

## SITUATION REVIEW AND ANALYSIS OF ACCREDITATION SYSTEM IN INDIA

In India, health care services are provided by many entities, who use varied forms of organisation and practice different systems of medicine. The provision is mainly through the public and private sectors. The public sector health services are primarily provided by the state governments and to some extent central government, municipal corporations and other local bodies. In addition to the health ministries government health services are provided by the other various, ministries and departments of the government and through Employee State Insurance Scheme (ESIS) for the organised sector employees. The private health sector consists of the 'not-for-profit' and the 'for-profit' health sector. The not-for-profit health sector includes various health services provided by non government organisations (NGOs), charitable institutions, missions, trusts, etc. Health care in the for profit health sector is provided by various types of practitioners and institutions. These practitioners range from 'General Practitioners' (GPs) to the super specialists, various types of Consultants, Nurses and Paramedics, Licentiates, Registered/Rural Medical Practitioners (RMPs) and a variety of unqualified persons (quacks). The 'informal' sector consists of practitioners not having any formal qualifications, like the tantriks, faith healers, bhagats, hakims, vaidyas and priests who also provide health care. The institutions falling in the private health sector range from single bed nursing homes to large corporate hospitals, and medical centres, medical colleges, training centres, dispensaries, clinics, polyclinics, physiotherapy and diagnostic centres, blood banks, etc.

**The NSSO's 42nd round findings show that for inpatient care nearly 60 percent approach public hospitals among both rural and urban population. But for routine medical care (Out patient care) 60 to 70 percent is provided by the private health sector (NSSO 1989. This is substantiated by other studies conducted in the country (Duggal and Amin 1989, Kannan et al. 1991, George. A., et.al, 1994, NCAER 1992) (1).** The findings also make it evident that a substantial financial burden of the household is borne for meeting health care needs. Compared to state expenditure on health the private household expenditure is nearly four to five times more than that of the *state* (Duggal R., Amin, S., 1989.p 94). In India, the private sector has grown to be the most dominant one in the health sector. **The share of the private health sector is between 5 to 6 percent of the Gross Domestic Product. This share at today's prices works out to between Rs. Rs. 20,000 and Rs 24,000 crores per year (2).** India probably has the largest private health sector in the world **(Duggal R., , 1992,).**

### **Situation review of private hospitals and nursing homes**

In India the contrasts with regard to private hospitals is vast. On one extreme there are the hi-technology, five star corporate hospitals and at the other end small nursing homes with 1 or 2 beds functioning from small residential places and sheds. During the last one and half decades the growth of corporate hospitals has been at very fast pace. Many corporate houses and non-resident Indians have recently joined this enterprise. Several large business houses in addition to their regular business have diversified into the field of health. During 1974, 16% of the hospitals and 21.50% of the hospital beds in India were in

the private sector and rest in the public. This proportion increased in 1990 to 57.95% of the hospitals and 29.12% hospital beds in the private sector. (CBHI, GOI, various years). There are reasons to believe that the number of hospitals in the private sector is much larger than the available data suggests. A survey undertaken by Andhra Pradesh Vaidya Vidhana Parishad found the existence of 2,802 private hospitals and 42,192 private hospital beds in Andhra Pradesh in 1993. The survey also showed that 67.60% of the private hospitals were located in urban areas (which were state capital, divisional HQ, district HQ and taluka HQ). The bed population ratio in private hospitals was 6.37 beds per 10,000 population as compared to public hospital which was 5.12 (APVVP 1993 ). The above data suggests that the size of private hospitals is much larger than official data brought out by the government. Secondly private hospitals are mainly concentrated in the urban areas. In many of the metropolitan cities, district head quarters and semi-urban places the majority of the hospitals/nursing homes have a bed size of 15 to 25. There has been very little information forthcoming and documented on the structure, functioning, role and quality of care provided by ph/nh's in the country. Very often information that is available is through media reports and studies which are far too few.

Only recently due to pressure by the judiciary many facts are coming out. In Calcutta a petition was filed by an advocate in the Calcutta High Court regarding the conditions of private hospitals and nursing homes. In response to this a committee was appointed by the speaker of the West Bengal legislative assembly in 1985 to prepare a report. This report found that the nursing homes lacked adequate floor space, ventilation, lighting, water, bathroom facilities and qualified doctors and nursing staff. (*The Telegraph, 2nd July*). In 1991 the Chief Justice of the Bombay High Court directed the Bombay Municipal Corporation (BMC), to set up a permanent committee to oversee and supervise the implementation of the Bombay Nursing Home Registration Act (BNHRA), 1949, and make recommendations.

The committee as one of its tasks decided to look at the functioning of existing hospitals and nursing homes in the city of Bombay. As part of the committee, 24 hospitals and nursing homes in the eastern zone of Bombay were studied (*Nandraj S, 1992*). The major findings of the study were that a seventh of them were functioning from sheds or lofts in slums and more than half were located in residential premises. More than sixty percent of the hospitals and nursing homes did not have a minimum of 50 sq.ft space for each bed. Most of them were congested, lacked adequate space, passages congested, entrances were narrow and crowded and there was inadequate space for movement of either trolley or stretcher.

Only 15 of them had a OT out of the 22 who were supposed to have one, while in 7 the OT also served as a labour room. It was observed that in some the OTs and labour rooms were in rooms originally designed as kitchen. Some had OT's that were pathetically as small as 48 sq.ft and leakage's were to be found in the OT and labour room with paint from the ceiling and walls peeling off. Seventy seven percent did not have a scrubbing room. Many of the hospitals and nursing homes were ill equipped, especially those providing maternal health services. For instance many of them did not have resuscitation

sets in the labour room for new born babies. In case of emergency availability of supportive services like ambulance services, blood, oxygen cylinders, generators etc. was insufficient..

Majority of them employ unqualified staff. Out of 24 hospitals and nursing homes only 1 hospital had employed a post graduate doctor, whereas 10 of them had doctors trained in other systems who were providing treatment in allopathic. Few hospitals had provision for the doctors to be present round the clock. Majority of the nursing homes utilised the services of visiting consultants. Less than a third have qualified nurses and Most of them had employed unqualified nurses.

The sanitary conditions of private hospitals and nursing homes leaves a lot to be desired. It was found that in 37.50% of cases, the hospital premises were dirty and beds in the general ward were dirty. The number of toilets and bathrooms were not in proportion to the number of beds provided in the hospital. It was quite shocking to note that many of the hospitals did not have continuous supply of water, and in some of them it was being provided from outside through tankers and other means. With regard to waste disposal none incinerate infectious waste material, but instead dump it in municipal bins. While these facts relate to Bombay, it should be apparent that the situation in the private health sector in other cities is likely to be similar, or perhaps even worse (*The Hindu 12th August 1992*).

Among the major complaints against private H/nh's are that of over charging, not providing the personalised care they claim to provide, subjecting patients to unnecessary tests, consultation and surgery, defunct equipment, not providing information about diagnosis and treatment, doctors absent for long periods even in the ICU, general disregard for patients and their highly commercial nature. (*Times of India 4th March 1991*). There is no rationale behind the level of fees charged by them and the law of market operates. Referrals are made to specialists and laboratories for a kickback.

The dismal conditions of hospitals and nursing homes functioning is because there is practically no monitoring and accountability to the people or the authorities concerned. In fact hardly there is any authority concerned about it. In most of the states in India there are no legislation's, regulations for ph/nh's. A study undertaken by the Medico Friend Circle (Bombay group) on regulatory and monitoring mechanisms existing in various states of India, found that the states of Tamil Nadu, Punjab, Andhra Pradesh, Kerala, Goa Daman and Diu, Mizoram, Gujarat, Orissa, Sikkim and Manipur do not have any rules, laws, regulations or even data of ph/nh's. Added to these states are Madhya Pradesh and Rajasthan. This was found out through visits and discussions with government officials of the respective state governments. To our knowledge Maharashtra, Union territory of Delhi and Karnataka have a legislation for private hospitals/nursing homes. In Delhi there is the Delhi Nursing Home Registration Act (DNHRA), 1953, Bombay Nursing Home Registration Act (BNHRA) 1949.(*Nandraj. S. 1994*) In Karnataka there is the Karnataka Private Nursing Homes Act, 1976.

Over the last two years there were many questions raised by members in the Andhra Pradesh assembly, regarding the regulations, functioning, norms, fees charged, exploitation of the patients, low wages paid to the employees, free treatment to poor patients etc. The Health minister's replies have been that there are no rules and regulations for ph/nh's in the state, and the matter would be considered. (AP, assembly questions, 1992-94).

In Bombay the Bombay Municipal Corporation (BMC) was not enforcing the BNHR Act. The judges in their order observed that "The **writ petition** has served the purpose of activating the concerned authorities, who seem to have woken up and taken certain steps in the direction of implementation of the various provisions of the law"**(3)**. The corporation during the hearings admitted that the officials had not visited nor taken action against any hospital or nursing home. In fact, one out of four hospitals were functioning without registration. Though the Act was applicable to entire Maharashtra, its implementation was found to be restricted to the cities of Bombay, Pune, Nagpur and Sholapur. Despite having one of the largest private health sector in the world the fact that it should function practically unregulated without any monitoring is a matter of grave concern. . In Delhi, the administration admitted that only 134 out of 545 nursing homes were registered. There is hardly any regulatory intervention or interference of the government in the private sector and on the health care market. Even the few existing laws and regulations are either toothless or not implemented at all. People's dissatisfaction with the private sector and their disillusionment with the medical establishment is quite low. *(Jesani A & Nandraj S 1994)*.

### **Analysis of efforts made for evolving standards and developing an accreditation system**

The need for standardisation has been a recent phenomena in the Indian health delivery system, more specifically for private hospitals. The need and development of standards for hospitals could be broadly viewed from the role played by the government, consumer organisations and health organisations and the various organisations of hospital owners and other professional bodies. In the past one decade there have been debates and discussions on issues of functioning, quality, finance, monitoring, accountability and standards of private hospitals and nursing homes in the country. These have taken place between hospital owners, health professionals, researchers, activists, consumer groups and government functionaries. One of the major concerns has been the issue of standards for hospitals and nursing homes taking into consideration their location, size and type of services provided. These efforts were mainly in two directions, one was to evolve minimum standards and the other to develop an accreditation system.

**Government's role :** As seen earlier the government role in monitoring the private hospitals in the has been very dismal. In Bombay and Delhi where there is legislation no minimum requirement and guidelines have been laid down in the Act regarding space, sanitary conditions, personnel, equipment, fees to be charged etc. to be followed by the hospital and nursing home authorities. Very surprisingly in Bombay the public health department of BMC which grades restaurants in the city on the basis of hygiene and

facilities which is also responsible for h/nh's. Only recently the Delhi administration has started evolving certain minimum standards for private hospitals. These are that the doctor-patient ratio should be 1:10, the nurse-patient ratio should be 1:5 in a general ward, and 1:1 in intensive care areas. The doctor holding a recognised degree should be present round the clock. A separate labour room and OT, each having minimum floor space of 180 sq.ft. The new rules also make it obligatory for the nursing home to display the charges to be levied for various services available at a prominent place.

There has been little or no effort to evolve any kind of guidelines, minimum standards for hospitals and nursing homes in the private sector. The government's efforts have largely been concerned with guidelines and standards for their own institutions. There are guidelines laid down for its own hospitals and institutions. Maharashtra and Andhra Pradesh have guidelines for running of government hospitals. In Maharashtra there are Hospital Administration Manuals Vol. 1 & 2 and in Andhra Pradesh there are the Hospital Standing Orders. (*Govt. of Maharashtra 1991*, *Govt. of Andhra Pradesh 1967*) These manuals/orders contain detailed instructions on the management of hospitals for the various services, in terms of duties, norms, instructions etc. In all probability other state governments too have similar guidelines due to the bureaucratic nature of functioning. The government periodically has appointed committees to evolve and upgrade standards and specifications for its own hospitals and institutions. The various committees that made specific recommendations in this regard were the Mudaliar, Ayar, Rao and Bajaj committees

In the recent past a study was conducted by the National Institute of Health & Family Welfare (NIHFW), New Delhi for the purpose of drawing up of norms for equipment for hospitals. It undertook a review of literature on the various standards existing for hospitals. The study mainly concentrated on government hospitals. It came up with guidelines on norms for essential and major equipment for 50, 100 and 500-750 bedded hospital. These were for basic diagnostic, therapeutic, supportive, other important service areas of the hospital and various departments of medical and surgical services of the hospitals. The norms laid down covered specifications of the equipment, their quantity and approximate price. (*Anand T R, Agarwal A K, 1992*)

The Bureau of Indian Standards (BIS) has developed standards for basic requirement for hospitals upto 30 beds (*IS: 12433 (Part 1) - 1988*) and standard on the classification and matrix for various categories of hospitals (*IS 12377*). The standards covers basic requirement for planning a 30 bedded general hospital in respect of functional programme, functional and space requirements, manpower requirements, instruments and equipment and essential requirements for building services and environment. The classification and matrix for 5 categories of hospitals (30, 100, 250, 500, and 750 bedded) and according to the functions (*BIS (a), (b) 1988*)

### **Consumer and Non-government health organisations role.**

The credit of focusing attention of the people regarding standards for private hospitals and nursing homes were the consumer groups. This was due to the fact that these groups

were working on various aspects of the private health sector. Alongwith the consumer bodies, groups of health professionals and hospital organisations were also involved for drawing up standards and to develop a accreditation system. These efforts though at a infancy stage show a potential for developing in the near future. These efforts were undertaken primarily by consumer and non-governmental organisations based in the cities of Bombay, Pune, and Hyderabad.

MFC along with other like minded organisations has been in the forefront on the campaign of accountability of private hospitals to the people and authorities. In this connection it filed a Public interest litigation in the High court of Bombay. As an outcome of the case the a committee was appointed by the Bombay high court consisting of experts to oversee the implementation of the BNHR Act and to make guidelines for the functioning of H/nh's in the city of Bombay. The committee could not complete the tasks due to the bureaucratic composition of the committee. As part of its campaign the group organised seminars, workshops and public meetings. One of the seminars was to suggest minimum guidelines for Pvt. H/nh's. The speakers at the seminar spelled out what they considered the minimum basic requirement for a 10 to 20 bed hospital. Among the minimum requirement emphasized by the speakers was an adequate supply of essential drugs, enough space, separate room to carry out medical procedures, arrangements for blood free from AIDS and hepatitis, 24 hour water supply with built-in sterilising equipment, portable X-ray machine, four to six oxygen cylinders, a safe wiring system and a generator among others. They also stressed the importance of availability of trained personnel round the clock. One of the speakers pointed out that standards had to be drawn up keeping in mind conditions in India and not necessarily as per British or American norms. Another speaker wanted the doctors to set the ideal standards first and then reach a compromise on attaining them over a period of time. Many of the speakers felt that the hospitals should be categorized according to the level of care they offer.(Times of India, 9th April 1992)

Meanwhile in Pune the Health -Committee of the Lok-Vignyana Sanghatana (the people's Science Organisation in Maharashtra) took the initiative in preparing minimum standards. After intensive discussions the committee for check-up for anesthesia before surgery came up with 'Routine Preoperative investigations for 'Minor surgery' in A.S.A. Grade 1 patients'

In Hyderabad the Institute of Health Systems (IHS) has started work on evolving an accreditation system for private hospitals in Andhra Pradesh. As a first step it has collected and maintains a database on mostly all private hospitals (government also included) in the state. Along with this it conducted an exit poll of patients treated in private hospitals in the city of Hyderabad. The study found that majority of the respondents were in favor of an accreditation system and felt the need for a third party inspection for compliance of standards.

### **Hospital owners and other professional bodies.**

There have been efforts to promote voluntary accreditation system by the Indian Hospital Association (IHA) both at Bombay and Delhi. In Bombay the IHA along with the Bombay Management Association joined hands to promote the scheme in the city. The scheme visualized that Pvt. h/nh's would be given accreditation according to the degree which they conform to the minimum standards set down by an accreditation committee comprising prominent members of the medical and legal fraternity. The accreditation fees varied from Rs 2000 for a 15 bed hospital to Rs 15,000 for one with more than 300 beds and the accreditation would be valid for two years. The organisers reason that they would depend on persuasion and the doctors self scrutiny and not have a policing role. The scheme was envisaged with the idea that the h/nh's would get accredited voluntarily (*The Independent, 24th February 1993*). The response to the scheme has been very luke warm. To the best of our knowledge the organisers did not lay down the basis for gradation and only three hospitals had come forward. Many of the Pvt. hospital and nursing home owners felt that the move was in the right direction but regarded it with skepticism and suspicion. It was felt that the committee should tone down the minimum requirements for areas such as space allocated per bed and the number of trained nurses. Many of them were hesitant to shell out the amount every two years.

The response of Pvt. hospitals and nursing homes for having minimum standards and to participate in an accreditation scheme has not been encouraging. Among the problems put forward are that the proposed standards were unreasonable and impractical for them to follow. Nurses were not available since majority of them join the government service and many go to the middle east. Private hospitals and nursing homes do not want to be monitored and be accountable. A vocal and powerful section of health care professionals are shamelessly asserting that the medical profession is only accountable itself and not to society. Nowhere in the world including the dogmatically pro-market USA there exists a unregulated market as in our country.

### **Future Design for Developing an accreditation system.**

As seen from the efforts made it is quite clear that the response by the private hospitals and nursing homes has been not so positive. The various efforts to evolve minimum standards and develop an accreditation system throws up some important issues.

Standardisation would benefit both the patient as well as the doctor/owner of the hospital/nursing home. The patients would benefit because today there is lot of arbitrariness in the modalities for diagnosis and treatment of various health problems and for the doctor/owner's since if standardisation is laid down there is no reason why the judiciary would accept this as reasonable standards.

There are various issues which need to be addressed for developing an accreditation system. Firstly certain minimum standards and guidelines have to be laid down. Secondly the accreditation system if it has to be implemented in an effective manner has to have some kind of legality and legitimacy. Efforts made for a voluntary system have not produced results. The private hospitals and nursing homes have been very defensive for a system of monitoring and accountability. Experience shows that especially in the

service sectors unless the persons delivering the services are directly accountable to the people there is a lot of dissatisfaction and indifference is generated. Thirdly the organisation launching the scheme should be accepted by both the hospital owners and consumers. It has to have impeccable credentials.

Generally the response of the h/nh's has been to demand more benefits from the government without being accountable. In a demand driven market it is left to various consumer organisations to push for minimum standards for H/nh's. With the consumer protection Act coming into force the various H/nh's are fighting for the Act to be not made applicable to the health sector.

### **Foot Notes :**

#### **1) Reported Utilisation of Health Care Facilities in Selected Important Studies**

(Percentages)

Study Total	Area	SOURCE OF CARE							
		Public Hospital	PHC/ Public Disp.	Private Hospital	Practitioner	Drug Store	Traditional	Self Care	Other
NSS - 1986-87 (All India) (OPD cases) 100	Rural	17.7	7.9	16.2	53.0	-	-	-	5.2
100	Urban	22.6	4.6	18.1	51.8	-	-	-	2.9
100 (Inpatients) 100	Rural	55.4	4.3	38.6	-	-	-	-	1.7
100	Urban	59.5	0.8	38.5	-	-	-	-	1.2
NCAER- 1990 (All India) 100	Rural	28.0	9.9	(44.4)		10.8	-	-	6.9
100	Urban	31.2	7.9	(44.8)		13.6	-	-	2.5
KSSP - 1987 (Kerala) 100	Rural	(23.0)		(53.0)		-	-	12.0	12.0
FRCH - 1987 (Jalgaon District) 100	Rural	(11.1)		(84.6)		-	1.7	2.6	-
100	Urban	(16.9)		(77.5)		-	3.7	1.9	-
FRCH- 1990 (Madhya Pradesh 2 dist) 100	Rural	2.8	14.8	(73.9)		1.3	1.0	6.2	-
100	Urban	14.8	0.3	(71.9)		3.2	0.8	9.4	-

SOURCES : 1) NSSO, 1989 2) NCAER, 1992 3) Kanan, Thankappan, et.al, 1991 4) Duggal.R S. Amin, 1989 6) George.A et.al, 1993

2) On the basis of data, estimates of total health expenditure in India for the fiscal year 1990-91 are as under :

	(Rs in crores)
Ministries of Health & Family Welfare	6000
Other Ministries (Railway, Defence, P&T, Mining etc.)	500
Corporate Sector (Public & Private) (assuming 60% of employees of	

organised sector get benefits of ESIS)	650
Municipal bodies (net of grants from Ministries & health)	2050
ESIS	300
Personal house hold burden (at Rs 175 per capita)	14500
Total Health Expenditure	<u>24000</u>

**The Total works out to 6% of Gross National Product.**

3) A Public Interest Litigation (PIL) was filed by Ms. Yasmin tavaría and Medico Friend Circle on the issue of the implementation of the Bombay Nursing Home Registration Act 1949. The respondents were the B.D. Parsee General Hospital, Bombay Municipal Corporation and the Government of Maharashtra. (Writ Petition No 2269 of 1990).

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