Title:

Setting the framework and agenda for people centered accountability of private and corporate healthcare sectors

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**Abstract:**

The thematic track on accountability of the private and corporate healthcare sector during the COPASAH Global symposium aimed to analyse the emergence of the global trend of commercialization of health systems, and transition of health care from a public good to a marketable commodity, at the cost of publicly funded health care in developing countries. It examined the implications of the lack of state regulation and oversight which has enabled the profit driven private healthcare sector to exploit vulnerable people through overcharging, malpractices and violations of patient’s rights. Finally, the track addressed challenges in advocacy of patients’ rights and showcases effective campaign strategies used by health activists in different countries to promote accountability of the private healthcare sector. Collectivizing learnings and insights from this track will help in contributing towards a powerful global counter-narrative, while providing activists with the tools to create awareness and engage with this critical issue.

**The theme of People- centred accountability of the Private healthcare sector at the COPASAH global symposium**

This paper draws on the interactions, perspectives and practices shared in the thematic hub on “Patients’ rights and private medical sector accountability” during the COPASAH Global Symposium on Citizenship, Governance and Accountability in Health in October 2019.

More than 30 practitioners from 10 Asian and African countries shared their experiences about community and civil society action to address challenges faced by the unchecked growth of the private health sector and its implications for the changing nature of healthcare. The thematic hub focused on possible approaches and models of engagement with state and other actors to introduce accountability mechanisms to ensure effective regulation of the private healthcare sector.

**Background**

The global emergence of a growing “for profit” private sector in healthcare, and the increasing commercialization of health care across most LMICs (Low- and middle-income countries), have critical implications for the future of healthcare. In many LMIC countries, underfunded public health systems are overwhelmed with inadequate staff, facilities and supplies. Large sections of people, including the poor, often have no other recourse but to turn to private healthcare providers and have to reckon with unaffordable health care and widespread malpractices such as unnecessary procedures, tests and overtreatment in the form of irrational medicines.

The hegemony of the medical - industrial complex is compounded by a lax regulatory framework and lack of accountability and oversight, which paves the way for private healthcare providers to get away with malpractices and violations of patients’ rights. The impact of commercialization in the private healthcare sector has proven disastrous for ordinary people. For example, in India alone, where the private health sector accounts for more than 70% of healthcare provisioning, 63 million people fall below the poverty line every year due to catastrophic health costs**1**. In Uganda and Kenya, the private healthcare sector is mostly unregulated and has almost monopolized certain domains of health services, while Sri Lanka is also witnessing an upsurge of market-based tertiary private care. Out of pocket expenditure on drugs is a major cause of impoverishment in many countries.

1. **Emergence of commercialization & corporatization of the private healthcare sector**

Across LMICs, most social accountability practices so far have focused on the public health sector with comparatively little attention addressed to accountability of the private healthcare sector, even though it dominates healthcare markets in many countries across Asia and Africa.

The structural adjustment and economic reforms program from the 1990s onwards flowing from a neo-liberal discourse, shrunk resource allocation for public health services and favored expansion of the private health sector. Healthcare was transformed from largely being a public good, into a marketized commodity. A public health researcher from India pointed out that India has amongst the lowest spending on public healthcare in the world – a mere 1.02% of its GDP, largely stagnant over decades. The private healthcare market is however expanding at 22% per annum, with scant regulation in medical education, drugs and diagnostics.

Mapping the shift in nature of medical practice over the past three decades due to the entry of the private medical sector, a public heath researcher shared her findings on impact of corporatization of healthcare on doctors in Maharashtra, India **2** which highlighted the change from individual private practice in the seventies, to small and medium hospitals in the nineties, to the emergence of the multi-specialty and corporate hospitals in the new millennium. High fees of private medical colleges, competition from corporate hospitals, patients’ expectations, high investment costs are factors causing many small and medium sized hospitals to shut down. On the other hand, corporate hospital chains offer lucrative employment options to medical professionals in terms of monetary benefits, access to infrastructure, technology and prestige. However, corporate hospitals pose challenges to doctors as well. Senior doctors with market credibility are offered hefty remuneration packages, while junior doctors are underpaid. Hospitals are run on profit centered business principles, where doctors need to fulfill targets and are assessed on their ability to generate revenue. The pressure to meet corporate targets undermines the professional autonomy of doctors, the doctor-patient relationship, and leads to malpractices and inflated cost of healthcare for patients.

Health rights activists shared similar accounts of lack of effective regulation and oversight mechanisms by the state, unimpeded practice of for- profit medicine and exploitation of the information asymmetry that exists between doctor and patient. In Uganda, failing public health systems push poor, dispossessed people to private clinics, which at the primary care level, function as referral points for large corporate hospitals. Prosecution success rate of medical negligence cases is minimal, and State medical councils are ineffective in curbing malpractices.

In Nepal, the 1990s were an era of political and economic liberalisation, following the abolition of monarchy. Neo-liberal pro-market policies dominated, leading to phenomenal expansion of the private healthcare sector. Today in Nepal, the distribution of manpower between the public and private sector is skewed, with more than one third of the total healthcare workforce serving in the private sector which also dominates medical and dental education. The implications of the skewed distribution of services and medical personnel are manifold -from high cost of healthcare services, unnecessary hospitalizations and irrational use of medical technology. Hospitals and healthcare workers are concentrated in urban areas. State regulation of the private healthcare sector, including price control is very weak, causing an imbalance of power between people and healthcare and catastrophic costs of healthcare.

Enabled by funding and influential political lobbying, the private sector has rapidly expanded and captured healthcare markets in many developing countries, facilitated by the banner of universal health ‘coverage’. The narrative of Universal Health ‘Coverage’ is preferred over Universal Health ‘Care’. There are examples of Kenya and South Africa where health insurance was a major political promise, enabling opportunities for the private sector to not just provide services, but also influence decision making at policy and governance level. The trend of privatization is visible in the approach to Public-Private Partnerships (PPPs). Despite lack of clear evidence of their efficacy, governments of many African and Asian countries are introducing the PPP model in not just the health sector, but also concerning social determinants of health like agriculture, education, infrastructure and transportation, while weakening public provisioning.

The presentations underscored the global spread of corporatization and privatization of healthcare, despite clear evidence that in the absence of regulation, a privatized healthcare sector threatens access to affordable and quality healthcare for all. Close attention also needs to be paid to the marketisation of social determinants of health such as water and nutrition, which also contributes to worsening access for a large vulnerable population.

There is an intersectional aspect to the privatization and commercialization of healthcare, contributing to gender inequality and exploitation of women through unaffordable sexual and reproductive health services provided to maximise profits. For example, in Nepal, deliveries in government hospitals are free of cost, but poor quality of services force women to turn to exorbitantly priced private hospitals. Families who must borrow money or sell assets to access private reproductive and maternal health services often make the difficult decision to not seek healthcare, putting women’s lives in danger.

**2. Patients’ rights as fulcrum to promote social accountability of private healthcare**

With increasing public awareness has come the demand for reform in the private health sector to make it more accountable. Healthcare however is an episodic concern and it is challenging to engage and mobilize communities on issues of accountability and regulation, given the inherently abstract nature of such demands. Here a focus on Patients’ rights could mobilize the community to raise their collective voices and draw attention to the lack of regulation in the private health sector and its impact on quality and cost of healthcare.

Activists involved in the campaign for Patients’ rights in India presented diverse strategies used for advocacy in India such as documentation of patient’s rights violations and denial in the private healthcare sector, awareness campaigns and advocacy with the state and central governments.

Campaign actions to increase awareness included organizing ‘People’s ballots’ in Maharashtra where people voted on their health rights and expectations. Advocacy related to Patient Rights Charter formulated by the National Human Rights Commission included online petitions and “Satyagraha” marches, demanding the Union Health Ministry to adopt and implement the charter. Sustained advocacy resulted in circulation of a shorter charter of rights and responsibilities to all States for implementation in 2019.

Patients and their caregivers, who have borne the brunt of denial of their rights, have turned to activism and are fervent advocates for Patients’ Rights. One such activist talked about his personal journey, highlighting failure of the Medical Council of India (MCI), the apex regulatory body for doctors and State Medical Councils to curb corruption or investigate patients’ complaints. Lack of stringent punitive measures has given rise to a culture of impunity, where doctors are emboldened to engage in corrupt unethical practices with no fear of repercussions. Patient victims and their families who decide to seek justice have to contend with bureaucratic behaviour, inordinate delays, multiple redressal forums and an opaque system heavily biased towards doctors.

A health rights activist from India shared insights about the campaign for Patient’s rights in the context of clinical trials. Many clinical trials were conducted in India by multinational pharmaceutical companies between 2005 to 2010 without transparency, ethics, proper enrollment and documentation. The campaign mobilized patient victims and used litigation along with media advocacy to seek redress. The most common violations were lack of informed consent being sought from participants. As a result of campaign litigation, it is now compulsory for Clinical Research Organizations (CROs) to provide product information sheets to patients and video record informed consent process. The campaign continues to focus on two major demands – ensuring that the government pays retrospective compensation to those harmed in clinical trials before 2013, and inclusion of the Patients’ Rights Charter in the Drugs and Clinical Trials Rules, 2019.

People in Uganda have been fighting for national health insurance since budget allocation for health and healthcare is decreasing, leading to drug stock-outs, sale of expired drugs and an ever-shrinking national list of essential medicines. Since economically vulnerable patients are powerless to negotiate with private hospitals, Uganda sees lot of patient detentions linked with non-payment of dues, denial of information, and lack of transparency. The campaign is asking the government to include the Right to Health in the Constitution, with health services becoming claimable entitlements. The law should institutionalize the Patient Rights Charter, while empowering patients to hold health services accountable. Other strategies include translation of the patients' rights charter from text to graphics to make it more accessible to community members, and enabling them to negotiate standards of care with their hospitals.

Experiences shared by practitioners underscored the importance for Patients' rights to become a global movement within international frameworks for social accountability. The struggle to legally enshrine Patients’ Rights in countries like India and Uganda shows the need for collective action and sustained advocacy, considering strong pushback against any form of patient centered regulation from the powerful private healthcare lobby.

**3: Collectivizing citizen voices and using litigation to push for accountability**

The Peoples Health Movement in Sri Lanka has consistently advocated for the Right to Health and their current campaign is focused on bringing this issue on the political agenda, while introducing a law to cap prices of vital drugs like insulin. Using their learnings from their decade long struggle for access to essential medicines, they focused on the lack of regulation in the rapidly expanding private health sector in Sri Lanka. However, their struggle to regulate the private sector has had limited success, since the influential private health sector lobby ensured that the government agency functions only as a registration agent with no powers for enforcing accountability.

In Uganda, practitioner efforts are focused on introducing regulation in Public- Private Partnerships (PPP) in health. The Access to Information law does not apply to private entities in Uganda, and the law stipulates that only information in possession of the state can be provided to the complainant. The example was shared by a Ugandan health activist, concerning a woman who lost her baby due to negligence in a private hospital which was the recipient of a government grant, but was denied access to her medical records. It was argued that if public funds are being given to a private entity, then the government is accountable to share information, as the private agency has to be held as acting on behalf of the government. Community advocacy campaigns are focused on a Bill on patients’ rights and responsibilities to protect vulnerable patients in PPPs, while bringing them within the realm of the Access to Information Act.

Formation of collectives of citizens and ethically inclined doctors are also an important approach to engage and involve key stakeholders in the campaign for ethical rational healthcare. The Alliance of Doctors for Ethical Healthcare (ADEH) in India is one such network formed due to the need to promote and support patient-centered rational medical practice, free from commercial influences. It serves as a platform for doctors who actively voice their concerns regarding the corporatization of healthcare, regulation of drug prices, equipment and consumables industry, honoring patients’ rights, and transparency in pricing. Another participatory initiative undertaken in the city of Pune, India is the Poona City Doctor Forum (PCDF). Founded to promote rational medicine, universal health care and improve doctor-patient relationship, the PCDF organizes awareness sessions and posts videos on healthcare and policy issues. PCDF operates a website where it crowdsources doctors in Pune whom patients have perceived to be patient friendly and responsive.

A public health activist presented the evolution of the Karnataka Private Medical Establishments (KPME) Act 2017 for regulation of the private healthcare sector. Since 2002, many social health insurance schemes have been introduced in Karnataka in which the private sector has a significant role in implementation. Strong linkages between politicians, private hospital associations and doctors’ associations ensured a united front to represent their interests. In this context, when the state government attempted to introduce more effective regulation through KPME amendment, there were major protests by the medical fraternity against pro-patient amendments, which were diluted as a result. While rate regulation could not be introduced, transparency of rates and Patients’ rights charter was ultimately included in the modified Act.

A leading consumer rights advocate from India who is a practicing lawyer, presented his experience of using litigation to cap the prices of cardiac stents in India which were being sold at exorbitant rates. Using public interest litigation (PIL) to exert pressure on the government, he was successful in his efforts to cap prices of cardiac stents and make them affordable by their inclusion in the list of essential drugs. He made a strong case for use of the judiciary as a strategy to introduce accountability and transparency in the healthcare sector.

Overall there is need to build strong popular alliances to counter the hegemony of the influential and organized private sector. Rights can only be enshrined in law, when a broad social coalition comes together and demands change collectively. It is equally important to marshal evidence through the epistemic efforts of knowledge-based experts, instead of relying solely on opinion-based advocacy. Civil society needs strong strategic advocacy coalitions, actively supported by research and evidence, to fully utilise opportunities for policy engagement.

**4. Implications for community practitioners and the health movement**

The movement for accountability of the private health sector assumes increased urgency with expansion of Public private partnerships in the health sector, along with increase of medical tourism and movement of patients between countries. There is a need for cross-border cooperation among health researchers, activists and Civil society organizations in LMICs to explore the transnational linkages fueling the growth and influence of the private health sector, while calling on respective governments to protect Patients’ rights by defining and institutionalizing them. Public health professionals need to recognise and hold accountable actors beyond the government such as donors and financial institutions like the World Bank, which promote public-private partnerships in healthcare.

As community practitioners explore diverse and innovative approaches to engage and mobilize people on this issue, it becomes clear that collectivizing voices, sharing learnings, networking with allied citizen groups across regions and countries is critical to counter the powerful private health sector lobbies. Moving beyond focusing on individual doctors and hospitals, community action should focus on pinning the liability on a system with failed checks and balances, which enables the private healthcare sector to put profit above patients. Experiences of the campaigners highlight the need to unite and form a powerful and well-organized global advocacy initiative backed by research, to demand protection of patients’ rights and effective regulation of the private healthcare sector, as well as Public private partnerships in the health sector. Civil society should formulate well researched and designed media outreach initiatives to generate awareness and sustained engagement amongst the public, while preventing the mainstream discourse on healthcare from being dominated by the influential private healthcare lobby. The prevailing policy framework which treats healthcare as a marketable commodity, must be replaced by widespread acceptance on behalf of state and society, that health and healthcare are fundamental human rights.

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