issues pertaining to the provisions of this Bill within its jurisdiction; and
(6) a complaint by a concerned organisation with proven *bona fide* credentials regarding the systemic violation of any of the rights of marginalised individuals/group under this Bill within its jurisdiction.

Clause 83: Constitution and Composition of the District Mediation and Conciliation Committee

(1) The Central Government, State Government, or Union Territory Government in case of a Union Territory having its own legislature shall establish, within 60 days of this Bill coming into force, redressal authorities within every district, hereon, referred to as the District Mediation and Conciliation Committee.
(2) The District Mediation and Conciliation Committee shall consist of:
    (a) one full-time Judicial Member, who shall be the Chairperson; and

(b) one full-time non-judicial members who shall be a representative of community-based organisations, Civil Society Organisations, people's organizations, or individuals working on health rights within the state.

Provided that the State Health Council shall call for nominations through widespread advertisement for the selection of the members within 15 days of this Bill coming into force.

(3) An individual shall not be qualified for appointment as the Judicial Member of District Mediation and Conciliation Committee unless they:
   (a) have been a Judge not below the rank of a District Judge; and
   (b) are trained in conducting mediations and/or conciliations.

   Provided that wherever applicable, the non-judicial member appointed to the District Mediation and Conciliation Committee shall be a marginalised individual or an individual belonging to a marginalised group and such individual shall be representative of the demographic composition of the District.

(4) The members shall hold office for a period of four years from the date of their respective nominations, which may be extended by a period not exceeding two years.
   Provided that the total tenure of the members shall not, under any circumstances, exceed six years.

(5) The members shall not hold any office of profit or be associated with the management or administration of the affairs of any party to a proceeding before the Committee for a period of two years from the date on which they cease to hold office.

Clause 84: Functions of the District Mediation and Conciliation Committee

The Committee shall:

(1) establish a procedure for:
   (a) the investigation, mediation, conciliation and just and fair settlement of all complaints and referrals;
   (b) lodging and recording all details of complaints referrals before the Committee;
   (c) categorising all complaints as either urgent or normal;
   (d) resolving urgent complaints within 24 hours; and
   (e) consulting individuals with expertise in case of complaints that require the input of a medical professional.

(2) establish an easily accessible mechanism by which all individuals seeking redress can approach the Committee.

(3) inquire into complaints in an objective, independent and comprehensive manner; and

(4) inquire into and settle a complaint in a timely manner, in any case within 14 days.
   Provided that in cases of an urgent complaint, in the interest of justice, the District Mediation and Conciliation Committee shall settle the complaint within 24 hours.

Clause 85: Functioning of the District Mediation and Conciliation Committee

(1) The District Mediation and Conciliation Committee shall not be bound by the procedure laid down by the Code of Civil Procedure 1908 (Act No 5 of 1908), but shall instead be guided by the principles of natural justice.

Provided that if the healthcare establishment fails to appear before the Committee on three dates of hearing, the Committee shall enter into a settlement *ex parte*.

(2) The State Government, Central Government or Union Territory Government in case of a Union Territory having its own legislature may make rules regulating the practices, and procedure of the District Mediation and Conciliation Committee, including:
    (a) the rules as to the procedure for hearing complaints, referrals, and
    (b) any such other matters as may be prescribed.
(3) The District Mediation and Conciliation Committee shall not be bound by the rules of evidence contained in the Indian Evidence Act 1872 (Act No 1 of 1872).
(4) The District Mediation and Conciliation Committee shall, for the purpose of inquiry and investigation under this Bill, have the same powers as are vested in a Civil Court while trying a suit under the Code of Civil Procedure 1908 (Act No 5 of 1908), in respect of the following matters:
    (a) summoning and enforcing the attendance of any individual and examining them under oath;
    (b) requiring the discovery and production of documents;
    (c) receiving evidence on affidavits;
    (d) subject to the provisions of clauses 123 and 124 of the Indian Evidence Act 1872 (Act No 1 of 1872), requisitioning any public record, document or copy, of such record or document from any office;
    (e) issuing commissions for the examination of witnesses, or documents; and
    (f) any other matter that may be prescribed.

Clause 86: Remuneration for Members of the District Mediation and Conciliation Committee

The members of the Committee shall be entitled to such remuneration as may be prescribed from time to time.

Clause 87: Officers of the District Mediation and Conciliation Committee

(1) The District Mediation and Conciliation Committee shall have such other officers as the members deem necessary for the effective and timely administration of its duties.
(2) The appointment and conditions of service of the officers and employees of the Office of the District Mediation and Conciliation Committee shall be determined by the members.
(3) The officers and employees of the District Mediation and Conciliation Committee shall be entitled to such remuneration as may be prescribed.

Clause 88: Provision of Assistance to the District Mediation and Conciliation Committee

(1) The District Mediation and Conciliation Committee may require the assistance of any officer of any department of the Government or a healthcare establishment in order to decide upon a complaint, and such officer shall be bound to render assistance in addition, and without detriment, to their official duties.
(2) The District Mediation and Conciliation Committee may utilise the services of any individual with expertise in public health in deciding the questions before it.

Provided that such individual shall be paid just and fair compensation by the State Health Council for the services rendered.

Clause 89: Resignation or Termination of Members of the District Mediation and Conciliation Committee

(1) The members may submit their resignation with reasons in writing in accordance with the rules thereunder.
(2) Where any member:
    (a) is convicted for an offence, or an inquiry into an offence under any law is pending against them;
    (b) is found guilty in any disciplinary proceedings, or a disciplinary proceeding is pending against them;
    (c) acquires such financial or other interests likely to prejudicially affect the performance of their functions; or
    (d) abuses their position so as to render their continuance in office prejudicial to public interest,

    the office of such member shall be terminated and the vacancy shall be filled in accordance with the rules thereunder.

Clause 90: Powers of the District Mediation and Conciliation Committee to Grant Relief

Where the District Mediation and Conciliation Committee is satisfied that a complaint or referral by the Internal Complaints Officer amounts to a violation under this Bill, they shall have the power to take the necessary steps including, but not limited to:

(1) in the case of a complaint or referral arising from a violation of the rights enumerated under this Bill, attempt to facilitate voluntary resolution of the dispute(s) by the parties, and communicate the view of each party to the other, assist them in identifying issues, reducing misunderstandings, clarifying priorities, exploring areas of compromise and generating options in an attempt to solve the dispute(s) and emphasise that it is the responsibility of the parties to take decision which affects them and shall not impose any terms of settlement on the parties;
(2) in the case of a complaint or referral arising from a failure to provide healthcare services; direct the relevant Village, Block, or District Health Council, as the case may be, to take necessary measures to ensure the protection of rights to health and healthcare of all individuals, in accordance with the AAAQ framework;

    Explanation: The power of the District Mediation and Conciliation Committee to make other recommendations shall include the power to direct the healthcare establishment, as the case may be, to submit regular reports regarding compliance with its orders.
(3) in the case of complaints or referrals arising out of an act(s) amounting to deficiency of service for which a remedy lies before the requisite consumer forum as prescribed by the provisions of the Consumer Protection Act, 2019 (Act No. 35 of 2019), and where such dispute cannot be settled by mediation, refer the case to the appropriate forum; and
(4) make such other recommendations as may be necessary for the complete realisation of the rights under this Bill.

Clause 91: Dismissal of Complaints or Referrals

After a preliminary investigation, if the District Mediation and Conciliation Committee is satisfied that:

(1) the complaint is frivolous, vexatious, or is not made in good faith;
(2) the referral made by the Internal Complaints officer does not warrant any further intervention;
(3) there is no sufficient ground to initiate medication or conciliation proceedings; or
(4) other remedies are available to the Complainant or Appellant, and it would be more beneficial for the Complainant or Appellant to avail of such remedies in view of the circumstances of the case,

it may dispose of the complaint or referral, after recording its findings and reasons in writing, and communicating the same to the parties to mediation.

Clause 92: Dispensing of Lawyer's Appearance and Waiver of Fees and Provision of Legal Aid

(1) There shall be no requirement for the parties to the mediation to engage lawyers to appear on their behalf before the District Mediation and Conciliation Committee; and
Provided that in cases where one of the parties to the mediation is a marginalised individual or an individual belonging to a marginalised group, or otherwise eligible to engage the services of the District Legal Service Authority as prescribed, the District Mediation and Conciliation Committee shall have the power to provide such individual with legal representation by engaging the services of the relevant District Legal Service Authority, if the party so desires.
(2) In cases where the one of the parties to the mediation is a marginalised individual or an individual belonging to a marginalised group, there shall be a waiver of filing fees, except a nominal amount of processing fee for the filing of complaints or referrals.

CHAPTER IX
OBLIGATIONS OF THE STATE

Clause 93: Specific Obligations of the State

(1) The State at all times is obligated to respect, protect and fulfil the rights enumerated in this Bill to the fullest extent and take necessary and sufficient steps, including the enactment or amendment of laws, within its respective jurisdictions to specifically address the following:
(a) recognise the right to health in a comprehensive manner through the enactment of laws, notification of rules and regulations, and bye-laws, and the adoptions of policies concerning the implementation of the right to health as enumerated under the provisions of this Bill;
(b) take necessary steps to ensure appropriate conditions for the enjoyment of the highest attainable standard of complete physical, intellectual, mental and social well-being, irrespective of any pre-existing conditions, by guaranteeing delivery of healthcare goods, services and facilities at the Village, Block, District, State, and National levels including the parallel urban framework;
(c) law down norms and standards, including the Indian Public Healthcare Standards to

assure that quality healthcare goods, facilities, and services are made available at the Village, Block, District, State, and National levels including the parallel urban framework;

(d) ensure that the healthcare infrastructure provides for comprehensive coverage of sexual and reproductive healthcare goods, facilities, and services, healthcare services for incarcerated persons and elderly persons, paediatric services for infants and children, especially in rural areas;

(e) establish the necessary infrastructure to provide for quality counselling and mental healthcare services , which shall include providing training and capacity building of mental healthcare professionals and healthcare workers within the territory of India;

(f) promote and encourage research and development;

(g) facilitate the dissemination of accessible information and educational material in multiple languages and formats;

(h) adopt measures to protect healthcare workers at the Village, Block, District, State, and National levels by providing standardised safety and protective equipment;

(i) ensure that healthcare services are provided in a culturally sensitive manner by conducting extensive trainings for healthcare workers to respond to the specific health needs of the marginalised individuals/groups;

(j) develop and introduce programmes that build capacities of individuals at the Village, Block, District, State, and National levels in order to enable every individual to make informed decisions with respect to their rights to health and healthcare;

(k) introduce policy measures and take such other steps as may be necessary to ensure that comprehensive sex education is integrated into the curriculum at all levels of education, including conducting trainings and capacity building of personnel to provide for such education;

(l) build and maintain infrastructure of healthcare establishment to ensure that healthcare facilities and services are accessible for persons with disabilities, including but not limited to visual, motor and auditory access;

(2) The State shall take necessary and sufficient steps to fulfil any other obligations that may arise under this Bill.

Clause 94: Financial Obligations of the State

(1) Notwithstanding anything contained in any law, the State shall take all necessary and sufficient steps within its respective jurisdictions for the following:

(a) undertaking appropriate financial measures and ensuring transparency in all budgetary decisions and measures and in allocation of funds and distribution of resources as per the provisions of this Bill;

(b) reduction of out-of-pocket expenses and elimination of catastrophic health expenses;

(c) prioritizing and increasing resource allocation to health and healthcare;

(d) decentralised planning and programming through consistent involvement of local communities; and

(e) special assistance to State Governments and local authorities for financial planning and management.

(2) The Central Government, State Governments and local authorities shall, within one year

of this law coming into force:

(a) incur expenditure to expand resources and facilities at the primary, secondary, tertiary and district levels in rural and urban areas to ensure acceptability, availability, accessibility and quality of healthcare;
Explanation: Any allocation and expenditure must be in accordance with evidence-based assessment of local needs and gaps in service delivery.

(b) adopt flexible and differential norms for allocating finances to ensure that states and local authorities can adequately respond to the physical, economic and socio-cultural needs of marginalised individuals/groups.
Explanation: Practices such as delay in financial devolution shall be eliminated and activities such as multi-year budgeting and flexible financing shall be promoted.

(3) Any budget allocation and expenditure shall be done pursuant to regular consultations with, and consistent involvement of, elected peoples' representatives and communities and shall be subject to monitoring by national, state and local Health Councils.

(4) The State shall ensure that no individual is denied available, accessible, acceptable and quality healthcare, including transportation to and from healthcare establishments, based on their inability to pay for their healthcare services.

(5) The State shall ensure available, accessible, acceptable and quality healthcare by, including but not limited to:

(a) increasing public financing as per the needs of the community;

(b) ensuring adequacy of financial resources for delivery of healthcare services; and

(c) formulating and implementing financing mechanisms that account for the inflation of the cost of healthcare goods, services and facilities.

CHAPTER X
MISCELLANEOUS

Clause 95: Bill to Have an Overriding Effect

Save as otherwise expressly provided, the provisions of this Bill shall have effect notwithstanding anything inconsistent therewith contained in any other law or in any instrument having effect by virtue of any law other than this Bill.

Clause 96: Power to Remove Difficulties

The Central Government and State Governments may repeal legislations inconsistent with the provisions of this Bill.

Clause 97: Protection of Action Taken in Good Faith

No suit, prosecution or other legal proceeding shall lie against the employees of the Central Government, the State Government, local authorities including the authorities established under this Bill or any member thereof or any officer or other employee or person acting under the direction either of the Central Government, the State Government, or any local authority, or in respect of anything which is done or intended to be done in good faith in pursuance of this Bill or any rules or guidelines made thereunder or in respect of the publication by or under the authority

of the Central Government, the State Government, or any local authority or authorities established under this Bill.

Clause 98: Delegation of Powers

The Central Government, State Government or a local authority, as the case may be, may by general or special order direct that any power exercisable by it under this Bill shall, in such circumstances and under such conditions, if any, as may be mentioned in the order, be exercisable also by an officer subordinate to that Government or a local authority.

Clause 99: Powers of Central Government to Issue Guidelines Under this Bill.

(1) The Central Government may, by notification, make guidelines consistent with this Bill and any rules thereunder, generally to carry out the provisions of this Bill.
(2) The appropriate Government may, by notification, make rules, for carrying out the provisions of this Bill.
(3) In particular, and without prejudice to the generality of the foregoing powers, such rules may provide for all or any of the following matters:
    (a) the Central Government may, by notification, make rules to carry out the provisions of this Bill;
    (b) the Central Government and State Governments may repeal legislations inconsistent with the provisions of this Bill;
    (c) the State Government may, by notification, make rules for carrying out the provisions of this Bill.

Provided that such rule making power shall be exercised by the Central Government and the State Governments in consultation with the civil society.

Clause 100: Powers of Appropriate Government to Make Rules Under this Bill.

(1) The Central Government or the State Governments, as the case may be, by notification, make rules, for carrying out the provisions of this Bill.
(2) In particular, and without prejudice to the generality of the foregoing powers, such rules may provide for all or any of the following matters, namely:—
    (a) giving effect to the provisions of this Bill, in particular the rights as enumerated under Chapters II, III, IV, V, and VI of this Bill;
    (b) altering the total membership strength of Block, District and State Health Councils under clauses 58, 59, and 61;
    (c) adding or amending the functions of the Village, Block, District, State and National Health Councils under clauses 60, 62, and 64;
    (d) the functioning, and tenure of membership, membership strength, and procedure for appointment and removal of members of the Block, District, and State Health Councils under clause 65;
    (e) the functioning, and tenure, and procedure for appointment and removal of members of the Village and National Health Councils under clause 65;
    (f) establishment of Social Audit for Health Networks at each Health Council at the Village, Block, District, State and National level under clause 69;

(g) establishment of Health Councils at the ward and Municipality/Municipal Corporation/Notified Area/Borough/Town Panchayat levels, as per the local urban needs and the latest National Urban Health Mission under clause 56(3), which will further have the power to lay down the functions, tenure, day to day functioning of such bodies;

(h) accountability, reporting and implementing mechanism through the existing bodies or authorities established under this Bill under clause 70(2);

(i) remuneration for members of all Health Councils and all members of District Mediation and Conciliation Committee including their officers under clauses 65 and 86;

(j) extension of period for reference to District Mediation and Conciliation Committee under clause 82;

(k) regulation of practices, procedure and jurisdiction of the District Mediation and Conciliation Committee under clauses 82 and 84;

(l) remuneration for the members of the Committee for Realisation of Health in Prisons under clause 66(3); and

(m) the functioning and tenure of membership of the Committee for Realisation of Health in Prisons under clause 67.

(3) As soon as any rule by the Central Government is made under this Bill, it shall immediately be placed before each House of Parliament while it is in session and if both Houses agree to modify the rule or to not enact a rule, such rule shall thereafter have effect only in its modified form or not have effect, as applicable.

Provided that each House of Parliament shall complete deliberation of any rule under this Bill over a period of 30 days and such 30-day period may be composed of one or more sessions.

Provided further that if deliberation of any rule under this Bill is not completed within one session, it shall be placed in the immediately following session.

Provided further that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

(4) As soon as any rule by a State Government is made under this Bill, it shall immediately be placed before the State Legislature while it is in session and if the State Legislature agrees to modify the rule or to not enact a rule, such rule shall thereafter have effect only in its modified form or not have effect, as applicable.

Provided that a State Legislature shall complete deliberation of any rule under this Bill over a period of 30 days and such 30-day period may be composed of one or more sessions.

Provided further that if deliberation of any rule under this Bill is not completed within one session, it shall be placed in the immediately following session.

Provided further that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

Clause 101: Power to remove difficulties

(1) If any difficulty arises in giving effect to the provisions of this Bill, the Central Government may, by order published in the Official Gazette, make such provisions that are not inconsistent with the provisions of this Bill as may be necessary for removing such difficulty.

Provided that every order made under this clause shall be laid as soon as may be after it is made before each House of Parliament.

(2) If any difficulty arises in giving effect to the provisions of this Bill, State Government may, by order published in the Official Gazette, make such provisions that are not inconsistent with the provisions of this Bill as may be necessary for removing such difficulty.
Provided that every order made under this clause shall be laid as soon as may be after it is made, before the State Legislature.

Notes on clauses

Clause 1. — This clause seeks to provide for short title, extent and commencement of the Bill.

Clause 2. —This clause seeks to provide the definitions of certain terms that have been used in various provisions of the Bill.
"Available", "accessible", "acceptable" and "quality" are the essential standards of the right to health. The definitions of these terms in the Bill have been adopted from General Comment No. 14: The Right to the Highest Attainable Standard of Health as part of Article 12 of the International Covenant on Economic, Social and Cultural Rights.
The definition of adolescent has been adopted from Section 2(i) from the Child and Adolescent Labour (Prohibition & Regulation) Act, 1986 as amended in 2016.
The definition of community participation has been adopted from Zakus JDL, Lysack CL., *Revisiting community participation* in HEALTH POLICY AND PLANNING (1998) (referring to the Declaration of Alma-Ata at the International Conference on Primary Health Care, 1978, which India has signed).
The definition of conversion practices has been adopted from the Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act, 2016 of Malta.
The definition of counselling has been adopted from the definition adopted by BACP (formerly known as the British Association for Counselling (BAC)) in 1986.
The definition of rare disease has been derived from the definition of "orphan drug" under the New Drugs and Clinical Trial Rules, 2018.

Clause 3. — This clause relates to individual's right to health and has been borrowed from the Constitution of the World Health Organisation adopted by the International Health Conference in New York on July 22, 1946. It seeks to provide for an all-encompassing right centring the well-being of the individual and is broader than the right to healthcare. Many other rights have been derived from the Patient Charter, 2019 of National Human Rights Commission General Comment No. 14 to International Convention on Economic Social and Cultural Rights adopted by the United Nations in 1966 and ratified by India on April 10, 1979.

Clause 4. — This clause relates to individual's right to healthcare. It seeks to provide for a comprehensive right based on the AAAQ framework that shall be accessible at every healthcare establishment. The AAAQ framework lays down the minimum set of standards necessary for ensuring delivery of healthcare services while upholding all ancillary rights of an individual.

Clause 5. — This clause relates to prohibition of discrimination on certain grounds that provide protections that are grounded in the rights enshrined under Part III of the Constitution of India.

Clause 6. — This clause relates to the protection of the right to live a dignified life, which has been held to be a constitutionally protected right in *Francis Coralie Mullin v. Administrator, Union Territory of Delhi* (AIR 1981 SC 746).

Clause 7. — This clause relates to the protection of rights of an individual in the domain of sexual and reproductive healthcare, which has been held to be a fundamentally protected right under the Constitution. It seeks to provide access to all forms of sexual and reproductive healthcare goods, services and facilities ranging from pregnancy care to testing for sexually transmitted infections. It also seeks to provide for access by adolescents to sexual and reproductive healthcare services while a police report or medicolegal report is pending.

Clause 8. — This clause relates to the provision of emergency and lifesaving healthcare services.

Clause 9. — This clause relates to essential pharmaceutical medicines.

Clause 10. — This clause relates to individual's right to determinants of health. It seeks to provide for multiple aspects such as food, water and housing that are fundamental to the realisation of the right to health under clause 3.

Clause 11. — This clause relates to confidentiality of a healthcare user.

Clause 12. — This clause relates to privacy of a healthcare user. It seeks to protect a healthcare user from disclosure of sensitive information without prior explicit, autonomous and informed consent.

Clause 13. — This clause relates to information and education. It seeks to provide all individuals with the right to information and education in an accessible manner and highlight the importance of access to accurate information for the realisation of the rights to health and healthcare.

Clause 14. — This clause deals with consent. It seeks to provide every individual with the right to provide explicit, autonomous and informed consent to ensure that all decisions concerning the health of an individual are vested with the individual, and where necessary, the caregiver of an individual.

Clause 15. — This clause relates to refusal of healthcare by an individual. It seeks to provide healthcare users the right to refuse healthcare services where the healthcare user makes an informed decision to do so.

Clause 16. — This clause relates to protection against denial of healthcare.

Clause 17. — This clause relates to having the right to die with dignity.

Clause 18. — This clause relates to inclusion of the general public in health planning mechanisms and any other policy instrument necessary for implementation of the provisions of this Bill. It seeks to provide inclusion of individuals from marginalised groups in health programmes and policies.

Clause 19. — This clause relates to the right to redressal as a right of every individual.

Clause 20. — This clause relates to clinical trials and research. It seeks to provide for rights of individuals participating in trials and research as defined under sub-clauses (e) and (h) of clause 2. It also seeks to provide for such processes to occur in accordance with established national and international standards.

Clause 21. — This clause relates to information. While clause 13 is a general right applicable to health as well as healthcare, this clause seeks to provide for a specific right to information on the various issues at a healthcare establishment at different stages.

Clause 22. — This clause relates to choice in treatments. It seeks to provide every healthcare user the right to exercise choice for the kind of treatment that they wish to seek, including alternative medicinal practices such as homeopathy, Siddha and Unani.

Clause 23. — This clause relates to choice in medical diagnostics.

Clause 24. — This clause relates to having the requisite information pertaining to a healthcare worker. It seeks to provide healthcare users with all the necessary information about their healthcare workers and the healthcare establishment. This clause explicit states that such information shall not be used in any prejudicial manner.

Clause 25. — This clause relates to continuity in care. It seeks to ensure that healthcare users' access to service is not interrupted owing to reasons such as change in geographical location or change of healthcare providers.

Clause 26. — This clause relates to discharge with dignity. It seeks to provide for the right of an individual to be discharged and receive their healthcare records.

Clause 27. — This clause relates to second medical opinion.

Clause 28. — This clause relates to referral and transfer from one healthcare establishment to another due to reasons including lack of capacity or resources.

Clause 29. — This clause relates to receiving body of a deceased person.

Clause 30. — This clause relates to safe environment. It seeks to protect the healthcare user against any form of harassment by a healthcare worker or establishment.

Clause 31. — This clause relates to caregiving services. It seeks to secure the right of healthcare users to access caregivers as defined under sub-clause (f) under clause (2).

Clause 32. — This clause relates the provision of services by a trained healthcare worker in a manner that is sensitive to the needs of a healthcare user.

Clause 33. — This clause relates to community-based practices. It seeks to protect the rights of individuals, particularly those belonging from marginalised groups to preserve their cultural and community-based practices and take into account their preferences for treatment using these practices.

Clause 34. — This clause relates to accessibility in healthcare establishments. It seeks to provide for accommodations for persons with disabilities to ensure all healthcare services and facilities are made accessible to them.

Clause 35. — This clause relates to protection against discrimination on the basis of certain characteristics pertaining to an individual's sexual orientation and gender identity/expression. It seeks to provide transgender, gender non-conforming, and intersex individuals the right to access gender affirming procedures and other healthcare services that they may require as well as protection against being subject to coercive practices.

Clause 36. — This clause relates to infants and children.

Clause 37. — This clause relates to elderly individuals.

Clause 38. — This clause relates to incarcerated persons. It seeks to secure the right to health and healthcare for incarcerated persons, which includes persons being detained in facilities that are not limited to prisons and ensure that there is adequate infrastructure in place for such individuals to avail all healthcare services within the facilities where they are being detained, and also the right to seek redressal for breach of their health rights.

Clause 39. — This clause relates to rare diseases. It seeks to protect the health rights of persons with rare diseases and also provide them with information, which includes information on mitigation, diagnosis and care for individuals with rare diseases.

Clause 40. — This clause relates to just and fair benefits for healthcare workers.

Clause 41. — This clause relates to habitable, safe, clean and humane work environment for healthcare workers.

Clause 42. — This clause relates to provision of appropriate and safe personal protective equipment for healthcare workers.

Clause 43. — This clause relates to a securing a harassment free work environment for healthcare workers.

Clause 44. — This clause relates to training and capacity building for healthcare workers.

Clause 45. — This clause relates to counselling for healthcare workers.

Clause 46. — This clause relates to decision-making and involvement of healthcare workers in planning and other schemes related to healthcare.

Clause 47. — This clause relates to compensation that is to be provided to the healthcare worker in cases of injury or death that is suffered during the course of employment.

Clause 48. — This is a non-obstante clause.

Clause 49. — This clause relates to prevention of repressive measures by the State during a public health emergency.

Clause 50. — This clause relates to provision of goods, services and facilities during a public health emergency.

Clause 51. — This clause relates to dissemination of information during a public health emergency.

Clause 52. — This clause relates to refusal of health care services in a public health emergency, including refusal to receive medicines and vaccinations.

Clause 53. — This clause relates to accessing transport services during a public health emergency.

Clause 54. — This clause relates to tracing of individuals during a public health emergency.

Clause 55. — This clause relates to monitoring. It builds on and strengthens the existing and the updated framework under the National Health Mission, the National Urban Health Mission and the National Rural Health Mission to provide for monitoring and accountability frameworks while ensuring community participation in governance of healthcare systems.

Clause 56. — This clause relates to community-based monitoring mechanisms. It seeks to provide for community based and participatory mechanisms at every level (that is, village, block, district, state and national levels and in the corresponding urban areas) to ensure monitoring and governance of health and healthcare related rights under this Bill.

Clause 57. — This clause relates to establishment of Village Health Councils.

Clause 58. — This clause relates to Block Health Councils.

Clause 59. — This clause relates to District Health Councils.

Clause 60. — This clause relates to functions of the Councils.

Clause 61. — This clause relates to State Health Councils.

Clause 62— This clause relates to functions of State Health Councils.

Clause 63. — This clause relates to National Health Councils.

Clause 64. — This clause relates to Functions of National Health Councils.

Clause 65. — This clause relates to remuneration.

Clause 66. — This clause relates to health in prisons. It seeks to provide for the composition of a committee dedicated to health rights to health rights of incarcerated persons in prisons.

Clause 67. — This clause relates to functions of the committee on health rights of incarcerated persons in prisons.

Clause 68. — This clause relates to publication of manual that shall be prepared by the National Health Council on health in prisons.

Clause 69. — This clause relates to Social Audit in Health Network Sector Planning.

Clause 70. — This clause relates to implementation. It seeks to provide for accountability of implementing bodies to the Health Councils.

Clause 71. — This clause relates to health information systems. It seeks to provide for establishment of health information systems at all levels, including at healthcare establishments.

Clause 72. — This clause relates to redressal mechanisms. It seeks to provide that every healthcare establishment referred to in sub-clause (k) of clause 2 shall designate such person, as it deems fit, as the Internal Complaints Officer who shall, on a day-to-day basis, deal with complaints of violations of the provisions of this Bill in the healthcare establishment, in such manner as may be prescribed.

Clause 73. — This clause relates to qualifications and tenure of the Internal Complaints Officer.

Clause 74. — This clause relates to jurisdiction of the Internal Complaints Officer.

Clause 75. — This clause relates to functions of the Internal Complaints Officer. It seeks to provide for adjudicatory as well as mediatory mechanisms in relation to any complaint that the officer may receive from a healthcare user or the healthcare establishment.

Clause 76. — This clause relates to resignation or removal of Internal Complaints Officers.

Clause 77. — This clause relates to training of Internal Complaints Officers.

Clause 78. — This clause relates to remuneration of the Internal Complaints Officers.

Clause 79. — This clause relates to power to grant relief by Internal Complaints Officers.

Clause 80. — This clause relates to staff of the Office of Internal Complaints.

Clause 81. — This clause relates to compliance with orders of Internal Complaints Officers.

Clause 82. — This clause relates to jurisdiction of the District Mediation and Conciliation Committee.

Clause 83. — This clause relates to establishment of District Mediation and Conciliation Committee, which shall be composed of a Judicial Member and a Community Member.

Clause 84. — This clause relates to functions of the District Mediation and Conciliation Committee.

Clause 85. — This clause relates to functioning of the District Mediation and Conciliation Committee.

Clause 86. — This clause relates to remuneration of members of the District Mediation and Conciliation Committee.

Clause 87. — This clause relates to officers of the District Mediation and Conciliation Committee.

Clause 88. — This clause relates to provision of assistance to the District Mediation and Conciliation Committee.

Clause 89. — This clause relates to resignation or termination of members of the District Mediation and Conciliation Committee.

Clause 90. — This clause relates to the powers of the District Mediation and Conciliation Committee to grant relief.

Clause 91. — This clause relates to dismissal of complaints or referrals by the District Mediation and Conciliation Committee.

Clause 92. — This clause relates to provision of legal aid and waiver of fees.

Clause 93. — This clause relates to the general obligations of the Central Government, the State Governments and the local governments for implementation of rights under this Bill.

Clause 94. —. This clause relates to financial obligations of the Central Government, the State Governments and the local governments for implementation of rights under this Bill. It seeks to provide for a minimum financial commitment that the Central Government shall especially fulfill without which the realisation of the rights under this Bill would not be possible.

Clause 95. — This clause relates to specific obligations of the Central Government, the State Governments and the local governments for implementation of rights under this Bill. It seeks to provide for a minimum financial commitment that the Central Government shall fulfill without which the realisation of the rights under this law would not be possible.

Clause 96. — This clause relates to the protection against any civil or criminal liability of a healthcare worker for an act done in good faith.

Clause 97. — This clause relates to the delegation of powers.

Clause 98. — This clause provides for the power of Central Government to make rules under this Bill.

Clause 99. — This clause provides for the power of State Governments to make rules under this Bill.

Clause 100. — This clause provides for power to remove difficulties.