Evolving Consumer-Friendly Healthcare Systems in India: improving policies and practices

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Proceedings

Opening Session

Pradeep S Mehta, Secretary General, CUTS

Pradeep S Mehta (PSM) welcomed the delegates and stated that the purpose of the conference was to present an interim report of the study on "Evolving Consumer-Friendly Healthcare Systems in India: improving policies and practices", carried out by CUTS and supported by Oxfam, India.

He started by expressing that the Right to Health is a basic human need and also an inalienable human right which has been recognized in a number of international and national legal instruments and enshrined in the constitution of India under Article 21. However, it seems that these commitments have not been translated into effective practices. PSM was of the opinion that if India is to achieve improvements vis-à-vis universal health coverage and come close to achieving the 2015 healthcare related targets of the Millennium Development Goals (MDG), there is an urgent need to highlight policy-areas that require our attention and systematic action. This is opportune, in view of the fact that the Government is in the process of developing the blueprint of the 12th Five Year Plan (2012-17) which not only focuses on curative care but also on prevention.

PSM emphasised that the Ministry of Health and family Welfare drafted the National Health Bill over two years ago in 2009 and the government should adopt it without further delays as it is an imperative need. He further elaborated that the rising cost of delivering healthcare services by the state and other partners in the health system is acquiring critical importance. It is an irony that despite the expanding healthcare network, a vast section of the population has no access to quality health services which are beyond their reach. The problem with existing healthcare delivery in India is multifaceted. One set of problems relates to the insufficient allocation of resources towards this sector and the resources earmarked are not properly utilized. While on the other hand, there are private healthcare services which are highly expensive, substandard and often unregulated which gives rise to unethical practices and suboptimal outcomes.

He drew the attention of the gathering to the disconnect between state and central level policies which have resulted in the existence of a loose regulatory frame work for the sector in the country. This adversely affects consumer interests.

PSM stated that the regulatory concerns regarding the quality of care provided by the healthcare professionals in India is another problematic area. The Medical Council of

India, for example, has a list of medical misconducts that can be brought before the council, yet it does not specify punishments. This makes the institution toothless. The Consumer Protection Act (COPRA 1986), can be a way for affected consumers to get their grievances redressed, but it remains grossly under-utilized across states.

He observed that as there is no standard pricing policy in India, since there is huge variation in prices clients pay for the same service. The large asymmetry in information, leads to wide scope for supplier-induced demand and price gauging. PSM pointed out that accountability is also a serious matter of concern to policymakers in the sector. This is reflected by the fact that more than one-third of the health enterprises in the country do not have any form of provider registration. Such loose accountability results in oligopolistic markets where collusion is an inherent characteristic.

PSM drew the attention of the delegates to the unprecedented number of mergers and acquisitions involving big Indian pharmaceutical companies (those with considerable generic 'product line') by large MNCs, who specialize in patented drugs. This would result in making the medicines more expensive and restrict the volume of generic medicines supply in the market.
Finally, PSM drew the attention of the gathering to a few policy areas that should be considered important for achieving better consumer welfare in healthcare:

- Adoption of Clinical Establishment Act 2010 - The state government should be persuaded to adopt the Clinical Establishment and Registration Act, which would bring some uniformity in the healthcare delivery

- Enhance Public Spending on healthcare - Public spending on healthcare continues to be low with the total expenditure of states and federal governments being1.06% of GDP in 2009-10, with the federal government alone spending 0.35% of GDP on health. The budgetary allocation on healthcare must increase.

- Irrational Medicines - These medicines should be identified and banned without delay. The government should make a mechanism of prescription audit of both public and private healthcare facilities.

- Ensuring Access to Medicines - The present situation wherein more than 80% of drugs consumed are paid for through out of pocket contribution by the consumer is unacceptable. There is a need to ensure availability of a majority of drugs through the public sector.

- All medicines in Essential Drugs List under price control - All Essential Drugs should be under price control. It should be made mandatory that the procurement and use of medicines in government hospitals and public sector undertakings be done based on the national List of Essential Medicines (NLEM).

- National Health Bill 2009 - Last but not the least, legislations like the National Health Bill (2009) which is waiting for approval should be adopted at the earliest.

Avinash Kumar, Oxfam India
Avinash Kumar (AK) began by highlighting some of the problems faced by consumers in the healthcare sector. He spoke about the cost burden involved and the out-of-pocket expenses that consumers have to incur to pay for their medical treatment and medicines. At times the problem is so acute that poor patients are pushed under a burden of debt in meeting their medical expenses and are further impoverished.

AK emphasized on the Right to Health as a fundamental right and hinted at the insufficient resource allocation by the government towards this sector. He stated that even the resources allocated towards the healthcare sector are not rationally utilized. All this is leading to terrible health outcomes. The infant mortality rate (IMR) and the maternal mortality rate (MMR) both are very high in some parts of the country. Many Indian women die for lack of proper care during pregnancy and child birth.

AK stated that India has a large healthcare sector and about 70-80% of the sector is privatized. The private sector is mainly motivated by maximizing its own profits and the remaining part of the healthcare sector is under government control which too, has an informal alliance with the private sector. In the interest of healthy competition, a proper balance should exist between the public and private sectors. The role of the public sector in healthcare should be strengthened as poor people can mainly rely on public health facilities, since private health services are often out of bounds for them.

He added that consumers should emerge as rightful claimants of the right to healthcare rather than being passive beneficiaries of it. This right goes beyond the language of consumers as it is essential and life saving. AK alleged that the National Health Bill (2009) is lying in cold storage and should be adopted at the earliest. He pointed out that policies in the patients' interest are taking a back seat while the interests of those seeking to advance their profits and commercial interests are being pushed through.

He concluded by saying that protection of consumers' right should be a joint bureaucratic and community led exercise. It should be a convergent exercise undertaken both by the bureaucracy and the civil society in the interest of consumers.

Session I: Prevailing Consumer Concerns in the Healthcare Sector in India

Lipika Nanda, Family Health International (FHI) Chaired the session. She welcomed all the in the session and highlighted that there is supply as well as demand side issues in public health sector. There is need to strengthen public health sector. Regulatory framework need to deal with issues. She then invited the speakers to present their work

Rijit Sengupta, CUTS
Rijit Sengupta (RSG) made the presentation on the project findings. He shared the objectives of the meeting to share findings of the research undertaken on the nature and impact of collusive behaviour in the healthcare sector of two states and draw lessons relevant for policy. He mentioned that out of the total healthcare expenditure, a large

chunk of its spent on medicines. In spite of the fact that medicines are made available to consumers free of cost and/or at a nominal price by many state governments – in reality many consumers have to procure them. He reported that one of the findings of the project was that in both the states (Assam and Chhattisgarh), a sizable population of consumers getting treated in government hospitals were buying medicines from private sources.

Through his presentation, RSG informed the audience about the research project and its objective to identify malpractices in the healthcare sector in the dates of Assam and Chhattisgarh and to assess scope and effectiveness of the present regulatory structure to deal with such deceptive practices. He express concern over the lack of appropriate regulatory oversight on the healthcare sector which remains a huge challenge, especially given the role that private providers play in the healthcare delivery in the country. Whether it is concern over cost, quality and availability of healthcare facilities; or the nexus between various players in the healthcare value chain, consumers continue to remain at the mercy of the providers and have little say or choice while seeking healthcare services in the country.

Sukumar Vellakal, PHFI gave second presentation on 'Consumer concerns in Health Security/Insurance schemes in India'. Major points of the presentations were: major insurance provider in Indian has complicated payment mechanism.
Pricing of insurance scheme is not scientific. These are highly undeveloped and unregulated. Policy Steps need to take mainly the scientific pricing, treatment protocol and transparence in functions.

S Srinivasan, LOCOST made presentation named 'Increasing availability of medicine in public health facilities' In his presentation, he took examples and TNMSC (Tamilnadu), Nagur and Chittorgarh Districts to Rajasthan. TNMSC is providing free medicine and treatment to the public and generic medicine are being promoted in Nagaur and Chittorgarh by the Districts Administrations. These are a success examples in public health sector.

Highlights of Open Discussion:

WHO representative asked about the Jan Aushidi Kendra introduce by the Ministry of Health & Family Welfare, Govt. of India to promote generic medicine. Srinivasan replied that there is need of political will to implement these initiatives. Presently only 44 Jan Aushidhi Kendra (Shops) is in place all over India.

RSG mentioned the final report be uploaded on web, which can be access by anybody. Reports will also be disseminated in Assam and Chhatisegarh. RSG also replied on the question of auditing of prescriptions. He told that help of some doctors and other were taken for auditing of the prescription.

Partner from Asssam also add this activity was opposed by some doctors and hospitals. Bust we got support from some medical representatives and pharmaceutical.

Other specific suggestions from participants were about information technology, which can reduce the corruption in health sector, and to give recommendation of COHED project to 12th five year plan.

GC Mathur, BINTY (One of consumer organization) suggest to recommend bar coding for medicine also, which will be helpful for keeping record in government medical shops.

LN sum up the discussion held among participants and gave thanks to the speakers.

Session II: Achieving greater consumer welfare in healthcare: better policies and effective regulation

Renuka Jain Gupta, Competition Commission of India

Renuka Jain Gupta began by giving a brief overview of the Competition Act, 2002. She said that health sector in India is complex with respect to its regulatory framework. She emphasized that the market is segmented consisting of both public and private players and the value chain is long. The quality and price of health services is another matter of concern.

She highlighted the relevant provisions of the Competition Act, 2002 i.e. sections (3) and (4) which deal with anti- competitive agreements in any sector. She briefly described the provisions under sections 3 and 4 of the Act. Section 3 pertains to anticompetitive agreements which prevent entry of others in the value chain etc. Similarly, provisions of section 4 prohibit abuse of dominance by any entity.

The speaker expressed that there are both public and private healthcare service providers in the country and there has been emergence of a large number of private sector operators in healthcare delivery over the years. She also discussed the existing regulatory framework in the sector. RJG mentioned that there are bodies like NABH and NABL, which are both accrediting authorities for hospitals and laboratories respectively but are not responsible for regulating or controlling them. She further highlighted that there are multiple institutions in the sector whose goals are often divergent. For regulatory effectiveness there is a need to harmonize the goals of such institutions.

The speaker concluded with the suggestion that the public and private sectors may come together for better delivery of health services. She hinted at a possible delegation of responsibilities between the two, wherein the primary and secondary health services are looked after by the public sector and the tertiary or super specialty activities are taken care of by the private sector.

Kabir Sheikh, Public Health Foundation of India

Kabir Sheikh made a presentation on "Making Sense of the Regulatory Architecture for Health Care Provision: Case Studies in Two States". The presentation aimed at taking a closer look at the regulatory structure for health care provision in the country and undertook case studies of two states viz. Delhi and Madhya Pradesh for the purpose.

KS began with defining the regulatory agenda in healthcare i.e. by giving a sense of regulation in general, regulation in the context of healthcare and the core regulatory targets. He differentiated between 'regulation' and 'regulatory policy'. While 'regulation' refers to government control over the activities of individuals and firms or government's action to manipulate prices, quantities and quality of products. 'Regulatory policy' refers to actions and arrangements undertaken by state and non-state actors to control and modify individual and organizational activity. He identified the domain of health regulation as covering – health services, pharmaceuticals, health technology, food quality, health insurance and medical education etc.

He further identified what the regulatory structure in healthcare seeks to regulate. These were identified as issues of competition, distribution, markets, medical ethics, behaviour of doctors and other personnel involved, standards of services, availability and quality of services, prices of services, access to quality healthcare and existence of malpractices etc. The speaker defined health care regulation as a means for achieving health equity, actualizing health rights and promoting collective goals of public health and development. The methodology adopted for the study is 'Backward Mapping' wherein enquiry is oriented from the 'bottom up'- with an understanding of field level phenomena and behaviours which generate the need for policy.

KS identified the core regulatory targets in the health care sector as costs of care for users, quality of care, conduct of providers and accessibility of care. The methodology adopted for the study consisted of in- depth interviews with health system actors and key informants and policy document review.

He also discussed about a system to map regulatory architecture in the given sector which comprised four aspects such as cost of care for users, quality of care, conduct of providers and accessibility of care as part of the target of regulatory policy measured against groups tasked with relevant activity, type of authority invested with group, relevant policy and laws and relevant activities expected of the organisation. The speaker suggested that the given system for mapping regulatory architecture in the health care sector would be of definite help to identify implementation gaps and design gaps in the regulatory policy. Design gaps will surface when particular target areas for regulatory policy are inadequately assigned or not assigned at all. Implementation gaps highlight differences in actual and expected roles of different organizations and groups.

The speaker first presented the case of the State of Delhi. The relevant Act governing healthcare services in the state of Delhi is the Delhi Nursing Home Registrations Act, 1953. One of the activities expected to be performed by the Department of Health and Family Welfare of the Government of Delhi (DoHFW) i.e. the relevant authority under the Act includes registration and renewal of private clinical establishments in accordance

with infrastructure and personnel standards. While it was found that there were subsequent dilution of standards and the current focus was mainly on infrastructure standards. Registration was not being universally implemented and many unregistered establishments were functioning. Another expected function of the authorities is periodic inspection of facilities to assess adherence to norms and in response to complaints. Whereas on the ground, it was discovered that inspections were inadequately performed, typically, only in response to complaints. This situation was attributed to lack of capacity, motivation, political factors within medical fraternity. Another significant function to be performed by the DoHFW under the Act consists of cancellation of the registration and imposition of penalties in case the establishment is operating without registration. However, it was found that the registrations of only a small number of establishments who were not following the prescribed standards were cancelled and action in case of non-registration was rare. These are some of the aspects related to quality of care. As regards the accessibility of care, the DoHFW is charged with the planning and establishment of hospitals based on assessment of need. While it was discovered during the course of the study that the DoHFW had reduced control over location of hospitals due to emerging PPP policies and greater controlling influence of Urban Development Authority.

Next the speaker put forward the case of Madhya Pradesh, wherein the Act governing the sector is "The Madhya Pradesh Ayurvigyan Parishad Adhiniyam, 1987." Under the Act, the Directorate of Health Services of the state takes cognizance of cases on receipt of complaint against practitioner or where a practitioner has been convicted in a court. Once cognizance is taken, an in-camera hearing and adjudication by the disciplinary committee takes place. If found guilty, the relevant authority suspends or cancels the name of the practitioner from the state medical register. It was found that the members of the medical fraternity were ambivalent about the value of the directorate's disciplinary role, given other mechanisms such as under COPRA, 1986. There was a lack of data on disciplinary procedures undertaken. While the directorate was found engaged in an additional function of receiving and forwarding complaints about non-qualified providers, it was found that there were no schemes being operated for the welfare of patients except for 'The Janini Sahayogi Yojana' which had been launched recently.

KS stated that design gaps were found in the regulatory structures for healthcare of both Delhi and Madhya Pradesh. In case of Delhi, RSBY and government subsidies to private hospitals both aimed at reducing costs of private care for economically weaker sections do not address the high incident costs in public facilities, or financial protection of non economically weaker sections. There is no direct control of care costs and no regulation of competition. Also no credible regulatory mechanism to limit practice by unqualified providers was found. For both quality of care and conduct of providers, there is absence of credible community based forum for grievance redress. Accessibility of care is not addressed through act or policy.

In case of Madhya Pradesh, no known laws or regulatory policies for the curtailment of costs for users of health care, other than the recently introduced Janani Sahayogi Yojana

were found. As far as the quality of care and conduct of providers is concerned, there was an absence of credible community-based forum for grievance redress.

The study undertaken by KS revealed certain implementation gaps or loopholes in the implementation of the healthcare regulatory architecture in both the states selected for the study. In case of Delhi it was found that information asymmetries impede the uptake of social insurance schemes. It was also discovered that, reduced investment in regulatory capacity of relevant departments hampers the enforcement of EWS free-bed condition for hospital subsidy.

As regards the quality of care, it was found that there was partial implementation due to personnel constraints and organizational inertia and active resistance from the medical fraternity. KS found that the role of the medical council had transformed to less of disciplinary function and it focused more on protecting the medical professionals' rights. As far as the accessibility of care is concerned, KS explained that health authority had been subordinated to urban development authority in determining location of new hospitals.

In case of Madhya Pradesh, the speaker discussed that the quality of care provided was not up to the mark due to shortage of personnel and problems of inter-departmental coordination. As regards the provider conduct, KS found that the self-regulatory council's commitment to disciplinary functions was adversely affected by proximity to associations that oppose regulation. Moreover, the council was found to be involved more with additional tasks such as reducing quackery, than the performance of its disciplinary role. As regards the accessibility of care, the study revealed that, the implementation of rural medical bonds was impeded by extensive contestation by doctors' groups. Besides, it was also discovered that there were problems in coordination between government departments involved in placements.

Finally, the speaker concluded by focusing on the underlying factors coming in the way of effective regulatory architecture for health care provision:

1. Pervasive influence of medical political interests (Regulatory agencies are largely constituted of medical professionals, or are reliant on their cooperation).

2. Discordance in inter-departmental relationships and coordination within the State regulatory machinery.

3. Severe constraints in numbers and capacities of personnel for regulation.

Emerging Lessons and Way Forward
Summarization by the Rapporteur

The deliberations at the conference focused on the following areas:

1. There was discussion about the Right to Health as a basic human need and an inalienable human right which finds place in a number of international and national legal instruments and has been enshrined in the Indian Constitution under Article 21. However, it was realized that this commitment has not been translated into positive action and has not received the importance that it deserves. A need was felt to give adequate attention to this basic human right and to highlight policy-areas that would require effective execution if India wishes to achieve improvements vis-à-vis universal health coverage and come close to attaining the 2015 healthcare related targets of the Millennium Development Goals. This was also considered important in view of the fact that the Government of India is engaged in developing the blueprint of the 12th Five Year Plan (2012-17) which focuses not only on curative care but also on prevention.

2. Another important point discussed pertained to the changing anatomy of the pharmaceutical sector in the country. There have been an unprecedented number of mergers and acquisitions involving big Indian pharmaceutical companies (those with considerable generic 'product line') by large MNCs, who specialize in patented drugs. This was seen as a worrying trend as it could make medicines more expensive and result in a limited supply of generic medicines. The government has taken cognizance of these developments and recommended the use of tools like 'compulsory licensing' to maintain supply of drugs in the market in case of short supply.

3. The deliberations stressed on the need to take a look at evidences of compulsory licensing from smaller countries, draw necessary lessons and see how the same can be adopted in India.

4. There was discussion about the inadequate allocation of government expenditure towards the health sector and also the sub optimal utilization of the resources diverted to this sector.

5. It was realized that there is a need to re invigorate the public sector in healthcare in India as 70-80% of the healthcare market is in private hands. It was felt that the public sector needs to be strengthened to correct the imbalance that exists between the public and private sectors in healthcare in India and to ensure healthy competition in the market.

6. A presentation was made on "Collusive Behaviour in Healthcare and impact on consumers: evidences from Assam and Chhattisgarh." The presentation was made by Rijit Sengupta of CUTS International. It gave evidences of collusive practices in the healthcare sector in the states of Assam and Chhattisgarh, where the study

was undertaken. It highlighted certain practices prevalent in the healthcare sector, based on the findings from the two states which can be attributed to loose regulatory frame work in the sector and adversely affect the consumers. The presentation emphasized on certain policy issues that need to be worked upon to address the collusive arrangements and malpractices in the health sector in the country.

7. The next presentation was made on "Consumer Concerns in Health Security/Insurance Schemes in India" by Sukumar Vellakkal from Public Health Foundation of India. It discussed the various elements of the insurance market in the healthcare sector in the country, the types of health insurance schemes, their objectives, their pricing frame work and impact of such package rates on consumers etc. The presentation highlighted the major concerns in the healthcare sector in India and also suggested certain policy steps that should be taken to address the various consumer issues in the healthcare sector in the country.

8. Another presentation was made on "Increasing the Availability of Medicines in Public Health Facilities" by S.Srinivasan from LOCOST, Baroda. It underscored the need to aim at ensuring access to good quality healthcare that is accessible, affordable and available to all in need as a matter of human right. He emphasized on the fact that even in the so-called developed economies except the U.S.A., free quality health care is a reality with nobody having to pay at the point of service and nobody denied free healthcare. The speaker laid stress on the importance of medicines in the healthcare system, not just for treatment but as they constitute 50-80% of the medical expenses. He stated that in view of our goal of universal access to healthcare, we can begin with providing free good quality medicines to all in the public health system and he emphasized that this is doable. Srinivasan said that providing medicines free to all in the public health system is important as medicines account for 70% of the out of pocket expenditure and is an important contributing factor to impoverishment. He highlighted the fact that the price control basket for drugs has become smaller over the years and the prices of inessential drugs are controlled, while those of essential drugs are left to the market. The speaker drew the participants' attention to the fact that some form of price control was practiced even in the most advanced developed economies. Srinivasan presented two case studies: one of the TNMSC where drugs are supplied free of cost and the District Level Intervention: Chittorgarh/Nagaur Model of Low Price Government Cooperative Medical Store. He further provided an estimate of the cost of providing medicines free under the above two projects. In case of TNMSC, the cost works out to approximately Rs.9380 crore at T.N. government prices. While in case of the Chittorgarh/ Nagaur model, it is about Rs. 30,000 crore at Chittorgarh prices. The speaker concluded by citing taking over of

major Indian drug companies by foreign entities as a threat to health and pharma security and also as endangering our hard earned self sufficiency in the sector. He emphasized that compulsory licensing option (CL) should be seen as an adjunct to price regulation and prevention of takeovers in the sector.

9. The first speaker for the next session was Renuka Jain Gupta from the Competition Commission of India. She began by giving a brief overview of the Competition Act, 2002. She said that health sector in India is complex with respect to its regulatory framework. She emphasized that the market is segmented consisting of both public and private players and the value chain is long. The quality and price of health services is another matter of concern. She highlighted the relevant provisions of the Competition Act, 2002 i.e. sections 3 and 4, which deal with anti- competitive agreements in any sector. She briefly described the provisions under sections 3 and 4 of the Act. Section 3 pertains to anticompetitive agreements which prevent entry of others in the value chain etc. Similarly, provisions of section 4 prohibit abuse of dominance by any entity. The speaker expressed that there are both public and private healthcare service providers in the country and there has been emergence of a large number of private sector operators in healthcare delivery over the years. She also discussed the existing regulatory framework in the sector. RJG mentioned that there are bodies like NABH and NABL, which are both accrediting authorities for hospitals and laboratories respectively but are not responsible for regulating or controlling them. She further highlighted that there are multiple institutions in the sector whose goals are often divergent. For regulatory effectiveness there is a need to harmonize the goals of such institutions. The speaker concluded with the suggestion that the public and private sectors may come together for better delivery of health services. She hinted at a possible delegation of responsibilities between the two, wherein the primary and secondary health services are looked after by the public sector and the tertiary or super specialty activities are taken care of by the private sector.

10. The last presentation was on "Making Sense of the Regulatory Architecture for Health Care Provision: Case Studies in two States" by Kabir Sheikh from the Public Health Foundation of India. The presentation focused on the basics of regulation in the health care sector in India and the core regulatory targets for the healthcare regulatory structure. He also discussed about a system to map regulatory architecture in the given sector which comprised four aspects such as cost of care for users, quality of care, conduct of providers and accessibility of care as part of the target of regulatory policy measured against groups tasked with relevant activity, type of authority invested with group, relevant policy and laws and relevant activities expected of the organisation. The speaker suggested that

the given system for mapping regulatory architecture in the health care sector would be of definite help to identify implementation gaps and design gaps in the regulatory policy. Design gaps will surface when particular target areas for regulatory policy are inadequately assigned or not assigned at all. Implementation gaps highlight differences in actual and expected roles of different organizations and groups. He first presented the case of the regulatory architecture in health care in the state of Delhi followed by that of the state of Madhya Pradesh. The speaker brought out the design and implementation gaps in the regulatory structures for both the states. Finally, he concluded by focusing on the underlying factors coming in the way of effective regulatory architecture for health care provision.