**Title:** **National workshop on ensuring accountability and responsiveness of the private health sector in India: a workshop report**

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**Introduction**

Increasing prevalence of unethical practices such as unnecessary investigations, overcharging, and violation of patients’ rights in private hospitals have drawn attention to the unregulated and commercialised private healthcare sector in India (1). This situation underscores the critical need for regulation of the existing, dominant private sector in India, for its effective engagement in achieving Universal Healthcare (UHC). In order to deliberate upon social accountability of private health sector, a two days national level workshop was jointly organised by SATHI (Support for Advocacy and Training to Health Initiatives) and Jan Swasthya Abhiyan on 26-27 November 2019 at Delhi, on ‘ensuring accountability and responsiveness of the private health sector in India’. It was attended by around 60 participants including health activists, public health experts, practicing doctors, researchers and policy makers from across India. Building upon political economy and transformations in healthcare, key components for regulation and accountability of private sector such as patients’ rights, Grievance Redressal (GR) mechanisms, enactment of Clinical Establishment Act (CEA), Standard Treatment Guidelines (STG) and rate regulation were intensely brainstormed during the workshop. A line or two on the final takeaway/consensus/decision arrived at, at the workshop.

**Setting the context- political economy of healthcare**

In the introductory address, Abhay Shukla, a few words to contextualise him would be good outlined the importance of this workshop. He said, in this workshop we will discuss the elephant in the room i.e. rapidly growing, huge and unregulated private healthcare sector. It is necessary to deepen our understanding about the intricacies of private sector and tackle it effectively. He added that, this is important and urgent in the context of recent NITI Aayog report (2) which has clearly emphasized the role of private sector in healthcare service. Following this, during the first session on key aspects of political economy of healthcare, he shared the data on scope and scale of private health sector in India, financialization and increasing investments. He outlined four phases of evolution in healthcare in India as follows- the first phase, 1950-70- individual practitioners, not for profit providers and public health care, second phase, 1980-2000- small and medium providers and third phase, 2000-to at present – large multi-specialty hospitals, making a move from commercialisation to corporatisation of HC. He added that in the fourth phase, state financing is becoming crucial in terms of either subsidisation or investments for supporting the growth of private HC sector. Corporate and large private health care providers are now turning to the State to massively fuel the ‘fourth phase’ of expansion – based on large scale ‘strategic purchasing’, consolidated with state-specific schemes. Indira Chakravarthi, who? illustrated manifestations of corporatisation of private healthcare such as shutting down of small hospitals, doctor’s autonomy at stake, performance targets set for doctors. She interrogated on hybrid partnerships of non-profit charitable hospitals and for-profit hospitals corporate entities. Abhay Shukla (no need of the full name each time; only the surname is good enough after the first mention) further proposed the need for taking a differential approach while having common principals for the regulation of wide spectrum of private healthcare providers ranging from individual practitioners to small and medium hospitals, to charitable hospitals, to the corporate hospitals.

**Patient rights in India and clinical establishment act**

Ankit Garg, a victim of gross medical negligence, shared his personal experience during the session on denial & violation of patient rights in India, which indeed touched the participants. Shakuntala and Arun Gadre, who? presented the narratives and analysis of documentation of 24 such cases collected from across India. Gadre pointed out that terrorising tactics are also being used to intimidate patients to succumb to commercial pressure. In the following session on patients’ rights charter, Shakuntala shared about a campaign for patients’ rights charter which is adopted by National Human Rights Commission (NHRC) however is still waiting for Health Ministry to adopt it. Abhijit More in the next session talked about the curious case of Clinical establishment Act (CEA), which was enacted in 2010 by the parliament and is 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 CEA. Sundar Raman argued that people want regulation for the affordability of Health services and trust. But unfortunately, CEA is silent on these points and is focusing on infrastructure, input, and human resources.

**Standard treatment protocol and rate regulation**

J.N. Srivastava from National Health Systems Resource Centre (NHSRC) gave a detailed presentation on STGs and discussed challenges faced in the implementation of STGs such as robustness of STG development process, bringing all stakeholders on board, endorsement by professional associations, participation by patient groups, usage by public & non-public sectors, linking with service package and system of periodic revision. Discussion during this session flagged that without STGs, purchase of care from private sector cannot be made reasonable. It was also, said that it may be easier to make STGs for simple procedure but it would be challenging to prepare and implement STGs for complicated medical conditions. Why?

Next day of the workshop started with a session on rate regulation which seem to be the most contentious and challenging component in the regulation of private sector. Arun Gadre described six variables in determining rates in private sector (3). He further shared genuine concerns regarding rate standardization such as would senior doctors get more fees? What about geographical variation? He asserted that without socio-political push, with technical solutions alone, it is not possible to regulate the rates. Drawing upon own experience, Jayant Kumar Singh, a victim of exorbitant charging in corporate hospitals, quoted the central government’s response to supreme court in Aadya’s case (4) -‘healthcare is an industry, they can’t be under any price control. Its an open market and they can charge anything’ and raised the question that where to go and what to do in such case of exorbitant, irrational charging in private hospitals. Puneet Bedi, a practicing doctor from corporate hospitals, shed light on crucial role played by insurance companies in deciding charges by private hospitals. He cogently advised that patients must negotiate the bill. There is always the scope to bring it down and it happens regularly.

**Policy directions for regulation of healthcare**

Session on policy directions for the regulation of Healthcare was indeed insightful to understand the situation at a policy level. It consisted of a panel of Sanjay Nagral, who? two research officers from NHRC, Vinod Paul, a Member of NITI Aayog. What was the core of the panel discussion? 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 increase healthcare spending and reaching 2.5% of GDP by 2025 is the set target. The health system today has quality and standards issues but PMJAY allows to improve, without bringing into laws and regulations. NHRC officials provided an update on patients’ rights charter, saying, they have asked the Ministry of Health (MoH) regarding enactment of charter however MOH has diluted those 17 points in the charter accepted by NHSRC. Sanjay 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 mechanism**

In the session on grievance redressal for patient victims & the role of State Medical Councils (SMC), Kanchan Pawar provided an overview of current platforms for grievance redressal such as SMC, Medical Council of India (MCI), consumer court and criminal court and raised the concern about ineffective GR process. Drawing upon the own experience, Shishir Chand criticised the unaccountable MCI and SMC. Dr. Arun Mitra highlighted the positive actions taken by Punjab Medical Council, such as issuing notice to doctors against accepting gifts from pharmaceuticals, being ghost faculty in colleges, endorsement of 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**

Sulakshana Nandi, during the session on social accountability of insurance schemes, presented the data on prominence of private sector in PMJAY. Overall 62% of the PMJAY funds are going to private sector (5). Average out of pocket expenditure (OOPE) in private sector is six times more than in public sector. Average OOPE in public hospitals is Rs. 2848 while Average OOPE in private hospitals is Rs. 17,493 (6). During the last session of the workshop, Dr. Anant Phadke argued that, regulation alone will not take us to UHC and flagged the need for socialising private sector for moving towards UHC. According to him, socialisation of public health system is easier however, it will be far more difficult for 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 profit but profiteering and cheating are not allowed. So private providers are making money, selling services to government but it’s not open market there, it’s a regulated market. He further argued that, if we want to bring UHC in the next ten years, then it will not be possible in the present state of health system. Priority will have to be given to the reform of public health system.

**Concluding remark**

In the concluding session, Abhay Shukla stated that a big churning is going on today in the health system of India. He pointed that, on one side, states like Rajasthan and Madhya Pradesh are drafting the right to health and healthcare act. Chhattisgarh too is seriously considering the implementation of UHC. These states are trying to chart the new pathways. While, on other hand, we have much debated PMJAY. Further he appealed that as a health movement, we need to re- calibrate and take forward our strategies to present the positive alternative. If we criticise PMJAY, we must be able to offer alternative which is far superior to PMJAY. According to him, such an alternative could be- public health system centred UHC, which will be based on strengthening and expansion of public health system, as well as expansion of state’s capacity to regulate private sector because state’s 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 private sector. He concluded the workshop by highlighting the need for furthering these brainstorming to concretise our proposals for social accountability of private healthcare sector while marching towards UHC in India.

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