Thematic Hub on

Accountability of Private Medical Sector

Associated with COPASAH

Today despite massive growth of the private medical sector across the world, and major social evidence of the negative consequences of market failure, regulation of private medical sector remains patchy and ineffective in most LMICs. Despite large scale dissatisfaction related to malpractices, unethical practices, overcharging, and violation of patients rights in private hospitals, movements around these issues are often non-existent or very small. Hence there is urgent need for a platform which would help develop the discourse on accountability of the private medical sector through involvement of activists and practitioners, along with facilitating exchange of experiences and perspectives.

Given this context the Thematic hub on “Patients rights and private medical sector accountability” associated with COPASAH has been initiated to develop a conceptual discourse and framework for social accountability of the private medical sector, especially keeping in view the context of South Asia. The hub seeks to promote networking among civil society organisations and networks on issues related to private health sector regulation and patient's rights, with a focus on South Asia. This concept note provides an overview of the Thematic Hub on Accountability of Private Medical Sector, describing some background on the current private medical sector in LMICs with a focus on South Asia, followed by a brief conceptual framework for developing a social accountability approach to this sector, followed by an example of initiatives from India, concluding with a description of this emerging Thematic hub.

I. Private Medical Sector – 'All is not well' with the unregulated giant

The private sector in healthcare, and privatization of health systems are becoming important issues today in the context of most LMICs (Low and Middle Income Countries). There is also increasing concern regarding regulation of the private sector, in context of mixed systems comprising both public and private segments. As pointed out in a recent Lancet series: 'The task of those concerned with health should be to subject the private sector to scrutiny—description, analysis, and evaluation...; the evidence on which to make wise policy decisions concerning the private sector is often weak or absent. That situation must change'. Here we will take a brief review of the private segment of healthcare systems in several South Asian countries, followed by a quick look at the current status of regulation of this sector.

The Private medical sector in South Asia (Bangladesh, India, Nepal, Pakistan, Sri Lanka)

The private health care sector is tremendously heterogeneous, ranging from independent informal and formal practitioners to small, medium and large hospitals, charitable hospitals and corporate hospital chains and diagnostic centres. While there are similarities among all these five countries as far as presence of a private sector goes, there are also significant differences among them with respect to the size, nature, and importance of the private sector, and the relationship between the private and public healthcare segments. A bird's eye view indicates that in this region Sri Lanka has a much better resourced public sector, with a smaller private sector, though this is a growing force even in Sri Lanka, due to greater investment from private players[2]. India has a very large and dominant private sector ranging from large for-profit corporate entities to not-for-profit trust hospitals, smaller doctor owned hospitals and nursing homes, individual practitioners and traditional healers. Similarly, Bangladesh, Nepal and Pakistan have weak public health infrastructure and low levels of public spending, and a private sector including for-profit and not-for-profit hospitals, general practitioners (both qualified and unqualified), chemists, and diagnostic laboratories[3]. The following section gives a very brief country-wise outline.

Sri Lanka has proportionally the smallest private medical sector among the group of South Asian countries, since *the public sector handled over 90% of the total patient admissions* in 2014 while accounting for 73% of the hospitals and 93% of bed capacity. The quality of treatment and management of inpatient care was found to be better in the public sector despite being available at a lower cost[4]. While the number of private hospitals has increased during 1999 to 2011, *private hospital beds represented only 6% of the total hospital beds,* consisting mainly of a few leading hospital chains and large number of small regional players. The top five private hospitals accounted for nearly half of the private-sector bed capacity in 2014. *Medical tourism was reported to be a key growth driver,* while rising per capita income was also seen as increasing demand for private healthcare[5]. This was accompanied by shift in the private sector from smaller to larger facilities having over 100 beds[6].

In Nepal nearly *two-thirds of healthcare delivery facilities are privately owned and operated*[7]. There are an estimated 3000 private healthcare enterprises in Nepal, of which around 70% are diagnostic clinics, and 26% are primary clinics, secondary and tertiary hospitals. Growth of secondary and tertiary private sectors is outpacing growth in the public sector. *Significant foreign investments have been made since 2010,* especially in private tertiary hospitals while established business groups of Nepal, as well as groups of high net worth doctors have set up healthcare companies.

In Bangladesh private presence in secondary and tertiary level medical care has emerged over the last one and a half decade. As of November 2016 there were 14,337 registered private hospitals, clinics and diagnostic centres, while the total number of government hospitals under the DGHS was only 610[8]. Local businesses and entrepreneurs from the pharmaceutical and diagnostic care industries have expanded to set up multi-specialty hospitals. Bangladesh has a liberal FDI regime, with no limit for equity participation and repatriation of profits and income. In the late 2000s, Goldman Sachs identified Bangladesh and Pakistan among the eleven next big emerging markets (N 11), which was expected to have implications in healthcare arena, for healthcare financing and potential for private investment in infrastructure[9].

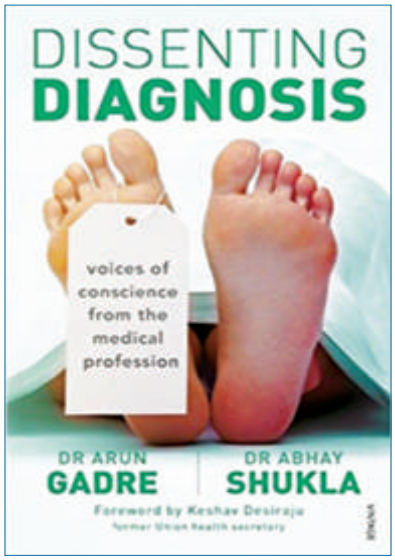
India has one of the largest private healthcare sectors in the world, and the private healthcare industry here is much more developed compared to the previous three countries, where it is in an emerging phase. The private healthcare sector in India is more established as well as diversified, and more influential in policy making. Available reports show that *the private sector is dominant and provides about 80% of outpatient services and 60% of inpatient services*[10]. Further, private facilities are expanding to smaller towns and cities, with 48% of all private hospitals and two thirds of corporate hospitals reported to be located in smaller cities[11]. The most significant development is that *there has been organized promotion of healthcare provision as a big business opportunity and the rise of corporate hospitals and healthcare industry*[12], projecting healthcare provision as a highly profitable economic venture. The health care sector in India has become an attractive area for private capital investment by global financial institutions such as International Finance Corporation (IFC). Further several Indian multinational healthcare companies have growing presence in neighbouring South Asian countries, as well as in the Gulf and in some African countries.

In Pakistan, health care is highly privatised, with public health expenditure as percentage of GDP falling from 0.72% in 2000-01, to just 0.42% in 2014-15. *Private spending on healthcare was estimated to be 70%, out of which 98 % expense was borne by households.* According to an IFC report (2011), an increasing number of trusts, NGOs and social welfare organizations had invested in not for profit health facilities, which were serving a very large cross section of the population. Most businesses were individual or family owned, however there was an increasing trend of individuals considering hospitals as investment business for commercial return[213]. The government was exploring PPPs and encouraging private sector to provide facilities in villages and small towns. The IFC report observes that "Low public expenditure by government, lack of expansion in the public health sector, increasing population with rising income levels indicates a high potential for growth for the private hospitals".

An important, noteworthy development in the region is the *active role of the International Finance Corporation (IFC - a World Bank institution) in not only promoting the growth of the private sector in these countries, but also actively financing its growth and expansion* through measures such as lending and directly investing in hospitals for expansion, and also investing in private equity funds and companies that in turn invest in healthcare companies in 'emerging economies'. In fact several large global private equity companies have created specific funds for investing in hospitals in South Asia and the MENA (Middle East North Africa) region[14]. Groups of private hospitals are also growing in Latin American countries such as Brazil, Mexico, Colombia and Peru. It is reported that the industry is, however, less developed in this region than in some the emerging markets of Malaysia, India and South Africa. Healthcare companies from the latter countries have expanded to multiple other countries and have listed on stock exchanges to access more capital to finance their expansion[15]. *Overall in LMICs across the world, the private medical sector is a growing and significant player in almost all healthcare systems.*

Performance of the private healthcare sector – Blind optimism belied by troubling reality

It is useful to recall arguments made by international institutions such as the World Bank since the early 1990s, favouring growth and increased participation of the private sector in health care. It was claimed that private services are better in terms of efficiency and quality etc. However increasing number of studies and accounts point to the myriad problems with the private medical sector. While the Oxfam report remains a landmark reference[16], further studies have also shown that the public sector provided better quality care than the private sector. Studies on performance of health insurance programmes and other forms of PPPs demonstrate a wide range of problems with private providers. *The pathbreaking book 'Dissenting Diagnosis'*[17] *published in India based on testimonies of 78 'whistleblower' doctors has ripped the lid off myriad malpractices in the commercialised private medical sector,* including unnecessary interventions, and irrational care driven by profit seeking, pharma industry – doctor nexus, institutionalised kickbacks, and inflated, arbitrary costs of care.



Danger of ineffective or 'captured' regulation, imperative of social accountability

Given this context of large and often dominant private sectors within the health systems of many LMICs, the mechanisms for regulation are often weak, under-resourced, bureaucratic and inadequately effective[18,19]. There are major gaps in policy design and implementation, human resource constraints, problematic organizational relationships, and major risk of 'capture' of the regulatory bodies by private interests[20]. Regulation may be minimal, limited to addressing physical infrastructure issues, and standards may be influenced by either academic experts or the corporate healthcare industry. There is an emerging view that the *problems with regulation of the private sector are not just narrow, technical issues of poor design,* rather healthcare services have certain unique features requiring special regulatory strategies compared to other services or products. In fact *regulation is a socio-political process which must address issues of quality, safety, affordability, access, transparency, accountability, equity and justice*[21,22]. Further the goal of universal health care provides a basis for *taking a Health systems perspective to deal with the private sector*, and the main aim of government policies must be to develop a healthcare system that ensures availability of good quality, free or highly affordable care guided by public health logic, so that this system meets the needs of the population as a whole, especially working people and marginalised populations[23].

Linked with such a broader socio-political and people-oriented approach to regulation is the *need to explore 'bottom-up governance', and related concepts of social accountability of regulators, and social regulation,* related to the entire Health care system including private medical sector. *Social accountability* refers to formal or informal mechanisms through which citizens and/or civil society organisations bring officials or service providers to account. *'Social regulation' refers to action-oriented approaches designed to reinvent and democratise regulation, with greater participation and accountability of the regulatory process to users and the public.*

This includes developing participatory oversight mechanisms for regulatory bodies, such as patient and citizen involvement in monitoring of enforcement of rules and regulations related to health care providers, from a patient-oriented and rights-based perspective.

Regulation is required to strengthen social logic, control profit logic in Healthcare

II. Forging a people-centred approach to private healthcare: integrating social accountability and regulation in a rights-based framework

In order to tackle the widespread problems faced by ordinary people concerning private health care, there is need for health system initiatives, combined with large scale social action. Building effective regulatory frameworks must go hand in hand with developing a climate of social accountability and patients rights. We must recognise that current weak regulation, or gaps in regulation of the private medical sector in many LMICs is linked with minimal political will to regulate this sector, since the private healthcare industry often has significant financial and political clout. Weak political will may also be linked with lack of public expression of demand for accountability of the private medical sector, even though there may be widespread yet diffuse discontent in the population about practices of the private sector. Nevertheless there is a strong case in favour of effective regulation of private healthcare providers, with components of social accountability.

Key arguments supporting the need for such regulation include

The Human rights argument:

In context of frequent violation of Patients rights in private health care facilities, it is worth reiterating that responsibility of the state regarding promotion of Human rights includes protection of citizens from rights

violations by third parties. The UN CESCR General Comment 14 on the Right to Health brings forth the indisputable role of the Human rights framework in dealing with the private health sector. *It must be emphasised that Patients Rights are Human Rights* – and hence effective regulation of private healthcare providers must be ensured by the state, especially to guarantee protection of Patients rights.

The Public funding argument:

In many LMICs, the private medical sector including 'charitable' hospitals have received significant public subsidy in various forms. This may include subsidised land in urban locations, and inflow of highly trained doctors from publicly funded medical colleges, which may be a continuous and massive subsidy from public systems to the private medical sector. Further, many governments have initiated large scale publicly funded health insurance schemes and 'Public-Private Partnerships', wherein significant public funds are made available to private providers.

Given historical as well as ongoing flow of public subsidies and finances to the private medical sector, the need for concomitant public accountability systems cannot be denied. It is logical that all services which have been supported through public funds in any form (which would include the entire private medical sector), must also be held publicly accountable, through a framework of effective regulation and rights.

The Market failure argument:

Health care is a sector which is notoriously prone to 'market failure', due to massive asymmetry of knowledge and power between healthcare providers and patients, as well as the unique vulnerability of patients. In an unregulated 'free' market, unfortunately doctors and hospitals are often free to exploit patients by over-treating, over-operating and over-charging them. Globalised pharmaceutical and medical technology industries are continuously introducing new drug molecules and technologies. These massive industries lure doctors with graft and incentives, further distorting the situation to the detriment of patients. Given this context, *the only logical antidote to market failure, to correct the major imbalance between health care providers and patients, is effective public regulation with social accountability,* which could ensure that the interests of citizens are placed at the centre of the health care system.

Regulation should be accountability writ large

Regulation of the private medical sector has often been looked upon as a bureaucratic function of the state, divorced from issues of patients rights, and accountability of private hospitals to patients and citizens who use health services. However *if we agree that regulation is a form of social accountability writ large, then regulators must be systematically accountable to citizens*, and citizens concerns must be strongly reflected in the regulatory framework. Otherwise regulatory bodies may be captured by elites, or regulation may remain minimal or may become an additional channel for corruption.

Given this context, we propose that *demand for protection of Patients rights could be an important fulcrum for social mobilisation related to regulation and social accountability of the private medical sector,* by the health movement and civil society organisations. Along with this there is also need for working within the medical profession, and developing a voice for social responsiveness from sections of doctors interested in ethical, rational care, who may be concerned about the negative impacts of gross commerciali-sation on their profession.

Residents vote for reforms in healthcare system

98.7% vote in favour of bringing private hospitals under regulatory framework

SHWETA SANDILYA
PUNE JULY 1

"PATIENT'S VOICE, Citizens Initiative Campaign", started by the Jan Arogya Abhiyan, conducted a unique voting for patients' rights, concerning "defaults for protecting patients' rights, preventing exploitation of patients at private hospitals, including corporate hospitals, and improving the quality of healthcare in public hospitals."

The voting took place in various parts of Pune district from June 15 to June 30. The results of the voting process were announced by the Abhiyan at Patrakar Bhavan on Saturday. Atul Pethe, theatre director; Poornima Chikarmane, unorganised workers' leader; Prof Anjali Maydeo, Dr Abhay Shukla and Dr Abhijit More, health activists, were present.

In the unique voting process, 21,351 votes were cast. People from various residential societies, slums, villages, laughter clubs, companies, colleges, self help groups and "wari" participated. As many as 630 people voted online. The voting process was conducted at more than 80 places in Pune district. Government employees, doctors, nurses, IT professionals, unorganised workers, waste pickers, domestic helps, farmers, farm labourers, senior citizens, sex workers, people belonging to nomadic tribe community, auto drivers, teachers and people across all social strata participated in this voting.

When asked about the motto of the campaign, health activist Abhijit More said, "The campaign started with a perspective of "not to violence against doctors and yes to patients rights. Both doctors and patients will need to come together to solve the issues in the medical profession."

The voting was based on three questions: Should Maharashtra government regulate and standardise private hospitals to check commercialisation? Should government take concrete steps to improve quality of care in public hospitals? Should government immediately enact legislation to protect patients' rights?

Out of the 21,351 people who voted, an overwhelming 21,067 (98.7 per cent) voted in favour of bringing private hospitals under regulatory framework while 21,247 (99.5 per cent) agreed that government should take concrete measures to improve quality of care in public hospitals. 21,225 (99.4 per cent) people demanded enactment of legislation to protect patients' rights. "This indicates that the people from all walks of life are dissatisfied with current health options and they strongly seek reforms in the healthcare system," More said.

The campaign emphasised on poor quality of care in public hospitals, unrestrained commercialisation of healthcare, unindicated surgeries, unindicated investigations, prescribing costly medicines, cut practice, huge and unjustifiable profiteering in stents. "Profiteering seems to be the sole motive of hospitals... Hospitals must be engaged to follow protocols. The government is responsible to ensure that health care is offered within affordable limits," said Poornima Chikarmane of Kagad Kach Patra Kashtakari Panchayat.

Discussing about the unsound relationship of patients, doctors and government, Dr Abhay Shukla, co-convener of Jan Swasthya Yojana, said, "There is tension between the three stakeholders: government, patients and medical professionals."

He called upon doctors to join the campaign and added that political representatives must take cognisance of the election and pass the act.

Malati Gadgil of Kagad Kach Patra Kashtakari Panchayat, said she had witnessed a horrifying case where one of her workers from Taljai vasti was diagnosed with breast cancer. She went through two biopsies where her results showed negative. "But still doctors asked her for the third biopsy, which was painful, of which the results were same. The patient had to pay Rs 25,000 and had to take a loan." She said the government should seriously consider National Health Policy and not just insurance policy.

The voting took place in various parts of Pune district from June 15 to June 30. Pravin Khergire

III. Example of campaign experiences from India – developing a three pronged strategy

Documented experiences of patients, specific studies, and testimonies by ethical doctors have established that *unnecessary procedures and medications, perverse system of kickbacks, super profiteering during hospital supply of stents, implants etc., and other malpractices are rampant in private hospitals in India.* Every year more than 60 million people in India are pushed below the poverty line due to unaffordable health care expenditures. While regulation of private hospitals and legal protection of patients rights must be ensured to stop such medical malpractices, it has been a challenge to develop effective campaigns around such issues. Nevertheless in Maharashtra state of India, over the last decade civil society organisations, health activists and health professionals have developed a range of interrelated strategies to build effective social mobilisation and advocacy around accountability of the private medical sector. The *'three pronged strategy' centred in Maharashtra state, India consisting of the following related approaches.*

1) Mobilising citizens for protection of patient's rights and regulation of private medical sector

The *Maharashtra state chapter of People's Health Movement (Jan Arogya Abhiyan)* is a wide network of civil society organisations, health activists, doctors and public health professionals. This coalition has been mobilising people and advocating with decision makers for protection of patients rights and related regulation of private hospitals across the state, since over a decade. The recent most chain in this series of actions is the *'Patients Voice, Citizens Initiative' campaign*, which reached out to tens of thousands of people from extremely diverse social backgrounds, by conducting a 'mass poll' on patients rights in different parts of Pune district in mid-June 2017. The objective has been building social momentum for protection of patient's rights, preventing exploitation of patients in large private hospitals including corporate hospitals, and improving the quality of care in public hospitals.

During the first phase of the campaign, health activists approached ordinary people with a short polling slip, asking their opinion on three questions - Should the State Government regulate and standardize private hospitals to check commercialization? Should Government take concrete steps to improve quality of care in public hospitals? Should Government immediately enact legislation to protect patient's rights? *Activists reached out to over 21,000 people, and each of them gave their 'vote'.* Ballot papers and boxes were taken to various residential societies, slums, villages, companies, colleges, conducting the voting process at more than 80 places in the city and district. People from across the social spectrum enthusiastically participated and voted, with the *overwhelming majority of over 99% voters expressing their firm support for patients rights, regulation, standardization of private hospitals, along with improved quality of care in public hospitals.* The results of such 'polling' are being strongly communicating to media, legislators and decision makers.

2) Bringing together conscientious citizens and rational doctors to foster dialogue through 'Citizen – Doctor Forums'

Citizen-Doctor Forums (CDF) have been formed in the cities of Mumbai and Pune of Maharashtra state.

CDF Mumbai is a growing joint platform of aware citizens and ethical doctors in Mumbai, to promote much-needed dialogue between society and medical community. It intends to strive for justice to the patients suffering from medical malpractices, and is creating public pressure on the Medical Council to ensure major reforms, while also providing support

and advice to patients who face problems while accessing care in private hospitals. Pune Citizen Doctors Forum (PCDF) is consists of volunteer-citizens and like-minded doctors, to bridge the current trust deficit between patients and doctors trying to do ethical, rational practice. PCDF is preparing a data base of patient-friendly doctors from Pune city so as to offer a list of such doctors to patients in need, while creating a web based platform (www.medimitra.org) which can be used by patients to suggest names, and provide feedback on doctors whom they have found to be patient-friendly. This information can be used by others patients who are looking for patient-friendly, rational, ethical doctors. PCDF also periodically organizes discussions among citizens and doctors on key topics related to health care, and is planning to publish standard educational material in lay language on rational care for common health problems.

3) Organising doctors to promote rational, ethical healthcare - Alliance of Doctors for Ethical Healthcare (ADEH) is an emerging national network of doctors in India committed to promoting ethical and rational health care, while challenging current malpractices within the medical profession. A few hundred doctors from various parts of India have so far joined ADEH, since they realised that there are several 'voices of conscience' among doctors within the sea of commercialisation, but these doctors are scattered and did not have a platform to raise their issues. These doctors who themselves practice in a rational and ethical manner, and are agitated about the increasing malpractices, have often faced their own survival struggles, due to 'resisting' the prevalent malpractices. ADEH has publicly intervened in the debate surrounding restructuring of Medical Council of India, and provided technically informed inputs to the National Pharmaceutical Pricing Authority (NPPA) of India towards fixing the ceiling price of coronary stents and other medical devices to make these affordable for common people. *ADEH has now planned to organise a National convention on Doctors for ethical healthcare in April 2018.*

These three approaches are being developed in a synergistic manner, with the objective of mobilising citizens, involving sensitive doctors, and facilitating dialogue towards improving the responsiveness and accountability of health care. While this is just one small example of possible strategies, in the coming period many such initiatives and experiences from different areas may be identified and shared through the thematic hub, to enable cross learning and refinement of approaches to ensure accountability of the private medical sector in various countries.

IV. Key activities planned by Thematic Hub on Accountability of the Private Medical Sector

The hub would promote networking among civil society organisations and networks on issues related to private health sector regulation and patient's rights, with a focus on South Asia. These efforts would support and complement existing networks like the People's Health Movement. The thematic hub will engage in relevant knowledge generation through publication of papers and policy briefs. It is expected that this hub would help to orient and inform health activists and civil society members, enabling them to raise key issues related to the private healthcare sector, in the spirit of accountability and rights.

The thematic hub will work through organising global thematic webinars, networking and alliance building in South Asia, regional consultations, and capacity building of activists. Key activities would include -

1) Forming an e-group of the Thematic Hub, and sharing regularly about accountability of private medical sector and patients rights, especially in South Asia context.
2) Organising a Regional consultation on accountability of private medical sector and patients rights involving civil society activists from India, Bangladesh, Nepal and Sri Lanka, during January 2018 at Mumbai.
3) Organising webinars on accountability of private medical sector and patients rights, focussed on South Asia context but with relevance for various LMICs. These would have involvement of interested civil society activists and health professionals from various countries.
4) Developing policy briefs and widely disseminating these; sharing literature on this theme, which would be uploaded on COPASAH website.
5) Preparations related to the theme for the Global symposium on Health sector accountability, including organising various workshops and sessions.

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