Healing the Private Health care sector in India

Is some radical treatment required?

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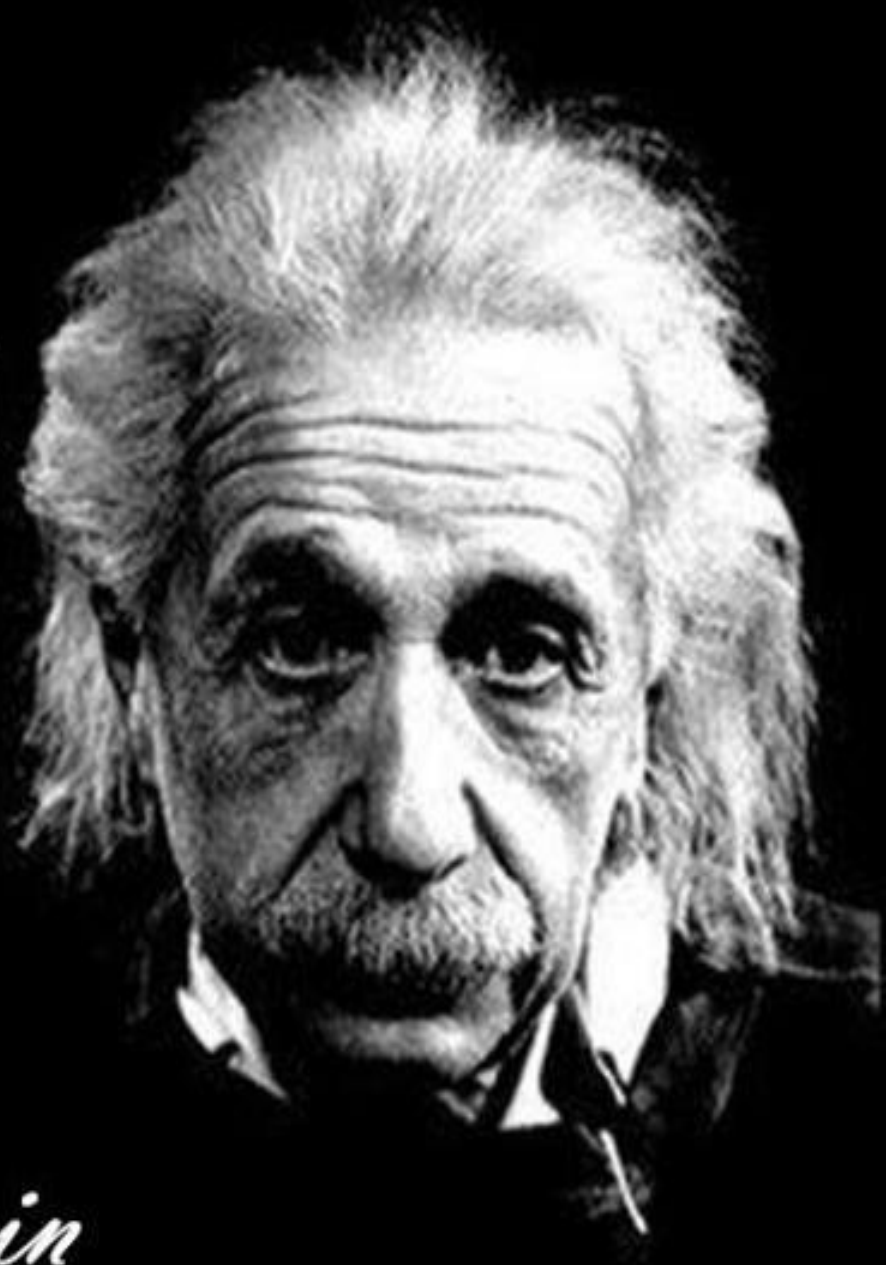
we cannot solve
our problems with
the same thinking
we used when
we created them



~ Albert Einstein

Some essential ingredients of the cure

- Operationalising and widely publicising **Patients rights** in the health care sector
- **Regulation of private medical sector** through appropriate Clinical establishments acts (Social regulation)
- Major Restructuring and **Reform of Medical councils**
- Moving toward a system for **Universal Health care (UHC)**

What happens when a
Large, dominant private medical sector
and
Weak public health system coexist?

Private Sector Dominated

Mixed Health Systems Syndrome

Unregulated, profit driven private sector

Underfunded, poorly managed Public sector

Absenteeism, neglect

Weak referral linkages within public system

Lack of medicines and diagnostics, poor maintenance

Legal and illegal private practice

Patients channelised to private hospitals

Flourishing private diagnostic centres and medical stores

Poor quality of public health services

High costs and irrationality in private medical care

Symptoms of MHSS

- Overwhelming predominance of Out–of-pocket payments, catastrophic spending
- Massive inequities in health care access
- Public subsidisation of private sector, with formal and informal flow of resources
- Large problems of governance in Public health system can persist without social unrest, because private sector provides for the dominant, vocal and powerful sections
- Private sector ‘sets the tone’ for entire health system including treatment practices, acts as a massive ‘magnet’ for doctors, constricts availability for public system
- Private medical colleges based on massive ‘donations’ distort the entire ethos of medical profession

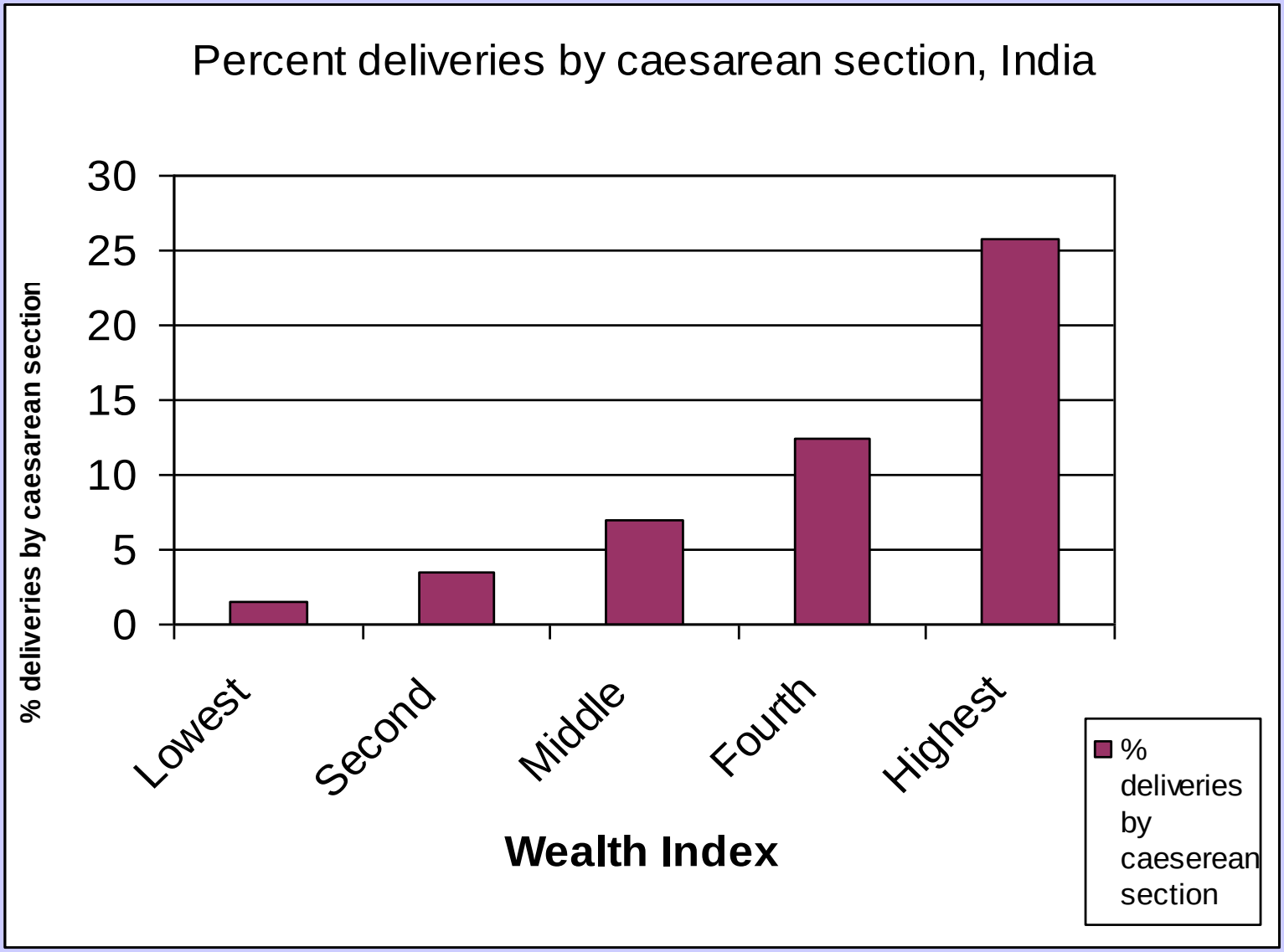
Malpractices & Irrational care - inevitable side effects of gross commercialisation of health care

- Today growing malpractices, irrational care and [illegible]ecessary procedures are inevitable products [illegible] commercialisation of h[illegible]
- Rationa[illegible] issue of morality of [illegible] rational health care, society must [illegible] whereby 'market failure' is eliminated through r[illegible]gulation, health care is made socially accountable and becomes less of a market commodity and more of a public good

It is difficult to remain good
When goodness is not in demand - Brecht

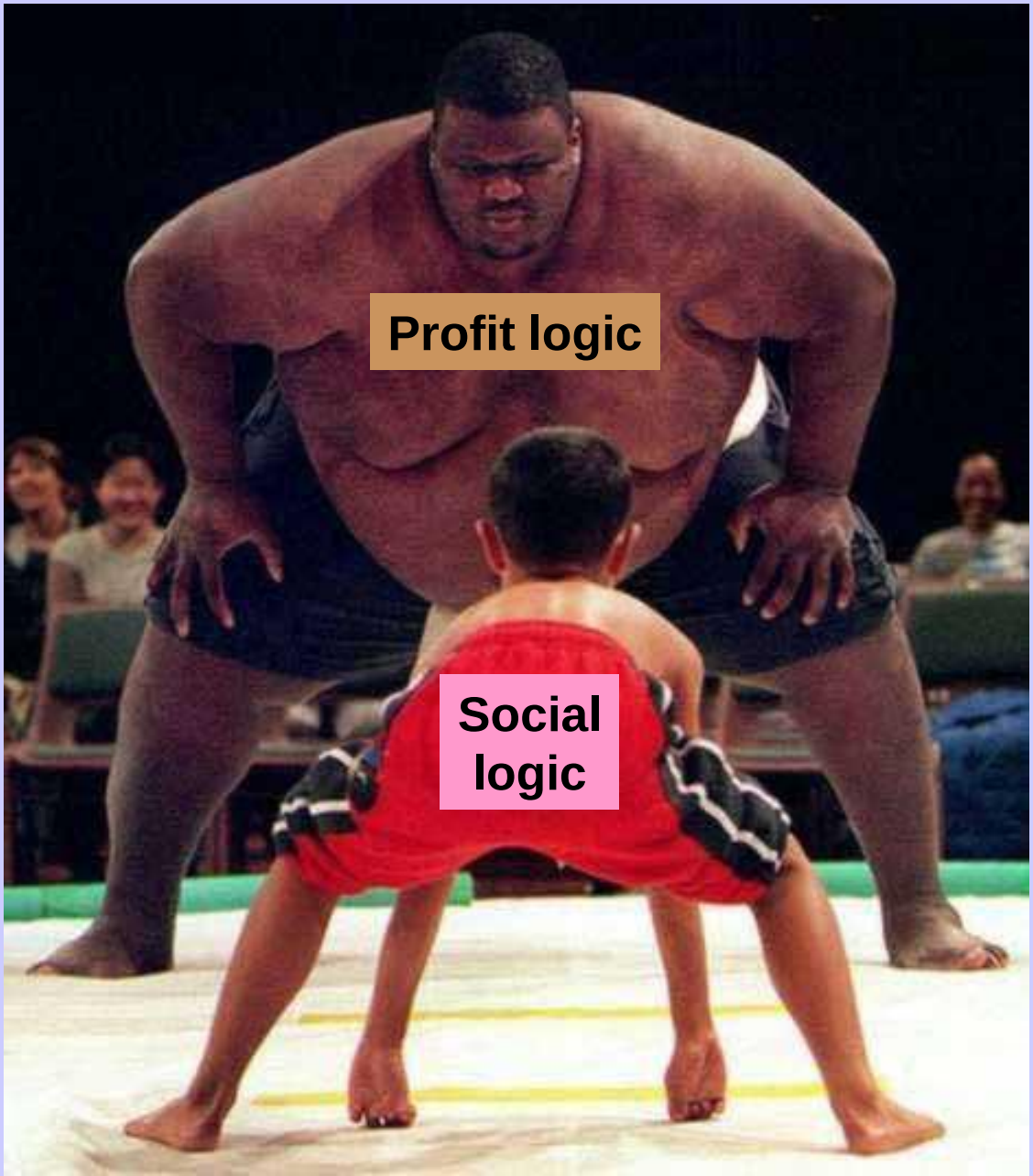
We are seeing today the results of
Gross commercialisation of health care.
To remedy this, systematic scale public action is required!

Poor women die from lack of cesarean operations, their rich sisters suffer from excess cesareans



Source - NFHS 3

Two contending logics in the Health care sector



Global Pharma industry

Private Medical Education

Unethical Promotion, irrational medicines

Corruption in MCI, Growing number of Investment doctors

Private Medical Sector

'Targets', Profiteering driven malpractices

Publicly funded Health insurance Schemes

Corporate hospital Industry

Insurance Industry

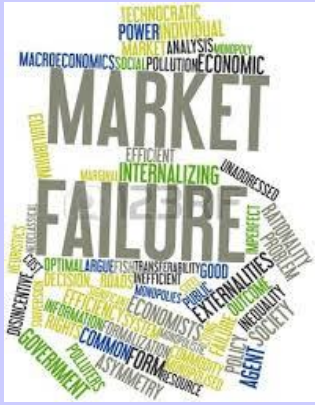
Charity may be abolished.
It should be replaced by justice.

- Dr. Norman Bethune

Why regulate the Private Medical Sector?

i. ***The Human rights rationale:*** ***Patients rights are Human rights*** – ***state obligation to protect***

ii. ***The Market failure rationale:*** ***Realisation of Rights requires Regulation***



iii. ***The Health systems rationale:*** ***Public health services are constrained due to unregulated Private medical sector; major public subsidies are being given to private sector***

iv. ***The Ethical imperative*** – ***ethical duties of doctors translate into rights of patients***

Is the private medical sector accountable?

- IMA and most private providers claim they are like any other business or profession, and are not specifically accountable to society
- However the entire **private medical sector in India has grown based on massive public subsidies**, it benefits from doctors educated with large scale public funds
- Due to massive ***information asymmetry***, major ***vulnerability of patients vis-à-vis doctors*** and inability of individual patients to deal with health care establishment due to a ***highly 'uneven playing field',*** private medical sector must be made to conform to certain social norms and accountability
- **Preferred mechanism for enforcing accountability is effective social regulation**

Charter of Patients Rights in Private hospitals

1. **Right to Emergency Medical Care**
2. **Right to information, including info about rates of services**
3. **Right to patient records and reports**
4. **Right to confidentiality and privacy**
5. **Right to informed consent**
6. **Right to second opinion**
7. **Right to choice of medical store or diagnostic centre**
8. **Right to take discharge of patient, or receive body of deceased from hospital, without preconditions**
9. **Right to protection as per ICMR guidelines, during participation in clinical trials**

Legal justifications

- **Right to Emergency Medical Care**
  - Supreme court judgment ***Parmanand Katara v. Union of India* (1989)**
  - Judgment of National Consumer Disputes Redressal Commission ***Pravat Kumar Mukherjee v. Ruby General Hospital & Others*** (2005)

    MCI Code of Ethics sections 2.1 and 2.4
- **Right to Information, Medical reports and records**
- Section 9 (i), Clinical establishments (Central Government) Rules
- MCI Code of Ethics section 1.3.2
- Central Information Commission judgment, Nisha Priya Bhatia Vs. Institute of HB&AS, GNCTD, 2014

Patients rights in private medical sector – currently scattered across regulations and not adequately ‘justiciable’ – these need to be consolidated and made fully operational with grievance redressal, through -

Clinical Establishment Acts

Regulation is now on the agenda –
Question is what type of regulation would effectively promote people's interests yet be practical?

- Due to variety of reasons, Regulation of private sector is now unfolding across India
- But history of public regulation of private actors in India is checkered, often a basis for corruption.
- Twin dangers – 'elite capture' and 'expert capture'
- IMA wants minimal regulation; corporate sector would like excessively demanding infrastructure / technical standards to weed out competition; bureaucracy is promoting largely unaccountable top-down regulation
- If people's health interests are not taken into account effectively, public good and patients rights will continue to be ignored, threat of corporatization

Some core components of a regulatory framework from people's standpoint

- Observance of range of Patients rights
- Moving from transparency towards standardisation of rates of services
- Standard treatment guidelines to minimize irrational care
- Grievance redressal mechanisms
- District level multi-stakeholder appellate body with civil society representation for accountability
- Dedicated public regulatory structure with adequate budget and additional staff at different levels

Social regulation =

State supported legal regulation

+

Participatory monitoring with accountability of regulators to citizens

+

Professional self regulation by doctors

Multi-stakeholder oversight bodies at various levels

The slow and tortuous development of CEA framework at national level

- National CEA passed in 2010
- National CEA Rules adopted in 2012 with significant added provisions like regulation of rates
- So far nine states incl. – UP, Bihar, Jharkhand, Rajasthan, Himachal, Assam adopted the central act
- However, due to strong resistance from private medical sector and weak public voice, as well as some technical complexities, slow development of official standards, hence act not yet implemented in any state
- Regulation of rates is an especially contentious issue

The basic reason that programs fail is not incompetence, ignorance or stupidity, but because they are constrained by the interests of the powerful.

- Richard Levins

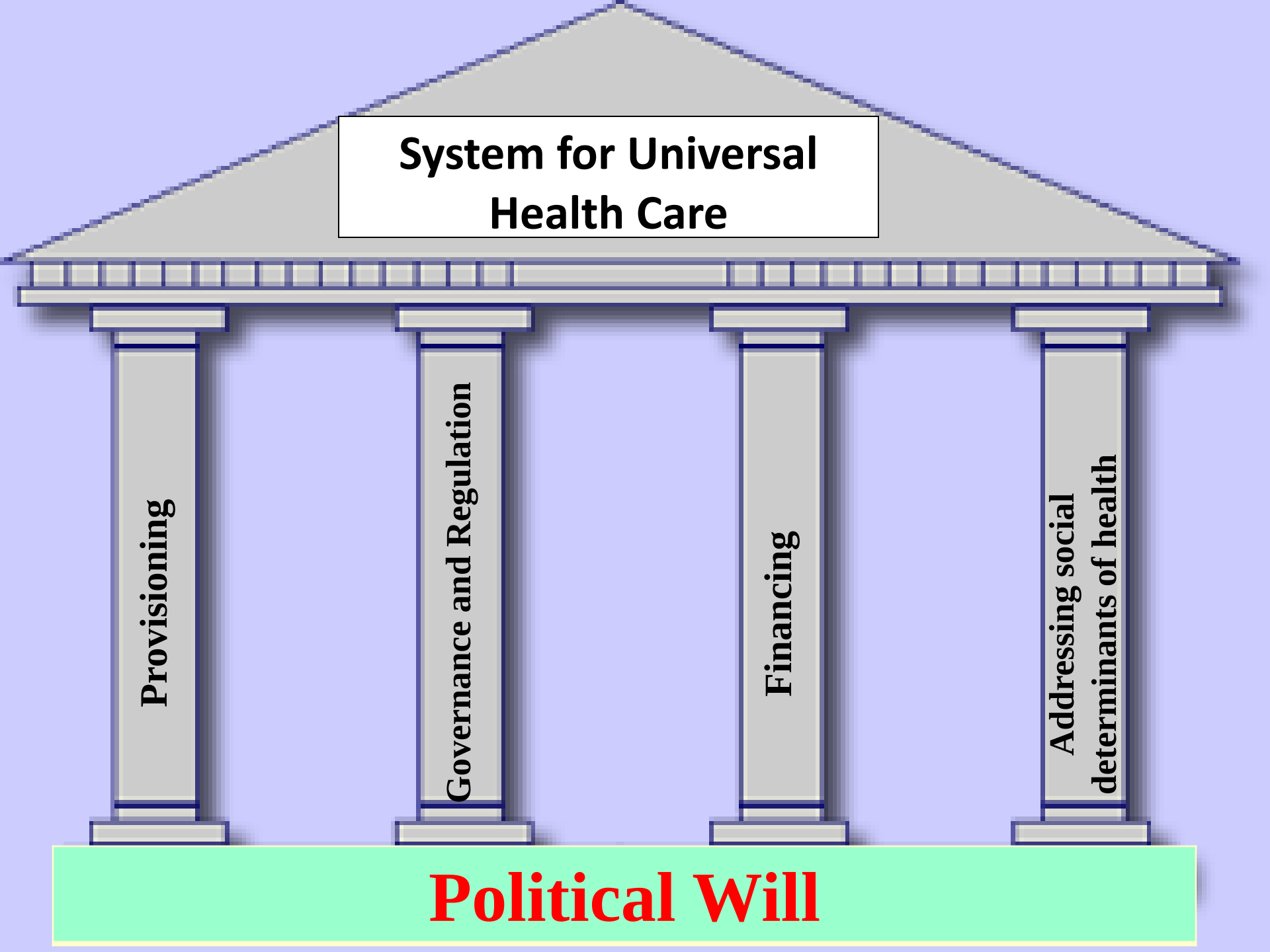
JAN SWASTHYA ABHIYAN DEMONSTRATION AT MAHARASHTRA STATE LEGISLATURE FOR STATE CEA WITH PATIENTS RIGHTS

To change the piper's tune,
it might be necessary to pay the piper …

Comprehensive and effective regulation of private medical sector could be increasingly realised by moving towards a publicly funded system for
Universal Health Care (UHC)

Features of Universal Health Care

- Right to Health Care for all, No exclusions or targeting
- No payment at point of service, no role for commercial insurance in UHC system
- Free healthcare through a network of improved, expanded public hospitals and contracted-in, regulated private providers
- Special efforts and programmes for marginalised groups
- Elimination of unnecessary medicines, investigations, procedures – reducing huge wastage and over-medicalisation
- Uniform norms for urban and rural areas, with integrated care from primary to tertiary levels
- Reducing ill-health through integrated action on key factors related to health
- Participatory governance at all levels with Patient's rights!


System for Universal Health Care
Provisioning
Governance and Regulation
Financing
Addressing social determinants of health
Political Will

Compartmentalized existing public healthcare		
Public Health Dept facilities	**Medical Colleges**	**Municipal Corp/ Council hospitals**
Railway hospitals	**PSU hospitals**	**ESIS hospitals**

Integrate existing public providers and significantly expand and strengthen public provisioning

In-source regulated private providers as per requirements

Integrate all providers into a comprehensive system of UHC
(rural & urban, primary, secondary & tertiary)

In-sourcing of regulated private providers to complement the public system

- **Completely different from current 'PPPs' -** Contracting-in with regulation and rationalisation to bridge the gap, in a manner that would complement and strengthen public systems – will work as extension of public system
- **Charitable trust hospitals -** 20% reserved beds to be brought under public management for UHC
- **Individual practitioners –** may be completely in-sourced to work in various levels of UHC facilities
- **Private nursing homes and hospitals- two options**
  - **Complete in-sourcing –** no patients outside UHC
  - **Primarily in-sourced-** at least two-thirds of their beds / patient facilities for UHC patients

Comprehensive regulation of treatment practices, costs and standards …..Progressive socialisation

Without democratic transformation of Health system governance, achieving a people-oriented system for UHC will remain a dream!

1) Generalization of Community monitoring
2) Direct democracy forums- Jan Sunwai, Arogya Gram Sabha

1) Health and Social Services Council at block, district level to manage health system locally
2) State Health Council, State Health Assembly

1) Public display of information
2) Protection to Whistleblowers
3) Participatory regulation of private medical sector

1) Internal democratisation of health system
2) Consultative mechanisms involving health sector employees

Enact new comprehensive legislations

- **Right to Healthcare Act**
  - Entitlements and redressal mechanisms regarding right to healthcare
  - A framework for UHC providers and administrators
  - Define standards, structures and community oriented monitoring and redressal mechanisms for UHC
- **Public Health Act**
  - To deal with health determinants and essential public health functions
  - To bring together existing laws, develop legal framework on social determinants of health in a cohesive fashion and ensure effective inter-departmental coordination
- **Clinical Establishment (Registration and Regulation) Act**
  - To standardise quality of care, costs and human resources in all clinical establishments, whether involved or outside of UHC
  - To provide a charter of patient's rights and responsibilities, provisions for regulation of rates and grievance redressal

Create new institutions for UHC

- **Health Regulatory and Development Authority** (and similarly district level authorities), to co-ordinate and integrate all public providers, in-source certain private health care providers and ensure rational referral chains
- **Health System Evaluation Unit** under HRDA to evaluate performance of both public and private health facilities at all levels, to ensure standards, appropriate costs and rationality of care.
- **Director for Clinical Establishments**, Local Regulatory Authorities and appellate bodies, for regulation of clinical establishments and ensuring Patients rights in context of all establishments.

Estimated scale of finances needed for UHC in Maharashtra

Primary care (including first referral hospitals)	11,449 crores
Secondary/Tertiary care (including medical and health education)	5,700 crores
Administration, health authorities and UHC agencies, medical research, accounting and audit, information management	1,543 crores
Capital investment for expanding public health services, maintenance and renewal of assets and contingencies	5,608 crores
Total annual cost of UHC	**24,300 crores**
(Rs. 2132 per capita or 1.74% of State Domestic Product)	

Raising finances for UHC

- Maharashtra's Per capita income is Rs. 1,30,000 but per capita spending on public health services is just Rs. 630 (for Goa it is Rs 2,200). Average spending of over Rs 2245 on healthcare which is nearly 4 times what state government spends!!!

The resources are not difficult to raise…

- **Mainly from general taxation**; negotiation with Central Government for larger scale resources for UHC
- **Reducing tax exemptions to corporate sector**; judicious use of various exemptions that are presently being offered to the corporate and business sector
- Comprehensive **Financial Transaction Tax**
- A **state health tax** on lines of professional tax, for those who are in regular employment or business but not covered by social insurance

Moving from insurance schemes to UHC

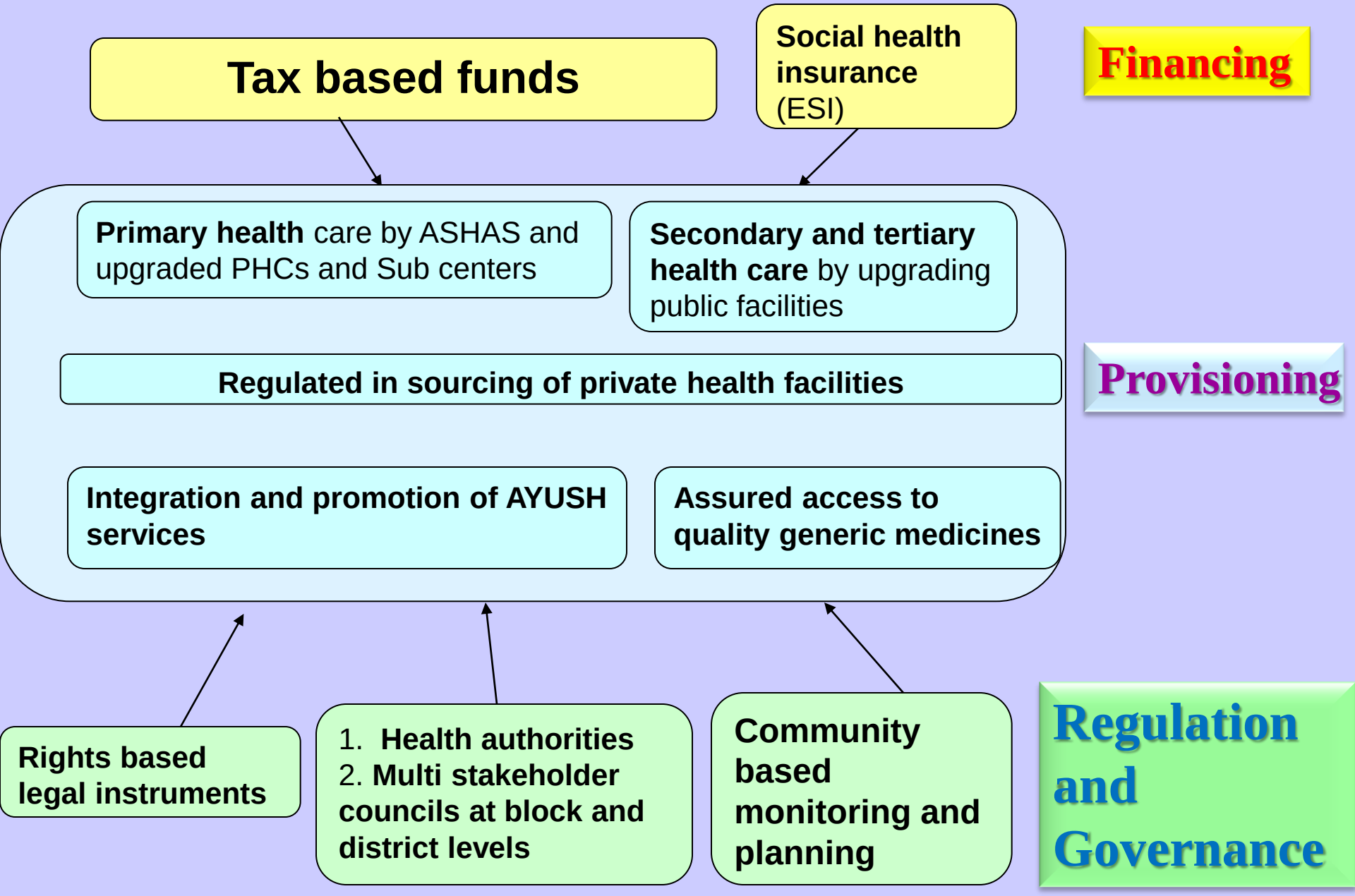
Commercial insurance based schemes like RSBY-

- Commercial insurance companies should not be used to purchase health care services on behalf of the government. These fragment care, inflate cost, lead to poor outcomes; no example in the world of comprehensive Universal Health care through commercial insurance
- RSBY and other such schemes- transform, reshape, eliminate role of insurance companies and merge them with UHC System

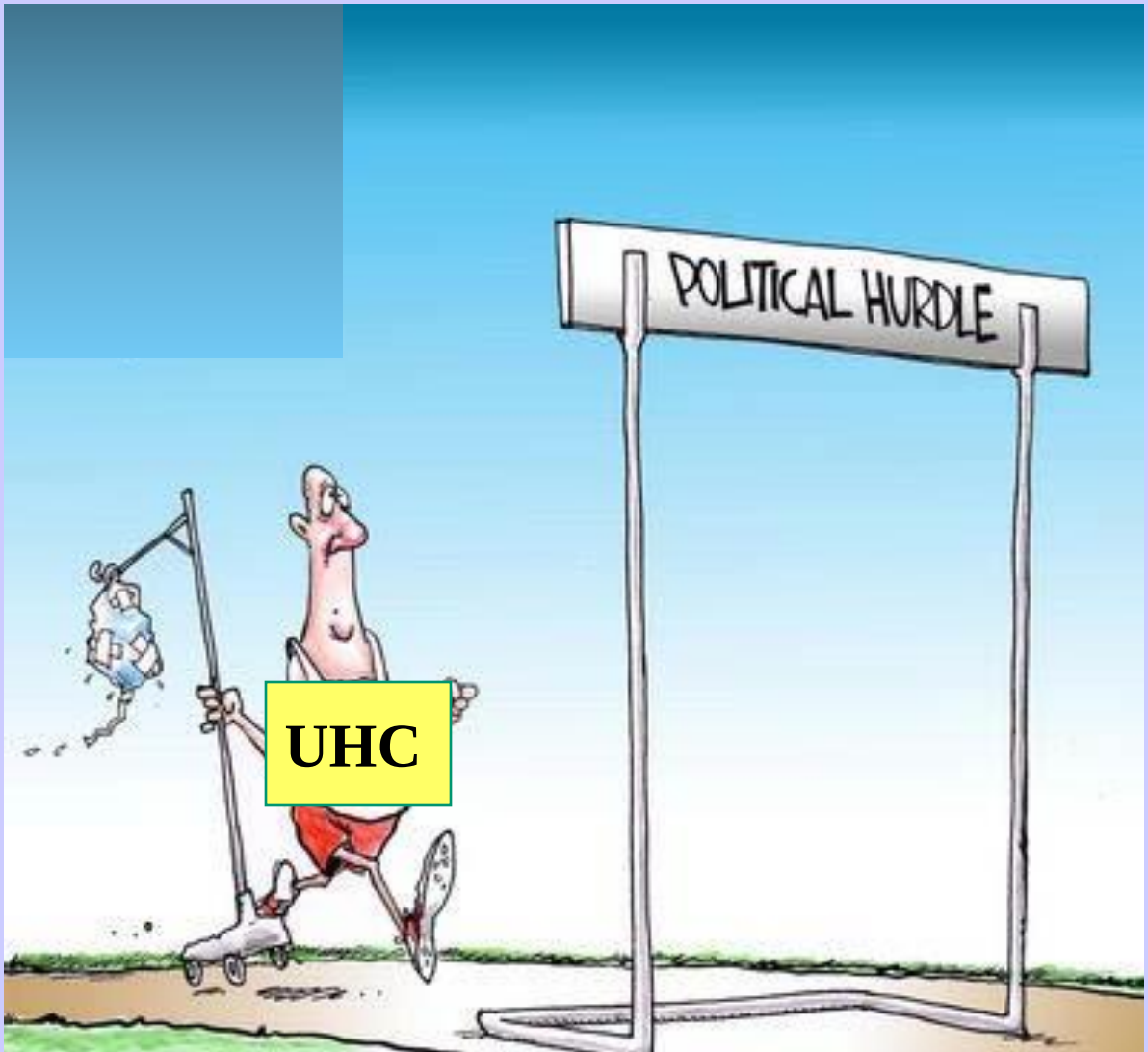
Employee's State Insurance Scheme (ESIS)-

- Largest social health insurance programme for organized sector workers
- Substantial healthcare & financial resources; very low utilisation
- ESIC hospitals (run by State Public Health Department) need to be integrated with UHC. 50% beds to be reserved for existing beneficiaries in first phase.
- Salary ceilings for ESI should be removed and care should be provided to unorganised sector workers also.

- Formation of participatory '**Health and Social service councils'** with elected representatives, officials of various departments and broad range of civil society and community representatives at Taluka / Ward and District / City level
- Can ensure effective **convergence of services** (water supply, sanitation, nutrition, food security, environmental conditions etc.) **in a rights based framework**
- **Monitoring and advocacy function of Public health department with dedicated staff** to ensure that various social determinants are addressed in effective manner
- Supported by **political endorsement** from the highest levels and **administrative mandate** to order action


Tax based funds
Social health insurance (ESI)
Financing
Primary health care by ASHAS and upgraded PHCs and Sub centers
Secondary and tertiary health care by upgrading public facilities
Regulated in sourcing of private health facilities
Provisioning
Integration and promotion of AYUSH services
Assured access to quality generic medicines
Rights based legal instruments
1. Health authorities
2. Multi stakeholder councils at block and district levels
Community based monitoring and planning
Regulation and Governance

UHC is a realisable dream – But only if Political will is developed!



दर्द का हद से गुज़र जाना है
दवा हो जाना ...

(*When the pain crosses all limits, this opens the way for the treatment)*

– Mirza Ghalib