

BEYOND LAW AND THE LORD

Quality of Private Health Care

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Although the private sector in health care is large and growing, it is poorly regulated with hardly any regard to quality of care.

The World Bank paper on 'Health Financing in India' and the 'World Development Report 1993' advocated privatization and liberalization of the health sector. How relevant are these policy prescriptions for the Indian context? What exactly is the nature of the private health sector in India? What are the regulatory and monitoring in this sector?

The private health sector is a large and important constituent in the country's health care delivery system. The share of the private health sector in India is between 4 to 5 percent of the Gross Domestic Product. This share at today's prices works out to between Rs. 16,000 crore and Rs. 20,000 crore per year. India probably has the largest private health sector in the world (Duggal and Nandraj, 1991). This sector has enlarged greatly in the post independence period, especially in the 80s. A substantial financial burden of households is for meeting health care needs (1). This gains significance when we realise that nearly half of the country's population does not have enough resources to meet its food requirements. Compared to state expenditure on health the private household expenditure is nearly four to five times more than that of the state (Duggal and Amin, 1989).

Extent of Private Practice

Data on sectoral distribution of doctors is not easily available because many states do not file that required information in the ministry of health. A study conducted in 1963-64 by the Institute of Applied Manpower Research showed that out of a total of 1,00,189 doctors 39 per cent of them were in government service and 61 per cent doctors in the private sector of the allopathic system of medicine. Out of those in private sector 88.4 per cent were self-employed and 11.4 per cent were employed in the private health establishments. (Jesani and Ananthraman, 1993). A study in Ahmednagar district, Maharashtra, identified a total of 3,060 doctors belonging to all systems of medicine in the district, of whom 92 per cent were in the private sector (including a very small percentage in the voluntary sector). Of the 3,060 identified doctors, 91.5 per cent were general practitioners and 8.5 per cent were specialists, information not being available for 10 per cent of the doctors. Of the total doctors identified 51 per cent were in urban areas and the rest in rural areas. In urban areas, GPs constituted 77 per cent and specialists 13 per cent while the degrees and specialisations of 9 per cent of the doctors were not known. In rural areas, 85.5 per cent were GPs, specialists constituted only 1.8 per cent and the information on 11.9 per cent was not available. Further with regard to break up of specialists out of the total 234 specialists, 22 per cent were gynecologists, 20.5 per cent were surgeons, 12 per cent were physicians, 10 per cent were pediatricians, 7 per cent were ophthalmologists, 6 per cent were anaesthetists, 5 per cent were dermatologists and orthopaedics, 4 per cent were ear nose & throat (ENT) specialists, 2 per cent were psychiatrists, 6.5 per cent fall in the category of others (includes radiologist, pathologists, cardiologists, plastic surgeons, physiotherapists) (FRCH,(a)1993)

Practitioners also consist of those having dubious qualifications and degrees or having no qualifications at all such as those who have worked as helpers, compounders or assistants for other doctors for a period of time and have picked up the skill in the process. In this category sometimes spouses of doctors are also included, who sit in the clinic when the doctor is away. Also included in certain cases are the sons/daughters who 'inherit' the practice of their parents. A study conducted in Madhya Pradesh showed that of all those treated by private facility, 52.24 per cent of the illness episodes in rural, 17.83 per cent in urban areas were treated by licentiates/RMPs (George, Shah and Nandraj 1993). The extent of quackery can be gauged from the advertisements which appear regularly in leading newspapers of the country for cure of various illnesses. The decay has set in so much that posters are displayed openly at local railway stations of Bombay urging people to become a doctor (2). In Maharashtra the government appointed a committee to look into the matter of quacks and take action against them. With the help of public health machinery at various levels 4,971 bogus doctors were identified and the list sent to the state and police authorities for further action Sampark, August 1993. Till date no action has been taken on the report.

In India, during 1974, 16 per cent of the hospitals and 21.5% per cent of the hospital beds were in the private sector and rest were in the public sector. This proportion increased in 1990 to 57.95% per cent of the hospitals and 29.12 per cent hospital beds in the private sector. There are reasons to believe that the number of hospitals in the private sector is much larger than what the available data suggests. According to data in Health Information of India 1992, there were only 1,319 private and voluntary hospitals in Maharashtra, and the Directory of Hospitals brought out by the Ministry of Health listed 1,174 hospitals in Maharashtra. But the Bombay Municipal Corporation listed 907 private hospitals and nursing homes in Bombay city alone (excluding Thane), on the basis of its registration data which again is an underestimate. Another instance of under reporting of data is brought out by a survey undertaken by Andhra Pradesh Vaidya Vidhana Parishad, which found the existence of 2,802 private hospitals and 42,192 private hospital beds in Andhra Pradesh in 1993. According to data available with GOI as on January 1 1991, however Andhra Pradesh had only 266 private and voluntary hospitals and 11,103 private hospital beds. (Health Information of India 1991). The survey also showed that 67.60 per cent 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 sector was 6.37 beds per 10,000 population and in the public sector 5.12 per 10,000. Ahmednagar district, Maharashtra, had 274 hospitals and nursing homes in the district, of which 82 per cent were privately owned, 7per cent by the public sector and 4 per cent by voluntary-missionary and 7 percent not known. The response to the mailed questionnaire from 90 hospitals showed that there were a total of 2,241 beds and the private hospitals accounted for 1,050 beds (FRCH, (a) 1993,).

The above data suggests that the size of private hospitals is much larger than official data brought out by the government. Secondly that indoor care provided by private hospitals is much larger than public hospitals and this growth has taken place mainly in urban areas. The increase has occurred not so much because private hospitals are better equipped, more efficient and manned by better qualified and more humane staff as because public hospitals have simply failed to keep pace with the demand, have been starved of funds, are neglected and run down.

A recent development in private health sector has been the growth of corporate hospital, rightly termed 'Medical Industrial Complex' (Relman 1988). In 1983, the first corporate hospital in India was set up in Madras. It was established by Apollo Hospitals Enterprise Ltd (AHEL), which within five years recorded a turnover of Rs 11.48 crore and a net profit

of Rs 1.66 crore. Many corporate houses and non-resident Indians have recently joined this enterprise. e.g. Hindujas, Escorts group, Standard Organic group, Surlux Diagnostic Centers, United Breweries group, Goenkas, Birlas and the Modis. In a span of two years, 1984 to 1986, over 60 diagnostic centers have entered the market with an investment of over Rs 200 crore in sophisticated equipment. Today Bombay has 13 body scanners, Delhi has 11, Madras 8, Calcutta 3, Hyderabad 2, Pune 3 and Ahmedabad 3. (Jesani & Ananthraman 1993). Each of the MRIs cost Rs 6 crore a piece. The United Group owns over 32 body scanners and 14 brain scanners in the country (Indian Express, May 18, 1989). Suffice to say that with the rise of the corporate sector, the cycle in health care does not start with a trained medical person and a sick person in search of each other, but with an investor in the share market in search of profitable investment : the availability of newer medical technology and a market in medical care being merely an attractive form of investment (Phadke 1993).

Most of the big corporate and trust hospitals are concentrated in metropolitan cities. Many of them use the facade of register themselves as trust hospitals with a view to getting various benefits from the state and escape various taxes.

QUALITY OF PRIVATE CARE

Only recently attention has been focused on the serious anomalies with regard to the functioning and quality of care being provided by private practitioners. This was possible because a number of cases of medical malpractice and negligence filed in the court of law by the victims and their relatives as well as due to role-played by the media and different consumer organisations.

For specialised treatment like hospitalisation and investigations, the GP would refer the patient elsewhere. Informal discussions and meetings with private doctors revealed that in metropolitan cities like Bombay, Delhi, Calcutta, etc, and also in smaller urban areas like Ahmednagar, Nasik, Pune there is form of 'cut-practice' operating. For referrals made, a part of the fee charged to the patient is given to the referring doctor. A GP/consultant gets a cut if s/he refers a patient to a consultant, hospital/nursing home, laboratory, diagnostic center etc. In Bombay, the cut-ratio is as high as 30 to 40 percent of the fees charged. As per a new system which has started operating, if a consultant wants to start practice, s/he should deposit a certain amount of money with the local GP for referrals to be made by him/her. In some towns of Maharashtra informal associations of doctors have standardised the ratios of cuts to be given. Recently in a suburb of Bombay the GPs exerted pressure on the owners of private hospitals/nursing homes to increase the ratio of the 'cuts'. Cut-practice operates with everybody's knowledge but there has been no documentation or study of this aspect. Cut-practices inevitably leads to unethical and unnecessary investigations, referrals, hospitalisation, high costs, etc. For those doctors who want to practice ethically and rationally survival in this atmosphere is difficult.

The technical/medical knowledge of the doctors regarding treatment being provided to the people needs to be examined. Two studies on knowledge and awareness among doctors regarding tuberculosis and leprosy were conducted in Bombay. It was found that for treating tuberculosis patients, 100 private doctors prescribed 80 different regimens, most of which were inappropriate and expensive. (Uplekar and Shepard 1991). With regard to leprosy, it was found that there was a gross lack of knowledge and awareness among private doctors about the disease and about the National Leprosy Control Programme. (Uplekar and Cash 1991). The medicines and injections, which the doctors use, are either samples given by the medical representatives or those bought from the open market. Usually the doctor gives those medicines and injections received as samples

or sells at a higher rate those bought. This is unethical since the doctor infringes on the Pharmacists trade. Some of the doctors also give medicines in loose paper packets or bottles. This practice is incorrect since the patient does not know what the packets/bottles actually contain. There is rampant and use of irrational medicines and injections by the doctors in the private health sector. In Jalgaon district Maharashtra for illness episodes of diarrhoea, 72.5 per cent received injections, for cough & cold, 66.7 per cent received injections; for malaria, 87.5 per cent received injections; for measles, 61.1 per cent received injections and for heart diseases 76.5 percent received injections (Duggal and Amin 1989). Irrational practices are common among doctors in the public as well as private health sectors. But it is on the higher side in the private sector. In the study conducted in Madhya Pradesh it was further found that out of 884 illness episodes which received medicines along with injections, 86.09 per cent of them received it from the private health facility. (George, Shah, Nandraj, 1993).

Further, preliminary results of a study being conducted in a typical district of Maharashtra found that unnecessary use of injections, irrational drug combinations, hazardous drugs and unnecessary drugs were prescribed more in the private sector. Out of a total of 633 prescriptions analyzed from 27 private clinics it was found that 28.9 per cent were of irrational drug combinations, 9.6 per cent were for hazardous drugs, 45.7 per cent were unnecessary drugs and 26.5 per cent were unnecessary injections. Compared to 591 prescriptions from 17 public clinics, it was found that 2 per cent were irrational drug combinations, 0.5 per cent were for hazardous drugs, 28.4% were for unnecessary drugs and 24.2 per cent per cent were for unnecessary injections (FRCH (b)1993). The main source of continuing education for doctors are the medical representatives. Medical representatives of the pharmaceutical industry, including those from the renowned multi-nationals, in their race for fulfilling targets approach those not having proper or dubious qualifications. In this manner, they also encourage quackery.

The Time spent on the patient for diagnosing and explaining would depend on the load of patients, the doctor has per day/hour and or demand for the services. A public opinion study conducted by Medico Friend Circle showed that out of 208 respondents 61 per cent of them felt that the waiting period to see a doctor was highly unreasonable : that is, beyond 20 minutes (MFC, Bombay Group, 1993). Besides many of the doctors while dispensing medicines and injections or recommending investigations, do not provide information to the patient regarding the diagnosis and side effects. In fact, many of them get angry when questioned about the side effects of the drugs prescribed, the investigative procedures recommended or regarding the diagnosis. The MFC study found that 41 per cent of the doctors did not give information about the diagnosis and among those who gave information only half gave complete information. Only 16 per cent of the respondents were given information on side effects of drugs. About 48 per cent of the respondents were completely satisfied with the behavior of the doctors, 27 per cent partially and 17 per cent not at all.

Doctors' charges are more often than not exorbitant and irrational. The charges levied are arbitrary, irrational and without any proper basis. The question of fees and charges raises ethical issues, the important one being the basis on which the price skills in a profession which is meant to be caring are computed. There are no restrictions or guidelines for the fees charged by the practitioners or consultants in the country. There is no standardization of fees in the country. In the MFC study, in answer to the question regarding standardisation of fees charged by the doctor, it was found that 65 per cent of them felt that there should be some form of standardisation of fees. The study also found that nearly 76 per cent of the doctors did not give a receipt for the payments made, only 24 per cent of them gave receipts after being asked for it.

The earnings of doctors have been studied only recently. A study undertaken in Bombay city found that a GPs net income, on an average, works out to Rs 16,560 per month (George 1991). Another study conducted in Delhi found that on an average the net income of a GP practicing in a clinic or residence was Rs 24,290 p.m., and a graduate gynaecologists income was found to be Rs 28,910 p.m. With regard to those having post graduate qualifications in medicine, the average income was found to be Rs 27,880 p.m., for general surgery Rs 37,870 p.m.; and for gynecology Rs 53,870 p.m. (Kansal 1992).

The fees of the doctors has grown apace with private health care. The NCAER study showed that 55 per cent of the household expenditure on health care was spent on private doctors and only 39 per cent on public institution. Many patients and their family members have been pauperized during the course of treatment from the private health facilities.

Figures regarding cases treated, diagnosis, type of treatment provided, amount charged etc. are not easily obtainable from private hospitals and nursing homes. Only recently due to the demands made by the judiciary, various facts have come 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 1989).

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. This judgment came about due to a public interest litigation filed by a victim's daughter and the activists of MFC (MFC) (Bombay Group). In this case a homeopath doctor administered a wrong blood type during transfusion to the patient in an allopathic hospital. The case raised questions regarding standards of medical practice in private hospitals and nursing homes, quality of staff employed and treatment offered, equipment used, the general administration of these hospitals and their accountability to the people at large. The case also further highlighted the role of the implementation agencies.

The committee decided to look at the functioning of existing hospitals and nursing homes in the city of Bombay. As part of the committee, the author studied 24 hospitals and nursing homes in the eastern zone of Bombay [Nandraj 1992]. The major findings from the study are used here to throw light on the various broader issues with regard to private hospitals and nursing homes.

In India the contrasts in the private health sector with regard to the hospitals is vast. While there are the huge corporate hospitals but majority are those having 10 to 30 beds, with the average number of beds in Bombay being around 10. As it is quite well known very few hospitals function from an independent building. The study in Bombay found that 62.50 per cent of the hospitals were located in residential premises, and 12.5 per cent were run from sheds which had roofs of asbestos, tin. etc and only 8.33 per cent had a independent building. The study further found that 50 per cent of the hospitals were located in poorly maintained buildings or were in a dilapidated condition. Hospitals functioning from residential premises pose various difficulties. Residents staying in the premises are put to a lot of hardship. Secondly, a residential premise is not suitable for a hospital or nursing home with its narrow passages and small doors. The urban development department of the BMC specifies that the hospital if run from a residential

building, should be located on the ground floor or the first floor only and that they should have a separate entrance. In rural areas, a practicing GP generally keeps one or two beds in the clinic for the exclusive use of his/her patients since the facilities for indoor care are quite distant. These could also be considered as hospitals since they provide indoor care.

The study in Bombay found that out of 22 hospitals and nursing homes supposed to have an operation theater (OT), only 15 had OT, in 7 of them the labour room was combined with the OT. The average area of the OT was less than 100 sq.ft. It was generally observed that some of the OTs and labour rooms were in the kitchen. Leakages were to be found in the OT and labour room with paint from the ceiling and walls peeling off and 17 hospitals and nursing homes did not have a scrubbing room. As for emergency there were no supportive services like ambulance services, blood, oxygen cylinders, generators etc. 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. Many nursing homes claim to provide ICCU services but many of them do not have or able to afford the necessary equipment. They do not have doctors round the clock. And even those that do rarely have an allopathic doctor trained in cardiology.

Private hospitals and nursing homes fall very short of the requirement. Majority of them employ unqualified staff. In Bombay out of 24 hospitals and nursing homes only 1 hospital had employed a post graduate doctor, whereas 10 had doctors trained in other systems. Few hospitals had provision for the doctors to be present round the clock. Majority of the nursing homes utilised the services of visiting consultants. Many private hospitals are staffed or run by doctors employed in public hospitals. It is quite common for such doctors to lure patients to their private hospitals, while misusing public facilities.

Only 7 institutions employed qualified nurses and that too one nurse each. Most of them had employed unqualified nurses who were either trained by doctor or had received training for about 3 to 6 months from various private training institutes which have also sprung up to meet the needs of private hospitals. These nurses are paid measly salaries and their working conditions are pathetic. During informal discussions with the nurses it was found that they were paid around Rs 500 to Rs 700 per month in Bombay. In another study in Delhi it was found that the condition of those employed in private health establishments, were working in extremely grim conditions. For almost all of the categories of personnel, the maximum salaries drawn by private medical employees was lower than that of the government employees in the same category. This apparently is an exploitation of lower staff by high-income private practitioners (Kansal 1992).

The sanitary conditions of private hospitals and nursing homes leaves a lot to be desired. The Bombay found that many of the hospitals were congested, lacked adequate space : passages and entrances were narrow and crowded. There was not enough space for easy movement of a trolley or a stretcher. The study in Bombay found that in 37.50 per cent of cases, the hospital premises were dirty as were the beds, especially in the general ward. More than 60 percent of the institutions did not have a minimum of 50 sq.ft space for each bed. Lighting facilities were found to be inadequate in 10 of the hospitals and nursing homes.

The area surrounding the hospital plays an important role in the treatment of a patient. During the study it was observed that one of the hospitals was situated near a factory and the entire atmosphere was visibly polluted. Noise emanating from the factory was well over prescribed limits. Many of the nursing homes were found to be situated close to a busy traffic spot. Our findings with regard to waste disposal were shocking. All the hospitals studied, disposed of their waste in the common garbage dump. This form of

disposal has serious implications, because of the increased risk of spreading infectious diseases, AIDS. Secondly, waste disposed thus may be recycled for further use as reports from Delhi have shown.

The number of toilets and bathrooms were not in adequate proportion to the number of beds provided in the hospital and also the area provided for such facilities are very small. During visits to the hospitals in one of the hospitals the blood stained linen was being washed in the common bathroom and being dried in the passages. 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.

In the recent past care provided in private hospitals has come in for closer examination. Private hospitals tend to perform unnecessary investigations, tests, consultations and surgeries. Doctors in private hospitals more often do not reveal the diagnosis and go on recommending tests to 'diagnose' the ailment. Whereas in the public hospitals, doctors are required to write the diagnosis on the case paper. Due to the fact that the surgeries are 'profitable' many private hospitals are found to be conducting unnecessary surgeries. The KSSP survey revealed that 31 per cent of deliveries were by caesarean section. More significant 70 per cent of the hospitals where caesareans were routine were privately owned (Kannan et al, 1991). In Maharashtra the Mangudkar committee found that the average rate of caesareans childbirth in government hospitals was 5 per cent while in private sector it was nearly 30 per cent. According to a member of the committee private clinics charge between Rs 2,000 and Rs 5,000 for caesarean delivery while normal delivery fetches them Rs 300 to Rs 700. Ultrasound investigation, amniocentesis, epidural anaesthesia etc. are done unnecessarily, particularly in private nursing homes. One of the doctors in Bombay commented "Very often endoscopy is done just because the hospital has the facility" (The Week, Jan 5 1992). In the bigger hospitals there is pressure on the doctors to ensure that all the beds are occupied at all times and equipment available in the hospital are used fully. Admittedly, many hospitals fix the amount of 'business' a physician/surgeon has to bring.

The majority of private hospitals and nursing homes across the country are generally refer patients who develop complications to public hospitals so that they are not liable for cases of death. Most of these hospitals refuse admission to accident cases and those cases involving medico legal work, even when patients are in a very serious condition. Many institutions refuse admission to patients, unless a certain amount of money is not paid beforehand. Public hospitals in most cases do not refuse admission to serious patients, if they have the facilities. In public hospitals one can still demand services while in private hospitals they can turn patients at their will.

Most private hospitals are run by 'medical entrepreneurs'. Many do not maintain proper books of accounts. The charges are different for diverse kinds of nursing homes. The charges include consultation fees and charges for bed, nursing, operation, operation theater, various investigations and disposables used, for medicines, etc. These charges are levied by different entities - for instance the Doctor conducting the operation would be different from the one who owns the nursing home, the anesthetists charges are again separate. We found that the accounts in only one paediatric baby care nursing were maintained properly. There it was found that the total gross income for one month was Rs 2,20,000 (Nandraj 1992). A study undertaken in Delhi of the earnings of the private practitioners and that of the ones running nursing homes with graduate (MBBS) qualifications, their net income per month was Rs 73,650/ and the ones having post graduate degrees the earnings were up to Rs 79,960.p.m. (Kansal 1992). In Delhi the amendment under discussion is seeking to get the charges levied by the hospital, displayed in a prominent place.

Private hospitals are known to have an unhealthy nexus with the pharmaceutical industry. 6 patients who had every chance of survival died in a prestigious private hospital in Bombay due to the administration of a sub-standard drug during operation. Reports alleged that 3 doctors attached to the hospital were connected with the ownership of the company, which had supplied the drug. Private hospitals are less accountable to the people than government hospitals. If they have not had as much bad publicity as public hospitals, it is primarily because patients reluctance to name names, or reveal information and reliable because of the inaccessibility of reliable information.

REGULATORY BODIES

The rules and regulation framed for practitioners broadly fall under their respective State Council Acts for various systems of medicine. The practitioners are also governed by the Drugs and Pharmaceutical Act of 1950. Recently private practitioners and hospitals have been brought under the purview of the Consumer Protection Act. Medical councils are statutory bodies that set the standard of medical practice, 'discipline' the profession, monitor their activities and check any malpractice. The certificate of registration issued by the council which has to be displayed in a conspicuous place in the place of practice. The council has to maintain a register of the doctors and this has to be updated regularly. Renewal of registration has to be made periodically. Those not registered with the medical council cannot practice. Although the bulk of the practitioners in the country are trained in other systems of medicine like Homeopathy, Ayurveda, Unani, Siddha, etc. most of them practice allopathy.

The medical councils regulating the conduct of doctors have failed in their duties miserably. They have even failed in their basic duty of maintaining and updating the register of doctors. This is reflected in the data brought out by Health Information of India where many state medical councils have not sent in the required information to the central government for years together. In the Maharashtra Medical Council (MMC) the register of doctors is outdated and full of errors. Secondly, there have been very few instances of doctors being penalised for negligence or violating the code of ethics. The enquiries are held in secrecy. The Maharashtra Medical Council (MMC) was unable to produce even a single record of action taken against erring doctors. The medical councils in the country are in a mess. They have given permission to private medical colleges which are substandard, understaffed, those not meeting the minimum prescribed standards, like having their own hospitals etc. and have failed to resist the pressure from politicians for opening of new medical colleges.

The Recent elections to the MMC clearly brought out the way things are managed in the council. Elections are held through the postal ballot method. The registers of the council were not updated; so in a few instances ballot papers were sent to doctors who had long expired. The names of doctors who had registered with the council were not found in the register; doctors who were indicted in the law courts and with dubious degrees were candidates in the fray. There was massive rigging in the election process. A panel of doctors who were in the fray paid money to the postal department and intercepted ballot papers which were not meant for doctors who were absent or dead, etc and stamped them. Blank ballot papers were collected in an organised manner from doctors across the state and stamped. In an open forum some of the doctors in fact endorsed this practice, saying that there was nothing wrong with this procedure. Clearly, there is something seriously wrong. Politicians doing the same thing would have been accused of fraud. Do doctors expect patients to believe that a council elected in this manner is capable of disciplining unscrupulous practitioners? [Pandya S 1993].

A study undertaken on behalf of the MFC (Bombay group) on rules, acts, regulatory and monitoring mechanisms existing in various states of India, came out with disturbing findings. A mailed questionnaire was sent to all the health departments of the state governments and union territories in India. Tamil Nadu, Punjab, Andhra Pradesh, Kerala, Goa Daman and Diu, Mizoram, Gujarat, Orissa, Sikkim and Manipur responded to the questionnaire. None of these states have any rules, laws, regulations or even data for private hospitals and nursing homes. Government of Kerala specifically wrote back "This state government has no control over private hospitals/nursing homes functioning in this state at present, as there is no legislation now for this purpose". 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 only in Maharashtra and Delhi there is a legislation for private hospitals/nursing homes. In Delhi there is the Delhi Nursing Home Registration Act (DNHRA), 1993. One of the largest private health sector in the world, providing 70 percent of care in India, functions practically unregulated!

The broad features of the BNHRA and DNHRA Acts are somewhat similar. The objectives of these acts are to provide for registration and inspection of nursing homes. The acts stipulate that every year the nursing home and hospitals are required to make an application for registration or renewal for registration to the local supervising authority, which could be the municipal corporation, municipal body, district board, district panchayat etc. During the time of application detailed information should be provided in terms of qualification of staff, adequacy of staff, sufficient and proper equipment, adequate accommodation facilities and space, and regarding sanitary conditions. Maternity homes have to specify whether they have got on their staff a qualified midwife. The Maharashtra Act provides for the local authority to formulate bye-laws. On receipt of application for registration the local authority may refuse to register the application if any person employed in the nursing home is found unfit, whether by reason of age or otherwise if the nursing home or hospital is not under the management of a qualified medical practitioner or a qualified nurse, or does not have adequate space, equipment etc. Failure to register under the BNHRA could mean a fine of Rs 500 for the first offence and imprisonment for three months.

There are other regulations that are also applicable to hospitals and nursing homes such as those referring to or related to buildings, drainage and sanitary facilities; laws regarding Employees- Provident Fund, minimum wages, maternity, working conditions among others. In addition to these hospitals registered as trusts or public societies have to follow the legislation formed for the trusts and public societies. These laws make it essential to file returns periodically to the appropriate authority.

During the proceedings of the public interest litigation it was found that the municipal corporation, the authority for registration in the city of Bombay, was not enforcing the Act. The municipal corporation started registering the hospitals and nursing homes after the case was filed. 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". The municipal corporation during the hearings admitted that in several wards of the city, the officials had not visited the hospitals for the past two to three years consecutively. Many of the nursing homes were not registered with the local ward office as per requirement. In fact, one out of four hospitals were functioning without proper registration. It admitted that for the last three years it had not taken action against any hospital or nursing home nor collected fines. It has not prosecuted a single nursing home upto now. The municipal corporation could not submit a complete list of private hospitals

and nursing homes functioning in Bombay to the court. In Delhi, the administration admitted that only 134 out of 545 nursing homes were registered. The BNHRA act is applicable to all of Maharashtra, however its implementation was found to be restricted to the cities of Bombay, Pune, Nagpur and Sholapur. During the hearing of the case, the State Government issued a directive to all the municipal corporations, councils and municipalities in Maharashtra urging them to implement the provision of the said Act. However during field work the author found that the directive was not implemented as the local bodies did not have enough information regarding the Act, (one of them did not even have a copy of the Act), and also the bye laws were not yet formulated by the bodies. Both the Acts are very deficient. The use of the words like 'adequate' makes the provisions ambiguous. They do not spell out what 'adequate' means with regard to the provision of the acts. There are no minimum requirement and guidelines regarding space, sanitary conditions, personnel, equipment, fees to be charged etc to be followed by the hospital and nursing home authorities.

The judges in the Bombay High court recognized the inadequacy of the existing Act and also its poor implementation directed the Bombay Municipal Corporation (BMC) to appoint an apex committee and three zonal committees to look into the implementation of the act and make recommendations. The committees were overwhelmingly filled with bureaucrats of BMC, who in the first place were supposed to implement the act. Right from the inception bureaucrats in the committees started placing obstacles in the committees functioning. And very little progress has been made on the matter.

Corrective action needs to be taken to bring about reforms in this sector. As a first step people should be made aware of their rights and duties vis-a-vis the health care system, specifically the private health sector. There should be adequate representation of the people and consumer organisations on the various regulating and monitoring bodies functioning at various levels. Legislation should be enacted where there is none legislation and the various existing legislations should be implemented. The State should ban and take strong action against the private practice of doctors employed in Government institutions. One of the main reasons behind the non-functioning of the public health system is due to the private practice of the Government doctors and other functionaries. With regard to private practitioners, the state and medical councils should ensure that only properly qualified persons practice. Through licensing and other means the proper geographical distribution of practitioners and hospitals in the country to prevent over-concentration in certain areas. There should be regular medical and prescription audits and the renewal of license and registration should be dependent on it. Records should be maintained properly and the patients should have access as a matter of right. Minimum standards and requirement for various types and kinds of hospitals and nursing homes should be laid down. With regard to charges and fees there should be standardization of fees charged by the practitioners and fixation of reasonable charges by hospitals and nursing homes for the services provided. These should be displayed prominently in a conspicuous place. There is a need for overhauling the medical councils in the country. They should make provision for the registers to be maintained properly and keep them open for public scrutiny. There should be provision for continuing medical education on a periodic basis with renewal of registration dependent on it.

Notes

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Notes

- (1) In 1986-87, 42nd round of National Sample Survey organisation (NSSO) found that for hospitalized cases 36.85 per cent episodes in rural and 36.59 per cent episodes in urban areas used private hospitals and nursing homes. With regard to OPD, 53.01 percent cases in rural and 51.83 per cent cases in urban areas utilised the private doctor. Private hospitals and nursing homes accounted for 15.88 per cent cases in rural areas and 17.33 per cent in urban areas. The per capita expenditure on health per year by the household was Rs.56.18. (NSSO, 1989). NSSO data are gross underestimates when compared to micro level studies conducted by other organisations. During the same period the Foundation for Research in Community Health (FRCH) conducted a study in Jalgaon district of Maharashtra. This study brought out that in 83.45% of acute illness episodes private practitioners and hospitals and only in 9.07% public health facilities were utilised. The per capita expenditure on health was found to be Rs. 182.49 per year. 7.64% of total consumption expenditure and 9.78% of reported income were spent by the household on health care. (Duggal and Amin 1989). Kerala Shastra Sahitya Parishad (KSSP) which undertook a study in rural Kerala in 1987 found that in 66% of illness episodes approached private health facilities. The per capita cost per year incurred by the household on health was Rs.178.33. The percentage of the reported income spent on health was found to be around seven percent. (Kannan, K.P., Thankappan K R, Raman Kutty V, and Aravindan K P, 1991). National Council of Applied Economic Research (NCAER) conducted an all India study in 1990 which brought out that the private doctor was utilised in 54.75% of illness episodes in urban areas and 55.46% of episodes in rural areas. The average household expenditure for treatment worked out to Rs. 142.60 per illness episode in urban areas and Rs. 151.81 per episodes in rural areas. (NCAER, 1992). During 1991, the per capita expenditure incurred by the State was Rs.58. (Duggal Nandraj, Shetty, 1992). Another study conducted in two backward districts of Madhya Pradesh, Morena and Sagar by the above organisation in 1991 showed that out of 1,932 illness episodes reported, 69.05% were treated by private health facilities. The per capita expenditure incurred by the household on health worked out to Rs.299.16 per year. (George, Shah, Nandraj, 1993). The per capita expenditure incurred by the state during 1991 on health was Rs.45.
2. Become a Doctor, Join Bachelor of Electropathy Medicine and Surgery (BEMS), Minimum qualifications 10th/12th std/equivalent, 3 years course.

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