In the Name of Charity

SHWETA MARATHE, INDIRA CHAKRAVARTHI

In the context of a renewed interest in the functioning of charitable hospitals in Maharashtra, and the intention of the state charity commissioner to ensure compliance with the Indigent Patient Fund scheme, some related issues have been revisited and suggestions forwarded for modifying the scheme. Attention is drawn towards the misuse of trust hospitals and the consequences of having no ceiling on charges for close to 80% of the beds in these hospitals.

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Shweta Marathe (*shweta51084@gmail.com*) and Indira Chakravarthi (*indira.jnu@gmail.com*) are associated with SATHI, Pune.

It is a well-known fact that the charitable hospitals constitute a significant component of the private healthcare sector in Maharashtra, especially in Mumbai and Pune. As of 2017, there were 444 trust hospitals across the state, of which nearly 35% were located in Mumbai (76), Pune (57) and Thane (20) (Government of Maharashtra nd). The history of the setting up of such hospitals in Mumbai, their reluctance and (non)compliance with respect to providing free and subsidised medical care while availing subsidies and concessions, and the government's (in)action to ensure their compliance and accountability, are all well-documented (Kurian 2013). To summarise it briefly here—as per Section 41AA of the Bombay Public Trust Act (BPTA) 1950, under which the trusts running these hospitals are registered, these are state-aided public trusts[1] which have received government subsidies and concessions on land, electricity, building rules, income tax and import of medical equipment, and in return they are expected to provide free and subsidised medical care to economically weaker sections. Section 41AA also grants power to the charity commissioner and the state government to issue directions for implementation of the free and subsidised care.

The provisions of Section 41AA of the BPTA came into effect from August 1986. However, the charity commissioner in Maharashtra did not issue any directions to the state-aided public trusts to provide medical care accordingly for the next 20 years. The Indigent Patient Fund (IPF) scheme under the BPTA was made functional from 1 September 2006 after the intervention of the Bombay High Court, which ordered a "scheme of measurable charity" under which these trust hospitals were required to (i) reserve 10% of the total number of operational beds for indigent patients and provide medical treatment to these indigent patients free of cost; (ii) reserve 10% of the beds for the weaker section patients for treatment at a concessional rate; and (iii) physically transfer 2% of total patient billing as IPF to be utilised for the treatment of indigent patients. This scheme also provided for a monitoring committee to oversee the implementation of the scheme and to consider patient grievances, if any.[2]

The issues around the "limited charity" by charitable trust hospitals in Maharashtra have been in focus for some time now, with the state charity commissioner stating that "all the charitable hospitals across the state will be under scrutiny to verify if they are working as per stipulated norms. Action will be taken against those who deny treatment to poor patients" (Pathare 2017a). In December 2017, a group of charitable trust hospitals in Pune filed a petition in the Bombay High Court, seeking that the charity commissioner's office should stop forcing them to spend above the ceiling; the group of 56 hospitals claimed that they are often compelled to spend more than the mandated 2% of their entire billing for indigent patients, even while the IPF runs dry (Pathare 2017b). This is not the first instance of charitable hospitals trying to circumvent or avoid the requirements under the BPTA. In 2012, a group of 14 hospitals from Mumbai had appealed to the charity commissioner stating that they were incurring losses in treating poor patients (Debroy 2012).

Yes to Subsidies, No to Subsidised Care

It is well known that healthcare facilities get registered as a charitable trust hospital because they get hefty subsidies, such as lower import rates for medical equipment, land on long lease at low rates, subsidies in utility bills, and income tax exemptions. In cities like Mumbai and Pune, hospitals have been given land at ridiculously meagre rates of ₹1 per annum. Many institutions which are not running for charitable purposes escape taxation by virtue of the fact that they are registered as a trust and claim exemption under the Income-tax Act. Several well-known trust hospitals in Mumbai despite availing non-justified exemptionamounting to ₹249.66 crore, involving impact on revenue amounting to ₹77.14 crore, are

not fulfilling the conditions laid down in the BPTA and are doing little or no charity at all (CAG 2017; Duggal 2012).

The BPTA allows hospitals to accept donations from individuals or other sources for the IPF. So, effectively, hospitals have 2% funds from total billing as well as donations to provide the free or low-cost medical services to the indigent and the economically weaker sections. The Comptroller and Auditor General of India (CAG) (2017) report says that the management of the IPF by hospitals is lacking; either no IPF has been created, or if it is created, it accounts for less than 2% of the total patient billing. A sample survey by the state health department indicated that the Jaslok, Breach Candy and Bombay hospitals used only 4% to 4.5% out of the mandated 10% beds to treat the poor (*Mumbai Mirror* 2012).

As per the high court, charitable hospitals cannot ask for any deposits during admission of indigent patients, and the weaker section patients shall pay at least 50% of the bills of only medicines, consumables and implants. Both these guidelines are found to be violated according to the CAG (2016: 87) report—while three hospitals were found to be taking deposits irregularly from indigent patients, in two cases the weaker section patients were also charged 50% towards anaesthesia, ICU (intensive-care unit), doctors' fees, imaging, investigation, operation theatre and surgery. Until now, this scheme covers reservation for the indigent and weaker sections only as inpatients; 10% reservation to the outpatients under both the categories still remains unimplemented (CAG 2016).

Contrary to the claims made in the 2017 petition by hospitals, according to the BPTA, if the percentage of reservation provided by the trust hospitals exceeds what is specified in the act, then the higher percentage of reservation ought to be given. Thus, it is not the whim or diktat of the charity commissioner when hospitals are asked to spend above the ceiling, but a legal requirement to be fulfilled by the trust hospitals. Further, in the case of imbalance in the credit of the IPF account and the expenditure incurred in the treatment of indigent and economically weaker section patients for more than six months, the act specifies that the concerned hospital may bring this to the notice of the monitoring committee, which may then issue appropriate directives.

Limited Charity, Tall Profits

While discussing the limited charity of trust hospitals, it is important to also shed light on profiteering by them. They are often thought of as non-profit institutions. However, many of the older charitable hospitals have become more and more commercial in their operations. But, the point here is if they are commercial, has the state asked them not to be? There is no prohibition on a charitable trust to carry on their business and generate profits. "Non-profit" does not mean the trust should not generate profits, or run in perpetual loss. Profit, if any, should be ploughed back into the organisation for "charitable purposes" and not distributed by way of dividends to trustees or members of the organisations (Bombay Chartered Accountants Society 2015–16). Even though it is clear that the trust hospitals can generate revenues and earn profits, there is no control on how much they should charge for the various health services they provide.

As per the BPTA, the economically weaker section patient's bill of billable services shall be prepared at the rates applicable to the lowest class of the respective hospital. In return for the concessions, trust hospitals are expected to keep their overall charges low and function with a philanthropic spirit. Trust hospitals, however, provide medical services at prices comparable to other private or corporate hospitals (Chatterjee and Laxminarayan 2013). There is no regulation or control whatsoever on the charges for 80% of the beds in these hospitals. In Delhi in 2015, charges for a single room for a one-day stay in Sant Parmanand Charitable Hospital was ₹13,000, while in Fortis Hospital it was between ₹10,000 and ₹12,000 (Hooda 2015). The situation in Mumbai and Pune is not very different from this. It is well known that leading hospitals in Mumbai, such as Jaslok, Breach Candy, Hinduja, Nanawati and Saifee, which are run by charitable trusts, cater largely to the elite class and the sections that now have health insurance.

Except for a few trust hospitals that genuinely serve poor patients, increasingly many are operating as corporate hospitals in terms of management, functioning, facilities, marketing, as well as high charges and surpluses, for which they can hardly be held guilty because there is no policy or law in place that prohibits them from doing so. Given this situation, where 80% of the patients in trust hospitals are charged similar rates as in the corporate hospitals, while trust hospitals avail income tax exemptions and also receive donations, the claim that their IPF runs dry by the middle of the month or that they cannot treat the poor free of cost needs scrutiny. "If there is no charity forthcoming from them, it amounts to a huge economic and social crime that should be investigated" (Duggal 2012), and their non-profit status and the concessions granted to them need to be reconsidered and withdrawn.

Gaps in Monitoring and Action

The monitoring of the functioning of the IPF scheme by the charity commissioner's office has been found to be lacking (Kurian 2012). Information furnished by the charity commissioner after inspection of 78 hospitals in Mumbai, conducted during 2009–14, revealed that more than 59% of the hospitals were not inspected for more than a year (CAG 2016: 88). Further, no penalties were levied on the offending hospitals, even though the charity commissioner can direct the government to withdraw their concessions/benefits. There has not been a single instance of disciplinary action by the charity commissioner against any offending hospital.

In 2012, the collector of the concerned area had passed an order against the Kokilaben Dhirubhai Ambani Hospital, Mumbai on breach of conditions and for exploiting government land given at concessional rate for commercial purposes. The order said that the government should either take over the land allotted to the trust or charge 75% of the unearned income according to the land value. On appeal by the hospital trust, the then revenue minister stayed this

order. In 2017, the collector again issued an order imposing a fine of ₹174 crore (Suryawanshi 2017). However, all these orders still await implementation.

Time to Reassess and Modify

Though effective action so far is sorely missing, the recent and renewed interest and the reported intention of the charity commissioner to ensure efficient implementation of the IPF scheme are positive signs (Pathare 2018). Keeping in mind the overall scenario, along with ensuring implementation, certain modifications in the scheme and policies regarding trust hospitals are required. First, the IPF of each trust hospital should be made available online, to bring in transparency in the scheme. Second, it is high time that this old scheme gets re-evaluated. There should be an assessment of the subsidies and concessions given, turnover of the hospitals for the last few years, number of patients treated for free and at subsidised costs. Based on all this the "measurable charity" should be revised: the contribution towards IPF could be proportionate with subsidies, exemptions and profit earned by the hospitals, hence it may vary in different hospitals. The CAG (2017) had also recommended that the concessions given to these hospitals be reviewed. Although the state government in October 2017 announced the formation of a committee to probe the functioning of charity hospitals, the status of the probe is not yet known (*Times Now* 2017).

Third, the patient's rights need attention. The Consumer Protection Act (CPA) excludes free medical care provided by the trust hospitals. A patient who has availed services for "free" cannot file a case against the hospital. In fact, excluding patients in government hospitals and trust hospitals from the CPA penalises the poorest of the poor. They are forced out of poverty to seek free care, and for this very reason denied the right to demand a certain standard of care, and be compensated if that standard is not maintained (Agrawal and Banerjee 2011). The only mechanism to put forward grievances by the patients is before the monitoring committee. As per the BPTA, the monitoring committee is supposed to consider grievances of the patients and submit its report to the charity commissioner. Grievances under free medical care need to be included in the CPA and the monitoring committee should actively provide a space for patient grievances and redressal too. Fourth, at present, monitoring committee of the scheme is dominated by doctors and government officials. Hence, to have space for voices of citizens and patients, civil society organisations have consistently demanded for inclusion in the committee.

Most importantly, moving beyond the scheme-related recommendations, what is critical today is the regulation of rates of the 80% beds. While this is required not just for trust hospitals, but for the entire private healthcare sector, however, it has to be done urgently for trust hospitals in view of the large concessions they are given. When the public health system is weak and the cost of private healthcare is out of reach for the ordinary people, the responsibility of trust hospitals to serve the poor and weaker sections increases. If found short of doing so, it is the state's responsibility to evaluate their functioning, to ensure implementation of the scheme while also making appropriate modifications in it and the related policies, and to make sure that the trust hospitals live up to their stated mission of being charitable.

NOTES

1 The public charitable trusts registered under the provisions of the Bombay Public Trusts Act (BPTA), which are running charitable hospitals, including nursing homes or maternity homes, dispensaries or any other centre for medical relief and whose annual expenditure exceeds ₹5 lakh are "state-aided public trusts."

2 The members of the Monitoring Committee in Greater Mumbai Region are: Joint Charity Commissioner, Maharashtra State, Joint Director of Health Services (Medical), Mumbai, Secretary/Nominee of Association of Hospitals in Mumbai, and Health Officer, Municipal Corporation of Greater Mumbai. This committee shall hold its meeting once in a month and monitor implementation of the Indigent Patient Fund Scheme by each of the charitable hospitals.

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