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Patients Rights, Private Medical Sector and Accountability

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COPASAH GLOBAL SYMPOSIUM 2019

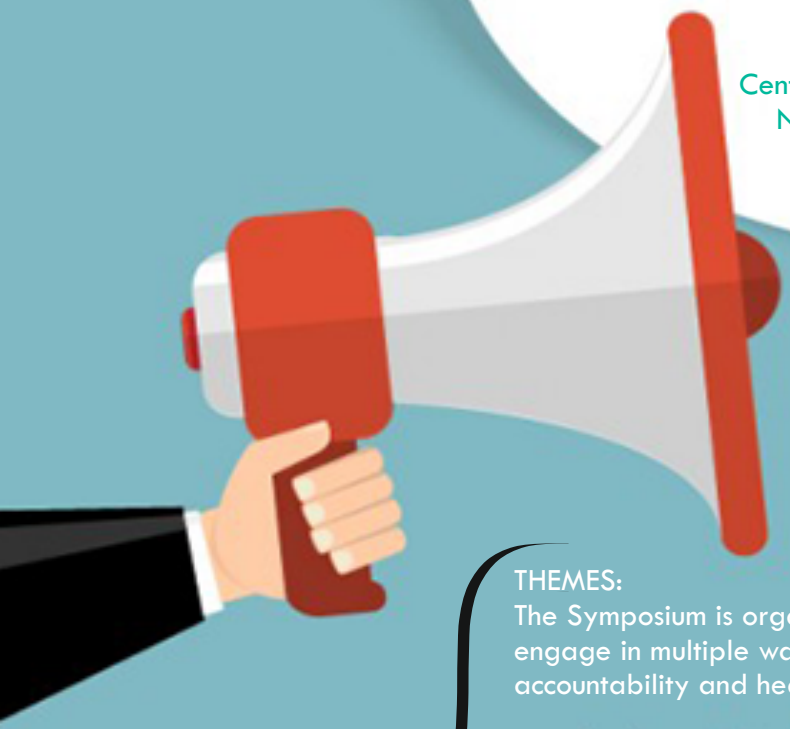
Citizenship, Participation, Governance and Accountability in Health

Role of the Community in Strengthening Accountability of Health Systems for Achieving Universal Health Care/ Sustainable Development Goals

Dates: October 15-18, 2019

Venue:
India Habitat Centre, Lodhi Road, New-Delhi, India

Co-Organizers:
PHM, ARC, IDS and APU



THEMES:

The Symposium is organised around diverse themes which allow the delegates to engage in multiple ways to share and exchange their experiences surrounding accountability and health care/systems.

- Community Participation in Governance and Accountability for Health systems strengthening
- Leaving No One Behind - Improving access to quality health services for Indigenous Communities and other marginalized Ethnic Groups
- Revisiting Reproductive Health - Completing the unfinished agenda of securing reproductive health and rights for all
- Setting the framework and agenda for demanding accountability of the private medical and health care sector
- Forging Alliances between the Community and the Health Workforce

EDITORIAL

COPASAH

PATIENT RIGHTS ACCOUNTABILITY

MY RIGHTS

Patient Rights Accountability and the Need For Transparent Institutional Mechanisms

E. PREMDAS PINTO

The promotion of the paradigm of health care as a 'private good' and the State's indiscriminate endorsement of private health care sector for the business of health care, has grossly undermined patient rights. *Investing in Health,* the World Bank Report (1993), is a watershed in this paradigm, as it legitimised the departure from considering health care as a public good. Globally, especially in the Low and Middle Income Countries, the national governments have been overenthusiastic in paving the path for the growth of the private health care sector, while providing diminished focus and scanty resources for upholding patient rights. Violation of patient rights, is a cumulative outcome of the failure in regulating private health care sector (with direct implications to patient rights) and most importantly of the subtle processes of dismantling patient protection mechanisms, processes and institutions. The story of India illustrates such phenomena.

The response of the government mechanisms for investigating complaints by

CONTENT

patients is inadequate. There is a breakdown in the erstwhile institutional mechanisms such as committees for investigating complaints whcih were meant to protect and support patients. These committees play a crucial role in determining the fate of a complaint, not only in cases of criminal negligence but also in civil proceedings. Navigation through the fragmented spaces for remedies across a maze of institutions (e.g. consumer court, medical councils, and police) is another uphill task that patients have to go through. The continued disintegration of the institutional mechanisms for redressal is amply evidenced through the lack of procedures for conducting investigations and a complete lack of transparency in the functioning of these committees. Despite all the efforts patients muster for mobilising redressal mechanisms, the system of accountability relies overwhelmingly on the judgment of medical doctors who understandably are reluctant to hold their peers accountable. In almost all cases that civil society has documented, the outcomes of such investigations by medical bodies appear to be unduly biased in favour of corporate hospitals and physicians allegedly involved in medical malpractices. Consequently, patients are left with an unfair choice of protracted litigation with uncertain outcomes in an undetermined future time or simply abandon their quest for justice.

Instituting transparent procedures and protocols for investigating patient complaints could be the beginning of the protection of patient rights. . Unlike the prevailing practice of inquiry that solely depends on medical records maintained by the hospitals - which are quite often said to be tweaked and tampered with - they ought to include hearing from patients and their families. The private health care sector is beyond the scope of any transparency legislation such as right to information act, the pursuant lack of access to required records further jeopardises the efforts of patients in moving towards justice mechanisms. Setting up protocols for transparent investigation by way of putting up the records in public domain, and streamlining institutional protocols for redressal, albeit preliminary,- are significant steps in moving towards protecting patient rights.

ABOUT THE AUTHOR

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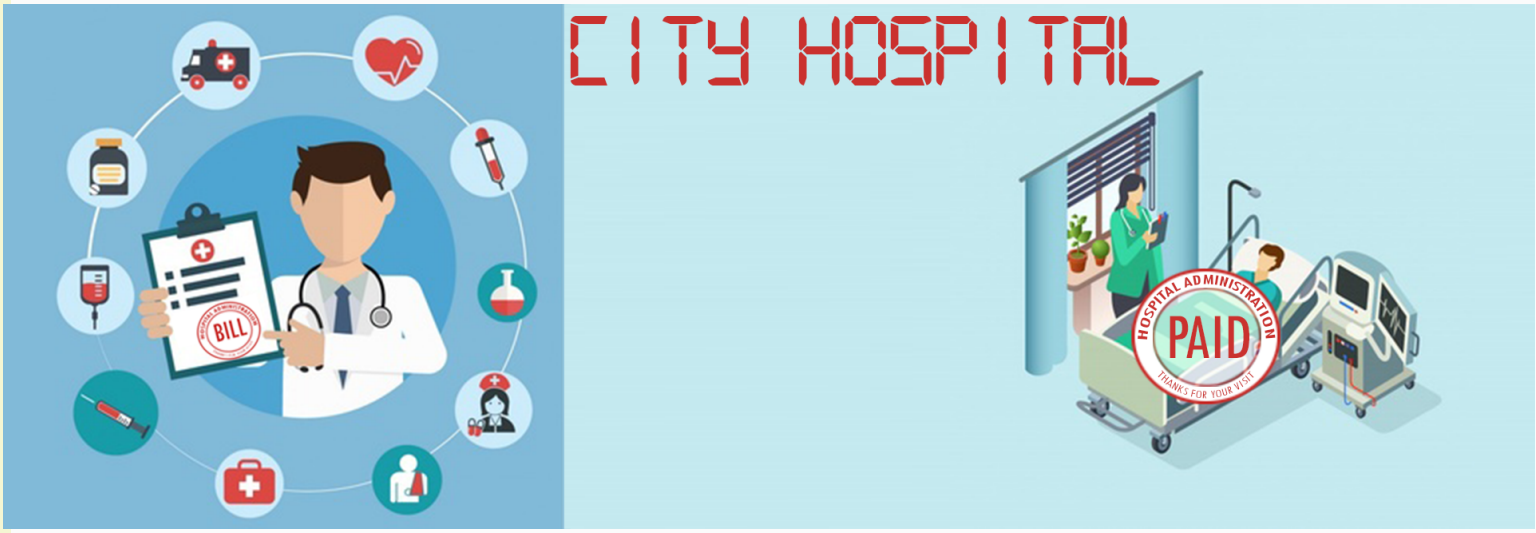


The Terrain of Private Medical Sector in South Asia

Support for Training and Advocacy to Health Initiatives (SATHI)
Pune, Maharashtra, India

I. Introduction

South Asia is the most densely populated geographical region in the world and one fourth population of the world is living here. The healthcare situation in this sub-continent is abysmal, with a notable exception of Sri Lanka. Most of the South Asian countries score low on Universal Health Care. Like other Low-Middle Income Countries (LMICs), health care in South Asia is a Mixed Health System, where publicly-financed government health delivery coexists with privately-financed market delivery.

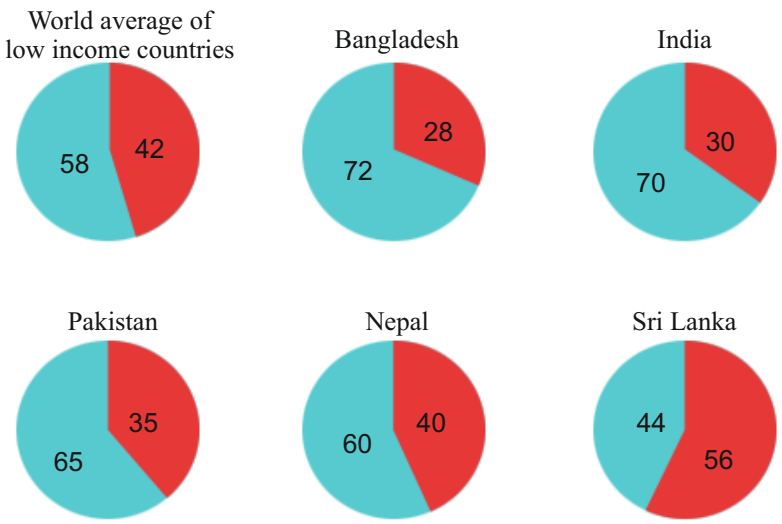
Despite massive growth of the private medical sector, and widespread evidence of negative consequences of market failure, regulation of private medical sector remains very weak in most LMICs including South Asia. Even with large scale dissatisfaction related to malpractices, unethical practices, overcharging, and violation of patient's rights in the private medical sector, the movements around these issues have remained weak until now. These situations call for urgent attention towards patient centered approach for regulation of private hospitals in key South Asian countries with important provisions including charter of patient's rights and responsibilities, grievance redressal mechanism for patients, standard treatment guidelines, transparency in rates, rate regulation with participation of civil society organisations, citizens representatives in the ongoing regulatory process to reflect citizens' concerns primarily.

II. Highly Privatized, Commercialized Healthcare Terrain in South Asia and a Weak Public Health Infrastructure: Some Glimpses

a) Most of the Governments in South

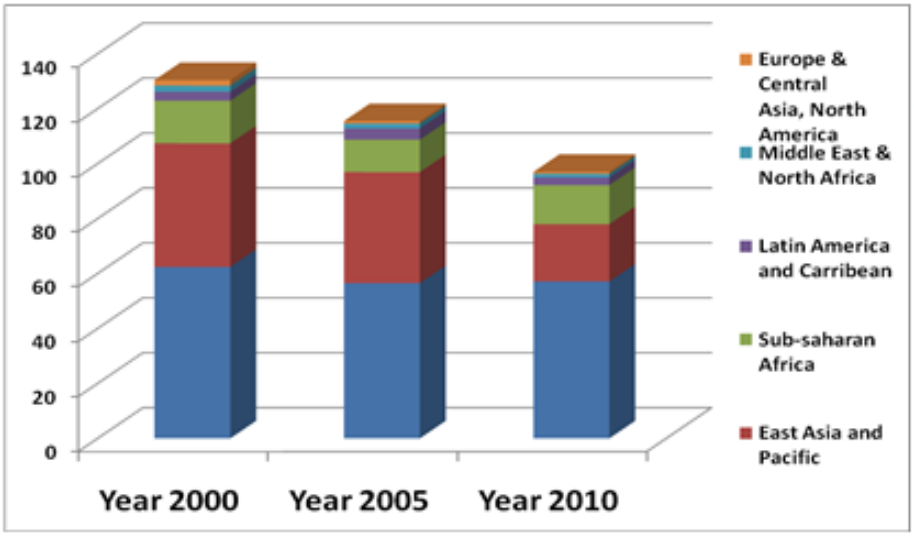
Asian countries spend poorly on public health than the world average of Low Income Countries. High out of pocket expenditure on healthcare is dominant reality in South Asia! Sri Lanka is the only notable exception. (Refer chart 1)

Chart 1-Low government expenditure percentage (in blue colour) VS high private, out- of pocket expenditure percentage (in red colour) in key South Asian countries (Source-World Bank Open Data, 2014)



b) 97 Million People were pushed below the $1.90 ($ 2011 PPP) poverty line by out-of-pocket health expenditure in 2010. More than 58% such people belongs to South Asia. (Refer chart 2)

Chart 2- Number of people (in millions) pushed below the $1.90 ($ 2011 PPP) poverty line by out-of-pocket health expenditure



(Source: Universal Health Coverage Global Monitoring Data)
https://blogs.worldbank.org/opendata/chart-100-million-people-pushed-poverty-health-costs-2010

c) Private Doctors, hospitals are dominant healthcare providers in key south Asian countries with notable exception of Sri Lanka.

The private health care sector in South Asia is quite heterogeneous, ranging from informal and formal practitioners to small, medium and large hospitals, charitable hospitals and corporate hospital chains and diagnostic centres. There are some similarities in the five countries of India, Pakistan, Nepal, Srilanka and Bangladesh in terms of presence of a private sector, but there are differences also in terms of size, nature, and importance of the private sector, apart from the relationship between the private and public healthcare segments. Private healthcare providers are dominant providers of healthcare in South Asia.

Chart 3- Private healthcare facilities in selected countries in South Asia for inpatient care[1]

	India (2011-12)		Nepal (2014)		Bangladesh (2013)		Pakistan (2012-13)		Sri Lanka (2011)	
	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public
Hospitals	54004	20306	350	97	2983	559	692	1142	155	592
Hospitals Beds	978000	675779	19580	6944	45485	45853	Around 20000	128998	5205	70000

II. Private Sector Presence across Countries

A bird's eye view indicates that **Srilanka** has a much better resourced public sector, with a smaller private sector, and overall lower levels of commercialisation of healthcare. However, the private sector is reported to be a growing force even in Sri Lanka, due both to greater investment from private players. INDIA has a very large and dominant private sector ranging from large corporate hospital and diagnostics, not-for-profit hospitals, smaller doctor owned nursing homes, individual practitioners (qualified and unqualified), chemists, and traditional healers. **Bangladesh, Nepal And Pakistan** have weak public health infrastructure and a diverse, rapidly growing private sector including for-profit and not-for-profit hospitals, general practitioners (qualified and unqualified) and diagnostic laboratories. However, this private sector is mostly located in large towns, cities as the paying clientele are concentrated in these areas. In NEPAL three quarters of hospital beds are located in the Central Region where access is relatively good, compared to virtually no private hospitals in the Far Western Region. An interesting trend is emerging in INDIA where private facilities are expanding to smaller town and cities. Currently 48% of all private hospitals and two thirds of corporate hospitals are in smaller cities.

A BMJ article notes that in India about 80% of outpatient services and 60% of inpatient services are provided by the private sector. In Nepal, 55% of patients access private facilities for acute illnesses and 57% for chronic illnesses. In Bangladesh 13% of patients use government services, 27% access qualified practitioners in the private or non-governmental organisation (NGO) sectors, and 60% access unqualified private practitioners. In a survey conducted in Pakistan in 2010-11,

1 Sengupta, A., Mukhopadhyaya, I., Weerasinghe M.C., and Karki, A. (2016) The rise of private medicine in South Asia. British Medical Journal 2017;357:j1482 | doi: 10.1136/bmj.j1482
2 Govindaraj et al (2014) Healthcare in Sri Lanka: What can the private health sector offer? HNP Discussion Paper World Bank.
3 Ibid
4 Ibid
5 Ibid
6 https://www.rvo.nl/sites/default/files/2016/01/Health%20sector%20in%20Sri%20Lanka.pdf

71% of people who had consulted a health provider in the past two weeks reported going to a private facility. Only exception is Sri Lanka where 90% in-patient cares and 40% out-patient care is provided by the public health system.

Chart 4- Concentration of private hospitals in relatively prosperous Central Region of Nepal and Western Province in Sri Lanka respectively7

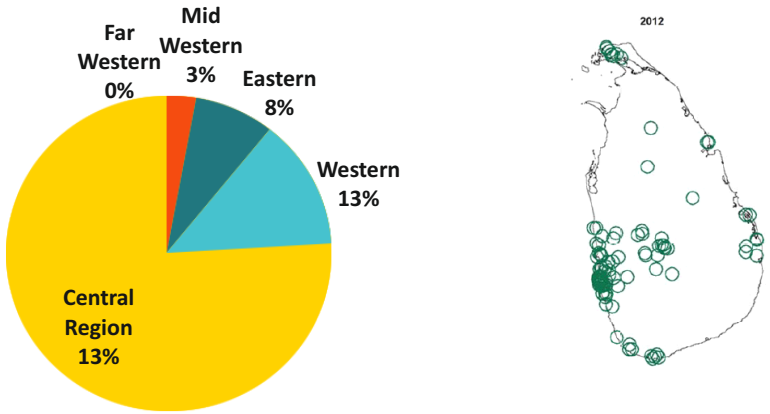


Chart 5- Tale of two healthcare systems- Where patient seek OPD and IPD care (in %)? - Private Sector dominated system in India Vs Public Sector anchored system in Sri Lanka

III. Growing Corporatization of Healthcare in South Asia with India as an Epicenter

India has one of the largest private healthcare sectors in the world. The private healthcare sector in India is more established, diverse and more influential in policy making. The biggest development has been that of organized promotion of healthcare provision as a big business opportunity and the rise of the healthcare industry[8], projects a healthcare provision as a highly profitable economic venture. The healthcare sector in India has become an attraction for private capital investment by global investment firms, private equity funds, and high-net-worth-individuals, and also by global financial institutions such as International Finance Corporation (IFC). There are several Indian multinational healthcare companies that have growing presence

in neighbouring South Asian countries, as well as in the Gulf and in some African countries, and have listed on stock exchanges to access more capital to finance their expansion[9].

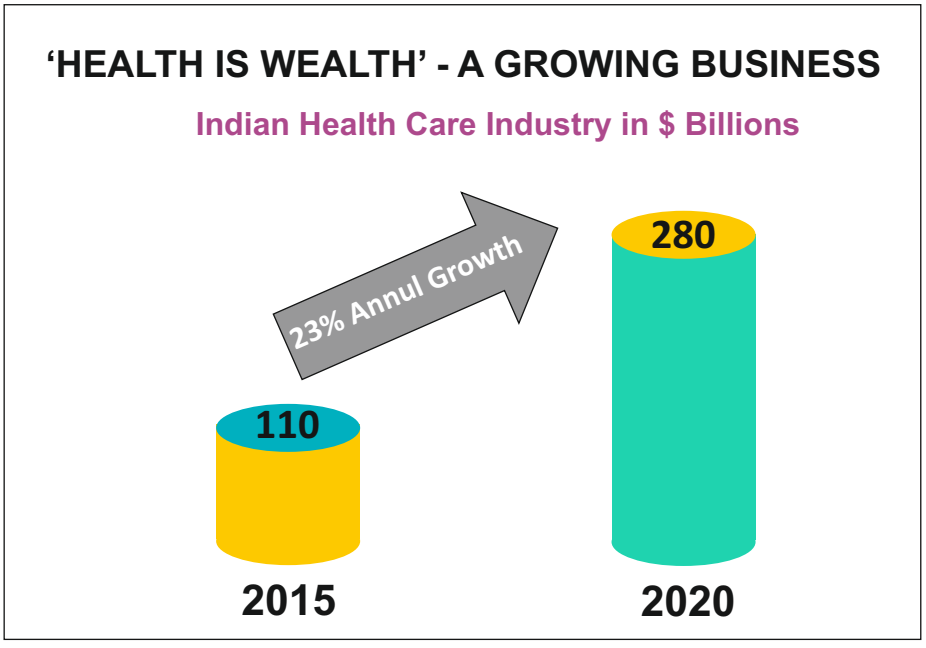
Bangladesh has a liberal FDI regime, with no limit for equity participation and repatriation of profits and income. In the late 2000s, Goldman Sachs

7 (Source- Overview of Public-Private Mix in Health Care Service Delivery in Nepal, Ministry of Health and Population, Govt of Nepal, June 2010 and Private Health Sector Review, Revised edition, August 2015, Institute for Health Policy, Sri Lanka)
8 The term "healthcare industry" is used as an umbrella term while referring to hospitals, diagnostic centers, drugs and pharmaceutical- medical equipment and devices and the insurance industries. The hospitals sector is reported to be the major segment, and hence the term healthcare industry is often used while talking about corporate and other big private hospitals.

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[10]. Nepal broadly follows a free markets approach to healthcare and allowed 100% FDI in private healthcare companies. 81% of FDI is channelled into private hospitals that too into tertiary hospitals mainly. FDI in healthcare sector has been growing at a CAGR of 45%, and top contributors have been India, Turkey and China[11]. In Sri Lanka, medical tourism is reported to be a key growth driver, which is concentrated in the Western Province. While rising per capita income is also being seen influencing the increasing demand for private healthcare[12]. This is accompanied by increase in the technologies available at private hospitals, and a shift in the private sector from smaller to larger facilities having over 100 beds[13]. A noteworthy development in the region is the active role of the International Finance Corporation (IFC - a World Bank institution) in promoting as well as actively financing growth and expansion of private big hospitals 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].

IV. Performance of the Private Healthcare Sector – Blind Optimism Belied by Troubling Reality

It has been claimed that private sector offers better services in terms of efficiency and quality etc. However a number of studies point to the myriad problems with the private medical sector. Delegates from Bangladesh, Nepal, Sri Lanka and India shared country wise experiences about gross medical malpractices, violation of patient's



9 Cleaton-Jones I.P. (2015) Private Hospitals in Latin America: An Investor's Perspective. World Hospitals and Health Services. 2015;51(2):7-9.

10 Jakovljevic M, Groot W and Souliotis K (2016) Editorial: Health Care Financing and Affordability in the Emerging Global Markets. Front. Public Health 4:2. doi: 10.3389/fpubh.2016.00002

11 Dolma Development Fund report on Market Data for Private Sector Investments in Nepal Healthcare Sector, 2014

12 Ranasinghe, N and Mudannayake, D (2015) Sri Lanka Private Sector Hospitals.Fitch Ratings NY. September 28. www.fitchratings.com

13 Amarasinghe, S. et al (2015) Private Health Sector Review 2012. IHP Technical Reports Series Number 2, Institute for Health Policy, Colombo, Sri Lanka

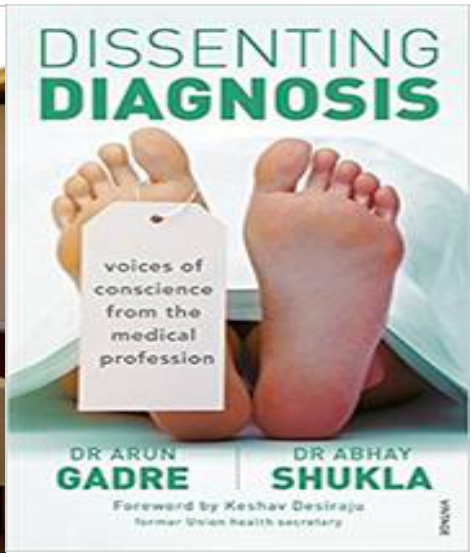


Photo- South Asia Learning Exchange Workshop on Patient's Rights and book 'Dissenting Diagnosis'

rights, over charging, unnecessary surgeries and poor state of regulatory frameworks in a South Asia Learning Exchange Workshop on Patient's Rights in Mumbai in January 2018. Examples were highlighted like about the tragic death of 7 year old girl Adya Singh due to dengue in one of the top most corporate hospital in India, in September 2017. The case attracted a lot of media attention over medical negligence, unjustified profiteering in big corporate hospitals. The hospital prescribed expensive medicines, billed them for 660 syringes and 2,700 gloves during the 15-day hospital stay of the patient. The 20-page itemised bill from the hospital added up to Rs 18 lakh[15]. Her father Jayant Singh shared thetragic story in the workshop. Another speaker Advocate Birendra Sangwan shared details about whopping 1000 to 2000% profiteering in cardiac stents in India before his successful legal battle through Public Interest Litigation in Delhi High Court, for capping prices of cardiac stents at Rs 29,000 only with massive 85% reduction in costs[16].

The path breaking book 'Dissenting Diagnosis'[17] published in India based on testimonies of 78 'whistleblower' doctors has also ripped the lid on myriad of malpractices in the commercialised private medical sector, including unnecessary treatments and interventions, and irrational care driven by profit seeking by large hospitals, pharma industry–doctor nexus, institutionalised system of kickbacks, and inflated, arbitrary costs of care.

Subsequently, in February 2018, an analysis of bills from four reputed private hospitals in National Capital Region of Delhi was done by the National Pharmaceutical Pricing Authority (NPPA)- Government of

15 http://www.sify.com/news/twitter-shocker-hospital-sloppiness-claims-7-year-old-parents-billed-rs-18-lakhs-news-national-rlun4djijiffa.html

16 https://www.hindustantimes.com/india-news/meet-the-man-who-fought-to-cap-coronary-stent-price-at-rs-30-000/story-8Nbn7MSAH1NBy17TZjJdUP.html

17 Dissenting Diagnosis - by Arun Gadre and Abhay Shukla, Penguin Random House India, 2016

India. It revealed that big private hospitals are making profits of up to 1,737% on drugs, consumables and diagnostics and that these three accounts for about 46% of a patient's bill [18]

In Bangladesh, percentage of caesarean section deliveries in private hospitals has been found to be whopping 68%. It indicates gross irrational medical practices and profiteering. According to one study, injections were used in 77.7% of the studied illness cases in the health facilities in Bangladesh[19].

Conclusion

All these instances, accounts and studies constitute only the tip of the iceberg. There is an urgent need for documentation of instances of patient's rights violation, medical malpractices in the key South Asian countries considering scarcity of such documents in the public domain.

Chart 6- Whopping 68% caesarean section deliveries in private hospitals in Bangladesh
Source- DGHS Health Bulletin, Bangladesh 2016

	Government Hospitals	Non-Government Hospitals	
		NGO	Private
Number of Normal Deliveries	549,836	99,645	132,940
%	**75%**	**82%**	**32%**
Number of Cesarean Section	175,888	21,081	285,644
%	24%	17%	**68%**
Other Assisted deliveries	6,330	293	1,306
%	**1%**	0	0
Total number of deliveries in corresponding category of hospitals	**732,054**	**121,019**	**419,890**

18 The office memorandum File N. 27(2)/2017-Div III/NPPA issued by National Pharmaceutical Pricing Authority, Government of India dated 20th February 2018; http://www.nppaindia.nic.in/order/overcharging_details(20022018).pdf

19 A comprehensive situation assessment of injection practices in primary health care hospitals in Bangladesh; Chowdhury AK, Roy T, Faroque AB, Bachar SC, Asaduzzaman M, Nasrin N, Akter N, Gazi HR, Lutful Kabir AK, Parvin M, Anderson C;

ABOUT THE AUTHOR:

This article is derived out of the Thematic Policy brief prepared by SATHI the thematic anchor for COPASAH's Thematic Hub on Patient's Rights and Private Healthcare Sector Regulation. Support for Training and Advocacy to Health Initiatives (SATHI) is civil society organization based in Maharashtra (India) working in health sector. SATHI has been contributing to strategies of the health movement for social accountability and responsiveness of private medical providers, since over a decade. For more information on SATHI visit http://www.sathicehat.org

Country Wise Glimpses of Current Regulatory Frameworks for Private Clinical Establishments

Support for Training and Advocacy to Health Initiatives (SATHI)
Pune, Maharashtra, India

The Clinical Establishment Act in India

Health is a state subject in India thus the state governments have a prerogative to make legislations to regulate private hospitals. However, the Clinical Establishments Act (CEA), 2010 was enacted by the Government of India for registering and regulating all types of public and private clinical establishments in the country, including single-doctor clinics. This is a kind of model act and has been adopted by 14 state governments and Union Territories

Features of the CEA

The Act provides for the creation of a regulatory authority at the national and state levels with minimal representation of civil society groups and majority representation of medical community in multi-stakeholder Clinical Establishment Councils. Standards to be followed by the clinical establishments are to be defined in consultative manner by these multi-stakeholder councils with the help of expert committees of medical personnel. The Act provides registering authority at district level which will have a representative from medical association. Other

key elements include the grading of clinical establishments, adoption of standard treatment guidelines, minimum physical standards, and rate display and rate standardisation.

However, there is no provision for patient's rights, grievance redressal mechanism for patients. There is no specification of dedicated structure, additional staff (and related dedicated budget) for implementation of clinical establishment act. The process of standards formulation is highly centralised at national level which may not augur well for local conditions in the huge country like India. Now, display of patient's rights charter has been incorporated into minimum standards. There are some problematic provisions from medical community point of view like mandatory stabilization of emergency patients within available resources and representation to police in the registration body. Despite of its participatory nature and overwhelming representation to medical community in councils, this act met severe resistance from medical community.

Even after seven years of passing the legislation, its implementation has largely remained on paper. Standards are not notified yet. As of now, only 11 states and UTs have started reporting initial provisional registration stage of implementation. Considering the mentioned drawbacks in the central legislation, with virtually no scope for state governments to influence the process and resistance of medical associations, many state governments like Chhattisgarh, Karnataka, Manipur, Nagaland, Telangana, MP, Orissa, West Bengal, Haryana and Kerala have enacted their state specific CEA act with some variations from central act. Maharashtra, Delhi, Punjab state governments are actively considering about legislating state specific acts. Provisions like charter of patient's rights and responsibilities, rate display, rate regulation and grievance redressal mechanism for patients are included in some state legislations. e.g. West Bengal state legislation has provisions for rate regulation, grievance redressal, patient's rights, separate regulatory commission; Karnataka state legislation includes provisions for rate display and mandatory self-regulation of displayed rates by hospitals, patient's rights and responsibilities charter, grievance redressal mechanism; Chhattisgarh state legislation has charter of patient's rights and responsibilities and grievance

redressal mechanism for patients.

However, despite of many good provisions, implementation of these legislations in fair, non-corrupt manner without harassing doctor community but at the same time offering justice to aggrieved patients and preventing elite capture of the process remains a challenge.

Medical Practice and Private Clinics and Laboratories Ordinance in Bangladesh

The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance of 1982 provides regulatory framework for private medical sector in Bangladesh. The Ordinance specifies that no person shall establish a private clinic without a license from the Ministry of Health and Family Welfare (MoHFW) and the ministry will grant a clinic the license after fulfillment of certain physical standards.

Clause 3 of the Ordinance spells out that Directorate General of Health Services (DGHS) office shall fix the maximum charges and fees that may be demanded in a private clinic or private laboratory for surgical operations, conduction of labour, electrocardiogram, pathological or radiological examinations and other medical examinations or services, as the case may be. Initially Ordinance had provision for fixing maximum fees for consultations also but it was subsequently deleted by 1984 amendment after doctors protested against it. Clause 4 prohibits private practice during office hours by registered medical practitioner in the service of the Government. Ordinance makes it mandatory to maintain register of patients with their names and addresses; maintain receipts in printed form for the charges and fees realized from the patients; prominently display a list of charges and fees.

If an owner or registered private medical practitioner wants to register clinic/hospital then he/she has to apply on a prescribed form to the DG with prescribed fee. The ordinance does not specify any time period during which a licensing decision will be made. DGHS or authorized persons by DGHS have inspection powers and DGHS can reject the application for license if conditions of registrations are not fulfilled after issuing

show cause notice to the applicant and giving opportunity to hear the applicant. Aggrieved applicants can appeal to MOHFW against the decision of DGHS within 30 days. Decision of the MOHFW on the appeal or review order would be final and it cannot be challenged in the court of law. Violation of the Ordinance is punishable with the fine or imprisonment up to 6 months.

This ordinance is legally still in force but its implementation has remained largely on paper. Even after 35 years of this ordinance, DGHS is struggling to keep updated database of private hospitals, clinics and laboratories. The department has only a seven-member inspection team for around 14,000 private hospitals, clinics and diagnostic centres. Shortage of manpower, lack of capacity and absence of proper regulatory measures made it difficult for DGHS to carry out proper supervision on such private healthcare facilities. Private hospitals and diagnostic centres are charging patients exorbitant fees at whim for lax government monitoring[1].

Table 1- Comparison- maximum charges as per Ordinance and actual market charges

Heads	Details	Maximum charges as per ordinance in TK	Market rates[2] in TK
Normal delivery	Delievery Charges including labour room	400	Normal Delivery – 10,000 Tk
Major Operations	Operating room charge	600	Caesarean Section- 50,000 Tk
	Anaesthesia charge with cost of drugs and	800	
	Operating charge	2000	

The Table 1: Shows that there is huge disparity between maximum rates fixed by 1982 ordinance and prevailing market charges.

1 http://www.thefinancialexpress-bd.com/2017/07/08/76255/Pvt-hospitals,-diagnostic-labs-fleece-patients/print
2 http://www.daily-sun.com/post/56772/Caesarean-births-in-Bangladesh-up-mostly-on-greed

This Ordinance is typical example of bureaucratic, over centralized piece of legislation with design flaws that failed to bring effective regulation. The focus is more on regulating physical infrastructure and there is no mention or scope for monitoring the actual quality of clinical care. There is no scope for participation of key stakeholders like doctors, hospital owners, consumer rights groups, patient's rights groups and civil society groups to make this regulation pragmatic and more acceptable. There is no provision for standard treatment guidelines, clinical audit, patient's rights and grievance redressal mechanism for patients. Any regulatory system must be supported by dedicated human and financial resources. Regulation of private healthcare sector is in itself huge task considering size, diversity of the private sector in South Asian countries. Hence, it cannot be left with already overburdened public healthcare top officials as an add-on task. Apart from design flaws, Bangladesh MOHFW failed in providing much needed dedicated human and financial resources for regulatory task. Besides that, the regulatory framework in Bangladesh has not kept pace with rapid changes in the structure, nature of private medical sector in Bangladesh over last three decades and as a result, it has failed in safeguarding interests of the patients.

Private Health Services Regulatory Council (PHSRC) in Sri Lanka

The 13th amendment to the Sri Lanka Constitution in 1987 shifted responsibility for regulation of private sector medical institutions from Ministry of Health and assigned it via the concurrent list to the joint responsibility of the central government and the provincial councils. The Private Health Services Regulatory Council (PHSRC) is a statutory body, independent of Ministry of Health, established under the Private Medical Institutions Registration Act, No.21 of 2006 (PMIRA,2006). The Act controls the registration, regulation, monitoring and inspection of all kinds of private medical institutions. Regulatory Council is composed of 12 Ex-officio members and 16 appointed members. Main functions of the council includes registration of private healthcare institutions, collection of health statistics for national programmes, grading of private healthcare institutions, maintaining minimum standards of recruited staff in private healthcare institutions, formulation of quality assurance programmes for patient care in Private Medical Institutions and monitoring the same. Besides that, council can carry out scheme of accreditation of private medical institutions.

While some non-doctor representatives are included in the council but representation to patient's rights groups and civil society groups is not given. Functions of the council do not include prescribing standard treatment guidelines which is essential pre-requisite for quality control. Charter of patient's rights and responsibilities is not included in the act. Council meetings are held once a month on a fixed date. Attendance by the government sector representatives has been poor, reflecting the difficulty of Provincial Director of Health services attending meetings in Colombo, given their other

commitments in their home provinces. In addition, although the DGHS/MoH is supposed to chair the meetings, the DGHS has often not attended, partly owing to his other heavy responsibilities. Government representatives complain that the legislation does not allow them to appoint proxy representatives to represent senior officials who cannot attend in person, e.g. a Deputy DGHS cannot attend in place of the DGHS. As per the law, DGHS shall preside over Council meetings and in the absence of the Chairman, the members present shall elect one from amongst them to preside over. As a consequence, the private sector representatives have been in the majority at most meetings, and frequently ended up chairing meetings[3].

Largely, the council is self-funded with money raised through share of registration fees, fines, grants, donations with practically no budgetary support from the government. After an initial inflow of funds when it started licensing of providers in 2007–08, its annual revenues have fallen substantially. This has affected its functioning. Assessment of the PHSRC shows that it is completely ineffective, failing to discharge its functions. The one function it does attempt is the annual licensing of private medical providers, but analysis shows that it does this badly, with most private hospitals failing to obtain their annual license, and an even greater proportion of other providers also not doing so. PHSRC licensing performance is actually deteriorating over time (see Table 2)[4]. PHSRC lacks adequate staff to carry out its statutory functions. At the PHSRC itself, staffing is inadequate even to handle the

Table 2- Attendance by government representatives at PHSRC meetings

Year	2007	2008	2009	2010	2011	2012
Total Meetings	12	12	12	7	10	11
DGHS attendance	8	5	8	2	4	1
Meeting with Public Majority(%)	15	25	67	14	50	55
Meetings Chaired by a Public Sector Representative (%)	67	42	67	43	60	18

Source- PHSRC Minutes of meeting;
Ref- Private Health Sector Review, revised edition 2015 , Institute for Health Policy, Sri Lanka

3 Private Health Sector Review 2012, revised edition 2015: Sarasi Amarasinghe, Sanil De Alwis, ShanazSaleem, Ravi P. Rannan-Eliya and Shanti Dalpatadu, Institute for Health Policy, Sri Lanka
4 ibid

registrations of private medical institutions. In 2012, only two people were employed on a fulltime basis, and additionally one person had been assigned temporarily from the MoH to ease out the workload. Act gets implemented through existing provincial health bureaucracy. None of the Provincial Directors of Health Services have dedicated units or staff for managing the licensing process. Institute for Health Policy, Sri Lanka observes that PHSRC is tolerating non-renewals of licensing[5].

Table 3- Diminishing performance of PHSRC, Sri Lanka (2007-2011)

Year	Share of private hospital complying with annual licensing requirement of PHSRC (%)
2007	85
2008	86
2009	81
2010	60
2011	48

Source: MoH registration list of private hospitals (January 2012); IHP PHNHs database 2012

Besides the registration of private healthcare institutions, PHSRC has prescribed physical standards for different medical institutions, issued only few treatment related guidelines, guidelines for display of rates, requested private institutions to follow prescribed range for consultation charges and range of charges for 33 common tests. It has set up a grievance redressal mechanism for patients through complaint sub-committee. Whosever violated the provisions of the act is charged with fine and imprisonment for 6 months for continued violations. However, data about punitive action taken so far is not available on its website.

On the whole, experience of PHSRC, Sri Lanka provides many insights into the danger of elite capture and expert capture of such regulatory mechanisms by vested interests. Composition of the council is an important factor and there is a need for adequate representation to health rights activists on such forums. Regulation of private providers in healthcare sector is mammoth task and cannot be dumped over the already overloaded public health bureaucracy. Regulation is an important task and it requires financial support from the government. Fate of self-financed regulatory mechanism remains uncertain. Dedicated staffs, resources are very much needed to implement regulatory framework optimally.

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The Punjab Healthcare Commission (PHC) Of Punjab Province in Pakistan

Regulation of healthcare establishments, public or private, is responsibility of provincial governments in Pakistan. Punjab province stands out brightly as far as laying down regulatory frameworks for hospitals are concerned. The Punjab Healthcare Commission (PHC) came into existence under PHC Act 2010 with aim to improve the quality of healthcare services delivery across Punjab by fostering a culture of Clinical Governance and offering greater protection against medical abuse and denial of quality healthcare in both the Public and Private sector Healthcare Establishments at the Primary, Secondary and Tertiary levels.

The PHC has been set up as an autonomous body governed by a Board of Commissioners, responsible for providing oversight in vision-setting and maintaining a strategic direction. The Board also monitors performance and achievements of the Commission at regular intervals. The Board takes all the decisions regarding penalties, suspension and revocation of licenses. Currently, a retired judge is holding the post of chairperson and 9 eminent persons are acting as board members. Currently, it has only 2 members belonging to medical profession. The Technical Advisory Committee (TAC) is an advisory body which acts as an advocacy arm for the Commission, engaging with stakeholders and consists of experts from diverse professional backgrounds. There is no representation to health sector civil society organisations in TAC. The mandate of PHC to regulate hospitals and safeguard patient's rights of 110 Million people is executed through eexecutive team of 123 staff when this policy brief was being written. The Chief Operating Officer is senior doctor and operational head of the Commission. The Senior Management consists of Directors heading different core directorates.

It is supported by other cells like procurement cell, monitoring and evaluation cell, legal cell, anti-quackery cell, finance cell etc. Within 14 days of receiving any application from a hospital or an individual doctor or homeopath or any healthcare establishment, the PHC issues conditional registration after physical verification and evaluation of the health facility. PHC

arranges training and capacity building of the persons on minimum service delivery standards, and after that, the final registration and license is issued. The PHC is mandated to enforce and regulate Minimum Service Delivery Standards (MSDS) through licensing of Healthcare Establishments, encompassing Allopathic, Homeopathic and Tibbi disciplines of treatments, which comply with the Standards. MSDS have been developed by the PHC through a consultative approach, bringing together healthcare experts, managers and healthcare practitioners from public and private sectors. These standards need to be fulfilled by healthcare establishments whether public or private for their continued registration. MSDS have been prescribed in areas like access, assessment and continuity of care (ACC), Care of Patients (COP), management of medication (MOM), patient rights and education (PRE) etc. However, there is no provision for rate display and rate standardization in the PHC Act.

The Directorate of Patients' Rights and Complaints is responsible for the development of Charters of Rights and Responsibilities for Patients and for Healthcare Establishments. It also started Complaints Management System in 2014 in line with the MSDS to meet the key objectives of the Commission. The Directorate is entrusted with the responsibility of effectively managing complaints dealing with maladministration, malpractice, medical negligence, non-compliance of charter of patient's rights, non-compliance of MSDS etc.

The Commission may investigate into a wide variety of matters like inordinate delay in provision of medical care, failure to take informed consent, failure to maintain adequate services for clinical management including but not limited to, assessment, diagnosis, treatment and follow up, undertaking the management of a patient without the availability of requisite competence, human resource, equipment or other facilities related thereto, inadequate clinical assessment and/or diagnosis failure to keep, maintain or secure record including medical record, in accordance with the standards prescribed by the commission, failure to foresee and take comprehensive precautionary measures against system failures and/or possible mishaps , inappropriate and unjustifiable costs of services or procedures, violation of rights provided in the charters, inadequate recordkeeping failure to prevent unnecessary diagnosis and or treatment, failure to install systems to prevent cases of sexual harassment, and or improper conduct, such as unbecoming at the healthcare establishment ,failure to release patient records ,failure to install systems to prevent substance abuse, billing or documentary fraud, flawed medical condition(s) or qualification(s) of the staff including contractual staff, failure to implement or comply with the standards, harassment of healthcare service provider or member of the staff of the healthcare establishment including but not limited to, verbal, psychological or physical harassment, damage to the reputation of the healthcare establishment; damage to the property of the healthcare establishment, quackery; or sale of drugs without prescription.

Thus, it is a single window system for patient's and healthcare

provider's grievances. Complaint is registered, assessed, acknowledged, and investigated by PHC based on available documents. If required, both parties are invited for hearing. Expert opinion taken if required. Final decision is made by Board of Commissioners.

There is no empirical study available in the public domain about effectiveness of PHC in regulation and standardization functions. In one of the newspaper story, PHC Chief Operating Officer had claimed some achievements on 28th March 2018[7] like

- PHC has registered and licensed more than 41,000 healthcare establishments (HCEs)
- PHC had carried out over 10,000 inspections, which included 5,747 pre-assessment and 4,560 regular inspections.
- For the capacity-building of the health professionals and implementation of the MSDS, the commission has arranged about 400 training sessions for 16,300 health professionals of more than 12,000 HCEs.
- PHC has sealed about 8,200 businesses of quacks, and imposed a fine of more than Rs 63.50 million on them so far.
- Seeing its success in the implementation of its mandate, other provinces are in the process of replicating the PHC Act and model.

Taking cue from PHC, other provinces like Khyber-Pakhtunkhwa and Sindh have also started their own Healthcare Commissions with some variations.

The concept, structure and scope of the Punjab Healthcare Commission looks more promising. However, there are no sufficient empirical studies available in public domain about its different aspects of the functioning of the Punjab Healthcare Commission but it's worth studying further.

Private Health Sector in Nepal

In the early 1990s, after political reforms, Nepal adopted an economic liberalization policy that resulted in the massive growth of private sector industries, including in the field of healthcare. Even with a progressive constitution in Nepal, which guarantees health as a fundamental right, and health policies aimed at achieving universal health coverage, there is a lack of corresponding enforcement of regulatory mechanisms for the private sector. The private sector has over two thirds of the hospital beds in Nepal and 60% of Nepal's doctor's work in this sector. However, there is little information on the quality of care provided by this sector. There is limited empirical information available on the size, composition, and characteristics of the private health sector. There is a lack of routine monitoring by regulatory bodies, and insufficient institutional structure or resources to monitor the sector and guide it towards achieving government policy. Hence, the private health sector has grown without robust standards and protocols in last two decades[8].

In 2013, Nepal Government had issued the Guidelines for Health Institutions and established upgrade standard which makes registration mandatory for all public and private health institutions covering all

7 https://www.urdupoint.com/en/pakistan/awareness-must-for-dengue-control-speakers-297061.html

8 http://blogs.bmj.com/bmj/2016/09/30/does-a-booming-private-healthcare-industry-in-nepal-benefit-its-people/

recognized streams of medicines in Nepal[9]. As per the guidelines, different authorities are responsible to issue licenses to hospitals, clinics etc. and to renew those licenses.

Licensing authority	Healthcare establishments with number of beds
District Public Health Office	25
Regional Health Directorate	26-50
Health Department	51-200
Ministry of Health	201 plus

The Guidelines lay down different provisions to be fulfilled like quality standards which includes physical and human resource standards along with list of essential medicines for health institutions and standards for infection prevention and hygiene in hospital, the hospital structures built must also be quake-resistant and in line with the building code, standard operating manual, display of patient's charter ,display of rates, round the clock emergency service provision, implementation of protocols developed in Nepal's national health programmes, reservation of 10% free beds for poor and destitute patients, special provisions for senior citizen in big hospitals etc. Provision for rate regulation and rates would be decided by a multi-stakeholder high profile committee. A geographical restriction on setting any new hospital also is mentioned in the guideline. Every hospital has to submit self-assessment report regarding observance of the guidelines to the public health authorities. Besides that, there are hospital waste management guidelines and guidelines for blood banks. The guideline further states that a 25-bed capacity hospital must have a land leasing agreement for 15 years before developing infrastructures, and coming into operation. The guideline also lay out conditions for up gradation of hospitals to have their own accommodation.

Besides these guidelines, the National Health Policy and the National Health Laboratory Policy identify the National Public Health Laboratory (NPHL) as the central specialized national referral public health laboratory for the country and the regulatory body to license public and private labs. NPHL monitors these laboratories through its external quality assurance of lab services and the quality control testing of samples. There is no information available about implementation of these guidelines and standards.

But, the Department of Health Services (DoHS) of Nepal claims that 80% of private health facilities reported to HMIS in the year 2015-16[9]. In the absence of any public data regarding this new regulatory mechanism, it is difficult to comment about its effectiveness and robustness. To ensure implementation of the

9 The annual report of the Department of Health Services (DoHS), Nepal for fiscal year 2072/73 (2015/2016)

guidelines, there is provision of Monitoring Committees at the levels of District, Region, Health Department and Health Ministry whose membership includes health bureaucrats and selected doctor representatives. But Monitoring Committees do not include civil society organizations at any level.

Though guidelines mention that hospital should display patient's charter but what content of the charter is not explained anywhere in the guidelines. The guideline has a provision for nine member multi-stakeholder Fee Assessment Committee to prescribe the rates, fees related standards in hospitals/health institutions.It is learned that Fees Assessment Committee has given its suggestions to the Government of Nepal in 2016-17 and Chief of Medical Service has been instructed to speedup up the process of regulation of private health institutions[10]. However, no other details are available about suggestions given by Fee Assessment Committee and its status of implementation.

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10 http://nepaliheadlines.com/%E0%A4%B8%E0%A5%8D%E0%A4%B5%E0%A4%BE%E0%A4%B8%E0%A5%8D%E0%A4%A5%E0%A5%8D%E0%A4%AF-%E0%A4%AE%E0%A4%A8%E0%A5%8D%E0%A4%A4%E0%A5%8D%E0%A4%B0%E0%A5%80%E0%A4%B2%E0%A5%87-%E0%A4%85%E0%A4%B8%E0%A5%8D%E0%A4%AA/

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Regulation of Private Healthcare Sector in South Asian Countries

Support for Training and Advocacy to Health Initiatives (SATHI)
Pune, Maharashtra, India

Burgeoning Private Health Sector in South Asian Countries

Different studies and accounts highlight that the private health sector in key South Asian countries has expanded within the vacuum of shrinking public health system. Low investment by governments of these countries in public health system coupled with privatization oriented policies, growing number of public-private-partnerships in healthcare sector and transfer of big proportion of funds towards private sector through publicly financed healthcare schemes in these countries has fuelled growth of the private healthcare sector. This has led to massive commercialization of healthcare in this sub-continent. To reassert public good nature of healthcare, there is urgent need to paradigm shift in policy making with emphasis on strengthening, expanding, qualitatively improving public health system in South Asia. Massive poverty in India, Nepal, Bangladesh, Pakistan and Sri Lanka owing to large scale out-of-pocket expenditure on healthcare necessitates the urgency of this policy shift. Such an expanded and improved public health system would have huge regulatory effect on private medical sector in checking its gross commercialization.

Regulation of Private Health Sector in South Asian Countries: India, Pakistan, Nepal, Bangladesh and Srilanka

Except for Sri Lanka, the South Asian countries of India, Pakistan, Nepal and Bangladesh have huge proportion of private healthcare sector. These South Asian countries have also started their journey towards some kind of regulation of private healthcare sector. The old command and control model of regulation has mostly given up its position to a new kind of regulation reflecting dominant marketization of healthcare. Private healthcare sector in South Asia has been asserting its might in the arena of policy making in regulation of private healthcare sector.

Except Bangladesh, all other South Asian countries have witnessed new kinds of regulatory legislative frameworks for both public and private hospitals in the last one and half decade. Regulatory mechanism in Bangladesh is typical example of command and control kind of regulatory framework which

essentially remained on paper owing to lack of political will, increased liberalization of economy, outdated standards and practical difficulties in securing adherence to the regulatory standards from private providers.

Sri Lanka, Pakistan, India, Nepal have tried to introduce some kind of new frameworks for regulation with varying degrees of participation of non-state actors at different levels. However, these frameworks mostly ended up with representation from private healthcare providers. It is to be highlighted that in these frameworks the representation of civil society organizations working on patient's rights issues, health activists, women's organizations, and prominent citizens remains very nominal (some exception of Punjab Healthcare Commission). This creates a contradiction within these apparently participatory structures where private healthcare sector got overwhelming representation that is supposedly to be regulated and civil society organizations working for patients got very less representation. There is an urgent need of strong intervention by people's health movement and to force appropriate authorities to change the composition and processes of these regulatory bodies in order to make it more patients centric.

Double Danger of Expert Capture and Capture of Regulation by Private Interests

Given the context of large and often dominant private sectors within the health systems of many LMICs like Bangladesh, India, Nepal, Pakistan, Sri Lanka the mechanisms for regulation are often weak, under-resourced, bureaucratic and inadequately effective[1, 2]. There are major gaps in policy design and implementation, human resource constraints, problematic organizational relationships, and major risk of 'capture' of the 'participatory' regulatory bodies by private interests and experts[3]. As a result, regulation may be minimal, limited to addressing certain physical infrastructure issues, and standards may be influenced by either academic experts or the corporate healthcare industry. Private Health Sector Regulatory Council (PHSRC) in Sri Lanka is an example of this capture. It is only country in South Asia with explicit Directorate of Private Healthcare Sector Development in Health Ministry. If not timely and vigorously intervened by people's movements then Indian story of regulation of private healthcare sector may go in same direction considering deeply entrenched nature of global healthcare capital in India. These situations call for an urgent need to remain alert to safeguard the emerging regulatory frameworks in Bangladesh, India, Nepal, Pakistan, Sri Lanka from these twin dangers of expert capture and elite capture.

Need to View Private Healthcare Sector as a Socio-Political Process

There is an emerging view that the problems with regulation of the private sector are not just narrow technical issues of poor design, but healthcare services in the private sector 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[4], [5]. It is a triangular contract between citizens, the state and healthcare providers. The participation of citizens and civil society organisations in most of the regulatory structures in key South

1 Peters, D., and Muraleedharan, V.R. (2008) Regulating India's health services: To what end? What future? Social Science and Medicine 66:2133-44.
2 Bloom, G., et al (2014)
3 Sheikh, K., Saligram, P., and Hort, K. (2013)What explains regulatory failure? Analysing the architecture of health care regulation in two Indian states; Health Policy and Planning 2013: 1-17
4 Same as footnote 16
5 Santos, F.P. and Merhy, E.E. (2006) Public Regulation of the Healthcare system in Brazil

Asian countries is missing to a large extent. There is a need for broader campaign for to bring citizens/patients at the centre of the regulation by creating more effective avenues for their voices within these regulatory structures and procedures. The goal of universal health care provides a basis for taking a Health Systems perspective to manage the private sector, and in the ambit of it the main aim of government policies must be to develop a healthcare system that ensures widespread availability of good quality, free or highly affordable care, so that this system meets the needs of the population as a whole, especially working people and marginalized populations[6].

Need of Bottom up Governance, Social Accountability of Regulators and Social Regulation of Private Healthcare Sector

Linked with such a broader socio-political context, 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 health care system including the private medical sector. Social accountability refers to formal or informal mechanisms through which citizens and/or civil society organizations bring officials or service providers to account. 'Social regulation' refers to action-oriented approaches designed to reinvent and democratize 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.

Using Patient's Rights as a Fulcrum for Social Mobilisation Related to Regulation

The regulation of the private medical sector has often been looked upon as a bureaucratic function of the state, largely divorced from issues of patient's rights, and accountability of private hospitals to patients and citizens who use health services. The idea of patient's rights charter and grievance redressal mechanism for patients is finding its place in emerging regulatory frameworks like Punjab Healthcare Commission in Pakistan, few state acts in India that of Karnataka, Chhattisgarh, a proposed bill in Maharashtra; new guidelines in Nepal, and PHSRC guidelines in Sri Lanka. Thus, social mobilisation around demands like protection of Patients' rights, and regulation of private hospitals to ensure affordability and quality of care, could be a central strategy of the health movement and civil society organisations. This also calls 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 commercialization on their profession.

Regulating Dominant Private Healthcare Sector a Mammoth Task

Regulation of widespread private healthcare sector in key South Asian countries is a challenging task in itself. It requires dedicated human resources to carry out different tasks like registration, inspection, data maintenance, developing physical and quality standards of care, developing standard treatment guidelines in consultative manner, monitoring compliance of regulatory guidelines/standards, effectively executing grievance redressal mechanism on continuous basis etc. In addition, regulatory authority requires dedicated budgetary support from the government. In the absence

6 Santos, F.P. and Merhy, E.E. (2006) Public Regulation of the Healthcare system in Brazil

of these two inputs, it becomes difficult for regulatory authorities to carry out its assigned functions. Poor performance of understaffed, underfunded Private Health Sector Regulatory Council in Sri Lanka exemplifies this situation.

Conclusion

A well-defined regulatory framework is quite essential. A pro-people framework to regulate the private healthcare sector needs to include different aspects such as:

- Include and protect patients' rights with effective and people-friendly redressal mechanisms
- Function to assure that patients' receive good quality, rationalised, evidence based treatment in the private healthcare sector at reasonable rates along with transparency in rates. Mere registration of private hospitals is not enough. Regulation of quality and affordability of care is more important.
- Take care of the concerns of rational and ethical private providers, small nursing homes, and genuinely not-for-profit hospitals, and health care facilities working in rural, tribal areas
- To not allow corporate hospitals to enforce their vested interests through technical sub-committees for defining standards and treatment guidelines to weed out small providers
- Prevent corruption and make the executive regulatory authority accountable to genuinely participatory bodies comprising of prominent citizens, civil society organisations working on health rights issues and rational health care professionals. Ensure watchfulness in composition of multi-stakeholder forums so that vested private interests cannot dominate the forums and citizen's voices can be effective enough A strong political is required for a pro-people framework which can be generated from below by mobilizing people around the issue of patient's rights, affordability of care and regulation of private healthcare providers on a massive scale to make it an important public issue. This requires dedicated efforts from people's organisations. Increasing number of urban middle class in South Asian countries can be effectively reached out to build such kind of campaign and overcome resistance from vested interests.

Sri Lanka is the first country to come up with new kind of regulatory framework in the form of PHSRC in South Asia(in 2006) but there is no concrete evidence to show any progress made beyond registration of hospitals. Process seems to be captured by private interests and understaffing, underfunding of PHSRC crippled it further.

In the absence of a strong political will, the implementation of Clinical Establishment Act (CEA) in India has faced significant hurdles. Even after seven years of the passing the legislation, standards have not been notified. Though increasing numbers of state governments are coming up with state specific legislations to regulate private clinical establishments with some variations in CEA ,2010 but the overall pace of regulation remains very slow. The state CEA are largely focusing on provisional registration aspect of regulation. Other aspects of regulation like quality of care, affordability of care, clinical governance are still not in discourse in India. Though Patient's Rights discourse has but it has a long way to go to make an impact.

Similarly the regulatory process in Nepal is facing difficulties in going beyond registration. In Bangladesh, the discourse on private sector regulation is yet to be begun. Initial attempts to bring in new legislation have met many obstacles.

Comparatively, Punjab Healthcare Commission in Pakistan has made significant progress as far as registration, anti-quackery drives, dengue prevention and trainings of healthcare establishments towards observance of minimum standards.

It has a robust legal framework which specifies many details including types of complaints to be made by patients/healthcare providers to PHC.

There is need to include healthcare experts from civil society organisations in technical committees. The overall focus is correctly placed on quality of healthcare with clinical governance as its vision. Patient's rights, consumer aspects of hospital-patient relationship, issues related to violence in healthcare premises, responsibility of private hospitals in preventing spread of communicable diseases are all brought under single authority. Overall, it appears promising model but, it is difficult to claim about its effectiveness in achieving its objectives in the absence of any independent evaluation report.

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South-Asia Learning Exchange Workshop on Patient's Rights and Private Medical Sector Accountability

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In many low and middle income countries (LMICs) especially in South Asia and Africa, the private healthcare sector is playing pivotal role in providing healthcare. This has created many opportunities for better healthcare as well as posed significant challenges regarding quality, affordability of care, ethical practices and patient's rights. There is a growing discourse of need for regulation of private medical sector and to protect patient's interest in healthcare set ups, especially protection of patient's rights. Recognizing a need for a platform to bring together activists and practitioners, who would help to develop a discourse on accountability of the private medical sector the thematic hub on Patient's rights and private medical sector accountability anchored by Pune (India) based organisation SATHI, associated with COPASAH initiated in 2017-18. It began as a platform for promoting networking as well as facilitating exchange of experiences and perspectives among civil society organizations and networks working on issues related to private health sector regulation and patient's rights, with a focus on South Asia. The thematic hub works by organisng global thematic webinars, networking and alliance building in South Asia, regional consultations, and capacity building of activists. As part of its networking, strengthening social accountability practices and learning from different experiences the thematic hub, held a two day Learning Exchange Workshop on Accountability of Private Medical Sector and Patient's Rights involving civil society activists from India, Bangladesh, Nepal and Sri Lanka on 23-24, January 2018 at Mumbai.

Objective of the Learning Exchange Workshop

Building upon the experiences and learning from various initiatives in LMICs, this workshop was organized to enhance the knowledge base of citizens, academicians, civil society organizations and doctors regarding broad range of issues related to conceptualization, awareness generation and implementation of patient's rights in LMICs. Over 60 health activists, doctors, public health experts, lawyers came together in this unique Learning Exchange Workshop on Patient's Rights. Different stakeholders together to share and learn from each other's experiences on private sector accountability existing in different parts of the country as well as at South East Asia level.

This workshop was first of its kind in bringing together activists from diverse campaigns and networks united by their concern regarding gross commercialization of healthcare and its negative impacts on ordinary people. Participants ranged from campaign for capping of prices of cardiac stents protesting against gross overcharging and negligence in corporate hospitals, successful campaign for regulation of private hospitals in Karnataka, Jan Swasthya Abhiyan units from Maharashtra, Tamil Nadu, Orissa, Madhya Pradesh,

Rajasthan and other states, Satark Mareej Abhiyan from Mumbai and Mumbai Citizens Doctors Forum, Pune Citizens Doctors Forum, People for Better Treatment, All India Drug Action Network etc. International participants in this workshop included senior health activists, lawyers from Bangladesh, Nepal, Sri Lanka and Kenya.

Sessions of the Learning Exchange Workshop

Spanned over a period of two days the sessions in the workshop focused upon bringing forth different experiences from number of states in India as well from different countries as well different stakeholders.

Perspectives and Experiences of Policy Makers and Shapers on Accountability

Representing Maharashtra state government, Director of Medical Education and Research Dr Pravin Shingare detailed about the steps taken by the department to regulate private medical sector, safeguard interest of the patients and legislation to curb the commission practice by doctors. Senior Consultant, National Health Systems Resource Centre, Government of India, Prasanth K S outlined about the The Clinical Establishment (Registration and Regulation) Act 2010 while providing details about status of implementation of Clinical Establishment (Registration and Regulation) Act (CEA) which is currently applicable in 11 states of India. Health Advisor, Delhi

Government Nimmi Rastogi discussed about steps under consideration for improving existing health services with emphasis on community involvement for health and environment. Prasanna Saligram, from Azim Premji University highlighted the Regulation puzzle, by providing examples of weak regulatory system and medical negligence as well as overcharging by the private sector hospitals. Dr. Arun Gadre a gynecologist and an in Maharashtra shared about the forum of Alliance of Doctors for Ethical Healthcare, its beginning and its position on the current practice in private sector.

Country Level Issues and Approaches for Regulation of Private Medical Sector

Different country representatives shared the experiences about health care systems and private medical sector and the countries represented in this panel included Kenya, Sri-Lanka, Bangladesh and Nepal. Representing Independent Accountability Panel (IAP) from Kenya, Winfred Lichuma, shared experiences from Kenya and expressed that Kenya does recognize health as a constitutional right since 2010. She delineated that Private sector has almost monopolized health care sector in Kenya and there are cases of medical negligence in the private sector. Telge Sirimal Wijitha Peiris, Public Health Consultant and Dr. Manuj Chrishantha Weerasinghe from University of Colombo, shared experiences from Sri Lanka highlighting that the private medical sector regulatory framework is very weak in the country. There are many serious flaws and the medical industry takes advantage of it, however continuous efforts are being geared in the country to campaign for right to health as a constitutional right.

Dr. Madhur Basnet, from B P Koirala Institute of Health Sciences and Dr. Jagadeesh Chandra Bist, Health Activist, from Nepal shared the experiences of the country. They highlighted that the wave of privatization in Nepal has come along with the liberalization since 1990's. The policymakers and government have not paid much attention towards regulation and there has been a recent move towards corporatization in the country and the public sector is weakening. There are several problems of patient rights violations as overcharging, unnecessary investigations, malpractice etc. in private medical sector in Nepal. There is no regulation on private medical sector and overall framework and its implementation is very weak. Dr. Md Sayedur Rahman, health activist and Executive Director of UBINIG, Farida Akhter from Bangladesh shared that malpractices were rampant in the private sector in the country. Kenya and Nepal experiences highlighted that countries have the constitutional right to health, where as India, Sri-Lanka and Bangladesh do not have it. The issues of patients' rights are similar across the countries with inadequate regulation, capping on pricing of health services. Bangladesh and Sri-Lanka have a well laid primary health care system. Private hospitals and Clinical Research Organizations from India are making foray into these countries. The discussion led out that there was a need to have greater alliance and to learn from each other experiences in order to improve the health care systems in respective countries.

Apart from the panel session case stories of violation of patients' rights in the private health sector were also shared in the workshop.

Lessons from Campaigns and Initiatives for Regulation of Private Medical Sector

The sessions on campaigns laid out experiences from different campaigns across different states and networks of India. Dr. Anant Phadke outlined about the campaign for Maharashtra Clinical Establishment Regulation Bill, Jan Swasthya Abhiyaan, (JSA) the People's Health Movement network in India and Jan Aarogy Abhiyaan (JAA), the Maharashtra chapter of JSA. He showcased different efforts taken by JAA like media advocacy on patients'

rights, state level conventions for patients' rights, patient's rights forum liasioning with political representatives to enhance rights etc. Akhila Vasan from Karnataka Janaarogya Chaluvali (KJC), a people's movement for health rights, dignity and well-being of all citizens, with a focus on the most disadvantaged and marginalized communities shared about the struggle to fight with the state to bring in force for amendments in Karnataka Private Medical Establishment Act (KPMEA). She elaborated that the story of KPME amendment is a story of citizens' battle against the exploitative profiteering private health sector. Malini Aisola from All India Drug Action Network (AIDAN) elaborated upon the campaign to regulate prices of essential medicines and medical equipments in India. AIDAN has a long standing campaign for essential affordable medicines through Public Interest Litigation (PIL). The chief focus of the PIL is on the limited coverage of drug pricing policy which covering just about 10 percent of the total medicines in the market. The other focus is on drug pricing control order, i.e. the drug pricing policy should cover all essential medicines and also pricing mechanism should switch to cost based mechanism which was in place earlier. Amulya Nidhi health activist from Swasthya Adhikar Manch, India shared about the campaign to safeguard participant's rights in clinical trials. He shared about a Public Interest Litigation (PIL) in Supreme Court to safeguard patients' rights undergoing clinical trials in the state of Madhya Pradesh about violation of rights at different levels. He elaborated that there are violations of patients' rights in clinical trials at various levels. Illiterate and vulnerable patients are selected for trials and no proper informed consent is taken, very less information is given to participants in clinical trials or to their families. There is a lack of transparency and no proper ethics committees are constituted. There is nexus between regulator, sponsor and investigator and this is all backed by a weak legal framework.

Parallel Sessions on Campaigns
Parallel Session I

Jayeeta Verma Sarkar from Campaign Against Medical Negligence- People for Better Treatment (PBT), Kolkata, India shared the experiences of PBT, voluntary organization constantly fighting and campaigning for medical negligence by doctors both in public and private sector. She highlighted the case of Dr. Kunal Saha and its historic judgment on medical negligence wherein the Supreme Court of India found four doctors and the institute of Advanced Medicare Research Institute (AMRI) in Kolkata guilty for negligent treatment causing death of wife of Saha. Nisreen Ebrahim from Campaign for Alert Patients and their Rights, shared about the work of Rangoonwala Foundation, Mumbai, India on multi-sectoral programmes covering community services, health, education, livelihoods and disability.

Deepika Joshi from Public Health Resource Network (PHRN), Chhattisgarh, India shared about the involvement in the Monitoring and Implementation of Chhattisgarh Nursing Home and Health Care Establishment Act. Manoj Pardeshi, General Secretary of Network of Maharashtra for people living with HIV, India, shared experiences of working for rights of the people with HIV in Maharashtra as well as at country level. Jitendra Tandel from Rugna Mitra and Citizens Doctors Forum, Mumbai, India shared about the Campaign for safety of dialysis patients in Mumbai. Being on dialysis himself for more than 12 years he outlined that 90% of doctors and nursing staff fail to show concern or respect to patients.

Parallel Session II

R P Y Rao from Society for Awareness of Civil Rights, Mumbai shared about the campaign for regulating the prices of wide spectrum of devices including coronary and peripheral stents, intraocular lenses, cochlear implants, pacemakers, catheters, syringes and needles. Govind Bhosale from Kagad Kach Patra Kashtkari Panchayat-

(KKPKP), Pune, shared about the experiences of KKPKP, a trade union of waste pickers working for the rights of the waste pickers including the health rights of the waste pickers. It was outlined by the representative that KKPKP has initiated number of programmes for the health of the waste pickers which primarily includes the health insurance of the waste pickers. The union is also actively involved in the campaign to avail free healthcare for poor patients in Charitable Trust Hospitals and it continues to fight to ensure that members eligible for treatment under the scheme receive their rights. Shreya Nimonkar (41) narrated her story of struggle of six years against medical negligence and gross medical error in private hospital. As result of the negligence she had to undergo a number of operations including hysterectomy. Currently she is involved in to bring strict laws in medical negligence and for doctors doing malpractice. Shashikant Mane from SANGRAM, a NGO working in Sangali district of Maharashtra for 25 years shared experiences of working for the rights of sex workers and people living with HIV and fight to provide free ART treatment at district and sub-district hospitals. Advocate Jyoti Bhakare a Pune based advocate shared experiences about consumer activism in health care. She outlined about cases of medical negligence, fabrication of documents, denial of documents to the patient, as well as misinterpretation of judgments by hospital lobbies to safeguard their self-interests. Pravesh from Mareez Haq Abhiyan, Uttar Pradesh, India, involved in the Campaign to safeguard patient's rights and implementation of Clinical Establishment Act 2010 shared the case of overcharging by the private sector for normal delivery against which the organization fought the case and involvement of local elected political leader, were able to book the errant doctor. It was highlighted by him that involvement of elected political representatives as well as extensive use of RTI can put pressure on bringing private sector accountability.

Alliance Building with Rational, Ethical Doctors and Health Workers

This session focused on the experiences of the different alliances of ethical doctors and health workers working towards patients' rights. Dr. Preeti Damle from Pune Citizens Doctors Forum (PCDF), explained about the growing dominance of private sector and the relationships between doctor and patient getting worrisome. She outlined that PCDF has emerged in order to have dialogue and create awareness and building trust between doctors and patients.

Dr. Mirajkar, a surgeon doctor and associated with human rights highlighted the initiatives taken by the Mumbai Citizens Doctor Forum (MCDF). He outlined that in MCDF doctors, social workers and lawyers are committed to work and fight against the medical negligence. Susana Barria, researcher at Public Service International at New Delhi, shared experiences of accountability of private hospitals towards the workforce. She outlined that there is exploitation of the workers in hospitals and shared experiences of nurses struggle in Kerala to get minimum wages.

Way Forward and Networking

Moderated by the private medical sector accountability thematic hub anchor Dr. Abhay Shukla, this session saw summation of the deliberations, discussions, experiences of the two day workshop as well development of the way forward to ensure patient rights and private medical sector accountability Across countries people are doing struggles. He suggested for strong foundation bases to bring private sector accountability and patient's rights in force like use of courts, official bodies media as a means to get justice as well as victim activism citizens mobilization. After much detailed discussion a consensus was arrived at to charter strategies for further action.

The detailed report of the Learning Exchange workshop can be accessed on: https://www.copasah.net/uploads/1/2/6/4/12642634/pvt._sector_learning_exchange_report.pdf

myPatient RIGHTS

Two Case Stories Highlighting violations of Patient's Rights by Private Medical Sector

Excerpted from South Asia Learning Exchange Workshop on Patients' Rights Report of Thematic Hub on Patients' Rights and Private Medical Sector Accountability (SATHI)

Advocate Birendra Sangwan- Activist and Petitioner for Cardiac Stent Price Capping, India

Delhi based advocate and activist, Birendra Sangwan shared his experiences of series of petitions in the high court of Delhi on cardiac stent price capping, India. He outlined that PIL against 38 hospitals were filed by him in Delhi High Court (HC) for overcharging cardiac patients by hospitals in the name of angioplasty procedures. Demonstrating that the instrument of PIL can be used in a constructive and effective manner, he elaborated that continuous petitioning led to reduction in prices of stents from INR 80,000 (about USD 1350) to INR 28,000 (approximately USD 400).

Jayant Singh, Campaigner against Fortis Hospital, Gurugram, Haryana, India

Jayant Singh, father of seven year old girl, Adya Singh, who was admitted in Fortis Hospital a corporate hospital in Gurgaon, Haryana, for treatment of Dengue narrated the tragic incident of death of his daughter due to medical negligence and profiteering. The hospital slapped a huge bill of Rs. 16 lakh on the treatment of the patient, which later on proved to be a highly inflated bill with 108% profit margin charged on medicines and upto 17.37% profit margin charged I on consumables. Following the experience of his daughter's death, Jayant, has started a campaign against the exploitation done by the corporate hospitals.

The cases of negligence by the private medical sector and violations of Patients' Rights has caught media attention

News related to the case stories:

A lawyer took on India's profiteering hospitals to end the obscene overpricing of cardiac stents
https://qz.com/915197/a-lawyer-took-on-indias-profiteering-hospitals-to-end-the-obscene-overpricing-of-cardiac-stents/

Regulate stent prices to prevent exploitation of patients: health campaigners
http://www.downtoearth.org.in/news/stent-prices-should-be-regulated-to-benefit-patients-health-campaigners-56910

Lawyer with a heart: Birender Sangwan's fight to cap price of coronary stents
https://www.hindustantimes.com/india-news/meet-the-man-who-fought-to-cap-coronary-stent-price-at-rs-30-000/story-8Nbn7MSAH1NBy17TZjJdUP.html

This Lawyer Is Responsible for Heart Stents Becoming Super Cheap in India
https://www.thebetterindia.com/91360/advocate-birendra-sangwan-reduce-price-heart-surgery/

Adya Singh's dengue death case: Fortis hospital doctor booked
https://timesofindia.indiatimes.com/city/gurgaon/adya-singhs-dengue-death-case-fortis-hospital-doctor-booked/articleshow/62014634.cms

Fortis dengue case: Adya Singh's father moves Supreme Court
http://www.dnaindia.com/delhi/report-fortis-dengue-case-adya-singh-s-father-moves-supreme-court-2587563

Gurgaon Hospital Overbilled Family of Child Who Died, By 700%: Report
https://www.ndtv.com/gurgaon-news/gurgaon-hospital-overbilled-family-of-child-who-died-by-700-report-1784864

Hush Money Undercut Patient Rights
https://thewire.in/health/fortis-and-medantas-refund-offers-betray-a-larger-settlement-culture

COPASAH Social Accountability Dialogue -V

Speakers Dr. Abhay Shukla and Dr. Abhijit More; April 3, 2018; 3.30 pm - 5:00pm IST

Background

In many low and middle income countries especially in South Asia and Africa, the private healthcare sector is playing a major role in providing healthcare. With advancement in medical technology and with commercialization of healthcare, the healthcare landscape is rapidly changing in low and middle income countries. This poses significant challenges for access to quality and affordable care by patients. Hence there is a growing discourse around the need to protect patient's rights, which can be a key platform for ensuring greater accountability of private healthcare providers.

This COPASAH Social Accountability Dialogue described in detail the current discourse on patient's rights, both in terms of existing legal and formal provisions such as charters for patient's rights, as well as common violations of these rights. A few existing mechanisms for protecting patients' rights were also presented as examples. It was discussed how mechanisms to ensure Patients rights need to be built into any regulatory mechanism for the health sector, with corresponding grievance redressal systems, to ensure that patient's rights do not remain on paper, but are made real entitlements for ordinary people.

The detailed report of the Dialogue can be accessed at: https://www.copasah.net/uploads/1/2/6/4/12642634/copsad_5_report.pdf

The recording of the CoPSAD can be accessed on: https://www.youtube.com/watch?v=p-Xaq644bvs&feature=youtu.be

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About the Speakers:

Dr. Abhay Shukla is a public health physician who has been working on health issues in collaboration with people's movements and grassroots NGOs as part of SATHI, a Health sector civil society organization in India. Dr Shukla has authored and edited several books on health system issues including co-authoring the book 'Dissenting Diagnosis', which exposes malpractices in the private medical sector. He is involved in action and research for the promotion of patient's rights, social regulation of the private medical sector, and developing a system for universal healthcare.

Dr. Abhijit More, a medical doctor and health activist. He is working as a Senior Project Officer in SATHI, a Pune based NGO in India working on health issues. He is also a co-convener of Jan Arogya Abhiyan (Maharashtra State Chapter of People's Health Movement-India) which is a network of civil society organizations working on health rights. He is involved in advocacy and campaigns for patient's rights, improving public healthcare system, regulation of private healthcare sector and Universal Health Care in Maharashtra.

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