

# Developing an approach towards Social Accountability of Private Healthcare Services

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(Support for Advocacy and Training to Health Initiatives)

With

COPASAH  
(Community of Practitioners on Accountability and Social Action in Health)



December 2013

With support from  
Open Society Foundations



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- Theories of change in community monitoring
- Tracking and assessing progress and evaluating impacts
- Role and ethics of facilitating organizations: putting people center-stage

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**SATHI** is the action centre of Anusandhan Trust based in Maharashtra state of India. In pursuit of the goal of “Health for all,” SATHI works to strengthen coalitions at local, state and national levels towards ensuring universal access to quality health services in a rights-based framework. Presently SATHI’s work spans three major areas: 1) Community based monitoring – as the state nodal organisation in Maharashtra, SATHI implements community based monitoring and planning with support from the National Rural Health Mission (NRHM), in collaboration with 25 partner civil society organisations. 2) Patient’s rights and social accountability of private medical sector - the SATHI team has played a pioneering role in promoting patients rights in the private medical sector in Maharashtra over the last decade. 3) Health system research and related advocacy – SATHI conducts research on areas like access to Health care and Health related inequities, procurement and availability of medicines, utilisation of flexible funds, malnutrition, etc. SATHI is presently coordinating policy research to propose a Public-centred system for Universal health care in Maharashtra.

For more information about SATHI, see [www.sathicehat.org](http://www.sathicehat.org)

**Acknowledgements:** Thanks to colleagues in SATHI who have contributed to the work based on which this paper has been written, and to various activists in Jan Arogya Abhiyan (People’s Health Movement – Maharashtra) with whom we have collaborated while developing accountability of private healthcare services and patients’ rights in Maharashtra. The authors acknowledge support from Open Society Foundations for this work.

**Cite as:** Phadke, A., More, A., Shukla, A. & Gadre, A. (2013). Developing an approach towards Social Accountability of Private Healthcare Services. SATHI, India and COPASAH

## **Developing an approach towards Social Accountability of Private Healthcare Services**

The paper will mainly deal with social accountability of private healthcare services in developing countries, with a focus on India as an example. The idea of social accountability of private healthcare services will be discussed as follows-

- Firstly, the rationale and perspective related to need for social accountability of private healthcare services
- Secondly, propositions about likely steps and processes by which social accountability of private healthcare services could be developed in developing countries
- Thirdly, examples of some efforts made towards building social accountability of private healthcare services in developing countries and lessons learnt from them.

### **1) Rationale and perspective**

The paper will explore key common features of the current nature of private healthcare sector across most developing countries e.g. chaotic, 'market' driven character with lack of regulation or grossly inadequate regulation, substantial irrationalities in care provision, lack of protection of patient's rights, lack of social accountability, lack of grievance redressal mechanisms etc. It is important to look at the private healthcare sector through a community lens, to understand how it is or is not meeting community health needs.

Subsequently, analysis of the qualitatively different nature of private healthcare sector from the public health system, from the point of view of accountability, will be presented. Various possible steps for developing accountability of private healthcare services will be discussed in brief. The need for social accountability mechanisms in the context of current failure of self-regulation by medical professionals, and weaknesses of existing state regulation mechanisms, leading to perceived accountability deficiency in private healthcare services will be discussed.

Given the role of citizen's action and social pressure in accountability processes, its limitations in case of private healthcare services in absence of legal regulation will be discussed, along with the need for legal framework for regulation.

### **2) Some steps and processes to move towards social accountability of private medical sector**

We will discuss in detail some steps and processes by which progressively, private healthcare services could be made more accountable to society. These steps and processes will be at the level of suggestions and propositions. Obviously there cannot be any uniform solution/approach to such a process, and the socio-economic-political situation in different countries will have a major role in shaping such processes. However, the paper will try to outline some possible options for action as follows:-

- Documentation of problems in the private medical sector from the viewpoint of users and voicing public demand for regulation
- Organised campaigns and dialogue around key issues like patients rights in context of the private medical sector
- Active role of citizens organisations in monitoring Public Private Interactions (PPIs) and Universal Health Care systems involving private medical services
- Demanding Grievance redressal mechanisms related to the private medical sector
- Need for involving pro-people professionals in regulatory processes related to formulating minimum standards, treatment protocols etc.

Based on such possible steps, the proposal of '*multi-stakeholder social regulation*' (involving healthcare professionals, the state and civil society organisations) of private healthcare services will be discussed. The vital role of the state in this proposed mechanism, and its qualitative difference from typical bureaucratic regulation would be emphasized in the paper. The issue of representation of 'public interest' in such 'multi-stakeholder social regulation' processes, and the challenge of 'process capture' by one or more powerful vested interests will be examined.

### **3) Case studies of specific efforts in India and Brazil**

In some countries civil society organisations, health activists, sections of pro-people medical professionals and the public at large have made significant efforts towards making private healthcare services more accountable to society. Although some of these initiatives may have more effective than others, these efforts can give us glimpses about actual actions which might be taken in this direction. The lessons learnt from both their success and failure could be useful for shaping advocacy towards social accountability of private healthcare services. This paper will focus on case studies from India and Brazil as examples of such efforts, and lessons that could be learnt from them.

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## **I. Rationale for Social Accountability of Private Healthcare Services**

Barring some exceptions like Cuba and Sri Lanka, Private Healthcare Services form a large component of Health Care Systems today in most developing countries. For example, the share of the private sector in various components of health care in India is as follows-

- Medical graduates: 90%
- Post-graduate doctors: 95%
- Outpatient care: 80%
- Inpatient care: 60%
- Medical colleges: 30%
- Manufacture of medicines: 99%
- Manufacture of medical instruments: 100%<sup>1</sup>

The private medical sector in developing countries has grown considerably since the onset of 'Structural adjustment' and neoliberal policies in the 1980s and 1990s. The trajectory of the private medical sector in India and its key features are briefly traced here to exemplify how such processes of unregulated proliferation of private providers have unfolded.

Following Independence, the Indian government embarked upon substantial expansion of Public Health Facilities, especially in rural areas. Thus Primary Health Centres were opened in progressively increasing numbers all over India. But at the same time, there was also unregulated growth of the private sector. Hence majority of patients continued to be serviced by the private practitioners and their proportion compared to doctors in the Public Health Services continued to increase. This is especially true after the increase in production of post-graduate doctors since 1980s, who progressively overshadowed the 'general practitioners' and began to set up private hospitals and 'nursing homes'. With increasing adoption of neoliberal economic policy by the Indian government since the early 1990s, the number of private medical colleges as well as corporate hospitals increased much more rapidly. In pharmaceutical production, whatever small but significant role that pharmaceutical units in the Public Sector played was progressively undermined after the 1980s, and the role of these manufacturing units declined even in absolute terms. The unrestrained, unregulated expansion of the private sector in all branches of health care, especially

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<sup>1</sup> Universalising Health Care for All, Jan Swasthya Abhiyan, November, 2012

since 1990s, combined with relative lack of growth of public systems, has thus resulted in the above situation of all encompassing predominance of the private sector. This growth of the private sector has led to setting up of some 'elite hospitals', but these form one end of a wide spectrum of private providers, which include smaller nursing homes and semi-qualified and unqualified practitioners, overall characterized by complete lack of regulation. Today the private medical sector is riddled with many problems and unhealthy features, which have become an obstacle in making full use of the resources in the health sector efficiently and appropriately to reach the goal of 'Health and Health Care for All', to which Indian government committed itself in the renowned Alma Ata conference in 1978.

Social regulation and social accountability of the private health sector would considerably facilitate overcoming of these problems, and sections of regulated private providers could help contribute to reaching the goal of 'Health Care for All'. The need for social regulation and social accountability of the private health sector arises on three counts, which would be argued in subsequent paragraphs –

1. Wide-spread irrational practices in the private sector leading to huge wastage of money spent by the patients and linked to their exploitation, something people in developing countries like India can ill afford.
2. Substandard care, violation of medical ethics and of patient's human rights
3. In real terms, given the underlying socialized nature of private health-care in the 21<sup>st</sup> century, it's formal 'private' character getting progressively outdated.

#### **1. Excessive, wasteful and costly irrational practices in the private sector**

##### *a. Massive wastage due to excessive/irrational medications –*

Various studies have reported significant extent of unnecessary use of medicines by private practitioners. Unnecessary use of antibiotics, vitamins, irrational Fixed Dose Combinations (FDCs), medicines with no or doubtful value etc. constitute a huge wasteful expense for patients. Out of the annual sale of medicines of about Rs. 600 billion (approx. USD 10 billion) in India, about one third are considered to be irrational.<sup>2</sup> This amount of Rs. 200 billion may be compared with the estimate of the High Level Expert Group of the Planning Commission that Rs. 300 billion (approx. USD 5 billion) would be sufficient to achieve the objective of 'Medicines for All' i.e. providing free essential medicines for all patients in a Universal Health Care System in India.

Irrational use of medicines takes place broadly at two levels. Firstly, practitioners of traditional systems of medicine and homeopathy are trained only in their respective disciplines and are by and large not formally trained in modern medicine. Yet most of them use modern medicines, though this '*cross-practice*' is patently illegal. A large proportion of them practice in rural areas, and due to scarce presence of qualified practitioners of modern medicine in rural areas, the society at large has accepted this illegal practice. Since their knowledge of modern medicine is perfunctory, (they acquire it informally by working as assistants in modern medicine clinics/hospitals) their practice is often quite irrational, though usually at a lower level of technical sophistication. Secondly, even doctors trained in modern medicine frequently over-prescribe or irrationally prescribe medicines like antibiotics, steroids, vitamin preparations and 'tonics', cough syrups, unnecessary drug combinations etc. This includes overuse or misuse of higher end antibiotics and other expensive 'me-too' brands, for which cheaper and equally effective rational equivalent drugs may be available. Pharma companies are able to 'convince' both kinds of doctors about the need to use the 'latest' medicines which these companies market, by means of dubious marketing techniques and incentives, though their superiority or relevance may not have been adequately

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<sup>2</sup> Pharma Policy 2012 and Its Discontents, S Srinivasan, Anant Phadke, Economic & Political Weekly January 5, 2013 vol xlviii no.1 EPW

established. Doctors are induced to use so called 'new' medicines many a times for conditions for which their use has not been approved on a scientific basis. All this has continued for decades and yet Medical Councils and Medical Associations have completely failed to control this.

***b. Unnecessary use of injections/intravenous fluids and surgeries***

In rational outpatient care, generally not more than 5% of patients require injections. But in many developing countries including India, majority of the general practitioners indulge in unnecessary use of injections. In India a study by SATHI of outpatient clinics in a sample of villages in various parts of Maharashtra in 2006-07 found that on an average 62% of outpatients received an injection - 40% of urban patients and 73% of rural patients. In case of less educated patients and patients in tribal areas this proportion was 80% and 86% respectively.<sup>3</sup> Many general practitioners misuse for personal gains, the popular misconceptions that injections have almost magical properties, that injections are necessary and more effective in any illness and so on. Similarly many general practitioners misuse intravenous saline/glucose infusions and propagate the mistaken belief that it has fantastic therapeutic properties and provides 'strength' to the patient. They use this infusion when not indicated, and thereby find a pretext to charge patients excessively.

Doing surgical procedures even when they are not necessary has been an increasing trend. The classic example is that of non-indicated removal of uterus (hysterectomy) which has been reported by studies from different parts of India.<sup>4,5</sup>

The fees charged by surgeons are also unreasonably high because of the mystification and aura around surgery in the minds of the ordinary people. A caesarean delivery which takes half to one hour is charged an amount in India which amounts to several times the monthly per capita income; the same holds true for an angiography, an invasive investigation performed by an interventionist cardiologist. It may be noted that when a physician treats a patient of heart attack for half an hour, s/he does not usually charge in thousands though his/her knowledge, training, skill and the criticality of his/her intervention is no less than that of a surgeon/interventionist. The latter charge exorbitantly by misusing the aura that surrounds surgical interventions.

***c. Excessive laboratory investigations***

With the advent of corporate interests in health-care, the tendency of carrying out excessive laboratory investigations has increased. Large private diagnostic centres and corporate hospitals while 'educating' doctors about certain new technologies, mislead them by dishing out half-truths about these interventions and often also directly, indirectly bribe them so that these doctors would refer patients to these centres/hospitals in exchange for a commission.

It may be noted that traditionally in general practice, investigations were often done in lower proportion compared to what was rationally required. This is because firstly they have been comparatively costly compared to the purchasing power/willingness of the patient to pay for these. Secondly the general practitioners would prefer to earn by treating patients through use of non-specific 'shotgun' therapy, i.e. by using many different medicines based on some guess work-diagnosis, and earning more by charging for medicines at inflated rates, or by unnecessary use of injections and intravenous infusions as mentioned above. However during the last decade, some purely commercial pathological laboratories and diagnostic centres have developed aggressive marketing strategies, and have lured general practitioners into referring patients for unnecessary investigations, in exchange for commissions.

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<sup>3</sup> SATHI study on Health care utilization and expenditure in Maharashtra, 2012

<sup>4</sup> Aarogyasri Healthcare Model: Advantage Private Sector - Rajan Shukla, Veena Shatrugna, R Srivatsan. Economic and Political Weekly, December 3, 2011 vol xlvi no 49.

<sup>5</sup> Chhattisgarh doctors remove wombs at random to claim insurance: Hindustan Times, July 17, 2012

The ubiquitous nature of various irrationalities mentioned above in private health care make a strong case for social regulation of the private health care sector, since self-regulation is almost non-existent and patients are paying a heavy price for unregulated and often irrational care.

## **2. Substandard care, violation of medical ethics and of patient's rights**

Although some private providers in India maintain certain standards (particularly related to infrastructural aspects) in their facilities, the quality of care is not uniform; on the whole it is often substandard. Medical Councils and Medical Associations have completely failed in instituting self-regulation to ensure standards. What is worse, they have not even made significant attempts in this direction. It is only recently, since 2010 that Medical Council of India or MCI (the regulatory body empowered by the constitution to ensure standards and ethics in among allopathic doctors) has made earning Continuing Medical Education (CME) credits mandatory so that medical practitioners must periodically update their knowledge. However, there is no monitoring, evaluation of this CME requirement and it is quite doubtful whether this new compulsion has improved *quality of care*.

It is not enough to make CME mandatory. Medical councils should formulate Standard Treatment Guidelines (STGs) for doctors to follow. In absence of any worthwhile CME and STGs, the prescriptions of doctors for even killer diseases like tuberculosis are often irrational. For example, a study by Uplekar et al in Mumbai on prescriptions of doctors for tuberculosis found that despite the availability of Standard Drug Treatment Regimes prepared by the WHO and the by the National Tuberculosis Control Programme, out of 106 doctors, only 6 gave the correct prescription! When the same study was repeated after 20 years, they found that there has been virtually no improvement in this scenario!<sup>6</sup>

The pharmaceutical industry has played a crucial corrupting influence on the medical profession. Medical Ethics demands that given the inherent vulnerability, helplessness of the patients, it is the doctor's duty to consciously keep patient's interests uppermost. But this ethical principle is routinely flouted by indulging in excessive/irrational use of medicines as mentioned above. Commercial competition and the drive to mint money at the expense of vulnerable people has led to increasing prevalence of other irrationalities, malpractices, also mentioned above. As we have 'progressed' from the 20<sup>th</sup> to 21<sup>st</sup> century, hundreds of thousands of sex-selective abortions to eliminate female fetuses have been performed in India by doctors during the last two decades, by misusing sonography. Medical Councils and Medical Associations have completely failed in instituting any self-regulation to ensure medical ethics. Now commercial surrogacy has become a new method of misuse of new reproductive medical technology. It is considered unethical, illegal in many developed countries, but so far it is 'official' in India, and many doctors are helping the rich people to exploit the reproductive capacities of poor women in India.

Using patients as guinea pigs by violating medical ethics of clinical trials has surfaced as a new addition to the list of unethical practices. The revelations during the Public Interest Litigation launched in 2012 by the Swasthya Adhikar Manch (Health Rights Forum) in India have brought forward the grossest violation of medical ethics in clinical trials in the country.<sup>7</sup>

Thus violation of medical ethics has been an important feature of medical practice in India, and Medical Councils and Medical Associations have completely failed to stem this rot.

Leaving aside the issues of rationality of medical practice and excessive charges levied, patients get a raw deal from private practitioners on at least two further counts—

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<sup>6</sup> Udawadia ZF, Pinto LM, Uplekar MW (2010)- Tuberculosis Management By Private Practitioners in Mumbai, India: Has anything changed in two decades? PLOS ONE 5 (8): e12023. doi: 10.1371/journal.pone.0012023

<sup>7</sup> Swasthya Adhikar Manch, <http://www.unethicalclinicaltrial.org>

- a. A lot is lacking especially in smaller hospitals in providing **basic minimum infrastructural facilities** to patients in terms of cleanliness, adequate space, privacy and sufficient trained paramedical staff.<sup>8</sup>
- b. **Patient's human rights** are violated to a substantial extent. For example, the right to emergency care, right to information, right to informed consent, right to second opinion, right to refusal of specific treatment, etc are violated quite frequently. Human rights are also often violated by undermining human dignity of patients, by not respecting patient's privacy or not keeping confidential the identity of the patient, from those who are not involved in patient's treatment. The dead body of a deceased patient might not be handed over to the relatives, until the full payment of all expenses has been made to the hospital. Patients might be coerced into buying medicines from a specific medical store in the hospital premises at hiked up prices, compared to buying the same medicines at lower cost from any other medical store.

Although there have been some welcome initiatives to foster a voluntary policy of commitment to respect patient's rights in some private health care services, the experience summarised in the later sub-section shows that self-regulation generally has not worked in private health care, in absence of a broader policy and legal framework. Widespread violation of standards, ethics and patient's human rights mentioned above in private health care implies that **social regulation of private health care is essential and overdue**, especially since self-regulation is either almost non-existent or has failed miserably at the expense of the interests, lives and health of patients.

### **3. Increasingly socialized nature of private health care in real terms**

Lastly, we would argue below that the rationale for social accountability and social regulation of private health care is derived from the fact that though the ownership and profits are private, in terms of key inputs like knowledge and skilled humanpower, in the 21st century private health care has been significantly socialized.

It is to be noted in the 21<sup>st</sup> century, key ingredients of the modern health care system - production of medical knowledge, training of health care providers and medical research have been socialized in the sense that medical sciences are not guided primarily by personalised understanding of health and health care. The very nature of modern medical science, technology and organization of health care is such that health-care decisions should follow socialized medical sciences and should not be constrained by personalized understanding of health and health care. This is in contrast to the olden times, when the traditional practitioners based themselves on their personal knowledge, and knowledge was passed on to them in person by more experienced practitioners. Today medical practice is not based primarily on personalized knowledge and experience, but is mostly based on research that has been done throughout the world largely with public funds. Similarly production of diagnostic, preventive and therapeutic modalities (whether medicines or others like imaging techniques or vaccines) have also been socialized; their production is based on social research and norms prepared at social level.

Given this background, in the current era, it is necessary that private providers follow scientific guidelines and protocols similar to those that doctors in Public Health Facilities are supposed to follow. Overall *in terms of the content of health care, there is very little 'private' in private health care*. What is private are the ownership of facilities, the profit generated through operation of the facility, and terms of contractual relations between patients and doctors. Hence there is overdue *need to socialise the socio-economic organisation of health care* in line with the already socialized

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<sup>8</sup> Bhate-Deosthali, Padma and Khatri, Ritu. Healthcare in the Private Sector: A Study of Private Hospitals in Maharashtra. Mumbai: CEHAT, xv,136 p., 2011



nature of its content; a key step in this direction is to institutionalize social regulation of the quality of private health care.

Further, now even in developing countries like India, the bills of private medical providers are increasingly being directly paid for, or reimbursed by the government through various schemes. These schemes have been subjected to major critique on a variety of grounds, and there are substantial arguments that these should be either scrapped or significantly transformed and merged into public health system centred provisioning systems. However since today so much public money is being paid to private hospitals in such schemes through contractual arrangements, there must be parallel social regulation of the rationality and quality of health care provided by private hospitals in these schemes, as part of the larger move towards regulation of the private medical sector.

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## **II. Some steps and processes to move towards social accountability of Private healthcare services**

In this section, we shall discuss in some detail some of the steps and processes by which, in a stepwise manner, private healthcare services could be made more accountable to society. These steps and processes will be at the level of suggestions and propositions. Recommending a uniform global approach would not be appropriate, and the socio-economic-political situation in different countries and contexts will have a major role in shaping such processes. However, some key actions in this direction could be as follows:-

### **1) Bringing private healthcare related issues into the public domain by exposing and documenting irrationalities, overcharging and other malpractices in the private medical sector**

So far the private healthcare sector has not been subjected to much public scrutiny in most developing countries, as compared to the public health system. Although there may be innumerable 'anecdotes' of negative experiences with private providers, the malpractices, irrationalities, exorbitant costs, denial of patient's rights, degradation of medical ethics, ill effects of corporatization of healthcare need to be formally documented in detail for public information, to stimulate powerful public action. These issues need to be brought up in the public domain with evidence. This could be done through-

- ✓ Formally documenting and publicizing major problematic experiences of patients through print and electronic media (after examining the relevant medical facts of each case with the help of teams of pro-people doctors)
- ✓ Conducting surveys related to private healthcare and releasing their findings in print and visual media
- ✓ Various booklets, pamphlets, posters addressing these issues could be prepared and distributed widely for public awareness. Findings of research papers on these issues could be converted into popular publications
- ✓ Awareness meetings can be conducted with various sections of society e.g. community organisations, middle class citizens, students, trade unions, and other civil society activists to sensitize them about the situation in private healthcare.

Thus private healthcare related issues can be brought under public scrutiny. Once they become 'publicly important issues' then it is relatively easier for civil society activists and ordinary people to demand social accountability of private healthcare.

## **2) Challenging the monopoly of medical professionals over regulation; asserting the role of patients as important stakeholders and organizing campaigns for patient's rights**

The failure of the medical community to self-regulate their profession and the often dysfunctional status of such self-regulatory mechanisms (in most developing countries) should be highlighted in the public domain. Secondly, monopoly of doctors over regulation i.e. exclusive self-regulation should be challenged through public forums, and attempts should be made to establish the role of patients as an important stakeholder in ensuring accountability of private healthcare services. This can be done by organizing campaigns for patient's rights (mentioned earlier), demanding legal enactment of patients' rights and formulating patients' rights committees, forums for such purposes.

Experience shows that compared to the somewhat technical issue of regulation of private providers, the *issue of patients' rights in private hospitals has a broader appeal and common people can easily relate with it*. Public programmes can be organized to campaign for patient's rights. For example, denial of patient's rights in specific cases can be documented and such testimonies of denial could be presented in a public convention, where civil society organisations, citizens, media, along with representatives from doctors' associations and hospital associations would participate. After presentation of 'denial testimonies', various social actors can effectively demand observance of patient's rights in private hospitals. Representatives of private hospitals should be invited to take a stand on this issue on public platforms. Experience shows that when representatives of private practitioners and hospitals face public pressure, then they tend to agree to observe patient's rights in their hospitals, clinics. Publicity through the media can create further positive impact.

Similarly, campaigns can be organized regarding the rights of people living with HIV/AIDS in context of private health facilities, since discriminatory treatment given to people living with HIV/AIDS is quite a well known fact, and it is an issue that can attract significant social support.

Patient's rights forums can conduct dialogue with various private hospitals, doctors' associations regarding observance of patients' rights. By mutual dialogue, misunderstandings could be resolved and a section of doctors who believe in reasonably ethical, rational practice could be won over to the side of patients and civil society, on the issue of respecting patients' rights.

## **3) Emphasizing the 'public good' nature of healthcare services, highlighting market failure in healthcare and need to negate 'market' logic of healthcare**

Healthcare should be viewed as a 'right' rather than as a commodity and hence as a 'Public good' rather than a private service. This should be emphasized while creating public awareness through various meetings, campaigns and publication materials. The neoliberal perspective which views healthcare purely as a commodity should be challenged in all possible ways. The 'public good' nature of healthcare also demands that whosoever may be the provider of healthcare (public system or private hospital), every provider should be accountable to society in a systematic manner.

## **4) Creating entry-points for social activism regarding the private healthcare sector; mobilizing public pressure to demand effective regulation of private healthcare**

Once the status of services, irrationalities, and patient's rights violation in private sector have been well documented, sufficient 'evidence' is generated and has been brought into the public domain through various means, then attempts can be made to create or find existing entry points for social activism. Appropriate laws, administrative orders, court judgments, existing public subsidies for private providers could be some of these entry points. Once such entry points are

identified, then social pressure and advocacy can be developed to promote related action. Attempts can be made to mobilize more sections from the society to demand effective regulation of the private healthcare sector. This strategy could help in creating public awareness and demanding further accountability, as seen from the example in the state of Maharashtra in India, regarding the Bombay Nursing Home Registration Act (BNHRA) 1949. It is an old and outdated act, yet the People's Health Movement (PHM) in Maharashtra tried to create a small space to further patient's rights by campaigning for its amendment and later on for approval of rules under the amended law. It mobilized various social activists, civil society organisations, newspaper editors for the campaign related to BNHRA.

If the existing regulatory structures are rudimentary or insufficient, then one can demand creation of new regulatory structures and strive to create spaces for civil society bodies like 'patient's rights forum' in these new structures. BNHRA which is a rather rudimentary act, served as a background for formation of new, improved Clinical Establishment Act at the Union Government level.

Public Interest Litigation (PIL) in the courts could be another way of demanding accountability processes. For example, such litigation was filed in the Delhi High court related to lack of observance of obligations to provide free beds to poor patients by so called 'Charitable' hospitals. Most of these hospitals, although registered as 'Charitable trusts' in order to avail of substantial public subsidies and cheap land in prime areas, have been functioning in an entirely commercial manner. Though they are obliged to reserve a proportion of their beds to treat poor patients free of charge, they had not been doing so. The PIL filed in this regard resulted in substantial orders being issued by the court, requiring the errant hospitals to provide treatment to poor patients more effectively.

#### **5) Public financing of private health-care demands social accountability**

Increasing numbers of developing countries are resorting to arrangements involving public funding for care given by private providers. In India, many state governments are coming up with publicly financed, privately provided and insurance company-administered health insurance schemes. Some countries are contemplating the idea of 'Universal Health Coverage' or 'Universal Health Care' by including both public and private healthcare providers.

Such arrangements throw up a wide range of issues and need to be critically examined. Along with closely examining the merits or demerits of every such arrangement from a public health perspective, one demand that Civil society organisations should raise in this context is that *in case of any kind of public financing, irrespective of whether providers are from public sector or private sector, every healthcare provider must be accountable to the people of the country. **Any service that is publicly funded must be clearly accountable to the public.*** Public financing, whether it is tax based or social insurance based, is public money; there should be proper accountability and monitoring mechanisms to ensure that public money is not wasted or used irrationally.

Ongoing public financing is one important rationale for demanding social accountability of private healthcare providers. Public financing of certain sections of private providers, especially if organised under a public-centred UHC framework having strong public health logic and systematic accountability mechanisms, can help the common people, civil society and political parties to demand effective regulation of private healthcare services.

It should further be strongly emphasized, that it is necessary to carefully scrutinise the terms and conditions under which private providers are involved in any such publicly funded system. The role of private providers should never be to substitute public providers, to weaken public provisioning or to preclude expansion of the public system, but should rather fill gaps where public provisioning is presently unavailable or very weak. The overall goal must be to strengthen the 'public' nature of health care and to move towards a more socialized system of health care, both

through expanding public health provisioning, and through regulating and rationalizing private providers.

#### **6) Active role of citizens organisations in monitoring private healthcare providers; demanding grievance redressal mechanisms for private healthcare**

Today effective mechanisms are required to ensure accountability of health services with people's active involvement. Community Based Monitoring of Public Health Services is one such tool being used to promote accountability of public health services, under the National Rural Health Mission (NRHM) in some areas in selected states of India<sup>9</sup>. In this programme, based on mutually agreed indicators, people in an area monitor and rate the quality of public healthcare services being provided. 'Public Hearings' are held once in a year involving public health officials, healthcare providers, members of the public, elected representatives and civil society organisations in that area, in the presence of media. People share their complaints about deficiency of services or denial of care, while Health-care providers in the concerned public facility have to respond to and resolve people's complaints in the public hearing. Quality of public health services have significantly improved in areas where such a system of community monitoring is in place, as compared to areas without such a participatory monitoring system.

Similar processes could be extended to cover private providers, particularly publicly financed and privately provided healthcare services to begin with. Citizen's organisations can and should play an active role in monitoring publicly funded and privately provided healthcare delivery, based on the principle that 'any publicly funded service should be as accountable as a public service'. If such arrangements are supposed to be for people's benefit, then they should be made systematically accountable to people. Besides this, civil society organisations can also demand certain forms of accountability based on grievance redressal mechanisms, within all private hospitals to resolve patient's complaints on a day-to-day basis.

#### **7) Demanding participatory and democratic regulatory systems (multi-stakeholder social regulation) as an alternative to bureaucratic and 'expert captured' regulatory systems**

Demanding regulation of the private healthcare sector and demanding its social accountability are related but not necessarily identical concepts. There could be purely bureaucratic top-down regulation; there could be an autonomous regulatory structure with a mixture of public officials, technocrats and medical professionals, but without any representation of civil society or various sections of society. These types of accountability structures would have their own limitations, since they may not reflect the concerns and experiences of actual users of services, and may not be sufficiently accountable to the communities of ordinary people whose interests they are supposed to protect.

Purely bureaucratic top-down regulation may lead to 'red-tapism', focus on peripheral aspects of physical standards with neglect of important process related issues, and unnecessary harassment of private providers which would be unfair and unjustifiable. Such a regulatory system is likely to be prone to corruption. Such a 'statist' kind of system has various drawbacks and is prone to '*elite capture*'. Another type of regulatory structure is technocratic regulation. It is based on a relatively autonomous structure where certain public officials, technocrats and medical professionals are involved in the regulation process. This process is prone to '*expert capture*'.

Both systems may also be in practice tilted in the direction of favouring the interests of private providers at the expense of patients' interests, since the latter are not adequately represented. In both kinds of systems, there is no people's voice and no social accountability; decision making powers are completely with the bureaucrats or technocrats.

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<sup>9</sup> See [www.cbmpmaharashtra.org](http://www.cbmpmaharashtra.org) for details

There is an alternative to 'non-regulation' as well as both these kinds of regulatory systems: a participatory, democratic regulatory system. In this kind of system, representatives of various concerned stakeholders (like elected representatives, public officials, representatives from various sections of the medical profession and civil society organisations, patients' rights groups etc.) would be organized in the form of Health Councils at various levels. These Councils would discuss the various problems of the patients and of other stakeholders and would take decisions democratically. The Brazilian system of Health Councils, though obviously not ideal, is a useful pointer in this direction (see case study-2 below). Such regulation should be mandatory for all private and public providers. The implementing agency i.e. officials along with technical experts would then implement the decisions taken by multi-stakeholder bodies. Citizens' organisations would monitor the service provision and periodic public dialogues would be organized to resolve citizen's grievances.

This form of regulation is more inclusive, decentralized and participatory. Thus, it is more conducive to enhance social accountability of health services. Democratic decision making by multi-stakeholder bodies ensures that every major stakeholder has their say in the process, and this makes the process more open to pro-people inputs. While decisions would be implemented by appointed public officials with the help of technical experts, the 'bottom-up' feedback mechanism (in the form of community based monitoring) could ensure that actual implementation is done effectively. Thus there would be oversight over the implementing regulatory structure by the people themselves; accountability of the regulatory structure is ensured and the process can be guarded from elite and expert capture, and hijack by powerful private interests.

This alternative structure has certain problem areas such as the issue of who would represent 'public interest' in such 'multi-stakeholder social regulation' process. The selection of people's representatives and civil society activists in the multi-stakeholder committees is an important process which needs to be organized in an open and maximally democratic manner. Unless this is done in a genuinely democratic way, there is a potential danger of 'vested interest capture' by one or more powerful vested interests represented in the multi-level, multi stakeholder committees. Another concern is how to deal with situations where basic differences of opinion emerge among the involved stakeholders. Here publicly agreed upon principles, guidelines and standards should act as a reference point, and with half of the members being public representatives of various kinds, even if voting has to be resorted to, it can be ensured that public interest would generally not be jeopardized.

### **8) Dialogue and alliance with a section of rational, socially responsive practitioners**

We find that a section (even though it may be small) of private practitioners would like to carry out ethical and scientific practice, and are uncomfortable with various malpractices in the medical profession. They are not opposed to participatory regulation of medical practice, are ready to respect patient's human rights and are against corporatization of private health services. Experience shows it is fruitful to have dialogue, collaboration with this section, which can catalyse interaction and alliance with the representative organizations of private practitioners.

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## Case studies of promoting accountability of private healthcare providers

### Case Study-1

#### Campaigning for Patients' rights in Maharashtra, India

In Maharashtra state of India, civil society organisations, health activists, pro-people doctors and the public at large have made some efforts towards making private healthcare services more accountable to society. The experience summarised below of advocating regulation of Private health services and protection of Patient's Rights gives an idea about the processes and steps that could be adopted to push forward the agenda of regulation of the private medical sector.

In the Indian context, Maharashtra is a relatively economically 'developed' state with a predominant private medical sector, with all its attendant problems. Jan Arogya Abhiyan, the Maharashtra chapter of the People's Health Movement, has continually focussed efforts on advocacy for strengthening of public health services, but also realised that there is a need to engage with the huge private sector 'reality'. However it was noted that the private medical sector is a different ball game, with no clear fulcrum for activism unlike in the public health system, where there is some basis for such advocacy because the government has committed itself to provide certain services. Hence as an entry point for pushing forward the issue of regulation of the private health services, PHM-Maharashtra launched a campaign around the demand to include patients' rights in the Bombay Nursing Home Registration Act 1949 (BNHRA-1949). Tremendous dissatisfaction among the public about the way private hospitals function was sought to be tapped, to mobilise public opinion on this issue of patient's rights.

Since its inception in 2000, PHM Maharashtra had been demanding enactment of rules under the BNHRA. Maharashtra government finally decided to amend the BNHRA-1949 in December 2005 to be able to set minimum standards for nursing homes, but the amendments were minimal. Nevertheless, PHM Maharashtra decided to use this 'window of opportunity' to push the issue of Patient's Rights. It was demanded that the rules to be formulated under this amended act should include Patient's Rights. Given the consistent pressure by various civil society groups, the Director of Health services offered that the draft rules could be prepared by a civil society organization and CEHAT, a health-NGO in Maharashtra associated with PHM was entrusted with this responsibility. In this process, activists of PHM-Maharashtra played an active role in bringing together various stakeholders (like government health officials, doctors associations, PHM-Maharashtra members, social organizations and activists working on health issues, consumer right groups, lawyers etc) to draft these *rules under the amended BNHRA act*. PHM-Maharashtra insisted upon inclusion of patient's rights, transparency and accountability measures. These draft rules were approved by Director of Health Services and put on department's website in July 2006 but *three successive Health Ministers of Maharashtra did not find it appropriate to give final approval to these draft rules and Patient's Rights!*

In this context, PHM-Maharashtra conducted various advocacy-activities to push forward the demand of giving final approval to these draft rules. Among others, these activities included -

- ✓ A signature campaign in 2006 and again in 2009 for approval to BNHRA rules including protection of Patient's rights with collection of thousands of signatures including those of renowned social activists, intellectuals,
- ✓ An e-petition campaign in mid-2009 addressed to the Health Minister
- ✓ Lobbying with Members of Legislative Assembly to raise question in the State Legislative Assembly sessions
- ✓ Campaign through media- periodic press conferences, articles etc.

A ***Patient's Rights forum*** was formed in Pune (the second largest city of Maharashtra) and it conducted the first ***'Patient's Rights Convention'*** in July 2009. Around 150 citizens, social organizations participated in this convention and the demand was made for immediate implementation of BNHRA draft rules 2006 and adoption of legally enforceable patient's rights. In this convention, representatives of Indian Medical Association (IMA)-Pune and Hospital Owner's Association-Pune were invited and they publicly supported Patient's Rights but expressed reservations about its legal enactment, citing the fear of 'Inspector Raj'.

As a follow up of this positive response from IMA, PHM-Maharashtra's constituent organizations organized dialogue-sessions with association of private doctors (Indian Medical Association- IMA) on issue of Patient's Rights in various cities and towns. In Pune city, Patient's Rights Forum and PHM-Maharashtra conducted several rounds of discussion with senior representatives of medical professionals associations in end-2009 and early 2010. As a result of the collaborative efforts of PHM-Maharashtra, Patient's Rights Forum, Indian Medical Association-Pune (IMA) as well as the then national president Federation of Obstetricians and Gynecologists (FOGSI)), after prolonged deliberations, negotiations, ***a joint 'Charter of Patients' Rights and Responsibilities'*** was formulated which was jointly released in a press conference on 10<sup>th</sup> February 2010 by these organizations together. But later in absence of broader policy and legal framework this Charter was not much implemented in practice.

A further development is enactment of the Central government's 'Clinical Establishment Act - 2010' followed by issuing of associated rules in 2012. While this act has certain positive elements related to standardization of private hospitals, it has no provisions for Patient's rights, and lacks mechanisms for involvement of citizen's organizations at district level. Hence PHM-Maharashtra demanded adoption of a state specific 'Maharashtra Clinical Establishments Act', with inclusion of provisions for participatory regulation and Patient's rights. Based on persistent demands and lobbying for such a modified act, a meeting was held with the State Health Minister in end of 2013, during which a decision has been taken to draft a State level act which would address concerns of both patients and doctors. It is now to be seen how this act is shaped under the contending influence of the private doctors lobby and civil society groups which are supporting patients' rights.

#### **Some insights:**

- Patient's rights can form a significant rallying point for various civil society organisations and citizens groups to socially foreground the broader issue of regulation of the private medical sector, while highlighting the range of problems being faced by patients in private facilities due to lack of regulation.
- Raising the demand for inclusion of provisions to protect patient's rights, in any regulatory framework concerning the private medical sector can help to shape such regulation in the direction of patient oriented accountability.
- Dialogue and negotiation with representatives of the private medical profession can lead to their recognising the need for protection of patient's rights, thus paving the way for wider social recognition and legal protection of patient's rights in private facilities.
- There is an emerging need to critique standard, bureaucratic and technocratic regulatory models and to highlight the need for multi-stakeholder, participatory regulatory processes. However concrete legal and organisational mechanisms need to be devised to operationalise such participatory regulation, which is a comparatively new concept.
- Bureaucratic regulation without accountability can be critiqued from the point of view of its proneness to promote corruption, especially in many developing countries. Similarly certain varieties of technocratic regulation focused on physical standards carry the danger of promoting higher-end, larger and corporate hospitals, while weeding out smaller and charitable health care institutions working with lower budgets. On these grounds, there can

be common ground among various social actors, including organisations of private practitioners and smaller hospitals, to critique bureaucratic and technocratic regulation, and instead to propose accountability and grievance redressal mechanisms along with more participatory regulation involving multiple stakeholders.

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## **Case study -2**

### **Multi-stakeholder Health councils in Brazil**

The Brazilian Unified Health System (SUS) is widely known as an example where a developing country has operationalised an effective system to cover its entire population, including the most marginalized and deprived sections, with comprehensive health care. Somewhat less well known are the democratic structures that underlie the SUS to ensure broad based participation in this system, namely the Health Councils. In this context of this paper, it is relevant that these councils are participatory structures which plan and monitor services by all providers involved in the SUS system – both public and private. In this sense, this is one of the relatively few large scale experiences of participatory oversight of not only the public health system, but also contracted private health care providers.

The background to these councils<sup>10</sup> lies in the movement in Brazil in the 1980s to increase public participation in government, expand participatory management of public institutions and develop “social control” over the state. Brazil’s Citizens’ Constitution in 1988 followed by the Ninth National Health Conference in 1992 envisioned the creation of the Unified Health System (SUS) with decentralization and social control as key components. (Large periodic ‘Health conferences’ are organized every four years at each level of government, which provide an important broad participatory forum to shape health policy.) In this context, Health councils have been set up in Brazil at Municipal, State and National levels with the principle of parity between representatives of civil society (50 per cent of seats) on one hand, and representatives of government (25 per cent of seats) and public and private service providers (25 per cent of seats). The number of members in each councils ranges from 12 to 48 (the National council has 48 members) and presently there are over 5,500 Municipal councils, 26 State councils and one National council.

Health councils make decisions, act as consultative bodies, exercise oversight while they approve annual plans and health budgets. They also assist health departments with establishing priorities and auditing accounts<sup>11</sup>. Although they have legal powers related to technical and administrative areas, the role of Health councils in shaping policy is considered particularly important. Federal transfers of funds to the SUS system in any Municipality are conditional on approval of the budget and health plan by the respective Health council.

A study of the Health Council in the city of Belo Horizonte<sup>12</sup> shows several positive impacts of decentralization of management of the SUS, with a key role being played by the Health council. Some of the positive results have been a restraint on fraud which has been a historical feature of

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<sup>10</sup> Municipal Health Councils (Brazil) – page on Participedia, [www.participedia.net/en/cases/municipal-health-councils-brazil](http://www.participedia.net/en/cases/municipal-health-councils-brazil)

<sup>11</sup> Brazil’s Health Councils: The Challenge of Building Participatory Political Institutions  
Vera Schattan P. Coelho. IDS Bulletin, 35: 33–39.

<sup>12</sup> Decentralization and Governance in the Health Sector, Belo Horizonte - Brazil, School of Governance/FUNDAÇÃO JOÃO PINHEIRO, BELO HORIZONTE, UNDP Decentralized Governance's Research Sub-Programme, 1998



provision of health services in Brazil; more rational use of funds to improve access to services even without higher investments, and the shortening of deadlines for payments made to private providers. The last impact is interesting since it reflects how along with citizens interests, legitimate interests of private providers might be promoted through such multi-stakeholder mechanisms. Overall increased public accountability and control has been a result of the Health council exercising one of its major legal functions, contributing to the Health systems' improved transparency and accountability. Regarding control over the quality of services, the Health council has effectively vocalized users' demands and complaints. The Belo Horizonte case study notes that Council members *"receive and forward denunciations, take part in the investigation, contact the media, organize public demonstrations and put pressure on the Executive. (The Council's) control activities have resulted in concrete governmental punishment measures - the shut-down of units and audits – or in positive actions such as the renovation of units, the allocation of funds, and other prompt actions in specific health districts."*

However the same case study notes tensions between public and private providers, and reluctance of private providers to subject themselves to accountability mechanisms in the Health councils; *"The segments that define the Council's profile are the health professionals, the representatives of the popular movement and the government, whereas the participation of private service providers is rather fragile. Nevertheless, as the SUS is dependent on the private sector for the provision of services, this weak involvement is a fundamental issue and shows how difficult it is to deal with the many diverse interests within the SUS."*<sup>13</sup>

It has further been noted that three major dilemmas emerge from analyses of the Health councils in Brazil<sup>14</sup>. The first is that of autonomy, and the extent to which the councils are able to effectively hold to account a state, with which its members have multiple linkages. The second is that of representation, and the extent to which the councils genuinely reflect the diversity of social actors and interests. The third is that of embedded inequalities of knowledge and power between citizen representatives and health workers and managers.

In terms of overall analysis, it has been observed that *"there are ingredients of institutional design used to shape Brazil's participatory institutions that do have something more generic to offer the design of future health systems. These include a legal framework that creates statutory obligations to engage citizens in deliberation over health policy and in holding the state to account; the creation of a network of institutions from the very local to the national level, lent functionality through resources committed by the state; the combination of deliberative Conferencias (Conferences) at which policy directions are determined and Conselhos (Councils) to track their implementation; and in going beyond the atomised individual to engage representatives of social movements, associations and neighbourhoods, renewing membership regularly to extend the capillary reach of the democratizing effects of engagement"*.<sup>15</sup>

#### **Some insights:**

- The health councils in Brazil present a rather unique model of participatory governance of a health system, which includes both public and private healthcare providers. In the context of this paper, the operationalisation of participatory governance related to private providers is especially significant. However, to the extent that this has been possible in Brazil, it is

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<sup>13</sup> UNDP Decentralized Governance's Research Sub-Programme, Ibid

<sup>14</sup> Engaging citizens: Lessons from building Brazil's national health system: Andrea Cornwall and Alex Shankland - Social Science & Medicine 66 (2008) 2173-2184

<sup>15</sup> Andrea Cornwall and Alex Shankland, Ibid

critically linked with the development of the unified health system (SUS) which contracts private providers into a publicly financed and managed universal healthcare system. This raises the question whether effective participatory regulation of private providers would be possible at all, without their being paid and regulated by a broader public system.

- Providing space for participation to private healthcare providers in the health council can enable them to raise their own legitimate concerns and issues, as exemplified by the Belo Horizonte case study, where the health council decided to shorten payment deadlines for private providers.
- However as the Belo Horizonte case study also shows, the involvement of private providers in their Health council is fragile and fraught with problems. The inherent tension between the profit making logic of a private provider, and the broader accountability logic of a publicly organised system, is bound to reflect in multi-stakeholder forums like health councils. This may be viewed as an inevitable contradiction that may be only partly resolved in the near future, or might ultimately be resolved only through progressive socialisation of private providers, by incorporating them into a publicly organised and financed system.
- The larger political setting in Brazil and widely participative processes like Health conferences provide the context in which health councils have developed, and have been able to institutionalise a certain level of participation in the management of the health care system. Hence any generalisation from the Brazilian health council model in relation to other countries needs to be done with care. However despite the limitations and qualifications noted above, these health councils provide us today one of the few working large-scale examples of participatory regulation and management of public as well as private healthcare providers. Therefore while exploring such models in other countries, we could draw upon the positive lessons of Brazilian health councils in terms of linked multiple levels of operation, legal institutionalisation and official support, broad-based representation to a variety of stakeholders including civil society organisations, and significant powers related to planning and approval of finances. At the same time, the challenges faced by health councils in Brazil, which might be expected in the context of evolving participatory healthcare regulation in many other developing countries, need to be kept in mind and pre-empted through appropriate strategies which would have to be evolved organically in specific country contexts.