

Developing an Approach Towards Social Accountability of Private Healthcare Services

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Foreword

The field of International Development is a rapidly growing and challenging field. While the idea of poverty alleviation and economic growth has for remained a central concern for economists, concerns like income inequality, social inclusion, participation, transparency and accountability have become increasingly common ideas in many development for a including the World Bank. As these ideas are embraced and become integrated in practical development interventions, it is also necessary to review and understand how these ideas emerged or were first articulated. While some ideas came from academics and universities, many ideas and concepts became accepted as a result of the persistent struggles of practitioners in the field. COPASAH (Community of Practitioners on Accountability and Social Action in Health) is a collective of practitioners who have been developing these ideas and applying these principles in the field of health governance in different places around the world. In these Issue Papers COPASAH members have deliberated over some of their key concerns to draw lessons for future practice.

Health care is a contested area of governance and public policy action. It is also an area of immediate concern being featured prominently in the erstwhile MDGs and in the contemporary SDGs. In this series of Issue Papers, COPASAH members share their insights in critical issues especially related to the inclusion and participation of the poor and marginalised communities and how these may be negotiated or kept centre stage within contemporary development practice. The Issue Papers draw upon the years of practice of COPASAH members and are practical and insightful at the same time. We are sure these will provide important pointers for practice for any development practitioner in the field of health governance. On behalf of COPASAH we look forward to your feedback and suggestions to continue the discussions and sharpen our practice.

About the Authors

The authors are affiliated to SATHI. SATHI is the action centre of Anusandhan Trust based in Maharashtra state of India. In pursuit of the goal of “Health for all,” SATHI works to strengthen coalitions at local, state and national levels towards ensuring universal access to quality health services in a rights-based framework.

For more information on SATHI, see www.sathicehat.org.

Developing an Approach Towards Social Accountability of Private Healthcare Services

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EXECUTIVE SUMMARY

This paper mainly deals with social accountability of private healthcare services in developing countries, with a focus on India as an example. The paper delves into the idea of social accountability of private healthcare services in the following areas:

- First, the rationale and perspective related to the need for social accountability of private healthcare services.
- Second, propositions of steps and processes by which social accountability of private healthcare services can be developed in developing countries.
- Third, examples of efforts made towards building social accountability of private healthcare services in developing countries and lessons learnt from them.

1. Rationale and perspective

This paper explores key common features of the current nature of private healthcare sector across most developing countries, for example, chaotic, 'market' driven character with lack of regulation or grossly inadequate regulation, substantial irrationalities in healthcare provision, lack of protection of patient's rights, lack of social accountability, lack of grievance redressal mechanisms and others. It is important to

look at the private healthcare sector through a community lens in order to understand if it is meeting the health needs of the community.

Subsequently, analysis of the qualitatively different nature of private healthcare sector from the public health system, from the point of view of accountability, will be presented. Various possible steps for developing accountability of private healthcare services will be discussed. The need for social accountability mechanisms in the context of the current failure of self-regulation by medical professionals, and weaknesses of existing state regulation mechanisms, leading to perceived accountability deficiency in private healthcare services will be discussed.

Given the role of citizens' action and social pressure in accountability processes, its limitations in the case of private healthcare services in the absence of legal regulation will be discussed, along with the need for a legal framework for regulation.

2. Some steps and processes to move towards social accountability of private medical sector

It discusses in detail some steps and processes by which progressively, private healthcare services can be made more accountable to society. These

steps and processes are made as suggestions and propositions. Obviously, there cannot be any uniform solution or approach to such a process, as the socio-economic-political situation in different countries has a major role in shaping such processes. However, this paper tries to outline some possible options for action such as:

- Documentation of problems in the private medical sector from the point of view of users and the voicing of public demand for regulation.
- Organised campaigns and dialogue around key issues like patients' rights in the context of the private medical sector.
- Active role of citizens' organisations in monitoring Public-Private Interactions (PPIs) and Universal Health Care systems involving private medical services.
- Demanding grievance redressal mechanisms related to the private medical sector.
- Need for involving pro-people professionals in regulatory processes related to formulating minimum standards, treatment protocols and others.

Based on these possible steps, the proposal of **'multi-stakeholder social regulation'** (involving healthcare professionals, the state and civil society

organisations) of private healthcare services will be discussed. This paper emphasises the vital role and involvement of the state that is critical to the proposed mechanism, and its qualitative difference from typical bureaucratic regulation. The issue of representation of 'public interest' in such 'multi-stakeholder social regulation' processes and the challenge of 'process capture' by one or more powerful vested interests will be examined.

3. Case studies of specific efforts in India and Brazil

In some countries, civil society organisations, health activists, sections of pro-people medical professionals and the public at large have made significant efforts towards making private healthcare services more accountable to society. Although some of these initiatives are more effective than others, these efforts can give us glimpses of the actual actions that are taken in this direction. The lessons learnt from both their success and failure is useful for shaping advocacy towards social accountability of private healthcare services. This paper focuses on case studies from India and Brazil as examples of such efforts, and lessons that can be learnt from them.

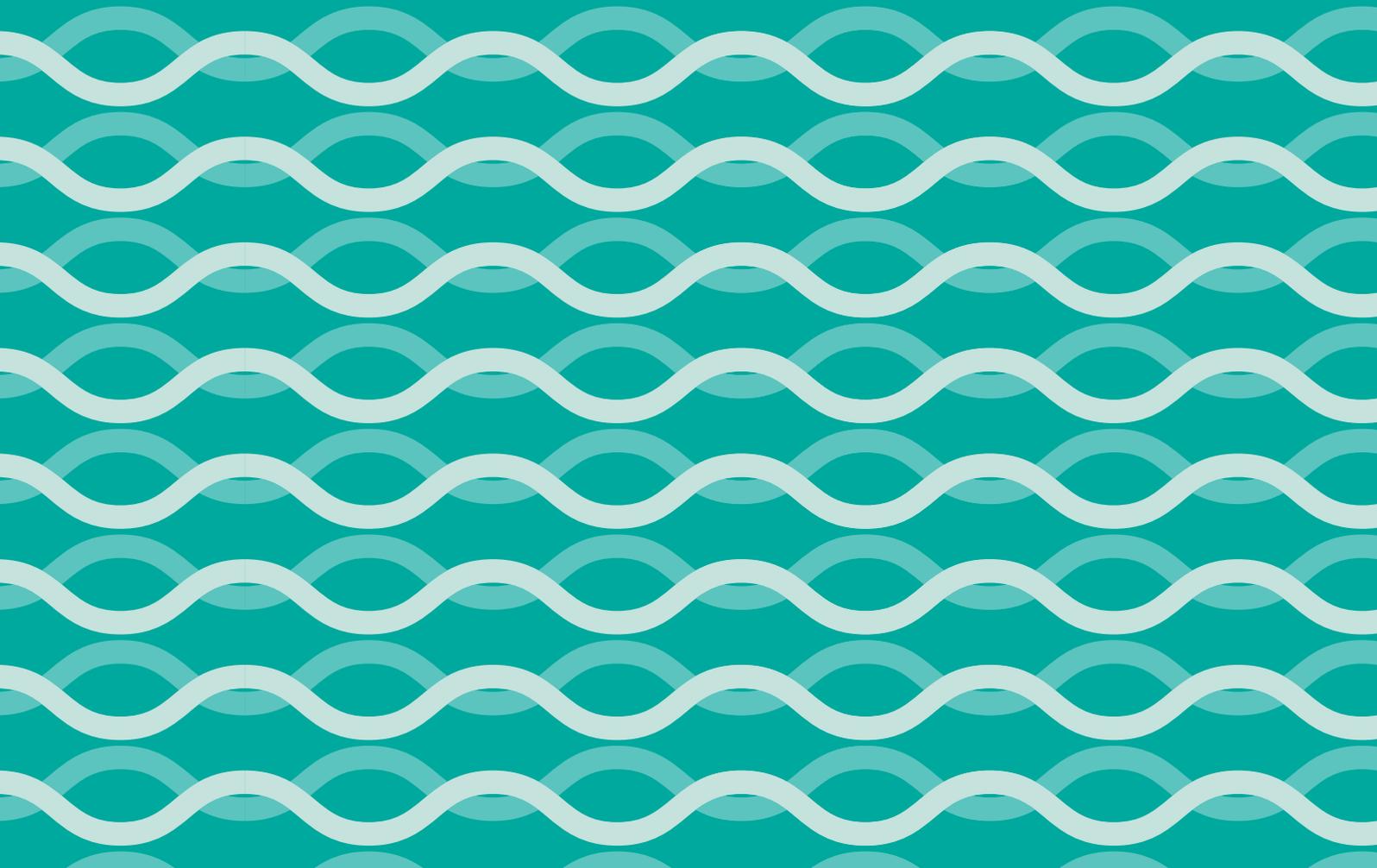


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1

RATIONALE FOR SOCIAL ACCOUNTABILITY OF PRIVATE HEALTHCARE SERVICES



Barring some exceptions like Cuba and Sri Lanka, Private Healthcare Services form a large component of Health Care Systems today in most developing countries. For example, the share of the private sector in various components of health care in India is as follows:

- Medical graduates: **90%**
- Post-graduate doctors: **95%**
- Outpatient care: **80%**
- Inpatient care: **60%**
- Medical colleges: **30%**
- Manufacture of medicines: **99%**
- Manufacture of medical instruments: **100%**¹

¹The private medical sector in developing countries has grown considerably since the onset of 'Structural adjustment' and neoliberal policies in the 1980s and 1990s. The trajectory of the private medical sector in India and its key features are traced here to exemplify how such processes of the unregulated proliferation of private providers have unfolded.

Post the independence of India, the Indian government embarked upon substantial expansion of Public Health Facilities, especially in rural areas. Thus, Primary Health Centres were opened in progressively increasing numbers all over India. However, at the same time, there was also the unregulated growth of the private sector. Hence, the majority of patients continued to be serviced by the private practitioners and their proportion compared to doctors in the Public Health Services continued to increase. This is especially true after the increase in production of post-graduate doctors since 1980s, who progressively overshadowed the 'general practitioners' and began to setup private hospitals and 'nursing homes'. With increasing adoption of neo-liberal economic policies by the Indian government since the early 1990s, the number of private medical colleges as well as corporate hospitals increased rapidly. In pharmaceutical

production, however, a small but significant role that pharmaceutical units in the Public Sector played was progressively undermined after the 1980s. The role of these manufacturing units declined in absolute terms. The unrestrained, unregulated expansion of the private sector in all branches of health care, especially

Since the 1990s, combined with the relative lack of growth of public systems, has thus resulted in the situation of the all-encompassing predominance of the private sector. The growth of the private sector has led to setting up of 'elite hospitals', but these form one end of a wide spectrum of private providers, which include smaller nursing homes and semi-qualified and unqualified practitioners, overall characterized by complete lack of regulation. Today, the private medical sector is riddled with unhealthy practices that have become an obstacle to making full use of the resources in the health sector efficiently and appropriately to reach the goal of 'Health and Health Care for All', to which the Indian Government committed itself in the Alma Ata conference in 1978.

Social regulation and social accountability of the private health sector would considerably facilitate overcoming these problems. Sections of regulated private providers could help contribute to reaching the goal of 'Health Care for All'. The need for social regulation and social accountability of the private health sector arises on three counts:

1. Widespread irrational practices seen in the private sector, leading to wastage of money spent by the patients. This is linked to the exploitation of the poor, something people in developing countries like India can ill afford.
2. Substandard care, violation of medical ethics and of patients' human rights.
3. In real terms, given the underlying socialized nature of private healthcare in the 21st century, its formal 'private' character is getting progressively outdated.

¹ Universalising Health Care for All, Jan Swasthya Abhiyan, November, 2012

1. Excessive, Wasteful and Costly Irrational Practices in the Private Sector

a. Massive wastage due to excessive/irrational medications:

Various studies have reported the significant extent of unnecessary use of medicines by private practitioners. Unnecessary use of antibiotics, vitamins, irrational Fixed Dose Combinations (FDCs), medicines with no or doubtful value etc. constitute a huge wasteful expense for patients. Out of the annual sale of medicines of about Rs. 600 billion (approx. USD 10 billion) in India, about one-third are considered to be irrational.² This amount of Rs. 200 billion may be compared with the estimate of the High Level Expert Group of the Planning Commission that Rs. 300 billion (approx. USD 5 billion) would be sufficient to achieve the objective of 'Medicines for All' i.e. providing free essential medicines for all patients in a Universal Health Care System in India.

Irrational use of medicines takes place broadly at two levels. Firstly, practitioners of traditional systems of medicine and homeopathy are trained only in their respective disciplines and are largely not formally trained in modern medicine. Yet most of them use modern medicines though this '**cross-practice**' is patently illegal. A large proportion of them practice in rural areas, and due to the scarce presence of qualified practitioners of modern medicine in rural areas, society has accepted this illegal practice. Since their knowledge of modern medicine is perfunctory, (they acquire it informally by working as assistants in modern medicine clinics or hospitals) their practice is often quite irrational, though usually at a lower level of technical sophistication. Secondly, even doctors trained in modern medicine frequently over-prescribe or irrationally prescribe medicines like antibiotics, steroids, vitamin preparations and 'tonics', cough syrups, unnecessary drug

combinations. This includes overuse or misuse of higher-end antibiotics and other expensive 'me-too' brands, for which cheaper and equally effective rational equivalent drugs may be available. Pharmaceutical companies are able to 'convince' doctors about the need to use the 'latest' medicines that these companies market, by means of dubious marketing techniques and incentives, though their superiority or relevance may not have been adequately established.

Doctors are induced to use so-called 'new' medicines for which their use has not been approved scientifically. All this has continued for decades and yet Medical Councils and Medical Associations have completely failed to control this.

b. Unnecessary use of injections, intravenous fluids and surgeries

In rational outpatient care, generally, not more than 5% of patients require injections. However, in many developing countries including India, majority of the general practitioners indulge in the unnecessary use of injections. In India, a study by SATHI of outpatient clinics in a sample of villages in various parts of Maharashtra in 2006-07 found that on an average 62% of outpatients received an injection: 40% of urban patients and 73% of rural patients. In the case of less educated patients and patients in tribal areas, this proportion was 80% and 86% respectively.³ Many general practitioners misuse for personal gains, the popular misconceptions that injections have almost magical properties, those injections are necessary and more effective in any illness. Similarly many general practitioners misuse intravenous saline/ glucose infusions and propagate the mistaken belief that it has fantastic therapeutic properties and provides 'strength' to the patient. They use this infusion when not indicated, and thereby find a pretext to charge patients excessively.

Performing surgical procedures when unnecessary has been an increasing trend. The classic example

² Pharma Policy 2012 and Its Discontents, S Srinivasan, Anant Phadke, Economic & Political Weekly January 5, 2013, vol XLVIII no. I EPW

³ SATHI study on Healthcare utilization and expenditure in Maharashtra, 2012

is that of non-indicated removal of uterus (hysterectomy) which has been reported by studies from different parts of India.^{4,5}

The fee charged by surgeons is unreasonably high because of the mystification and aura around surgery in the minds of the ordinary people. A caesarean delivery that takes half to one hour is charged at a rate in India that amounts to several times the monthly per capita income. The same holds true for an angiography, an invasive investigation performed by an interventionist cardiologist. It may be noted that when a physician treats a patient for heart attack for half an hour, s/he does not usually charge in thousands through his/her knowledge, training, skill and the criticality of his/her intervention is no less than that of a surgeon/interventionist. The latter charge exorbitantly, misusing the aura that surrounds surgical interventions.

c. Excessive laboratory investigations

With the advent of corporate interests in health-care, the tendency of carrying out excessive laboratory investigations has increased. Large private diagnostic centres and corporate hospitals while 'educating' doctors about certain new technologies mislead them by dishing out half-truths about these interventions and often directly or indirectly bribe them so that the doctors would refer patients to these centres or hospitals in exchange for a commission.

Traditionally in general practice, investigations were often done in lesser proportion compared to what was rationally required. This is because firstly, the medical investigation is costly compared to the purchasing power and willingness of the patient to pay for these. Secondly, the general practitioners would prefer to charge a fee for treating patients through the use of non-specific 'shotgun' therapy, i.e. by using many different

4 Aarogyasri Healthcare Model: Advantage Private Sector – Rajan Shukla, Veena Shatrugna, R Srivatsan. Economic and Political Weekly, December 3, 2011, vol xlvi no 49.

5 Chhattisgarh doctors remove wombs at random to claim insurance: Hindustan Times, July 17, 2012

medicines based on some guesswork- diagnosis, and earning more by charging for medicines at inflated rates, or by unnecessary use of injections and intravenous infusions. However, during the last decade, some purely commercial pathological laboratories and diagnostic centres have developed aggressive marketing strategies and have lured general practitioners into referring patients for unnecessary investigations in exchange for commissions.

The ubiquitous nature of various irrationalities in private health care makes a strong case for social regulation of the private health care sector since self-regulation is almost non-existent and patients are paying a heavy price for unregulated and often irrational care.

2. Substandard Care, Violation of Medical Ethics and of Patient's Rights

Although some private providers in India maintain certain standards (particularly related to infrastructural aspects) in their facilities, the quality of care is not uniform. Overall it is often substandard. Medical Councils and Medical Associations have failed in instituting self-regulation to ensure standards. Even worse is that they have not made any significant attempts in this direction. It is only recently, since 2010 that Medical Council of India or MCI (the regulatory body empowered by the constitution to ensure standards and ethics among allopathic doctors) has made earning Continuing Medical Education (CME) credits mandatory, so that medical practitioners periodically update their knowledge. However, there is no monitoring, evaluation of this CME requirement. It is doubtful if this new compulsion has improved the *quality of care*.

It is not enough to make CME mandatory. Medical councils should formulate Standard Treatment Guidelines (STGs) for doctors to follow. In the absence of any worthwhile CME and STGs, the prescriptions of doctors for even killer diseases like

tuberculosis are often irrational. For example, a study by Uplekar *et al* in Mumbai on prescriptions of doctors for tuberculosis found that despite the availability of Standard Drug Treatment Regimes prepared by the WHO and the by the National Tuberculosis Control Programme, out of 106 doctors, only six gave the correct prescription. When the same study was repeated after 20 years, they found that there has been virtually no improvement in this scenario.⁶

The pharmaceutical industry has played a corrupting influence on the medical profession. Medical Ethics demands that given the inherent vulnerability, the helplessness of the patients, it is the doctor's duty to consciously keep patient's interests uppermost. However, this ethical principle is flouted by indulging in excessive, irrational use of medicines. Commercial competition and the drive to earn money at the expense of vulnerable people has led to increasing prevalence of other irrationalities and malpractices. As we have 'progressed' from the 20th to 21st century, doctors have performed hundreds of thousands of sex-selective abortions to eliminate female fetuses in India during the last two decades, by misusing sonography testing. Medical Councils and Medical Associations have completely failed in instituting any self-regulation to ensure medical ethics. Now commercial surrogacy has become a new method of misuse of new reproductive medical technology. It is considered unethical, illegal in many developed countries, but so far it is 'official' in India, and many doctors are helping the rich people to exploit the reproductive capacities of poor women in India.

Using patients as 'guinea pigs' is a violation of medical ethics in clinical trials and has surfaced as a new addition to the list of unethical practices. The revelations during the Public Interest Litigation launched in 2012 by the Swasthya

Adhikar Manch (Health Rights Forum) in India have brought forward the grossest violation of medical ethics in clinical trials in the country.⁷

Thus, violation of medical ethics has been an important feature of medical practice in India, and Medical Councils and Medical Associations have completely failed to stem this rot.

Leaving aside the issues of rationality of medical practice and excessive charges levied, patients get a raw deal from private practitioners on at least two further counts:

- a. Lack of basic ***minimum infrastructural facilities*** to patients, especially in smaller hospitals where basic essentials such as cleanliness, adequate space, privacy and sufficiently trained paramedical staff are lacking.⁸
- b. ***Patient's human rights*** are violated to a significant extent. For example, the right to emergency care, the right to information, the right to informed consent, the right to the second opinion, the right to refusal of specific treatment. Human rights are violated by undermining human dignity of patients, by not respecting patient's privacy or breaching confidentiality of the identity of the patient, with those who are not involved in patient's treatment. The dead body of a deceased patient is not handed over to the relatives until the full payment of all expenses has been made to the hospital. Patients might be coerced into buying medicines from a specific medical store in the hospital premises at hiked up prices, compared to buying the same medicines at lower cost from any other medical store.

Although there have been some welcome initiatives to foster a voluntary policy of commitment to respect patient's rights in some private health care services, the experience

6 Udhwadia ZF, Pinto LM, Uplekar MW (2010) – Tuberculosis Management By Private Practitioners in Mumbai, India: Has anything changed in two decades? PLOS ONE 5 (8): e12023. doi: 10.1371/journal.pone.0012023

7 Swasthya Adikar Manch, <http://www.unethicalclinicaltrial.org>

8 Bhate-Deosthali, Padma and Khatri, Ritu. Healthcare in the Private Sector: A Study of Private Hospitals in Maharashtra. Mumbai: CEHAT, xv,136 p., 2011

shows that in the absence of a broader policy and legal framework, self-regulation has not worked in private health care. Widespread violation of standards, ethics and patient's human rights in private health care implies that **social regulation of private health care is essential and overdue**, especially since self-regulation is either almost non-existent or has failed miserably at the expense of the interests, lives and health of patients.

3. Increasingly Socialized Nature of Private Health Care in Real Terms

Lastly, it can be argued that the rationale for social accountability and social regulation of private health care is derived from the fact that though the ownership and profits are private, in terms of key inputs like knowledge and skilled human power.

In the 21st century, private health care has been significantly socialized. The key ingredients of the modern health care system such as production of medical knowledge, training of health care providers and medical research have been socialized in the sense that medical sciences are not guided primarily by a personalised understanding of health and health care. The very nature of modern medical science, technology and organization of health care is such that health-care decisions should follow socialized medical sciences and should not be constrained by a personalised understanding of health and health care. This is in contrast to the olden times when the traditional practitioners based themselves on their personal knowledge, where more experienced practitioners passed on knowledge. Today the medical practice is no more based on personalized knowledge and

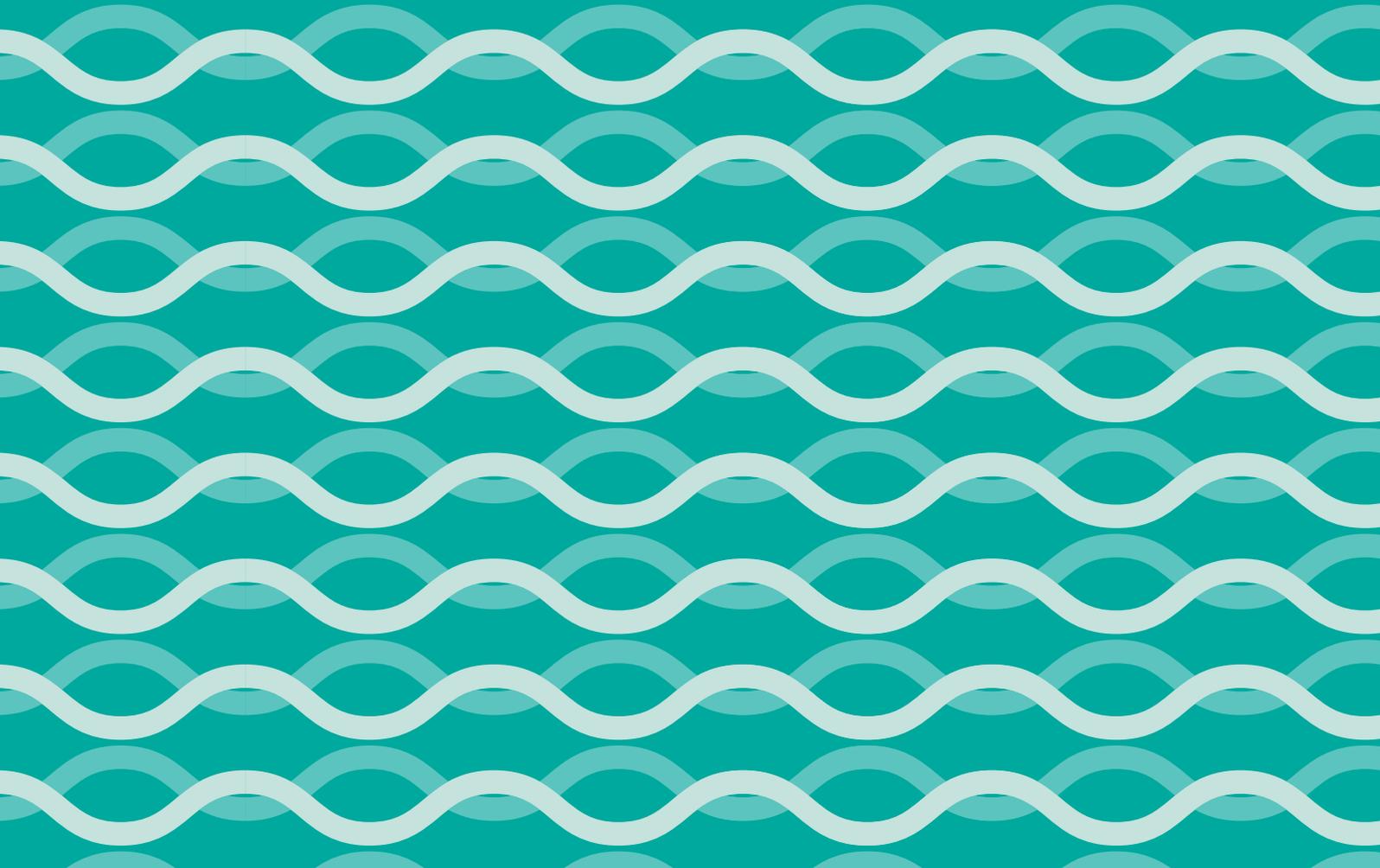
experience but is mostly based on research done throughout the world largely with public funds. Similarly, production of diagnostic, preventive and therapeutic modalities (whether medicines or others like imaging techniques or vaccines) are socialized, where the production is based on social research and norms prepared at the social level.

Given this background, in the current era, it is necessary that private providers follow scientific guidelines and protocols similar to those that doctors in Public Health Facilities are supposed to follow. *Overall in terms of the content of health care, there is very little 'private' in private healthcare.* What is private is the ownership of facilities, the profit generated through operation of the facility, and terms of contractual relations between patients and doctors. Hence, there is overdue *need to socialise the socio-economic organisation of health care* in line with the already socialized nature of its content; a key step in this direction is to institutionalize social regulation of the quality of private health care.

Further, now even in developing countries like India, the bills of private medical providers are increasingly being directly paid for, or reimbursed by the government through various schemes. These schemes have been subjected to major critique on a variety of grounds, and there are substantial arguments that either these should be scrapped or significantly transformed. To merge into public health system centred provisioning systems. However, since today public money is being paid to private hospitals in schemes through contractual arrangements, there must be parallel social regulation of the rationality and quality of health care provided by private hospitals in these schemes, as part of the larger move towards regulation of the private medical sector.

2

STEPS AND PROCESSES TO MOVE TOWARDS SOCIAL ACCOUNTABILITY OF PRIVATE HEALTHCARE SERVICES



This section discusses steps and processes to make private healthcare services accountable to society. These steps and processes are suggestions and propositions. Recommending a uniform global approach is not appropriate, as the socio-economic-political situation is different in countries where the milieu and context has a major role in shaping such processes. However, some key actions in this direction could be as follows:

1. Bringing private healthcare related issues into the public domain by exposing and documenting irrationalities, overcharging and other malpractices in the private medical sector

So far, the private health care sector is not subjected to public scrutiny as compared to the public health system in most developing countries. Although there may be innumerable ‘anecdotes’ of negative experiences with private providers, the malpractices, irrationalities, exorbitant costs, denial of patient’s rights, degradation of medical ethics, ill effects of corporatization of healthcare need to be formally documented in detail for public information, to stimulate powerful public action. These issues need to be raised with evidence in the public domain. This can be done through:

- Formally documenting and publicizing major problematic experiences of patients through print and electronic media, after thoroughly examining the relevant medical facts of each case with the help of teams of pro-people doctors.
- Conducting surveys related to private healthcare and releasing their findings in print and visual media.
- Publishing booklets, pamphlets, posters that address these issues to build public awareness. The findings of research papers on these issues can be converted into popular publications

- Awareness meetings can be conducted with various sections of society. For example, community organisations, middle-class citizens, students, trade unions, and other civil society activists to sensitize them about the situation in private healthcare.

Thus, private health care related issues can be brought under public scrutiny. Once they become ‘publicly important issues’ then it is relatively easier for civil society activists and ordinary people to demand social accountability of private healthcare.

2. Challenging the monopoly of medical professionals over regulation; asserting the role of patients as important stakeholders and organizing campaigns for patient’s rights

The failure of the medical community to self-regulate their profession and the often-dysfunctional status of such self-regulatory mechanisms (in most developing countries) needs to be highlighted in the public domain. The monopoly of doctors over regulation i.e. exclusive self-regulation needs to be challenged through public forums, and attempts should be made to establish the role of patients as an important stakeholder in ensuring accountability of private healthcare services. This can be done by organizing campaigns for patient’s rights demanding legal enactment of patients’ rights and formulating patients’ rights committees, forums for such purposes.

Experience shows that compared to the somewhat technical issue of regulation of private providers, the *issue of patients’ rights in private hospitals has a broader appeal and common people can easily relate to it*. Public programmes must be organized to campaign for patient’s rights. For example, documenting cases where patient’s rights are denied, capturing testimonies of denial that can be presented in a public

convention, where civil society organisations, citizens, media, along with representatives from doctors' associations and hospital associations can participate. After the presentation of 'denial testimonies', various social actors can effectively demand observance of patient's rights in private hospitals. The invitees to the public consultation can be representatives of private hospitals, to enable them to take a stand on this issue on public platforms. Experience shows that when representatives of private practitioners and hospitals face public pressure, they tend to agree to observe patient's rights in their hospitals, clinics. The media can create further positive impact.

Similarly, campaigns can be organized regarding the rights of people living with HIV/AIDS in the context of private health facilities, since discriminatory treatment given to people living with HIV/AIDS is a well-known fact, and it is an issue that attracts significant social support.

Patient's rights forums can conduct a dialogue with various private hospitals, doctors' associations regarding observance of patients' rights. By mutual dialogue, misunderstandings could be resolved and a section of doctors who believe in reasonably ethical, rational practice can be won over to the speak on behalf of patients and civil society on the issue respecting patients' rights.

3. Emphasizing the 'public good' nature of healthcare services, highlighting market failure in healthcare and need to negate 'market' logic of healthcare

Healthcare should be viewed as a 'right' rather than as a commodity and hence as a 'Public good' rather than a private service. This needs emphasis while creating public awareness through various meetings, campaigns and publication materials. The neoliberal perspective that views healthcare purely as a commodity must be challenged in all possible ways. The 'public good' nature of healthcare also demands that whosoever be the

provider of healthcare (public system or private hospital), every provider should be accountable to society in a systematic manner.

4. Creating entry-points for social activism regarding the private healthcare sector; mobilizing public pressure to demand effective regulation of private healthcare

Once the status of services, irrationalities, and patient's rights violation in the private sector is documented, sufficient 'evidence' is generated and is brought into the public domain through various means, then attempts can be made to create or find existing entry points for social activism. Appropriate laws, administrative orders, court judgments, existing public subsidies for private providers can be entry points. Once such entry point is identified, then social pressure and advocacy can be developed to promote related action. Attempts can be made to mobilize more sections from the society to demand effective regulation of the private healthcare sector. This strategy can help in creating public awareness and demanding further accountability, as seen from the example in the state of Maharashtra in India, regarding the Bombay Nursing Home Registration Act (BNHRA) 1949. It is an old and outdated Act, yet the People's Health Movement (PHM) in Maharashtra tried to create a space to further patient's rights by campaigning for its amendment and later on for approval of rules under the amended law. It mobilized various social activists, civil society organisations, newspaper editors for the campaign related to BNHRA.

If the existing regulatory structures are rudimentary or insufficient, then one can demand the creation of new regulatory structures and strive to create spaces for civil society bodies like 'patient's rights forum' in these new structures. BNHRA, which is a rudimentary act, served as a background for the formation of new, improved Clinical Establishment Act at the Union Government level.

Public Interest Litigation (PIL) in the courts can be another way of demanding accountability. For example, such a litigation was filed in the Delhi High Court that related to lack of observance of obligations to provide free beds to poor patients by 'Charitable' hospitals. Most hospitals, though registered as 'Charitable trusts' avail of substantial public subsidies and cheap land in prime areas, function commercially. Though they are obliged to reserve a proportion of their beds to treat poor patients free of charge, they were not doing so. The PIL filed in this regard resulted in substantial orders being issued by the court, requiring the errant hospitals to provide treatment to poor patients more effectively.

5. Public financing of private health-care demands social accountability

Increasing numbers of developing countries are resorting to arrangements involving public funding for care given by private providers. In India, many state governments are coming up with publicly financed, privately provided and insurance company-administered health insurance schemes. Some countries are contemplating the idea of 'Universal Health Coverage' or 'Universal Health Care' to include both public and private healthcare providers.

Such arrangements throw up a wide range of issues and need critical examination. Along with closely examining the merits or demerits of every such arrangement from a public health perspective, one demand that Civil Society Organisations should raise in this context is that *in case of any kind of public financing, irrespective of whether providers are from public sector or private sector, every healthcare provider must be accountable to the people of the country. Any service that is publicly funded must be made accountable to the public.* Public financing, whether it is tax based or social insurance based, is public money; there should be proper accountability and monitoring mechanisms to ensure that public money is not wasted or used irrationally.

Ongoing public financing is one important rationale for demanding social accountability of private healthcare providers. Public financing of certain sections of private providers, especially if organised under a public-centred UHC framework having strong public health logic and systematic accountability mechanisms, can help the common people, civil society and political parties to demand effective regulation of private healthcare services.

It must be emphasized, that it is necessary to carefully scrutinise the terms and conditions under which private providers are involved in any such publicly funded system. The role of private providers should not be to substitute public providers, to weaken public provisioning or to preclude the expansion of the public system, but should rather fill gaps where public provisioning is presently unavailable or very weak. The overall goal must be to strengthen the 'public' nature of health care and to move towards a more socialized system of health care, both through expanding public health provisioning, and through regulating and rationalizing private providers.

6. Active role of citizens' organisations in monitoring private healthcare providers; demanding grievance redressal mechanisms for private healthcare

Today, effective mechanisms are required to ensure accountability of health services with people's active involvement. Community Based Monitoring of Public Health Services is one such tool used to promote accountability of public health services, under the National Rural Health Mission (NRHM) in some areas in selected states of India⁹. In this programme, based on mutually agreed indicators, people in an area monitor and rate the quality of public healthcare services provided. 'Public Hearings' are held once in a year involving public health officials, healthcare

9 See www.cbmpmaharashtra.org for details

providers, members of the public, elected representatives and civil society organisations in that area, in the presence of media. People share their complaints about the deficiency of services or denial of care while health-care providers in the concerned public facility have to respond to and resolve people's complaints in the public hearing. The quality of public health services has significantly improved in areas where such a system of community monitoring is in place, as compared to areas without such a participatory monitoring system.

Similar processes could extend to cover private providers, particularly publicly financed and privately provided healthcare services. Citizen's organisations can and should play an active role in monitoring publicly funded and privately provided healthcare delivery, based on the principle that 'any publicly funded service should be as accountable as a public service'. If such arrangements are for people's benefit, then it must be made systematically accountable to people. Besides this, civil society organisations can demand accountability based on grievance redressal mechanisms within all private hospitals to resolve patient's complaints on a day-to-day basis.

7. Demanding participatory and democratic regulatory systems (multi-stakeholder social regulation) as an alternative to bureaucratic and 'expert captured' regulatory systems

Demanding regulation of the private healthcare sector and social accountability are related but not necessarily identical concepts. These can be bureaucratic top-down regulation, an autonomous regulatory structure with a mixture of public officials, technocrats and medical professionals, but without any representation of civil society or various sections of society. These types of accountability structures would have their

own limitations, since they may not reflect the concerns and experiences of the actual users of services, and may not be sufficiently accountable to the communities whose interests they are supposed to protect.

Bureaucratic top-down regulation may lead to 'red-tapism', focus on peripheral aspects of physical standards with neglect of important process related issues, and unnecessary harassment of private providers which would be unfair and unjustifiable. Such a regulatory system is likely to be prone to corruption. Such a 'statist' kind of system has various drawbacks and is prone to '*elite capture*'. Another type of regulatory structure is technocratic regulation. It is based on a relatively autonomous structure where certain public officials, technocrats and medical professionals are involved in the regulation process. This process is prone to '*expert capture*'.

Both systems may also be in practice tilted in the direction of favouring the interests of private providers at the expense of patients' interests since the latter are not adequately represented. In both kinds of systems, there is no people's voice and no social accountability; decision-making powers are completely with the bureaucrats or technocrats.

There is an alternative to 'non-regulation' of regulatory systems: a participatory, democratic regulatory system. In this kind of system, organizing representatives of various concerned stakeholders (like elected representatives, public officials, and representatives from various sections of the medical profession and civil society organisations, patients' rights groups and other) to form Health Councils at various levels. These Councils can discuss the problems of the patients and of other stakeholders and can take decisions democratically. The Brazilian system of Health Councils, though obviously not ideal, is a useful pointer in this direction (see Case study-2, Multi-stakeholder Health councils in Brazil, provided in the next chapter on case studies). Such regulation should be mandatory for all private and public

providers. The implementing agency i.e. officials along with technical experts can then implement the decisions taken by multi-stakeholder bodies. Citizens' organisations can monitor the service provision and conduct periodic public dialogues to resolve citizen's grievances.

This form of regulation is more inclusive, decentralized and participatory. Thus, it is more conducive to enhance social accountability of health services. Democratic decision making by multi-stakeholder bodies ensures that every major stakeholder has their say in the process, and this makes the process more open to pro-people inputs. While decisions would be implemented by appointed public officials with the help of technical experts, the 'bottom-up' feedback mechanism (in the form of community based monitoring) ensures that actual implementation is done effectively. Thus, there is a potential for oversight over the implementing regulatory structure by the people themselves. Accountability of the regulatory structure is ensured and the process can be guarded against the hijacking of the elite and powerful private interests.

This alternative structure has certain problem areas such as the issue of who would represent 'public interest' in such 'multi-stakeholder social regulation' process. The selection of people's representatives and civil society activists in the multi-stakeholder committees is an important process that needs to be organized in an open

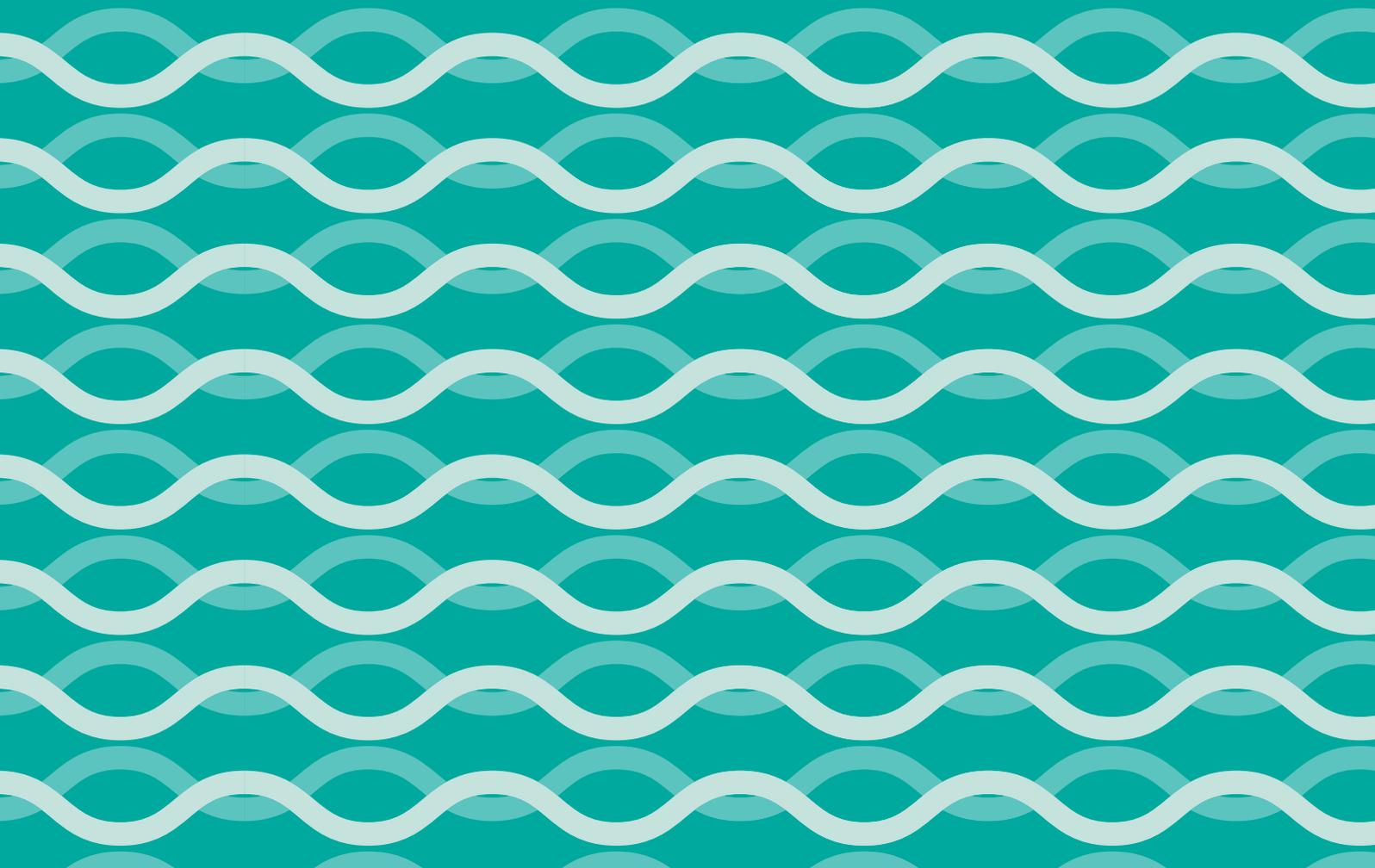
and democratic manner. Unless this is done in a genuinely democratic way, there is a potential danger of 'vested interest capture' by one or more powerful vested interests representatives in the multi-level, multi-stakeholder committees. Another concern is dealing with situations where basic differences of opinion emerge among the involved stakeholders. Here publicly agreed principles, guidelines and standards can act as a reference point, and with half of the members being public representatives from various fields, one can restore to voting, ensuring that public interest is not jeopardized.

8. Dialogue and alliance with a section of rational, socially responsive practitioners

We find that a small section of private practitioners likes to carry out ethical and scientific practice, being uncomfortable with various malpractices in the medical profession. They are not opposed to participatory regulation of medical practice, are ready to respect patient's human rights and are against the corporatisation of private health services. Experience shows it is fruitful to have dialogue, collaboration with this section of private practitioners who can catalyse interaction and alliance with the representative organizations of private practitioners.

3

CASE STUDIES OF PROMOTING ACCOUNTABILITY OF PRIVATE HEALTHCARE PROVIDERS



Case Study-1

Campaigning for Patients' Rights in Maharashtra, India

In the state of Maharashtra state, India, civil society organisations, health activists, pro-people doctors and the public have made efforts towards making private healthcare services accountable to society. The experience of advocating regulation of Private health services and protection of Patient's Rights gives an idea about the processes and steps that adopted to push forward the agenda of regulation of the private medical sector.

In the Indian context, Maharashtra is a relatively economically 'developed' state with a predominant private medical sector, with all its attendant problems. Jan Arogya Abhiyan, the Maharashtra chapter of the People's Health Movement has continually focussed efforts on advocacy for strengthening of public health services, but also realised that there is a need to engage with the huge private sector 'reality'. However, it is noted that the private medical sector is a different ball game, with no clear fulcrum for activism unlike in the public health system, where there is some basis for such advocacy because the government is committed to providing services. Hence as an entry point for pushing forward the issue of regulation of the private health services, PHM-Maharashtra launched a campaign demanding the inclusion of patients' rights in the Bombay Nursing Home Registration Act 1949 (BNHRA-1949). Public opinion was mobilised on the issues of patient's right, showing the tremendous dissatisfaction with the way private hospitals function.

Since its inception in 2000, PHM Maharashtra is demanding enactment of rules under the BNHRA. The Maharashtra government finally decided to amend the BNHRA-1949 in December 2005, setting minimum standards for nursing homes, though the amendments were minimal. Nevertheless, PHM Maharashtra decided to use this 'window of opportunity' to push the issue of Patient's Rights. It demanded that rules must be

formulated to include Patient's Rights under this amended act. Given the consistent pressure by various civil society groups, the Director of Health services offered to draft rules formulated by a civil society organization and CEHAT. A health-NGO in Maharashtra associated with PHM was entrusted with this responsibility. In this process, activists of PHM-Maharashtra played an active role in bringing together various stakeholders (for example, government health officials, doctors associations, PHM- Maharashtra members, social organizations and activists working on health issues, consumer right groups, lawyers etc) to draft these *rules under the amended BNHRA Act*. PHM-Maharashtra insisted on including patient's rights, transparency and accountability measures. These draft rules were approved by Director of Health Services and put on department's website in July 2006 but *three successive Health Ministers of Maharashtra did not find it appropriate to give final approval to these draft rules and Patient's Rights*.

In this context, PHM-Maharashtra conducted various advocacy activities to push for the final approval of the draft rules. The campaign included:

- Signature campaign in 2006 and again in 2009 for the approval to BNHRA rules including protection of Patient's rights. Thousands signed the campaign pledge including those of renowned social activists and intellectuals.
- An e-petition campaign in mid-2009 addressed to the Health Minister
- Lobbying with Members of Legislative Assembly to raise questions in the State Legislative Assembly sessions.
- Campaigns made through media- periodic press conferences and articles.

A **Patient's Rights Forum** was formed in Pune, the second largest city in Maharashtra and it conducted the first '**Patient's Rights Convention**' in July 2009. Around 150 citizens, social organizations participated in this convention

and demanded immediate implementation of BNHRA draft rules 2006 and adoption of legally enforceable patient's rights. In this convention, representatives of Indian Medical Association (IMA), Pune and Hospital Owner's Association, Pune were invited. They publicly supported Patient's Rights, expressing reservations about the legal enactment due to the fear of 'Inspector Raj'.

As a follow up of this positive response from IMA, PHM-Maharashtra's constituent organizations organized dialogue sessions with the association of private doctors (Indian Medical Association (IMA)) on the issue of Patient's Rights in various cities and towns. In Pune city, Patient's Rights Forum and PHM-Maharashtra conducted several rounds of discussion with senior representatives of medical professionals associations in end-2009 and early 2010. As a result of the collaborative efforts of PHM-Maharashtra, Patient's Rights Forum, Indian Medical Association–Pune (IMA) as well as the then national president Federation of Obstetricians and Gynaecologists (FOGSI) after prolonged deliberations, negotiations, **a joint 'Charter of Patients' Rights and Responsibilities'** was formulated that was released in a press conference on 10th February 2010. However, later in the absence of broader policy and legal framework, this Charter was not implemented in practice in its totality.

A further development is the enactment of the Central government's 'Clinical Establishment Act - 2010' followed by issuing of associated rules in 2012. While this Act has certain positive elements related to standardization of private hospitals: it has no provisions for Patient's rights and lacks mechanisms for involvement of citizen's organizations at the district level. Hence, PHM-Maharashtra demanded adoption of a state-specific 'Maharashtra Clinical Establishments Act', with the inclusion of provisions for participatory regulation and Patient's rights. Based on persistent demands and lobbying for such a modified act, a meeting was held with the State Health Minister towards the later part of 2013, during which a decision was taken to draft a State level Act

that will address concerns of both patients and doctors. It is to be seen how this Act is shaped under the contending influence of the private doctors lobby and civil society groups that are supporting patients' rights.

Some insights

- Patient's rights can form a significant rallying point for various civil society organisations and citizens groups to socially foreground the broader issue of regulation of the private medical sector while highlighting the range of problems being faced by patients in private facilities due to lack of regulation.
- Raising the demand for inclusion of provisions to protect patient's rights, in any regulatory framework concerning the private medical sector can help to shape such regulation in the direction of patient-oriented accountability.
- Dialogue and negotiation with representatives of the private medical profession can lead to their recognising the need for protection of patient's rights, thus paving the way for wider social recognition and legal protection of patient's rights in private facilities.
- There is an emerging need to critique standard, bureaucratic and technocratic regulatory models and to highlight the need for multi-stakeholder, participatory regulatory processes. However, concrete legal and organisational mechanisms need to be devised to operationalise participatory regulation, which is comparatively a new concept.
- Bureaucratic regulation without accountability must be critiqued for its proneness to promote corruption, especially in many developing countries. Similarly, certain varieties of technocratic regulation focused on physical standards carry the danger of promoting higher-end, larger and corporate hospitals, while weeding out smaller and charitable health care institutions working with lower budgets. On these grounds, there can be common ground among various social actors, including organisations of private

practitioners and smaller hospitals, to critique bureaucratic and technocratic regulation, and instead to propose accountability and grievance redressal mechanisms along with more participatory regulation involving multiple stakeholders.

Case study -2

Multi-Stakeholder Health Councils in Brazil

The Brazilian Unified Health System (SUS) is widely known as an example where a developing country has operationalised an effective system to cover its entire population, including the most marginalised and deprived sections, with comprehensive health care. Somewhat less well known are the democratic structures that underlie the SUS to ensure broad-based participation in this system, namely the Health Councils. In the context of this paper, it is relevant that these councils are participatory structures that plan and monitor services by all providers involved in the SUS system – both public and private. In this sense, this is one of the relatively few large-scale experiences of participatory oversight of not only the public health system but also contracted private health care providers.

The background to these councils¹⁰ lies in the movement in Brazil in the 1980s to increase public participation in government, expand participatory management of public institutions and develop “social control” over the state. Brazil’s Citizens’ Constitution in 1988 followed by the Ninth National Health Conference in 1992 envisioned the creation of the Unified Health System (SUS) with decentralization and social control as key components. (Large periodic ‘Health conferences’ are organized every four years at each level of government that provides an important broad participatory forum to shape health policy.) In this context, Health Councils are set up in Brazil

10 10 Municipal Health Councils (Brazil) – page on Participedia, www.participedia.net/en/cases/municipal-health-councils-brazil

at Municipal, State and National levels with the principle of parity between representatives of civil society (50 per cent of seats) on one hand, and representatives of government (25 per cent of seats) and public and private service providers (25 percent of seats). The number of members in each council ranges from 12 to 48 (the National council has 48 members). Presently there are over 5,500 Municipal Councils, 26 State Councils and one National Council.

Health Councils make decisions; act as consultative bodies, exercise oversight while they approve annual plans and health budgets. They also assist health departments with establishing priorities and auditing accounts¹¹. Although they have legal powers related to technical and administrative areas, the role of Health Councils in shaping policy is considered particularly important. Federal transfers of funds to the SUS system in any Municipality are conditional on approval of the budget and health plan by the respective Health council.

A study of the Health Council in the city of Belo Horizonte¹² shows several positive impacts of decentralization of management of the SUS, with a key role played by the Health Council. Some of the positive results have been a restraint on fraud which has been a historical feature of provision of health services in Brazil; more rational use of funds to improve access to services even without higher investments, and the shortening of deadlines for payments made to private providers. The last impact is interesting since it reflects how along with citizens interest, legitimate interests of private providers might be promoted through such multi-stakeholder mechanisms. Overall, increased public accountability and control has been a result of the Health Council exercising one of its major legal functions, contributing to

11 Brazil’s Health Councils: The Challenge of Building Participatory Political Institutions Vera Schattan P. Coelho. *IDS Bulletin*, 35: 33–39.

12 Decentralization and Governance in the Health Sector, Belo Horizonte – Brazil, School of Governance/FUNDAÇÃO JOÃO PINHEIRO, BELO HORIZONTE, UNDP Decentralized Governance’s Research Sub-Programme, 1998

the Health Systems' improved transparency and accountability. Regarding control over the quality of services, the Health Council has effectively vocalized users' demands and complaints. The Belo Horizonte case study notes that Council members *"receive and forward denunciations, take part in the investigation, contact the media, organize public demonstrations and put pressure on the Executive. (The Council's) control activities have resulted in concrete governmental punishment measures - the shut-down of units and audits – or in positive actions such as the renovation of units, the allocation of funds, and other prompt actions in specific health districts."*

However, the same case study notes tensions between public and private providers, and reluctance of private providers to subject themselves to accountability mechanisms in the Health Councils: *"The segments that define the Council's profile are the health professionals, the representatives of the popular movement and the government, whereas the participation of private service providers is rather fragile. Nevertheless, as the SUS is dependent on the private sector for the provision of services, this weak involvement is a fundamental issue and shows how difficult it is to deal with the many diverse interests within the SUS."*¹³

It is further noted that three major dilemmas emerge from analyses of the Health Councils in Brazil¹⁴.

- The first is that of autonomy and the extent to which the councils are able to effectively hold to account a state, with which its members have multiple linkages.
- The second is that of representation and the extent to which the councils genuinely reflect the diversity of social actors and interests.
- The third is that of embedded inequalities of knowledge and power between citizen

¹³ UNDP Decentralized Governance's Research Sub-Programme, Ibid

¹⁴ Engaging citizens: Lessons from building Brazil's national health system: Andrea Cornwall and Alex Shankland – Social Science & Medicine 66 (2008) 2173-2184

representatives and health workers and managers.

In terms of overall analysis, it is observed: *"there are ingredients of institutional design used to shape Brazil's participatory institutions that do have something more generic to offer the design of future Health Systems. These include a legal framework that creates statutory obligations to engage citizens in deliberation over health policy and in holding the state to account; the creation of a network of institutions from the very local to the national level, lent functionality through resources committed by the state; the combination of deliberative Conferencias (Conferences) at which policy directions are determined and Conselhos (Councils) to track their implementation; and in going beyond the atomised individual to engage representatives of social movements, associations and neighbourhoods, renewing membership regularly to extend the capillary reach of the democratizing effects of engagement"*.¹⁵

Some insights:

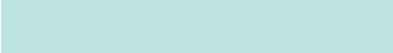
- The Health Councils in Brazil present a rather unique model of participatory governance of a health system, which includes both public and private healthcare providers. In the context of this paper, the operationalisation of participatory governance related to private providers is especially significant. However, to the extent that this has been possible in Brazil, it is critically linked with the development of the Unified Health System (SUS) which contracts private providers into a publicly financed and managed universal healthcare system. This raises the question whether effective participatory regulation of private providers would be possible at all, without their being paid and regulated by a broader public system.
- Providing space for participation to private healthcare providers in the Health Council can enable them to raise their own legitimate

¹⁵ Andrea Cornwall and Alex Shankland, Ibid

concerns and issues, as exemplified by the Belo Horizonte Case Study, where the Health Council decided to shorten payment deadlines for private providers.

- However, as the Belo Horizonte Case Study also shows, the involvement of private providers in their Health Council is fragile and fraught with problems. The inherent tension between the profit-making logic of a private provider and the broader accountability logic of a publicly organised system is bound to reflect in multi-stakeholder forums like health councils. This may be viewed as an inevitable contradiction that may be only partly resolved in the near future, or might ultimately be resolved only through progressive socialisation of private providers, by incorporating them into a publicly organised and financed system.
- The larger political setting in Brazil and widely participative processes like Health Conferences provide the context in which Health Councils have developed, and have been able to institutionalise a certain level of participation in the management of the health care system. Hence, any generalisation

from the Brazilian Health Council model in relation to other countries needs to be done with care. However, despite the limitations and qualifications, the health council provide us today one of the few working large-scale examples of participatory regulation and management of public as well as private healthcare providers. Therefore, while exploring such models in other countries, we can draw upon the positive lessons of Brazilian Health Councils in terms of linked multiple levels of operation, legal institutionalisation and official support, broad-based representation to a variety of stakeholders including civil society organisations, and significant powers related to planning and approval of finances. At the same time, the challenges faced by Health Councils in Brazil, which might be expected in the context of evolving participatory healthcare regulation in many other developing countries, needs to be kept in mind and pre-empted through appropriate strategies that would have to be evolved organically in specific country contexts.





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