REPORTS

Ensuring accountability and responsiveness of the private health sector in India: National workshop report

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Introduction

The increasing prevalence of unethical practices such as unnecessary investigations, overcharging, and violation of patients' rights, especially in private hospitals, have drawn attention to the unregulated and overwhelmingly commercialised nature of the private healthcare sector in India (1). This situation underscores the critical need for regulation of the dominant private healthcare sector, for its effective engagement in achieving Universal Healthcare (UHC) A two-day national level workshop to deliberate on 'Ensuring accountability and responsiveness of the private health sector in India', was co-organised by SATHI (Support for Advocacy and Training to Health Initiatives) and Jan Swasthya Abhiyan from November 26-27, 2019, at Delhi The workshop was attended by close to 60 participants including health activists, public health professionals, practising doctors, researchers and policy makers from across India. Building upon political economy and transformations in healthcare, key components for regulation and accountability of the private sector, such as patients' rights, grievance redressal mechanisms, implementation of the Clinical Establishments Act, and Standard Treatment Guidelines) and rate regulation were intensely debated over the sessions. These deliberations were important to unpack the key components for regulation of the private healthcare sector and they highlighted the challenges in each one. The workshop also helped to build consensus and engagement amongst diverse stakeholder groups on the various issues

Setting the context: political economy of healthcare

In the introductory address, Abhay Shukla, a public health professional, from SATHI, explained that it was the need of the hour to understand the intricacies of the rapidly growing, mammoth and unregulated private healthcare sectorto tackle it effectively. He stressed its importance and urgency in the context of the recent NITI Aayog report (2) which has prioritised the role of private healthcare providers in healthcare. Discussing the key aspects of the political economy of healthcare, Shukla shared the data on the scope and scale of the private healthcare sector in India, financialisation and increasing investment, and outlined four phases of evolution in healthcare in India: the first phase (1950-70) primarily involved individual practitioners, not for profit providers and public hospitals, In the second phase (1980-2000)- small and medium providers emerged and the third phase(2000-to the present) – witnessed the growth of large multi-specialty hospitals, making a move from commercialisation to corporatisation of healthcare. In the fourth phase, state financing is becoming crucial in terms of either subsidisation or investment supporting the growth of the private healthcare sector, by way of large scale "strategic purchasing", or consolidation with health insurance schemes. It was proposed that, given the wide spectrum of private healthcare providers ranging from individual practitioners to corporate hospitals, it is necessary to take a differential approach to each segment, while following common principles for the regulation of the wider sector Indira Chakravarthi, a public health researcher, illustrated manifestations of corporatisation of private healthcare such as shutting down of small hospitals, small hospitals emulating corporate hospitals; and performance targets being set for doctors, thus compromising their autonomy. She also explained the emerging trend of hybrid partnerships between non-profit charitable hospitals and for-profit hospitals and corporate entities

Patient rights in India and The Clinical Establishments Act

Ankit Garg, a victim of gross medical negligence, shared his personal experience during the session on "Denial and violation of patient rights in India", which indeed touched a chord with the audience. Shakuntala from SATHI and Arun Gadre, member, Alliance of Doctors for Ethical Healthcare (ADEH) presented the narratives and analyses of documentation of 24 cases of denial and violation of patient rights collected from across India. Gadre pointed out that patients are being intimidated by tactics such as threats of fatal consequences if the doctor's advice is not followed, to get

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them to succumb to commercial pressure. In the subsequent session on a patients' rights charter, Shakuntala shared details of a campaign for a Patients' Rights Charter which has been adopted by the National Human Rights Commission (NHRC); but it is awaiting Health Ministry approval. Abhijit More, health activist, talked about The Clinical Establishments Act (CEA), 2010, which has been adopted by 11 states and 6 union territories. He traced the status of implementation of CEA in different states and discussed contentious issues in the framing of the CEA. T Sundararaman, a public health professional, argued that people want regulation to make health services affordable, to ban commission practice; and establish ethical practice. Unfortunately, the CEA is silent on these points and focuses on infrastructure, input, and human resources.

Standard treatment protocol and rate regulation

J N Srivastava, of the National Health Systems Resource Centre (NHSRC), made a detailed presentation on Standard Treatment Guidelines (STGs) and the challenges faced in the implementation of STGs, such as the robustness of STG development process, involving all the stakeholders,, obtaining the endorsement of professional associations, participation of patient groups, utilisation by the public and private sectors, linking with service packages, and a system of periodic revision. The discussion during this session concluded that without STGs, purchase of care from the private sector cannot be made reasonable. It was also, said that while it may be easier to lay down STGs for simple procedures, preparing and implementing STGs for complicated medical conditions would be challenging due to variability of associated medical factors and lines of treatment required to address those.

Day II of the workshop started with a session on "Regulation of rates", the most contentious and challenging component in the regulation of the private sector. Gadre listed six key variables in determining rates in the private healthcare sector (3). He further shared concerns regarding rate standardisation such as whether senior doctors should receive higher fees; if the rates of the treatment should vary based on geographical location of the healthcare set up as cost of real estate cost seems to be a key determinant of the cost of healthcare in cities .It was asserted that without socio-political push, it is not possible to regulate the rates with technical solutions alone. Jayant Kumar Singh, a victim of exorbitant charging in corporate hospitals, drew upon his own experience and quoted the central government's response to the Supreme Court in his daughter Aadya Singh's case (4) that healthcare is an industry which operates in an open market and can charge anything. He, asked which agencies aggrieved patients and their families should approach and what action they should take in such cases of negligence or exorbitant, irrational charging in private hospitals. Puneet Bedi, a gynaecologist practising in the corporate sector, shed light on the critical role played by insurance companies in deciding the charges of private hospitals. He strongly advised that patients must negotiate over hospital charges. He stressed that this is necessary and can be fruitful.

Policy directions for regulation of healthcare

The session on "Policy directions for the regulation of healthcare" provided insights towards understanding the situation at a policy level. It consisted of a panel of Sanjay Nagral, senior surgeon and representative of Forum for Medical Ethical Society (FMES), two research officers from the National Human Resource Centre (NHRC), and Vinod Paul, a Member of NITI Aayog. The panel was organised to engage with policy makers on private sector regulation and hear from them about policy positions and further direction towards regulating the private sector. While responding to participants' questions concerning Pradhan Mantri Jan Arogya Yojana (PMJAY), Paul asserted that NITI Aayog is instrumental in crafting the PMJAY scheme to look at healthcare holistically for achieving UHC. The government is committed to increasing healthcare spending and reaching 2.5% of GDP by 2025, the set target. The health system today has quality and standards issues but PMJAY allows for improvement, without recourse to laws and regulations. NHRC officials provided an update, saying on a Patients' Rights Charter, the Ministry of Health (MoH) regarding enactment of charter however MOH has diluted those 17 points in the charter accepted by NHSRC. Nagral made interesting points that the insurance schemes have brought in certain ability in people to access the care which they otherwise could not access. Also, these schemes have played positive role also helping to control the cost in other hospitals in the vicinity which are not part of schemes.

Grievance redressal mechanisms

During the session on "Grievance redressal for patient victims and the role of State Medical Councils (SMC)", Kanchan Pawar of SATHI provided an overview of the current platforms for grievance redressal such as SMC, Medical Council of India (MCI), the consumer courts and criminal courts and raised concerns about the ineffective grievance redressal process. Drawing upon his own experience, Shishir Chand of the People for Better Treatment (PBT) criticised the unaccountable MCI and SMC. Arun Mitra, the former chairperson of the ethics committee, Punjab Medical Council, highlighted the positive actions taken by Punjab Medical Council, such as issuing notice to doctors against accepting gifts from pharmaceuticals, acting as ghost faculty in colleges, endorsing products and commission practice, exemplifying the kind of role medical councils could and should play.

Social accountability of health insurance schemes and socialising the health system

During the session on Social Accountability of Insurance Schemes, Sulakshana Nandi, public health professional, presented the data on prominence of the private sector in PMJAY. Overall, 62% of the PMJAY funds are going to the private sector (5). Average out of pocket expenditure (OOPE) in the private sector is six times that in the public sector. Average OOPE in public hospitals is Rs. 2848, as compared to Rs. 17,493 in private hospitals (6). During the concluding ession of the workshop, Anant Phadke, health activist, argued

that, regulation alone will not take us to UHC and flagged the need for socialising the private sector in order to move towards UHC. According to him, socialisation of the public health system is easier, and it will be far more difficult in the private sector. He cited global experiences from countries like Canada, Japan, Germany and US where private providers are forced to follow the logic of public interest. They can make profits, but profiteering and cheating are not allowed. So private providers are making money, selling services to the government but in a regulated market. It was further argued that, if we want to implement UHC in the next ten years, it will not be possible in the present state of health system. Reform of the public healthcare system will have to be prioritised

Concluding remarks

In the concluding session, Abhay Shukla stated that a churning is evident today in the healthcare system of India. On the one hand, states like Rajasthan and Madhya Pradesh are drafting Right to health and healthcare Acts. Chhattisgarh too is seriously considering the implementation of UHC. s. While, on the other, we have the much debated PMJAY. The health movement should re-calibrate and take forward strategies to present the positive alternative. If we criticise PMJAY, we must be able to offer an alternative which is far superior to PMJAY. According to him, such an alternative could be a public health system-centred UHC, which will be based on strengthening and expansion of the public health system, as well as an expansion of the State's capacity to regulate the private healthcare sector, as its existing regulatory capacity is quite weak (7). He acknowledged the contribution of insightful and scholarly discussions during this workshop, discerning intricacies in developing the social accountability framework for the private sector. The workshop concluded by highlighting the need for furthering these brainstorming sessions to concretise our proposals for social accountability in the private healthcare sector while moving forward towards UHC in India.

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The Eternal Grove – A garden of remembrance

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The Health and Humanities division, St John's Medical College, together with the student-led environment body *Ecologics,* initiated the plan to have a garden space dedicated to the remembrance of those who have donated their bodies to medical education.

The idea of the Eternal Grove emerged from a research study of body donors and their family members. The study found that family members often grappled with the decision of their loved one and needed a space ū sometimes to grieve, sometimes to get closure, and sometimes, just to know that their loved one's decision has been acknowledged and appreciated. A garden space with perennial trees and indigenous plants was seen as a good way to mark the eternal gratitude of the institution and students to the body donors and their families; and to provide a serene place where family members can remember their relatives when they have passed on. Having a central sculpture was seen as a necessary element to maintain the connection between students and the donors (their teachers).

The Eternal Grove is located adjoining the Embalming Centre, where the body is handed over by the family after the donor has passed on.

The Health and Humanities Division works with medical students in their first year to help humanise medical education. The use of art, poetry, reflective narratives and other forms of creative expression are fostered to enable students to put

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