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Violating the Law, yet Thriving
Study of Private Hospitals in Maharashtra[1]

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Introduction

India has witnessed a rapid expansion of the private health sector – a sector that comprises a wide range of providers in terms of system of medicine, size and ownership patterns. The growth of private sector has become steeper in the last two decades. The private health sector is highly commercialized with emphasis on diagnostics and curative services only. This has resulted in a larger role of the market in pharmaceuticals, medical equipment and of medical insurance corporations in the health sector.[2] The Government has played a critical role in this growth by reducing its expenditure on health, allowing mushrooming of private medical colleges, giving concession and subsidies on the import of medical equipment and giving the land to 'trust' hospitals at very nominal prices, etc. The vacuum created by the deterioration and in some places even absence of public health services was occupied by the private (for profit) health sector.[3] The private sector is the dominant provider of health care as evidenced by the higher utilization of health care from the private sector as compared to the public sector. During the last decade there has been an increase in utilization of health services of the private sector from 80% to 81%[4] in urban areas. In Maharashtra, this increase in utilization of private health services has been from 84% to 89%. The private sector is urban centered with the exception of a few states like Gujarat, Maharashtra, Andhra Pradesh, where the private sector is expanding in rural regions too. The divide between urban and rural is not just in terms of hospital and beds but also in terms of qualified doctors and staff. The doctor-patient ratio is better in urban areas; it is 1:2300 whereas in rural area, it is 1:26860.[5]

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Despite the huge growth in term of investment and size across all regions, the private sector functions without any proper legislation and standards for care. As the main provider is the private health sector, the patients spend from their own pockets but there is no guarantee of even minimum quality of services. This sector is using public money but does not share the social responsibility of the national health goals and good quality universal healthcare. For example, until recently the medical education has been highly subsidised and those graduating from these medical colleges predominantly join the for-profit private sector. The huge and mostly unregulated private health sector in low-income countries raises serious concerns. According to a review in the *Bulletin of the World Health Organization*, the quality of drugs, advice and care sold privately is often dangerously poor.[6] In the absence of any national legislation or mechanism for registration of health establishment, it is left to the states: a few states do have archaic laws for registration of private hospitals but these provisions are not sufficient for proper regulation and in almost all cases, these legislations, even if somewhat okay, are not implemented properly.

Other mechanisms governing medical practice like the MCI (Medical Council of India) and the CPA (Consumer Protection Act) are activated when there is medical negligence or serious malfunction. Due to lack of legally valid evidence, patients often are not able to pursue their cases of negligence even as the rigmarole of following up with courts, etc., proves to be daunting for patients. There is evidence that MCI has not been able to deliver justice to patients. We therefore make a distinction between these and the need for legislation for regulation of private health facilities

There is no uniformity in the size of the private hospital sector and the hospital sizes vary from 2 to 800 beds across cities. The required minimum standards of care have not been defined for this sector by the state as the medical profession has always argued that factors such as the nature of services, location, availability of staff and cost, make it impossible to have any uniform standards. This makes the situation grave as there is no guarantee of any minimum level of care that patients can rely upon when accessing services of private hospitals. Though 'trust' hospitals and overtly corporate hospitals satisfy more than minimum requirements with respect to infra structure and qualified doctors, earlier studies have found that on the average, especially smaller private hospitals, provide poor quality of health care, often housed in dilapidated buildings with very poor infrastructure. The absence of any accepted standard to assess the physical and clinical standards of private hospitals makes it even more difficult to assess quality of care.[7] In absence of laying down of standards of care for these hospitals and lack of any effective mechanism to monitor the quality of care, it becomes difficult for the patient to ensure good quality of services from these private hospitals. The majority of the private sector consists of sole proprietors/practitioners or small hospitals of 0 to 30-bed hospitals serving their urban and semi- urban clientele and focusing only on curative health care. Issues regarding quality of care, cost of care and level of regulation among these facilities become more important. The Bureau of Indian Standards (BIS) prescribes standards for hospitals larger than 30-bed strength. It is the smaller hospitals for which standards are neither well-defined, nor are there any incentive to upgrade standards.

Rationale for the Study

In Maharashtra too, a large percentage of care, both in-patient and out-patient, is by the private sector. Maharashtra is one of the eight states in India that has some law for regulation of private hospitals. 'The Bombay Nursing Home Registration Act (BNHRA),' enacted way back in 1949, has been implemented hardly as rules under this Act have not been formed during the last 60 years! However, partly due to the presence of an active civil society that has consistently raised issues relating to non-implementation as well as the limited scope of the law, this Act was amended in 2005 to make it applicable to the entire state of Maharashtra and minor additions were made about floor-space per patient and nurse-patient ratio. Regrettably, several other proposed amendments for inclusion of minimum standards of care and civil society participation in regulatory mechanisms were not included. Responding to this criticism by the Jan Aarogya Abhiyan, the coordinating network in Maharashtra of the People's Health Movement, and others, the Government of Maharashtra (GoM) decided to involve civil society organizations in the formulation of rules under the amended BNHRA and invited CEHAT to draft the rules for this amended Act. CEHAT prepared the draft rules through a consultative process involving several stakeholders and submitted them in June 2006. These draft rules included minimum standards of care for hospitals with ten beds as well as a Standard Charter of Patients' Rights. With a few modifications, these draft rules were posted by the Health Dept at the official web site for comments from the public at <http://maha-arogya.gov.in/actsrules/nursing/BombayNursingHome.pdf>. It was expected that after receiving comments from the public, these rules would be finally approved. However, till date these rules have not been approved by the Health Minister, despite repeated appeals by several civil society organizations comprising the Jan Aarogya Abhiyan and hundreds of citizens! The reasons are opaque. The reluctance of the state in taking any such positive, pro-people steps and resistance by a section of the medical fraternity, seem to have worked together.

It is in this context, CEHAT undertook a study to understand the standards of care offered by these hospitals and the perception of the providers to regulate the sector. An earlier study undertaken by CEHAT in 1997 had examined the physical standards in private hospitals in one district, Satara. This study also highlighted that the standards may vary with the level of development. Maharashtra is known for its large private sector that has shown steep growth in the past two decades. In the context of the amendment to the BNHRA which made it applicable to entire state, it was, and is, pertinent to examine standards of care in private hospitals across different districts as per level of development and the size of hospitals. We hope that the finding of this current study, the data collection for which was done during May 2007 to Oct 2007, would be useful for the state and the medical associations in understanding the current scenario of private hospitals and evolve standards of care keeping in mind the needs of patients and the ground reality.

Objectives of the Study

1. To assess the physical standards and quality of care provided by the private hospitals in a representative sample of private hospitals in Maharashtra

2. To understand the problems and the concerns regarding the existing BNHRA and accreditation

among the hospital owners in Maharashtra.

METHODOLOGY

Sampling

In order to get a representative sampling, two districts were selected from five geographical regions of the state, namely, Konkan, North Maharashtra, Western Maharashtra, Marathwada, and Vidarbha including Mumbai. Two districts from each of the above mentioned regions were arranged in ascending rank on the basis of selected indicators (level of urbanization, hospital beds per one lakh population, under-five mortality rate, female literacy rate and District Domestic Product at current prices) and were divided into two equal groups, that is, developed and less developed. One district from each of the groups was selected randomly. Thus, a total of ten districts, namely, Nashik, Thane, Pune, Satara, Amaravati, Ratnagiri, Osmanabad, Nandurbar, Aurangabad, and Gadchiroli have been selected. The city of Greater Mumbai too is included in the selected districts due to its unique features of complete urbanization, great expansion of the private medical sector, huge population base with a high standard of living and very high real estate prices.

List of Districts in the Study Sample

Sr. No.	District	Level of Development	Region
1	Thane	Developed	Konkan
2	Ratnagiri	Less Developed	Konkan
3	Pune	Developed	Western
4	Satara	Less Developed	Western
5	Amravati	Developed	Vidharbha
6	Gadchiroli	Less Developed	Vidharbha
7	Nashik	Developed	Northen
8	Nandurbar	Less Developed	Northen
9	Aurangabad	Developed	Marathwada
10	Osmanabad	Less Developed	Marathwada

Further all tehsils in the sampled districts were ranked and classified into three groups (high, medium and low development) depending on their level of urbanization. We selected one tehsil from each of these categories. The physical listing of the facilities in the selected districts was done for sampling so that it would give maximum proportional representation to the universe of the study. Around 10% of the sample from each district was taken. The total sample for the study was 267 hospitals drawn from these 10 districts and Mumbai. Six hospitals refused to participate and hence the final sample of nursing homes from where data has been collected for the study is 261.

Tools

Interview of Facility In-Charge and Duty Medical Officer/Nurse: Semi-structured and open-ended questions were designed to collect information on the existing physical, structural and clinical standards in the hospitals, their awareness of the BNHRA Act, and issues, opinions and concerns regarding the implementation of the Act.

Observation of the Hospital: Observation Schedules sought data on the availability and condition of mainly the physical and structural aspects of care.

Limitations of the Study

The study findings are based on the responses of the hospital owners on most of the indicators. Only some of the physical standards have been verified through observation.

KEY FINDINGS

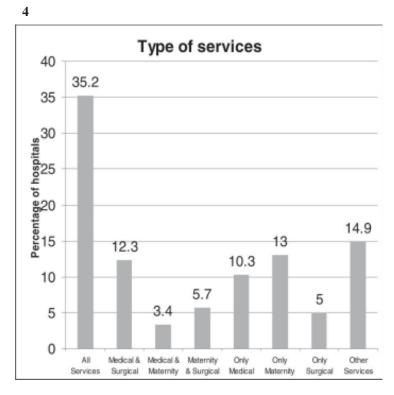### 1. Profile of Private Hospitals and Providers in the Sample

There has been a phenomenal growth in this sector during the last two decades across all regions. More than 50% of the hospitals in the study have been established in the last decade in the developed and less developed districts, thereby indicating a fast growing sector.

System of Medicine in Hospitals

Nearly 89.7% (234) of the owners of the hospitals were from the allopathic system of medicine. In the less developed districts, 96.8 % (30) of the hospitals belonged to the allopathic system of medicine. In a similar study, Nandraj and Duggal (in 1997) in Satara district had found that 75% of the hospital owners were trained in the allopathic system of medicine and the rest, about 25% were trained in another system of medicine.

Types of Services

The developed districts and Mumbai provide considerable medical, surgical and maternity services, but the hospitals in less developed districts predominantly provide medical services. More than 55% of the hospitals in less developed districts did not provide maternity and surgical services. This indicates the lack of available services for maternal and surgical care in the less developed regions.

Type of services

Bed occupancy in Hospitals

Bed occupancy is calculated by dividing the number of beds occupied on a daily basis in the preceding month by the number of beds in the hospital. The bed occupancy was 58%. In our sample, bed occupancy was found to be the highest in the hospitals in developed districts, followed by Mumbai. The highest bed occupancy (71%) was in hospitals with 21-30 beds. Nandraj and Duggal (1997) noted that bed occupancy was 51%. That it has increased to 58% indicates an increasingly higher utilization of the private health sector.

Ownership of Facility

"Self-proprietorship" was dominant with 86.2 %(225) of the hospitals' owners being sole proprietors. While 13.4 % of the hospitals were own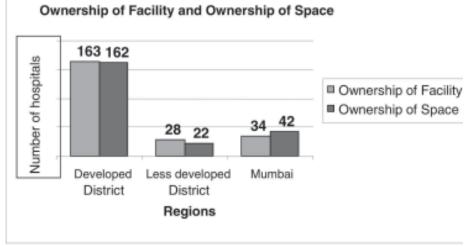ed in partnership, they were largely concentrated in Mumbai. The first owners were predominantly men (91%). Amongst second owners, 53% were women.

Ownership of Space/Building of the Hospital

Nearly 86.6 % (226) of the hospitals were housed in self-owned buildings and the rest of the hospitals were housed in rented buildings. Earlier studies (Nandraj, et al, 1997) had found that 60% of the hospitals were operating from rented places. Despite the high cost of property in Mumbai, 93% of the private hospitals in the city were/are self-owned. Out of the total sample from the less developed districts, 25% (8) hospitals

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Ownership of Facility and Ownership of Space

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Multiple Facility Practice by Provider

Around 40% (105) of the doctors said that they were involved in multiple facility practices, which was more common in developed districts than in less developed districts. The trend towards multiple facility practice was highest amongst the 'larger' hospitals that had more than 15 beds.
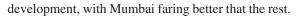
2. Adequacy of Human Resources

The availability of trained human resources in a hospital setting determines timely care and services for patients and is thus an important standard of care.

Medical Officers/DMO

The Duty Medical Officer is the resident doctor in the hospital. Nearly 54% (141) of the hospitals did not have a DMO. The study shows that the less developed areas and small hospitals were worse off. Only 17.7% (21) of the hospitals had DMOs from the allopathic system, while the rest belonged to other systems of medicine, mostly the Ayurvedic system.

One fourth of the hospitals did not have any qualified doctor to provide round the clock services. The hospital in-charge did not live in the hospital premises nor was there a DMO available at the hospital.

Nurses

Under the BNHRA, it is compulsory for all hospitals to have qualified nurses. The total percentage of the qualified staff was 35.6% (455) in our sample. The average number of qualified nursing staff[8] for each hospital in our study was 1.68 nursing staff per hospital which is well below minimum requirement for a hospital. We found that the ratio of qualified nursing staff reduced considerably with the level of

development, with Mumbai faring better that the rest.

However, the hospitals reported that they recruit unqualified nurses. The unqualified nurses were further categorised as trained in-house and untrained. It was found that 53% of the nurses were trained in-house and 10% were untrained. The presence of these unqualified nurses could pose a threat to the patient safety and life; and 80% of the nurses trained in-house were in hospitals from the developed districts. The average number of nurses trained in-house per hospital was 2.6. The average availability of qualified staff as well as unqualified nursing staff increased with the size of hospitals. For 21-30 bed hospitals, the availability of ANM was as high as 5.5 per hospital and of graduate nurses was 1.4. Even though it appears better, it is not in proportion with the actual requirement for the size of the hospital.

Other Paramedical Staff

Midwives: Of the 146 hospitals providing maternity services, 11 had midwives.

Ayabais or Ward boys: In 19 hospitals, neither ayabais nor wardboys were available.

Pharmacists: Out of 26 hospitals that had pharmacy shops, all had recruited pharmacists. Amongst these, two were unqualified.

Laboratory staff: There were 27 hospitals which had a laboratory but did not have the qualified staff to run it. There was one hospital where an M.D. Pathologist was present.
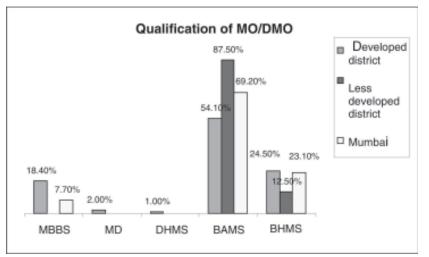
X-ray technicians: Around 40.6% (106) of the hospitals were providing x-ray facilities. Of these, 45 (42.5%) of the hospitals did not have the requisite staff. Of the 60 hospitals which did have the staff for the x-ray facility, 36.7 % (22) of the staff were not qualified to run an x-ray machine. Hospitals in less developed districts were more likely to have x-ray facilities, but less likely to have trained staff to manage them.

3. Standards of Care in the Private Health Sector

In absence of any minimum standards of care for the 0-30 bed private hospitals, we have looked at certain minimum standards that are essential for ensuring

minimum quality of care. The data collected on the standards of care may not be extensive but may be considered optimal, based on the earlier work done by CEHAT on the private health sector. This study has mostly looked at the structural aspects which includes functional plan in form of separate space for each activity in hospital, indoor staying facilities for patient, addition health services like O.T, ICU, ambulance services, record maintenance services and diagnostic services, basic facilities in hospital in terms of infrastructure like toilets, water supply, lifts, ramps, etc. In terms of process standards, availability of emergency services was looked into. Some aspects of process standards in term of information to patient, privacy, consent and grievance redressal also were looked into. The data on the human resources which constitute the important part of the structure component has already been discussed in earlier section.

Provision of Emergency Services

- 87% of the hospitals reported that they provided some form of emergency- medical/surgical/accidental care. However 50% of the hospitals were not providing round the clock services. Thus, highlighting the contradiction in reporting.

- The most commonly provided emergency services were accidental and surgical emergencies. (62 %)

- Forty-nine percent (130) of the hospitals had staff trained to deal with emergency situations and most of them were trained in-house.

- Only one hospital with 21-30 beds located in a developed district had staff trained for Cardio Pulmonary Resuscitation.

- Overall, it is evident that unqualified and untrained staff is entrusted with the job of providing emergency services.

Infrastructure and Facilities

It is important to look at the other infrastructure and services provided by the hospitals. Ideally, all the hospitals should follow the functional plan for their hospitals in terms of space for a separate record room, nursing station, treatment and dressing room, casualty/emergency room. This helps in better management of space and ensures the smooth working of the hospital. It also aids in providing quick services to the patient. The availability of infrastructure like operation theatre, ICU, ambulance and diagnostic services helps us analyze the variety of services available to patients under one roof.

- There was no functional plan followed by all the hospitals, whether they were from the developed districts or less developed districts. Astonishingly, the lowest among all was in Mumbai.

- Amongst the various facilities, we found that the availability of diagnostic services at hospitals like x-ray facilities and ultrasonography services was higher in the less developed regions as compared to other parts. Nine hospitals that had USG were unregistered under BNHRA.

- Only 5% of the hospitals reported having ambulance services.

- Facilities like refrigerator, telephone line, continuous water supply and toilets were present in most of the hospitals irrespective of size and across the regions.

Violation of Patient's Rights

The Draft Rules under the BNHRA 2005 available on the Maharashtra Government web site, awaiting the approval of the Health Minister, include a section on the Standard Charter of Patients' Rights. In the following section, we have highlighted the current status of private hospitals with regard to some of these rights. These were available on <http://mahaarogya.gov.in/actsrules/nursing/BombayNursingHome.pdf> till January 2009.

Violation of Universal Guidelines for Prevention of HIV/AIDS

- 13% of hospitals indulge (d) in compulsory testing for HIV.

- 50% conduct HIV tests compulsorily for all operative patients and those seeking ANC.

- Hospitals reported taking consent as well as provision of pre- and post-test counselling.[9]

Information given to the Patient

- Only 37.2 %(97) of the hospitals provided information about the services available at the hospital. In most of the hospitals, it was done by para medical staff.

- One fourth of the hospitals do not give IPD papers even on request, and half of them do not give OPD papers.

- About 9% did not give discharge papers.

- One fourth of the hospitals did not maintain a file for the patients.

Information on Medical Records

Maintain Records at Hospitals	Frequency	Percentage	Less developed developed	Developed developed	Mumbai
OPD Paper	214	82.0%	30 (96.8%)	146 (78.9%)	38 (84.4%)
IPD Paper	246	94.3%	31 (100.0%)	173 (93.5%)	42 (93.3%)
Investigation Reports	194	74.3%	29 (93.5%)	125 (67.6%)	40 (88.9%)
Discharge Papers	197	75.5%	27 (87.1%)	130 (70.3%)	40 (88.9%)
Bill of every Patient	173	66.3%	20 (64.5%)	116 (62.7%)	37 (82.2%)
File of each Patient	148	56.7%	24 (77.4%)	95 (51.4%)	29 (64.4%)
OT Records	205	78.5%	18 (58.1)	146 (78.9)	41 (91.1)
Anesthesia Records	182	69.7%	15 (48.4%)	130 (70.3%)	37 (82.2%)

Privacy and Confidentiality to the Patients

- Nine hospitals (3.4 %) reported that they did not provide any type of privacy and stated that that there was no need to provide the same.

- About 6.1% (16) of the hospitals did not have any female present during the examination of female patients by male doctors.

Maintenance of Medical Records

There are certain records which are essential for the patient as well as the doctors and the hospitals should share this information with the patient. The Table above summarizes the information about the records that hospitals maintained. The hospitals in the developed districts fare poorly on this account.

Redress of Grievances in Hospitals

- Nearly 61.7% (161) of the hospitals reported that they had some grievance handling mechanism.

- Fifteen hospitals had a designated person to look into the grievances of patients and these were larger sized hospitals.

- About 80% (130) of the grievance handling mechanism was in the form of complaints registered with the doctor. There was no independent mechanism for handling grievances against the owner-doctor.

4. BNHRA: Law for Regulation or for Mere Registration?

The BNHRA is one of the first laws that seeks to register nursing homes. As mentioned already, it was enacted in 1949 for the registration of nursing homes in Mumbai. However, it was not implemented by the Municipal Corporation of Mumbai for several years till a petition was filed in the Bombay High Court against the Bombay Municipal Corporation (BMC) for non-implementation of this law. The Court's directives pushed the BMC to set in the mechanism to register private hospitals. This law was amended in 2005 and made applicable to the entire state of Maharashtra.

The current study was conducted by CEHAT in 2007, two years after the amendment. The following section presents the compliance of hospitals registered under the law to minimum norms as mandated. For this, a comparison between the private hospitals registered (75%) and those not registered (25%) was drawn with regard to minimum requirements such as registration and display of registration, requirements of human resources and maintenance of birth and death records. In addition to these minimum requirements, there has also been a comparative study between registered and non-registered hospitals with regard to other parameters.

5. Non-Attainment of Minimum Requirements under the BNHRA

Display of Registration Number

Only 21.4% of the registered hospitals displayed their registration number.

Human Resources

Registration of the hospital does not ensure that the medical staff will be qualified and in proportion to the number of beds in the hospitals.

- The probability of having a qualified resident doctor in a hospital was 50%, whether a hospital is registered or not registered.

- Nearly 41% of the nurses recruited in registered facilities were qualified nurses. On the other hand, a large number (71.7%) of the nurses recruited in unregistered hospitals were trained nurses.

- Untrained nurses were present in registered as well as unregistered hospitals and form 10% of each.

- Of the 146 hospitals providing maternity services, 11 had midwives.

Registration and Maintenance of Birth and Death Records

In terms of maintenance of records, no difference was found between the hospitals that were registered and those not registered. The registration of facilities did not guarantee proper maintenance of records.

It can be concluded that registered facilities failed to adhere to even minimum requirements under the law. It is obvious that the registration was/ is seen as mere paperwork. In place of registration under Shops and Establishments Act, hospitals are now registered under BNHRA! The fact that even these minimum requirements had/have not been attained by hospitals calls for better scrutiny of papers at the time of registration better monitoring of these hospitals post registration.

DISCUSSION

- ***Rapid Growth of Private Hospitals with less than 30 beds***

The study captures the rapid growth of private hospitals in the state of Maharashtra across all regions, both developed and developed districts. We found that 50 % of the hospitals in the sample were established during the last decade. This is the period which also witnessed a rise in the corporate hospitals in the state. It indicates that the viability of hospitals with 0-30 beds and demand for the same was not affected by the entry of bigger hospitals. In fact, it shows a positive growth across all regions in the state. These hospitals were dominated by the allopathic system of medicine and maternity services. The entrepreneurs in the private health sector were doctors in contrast to corporate hospitals which were owned by business houses/MNCs. We found that most of the private hospitals were run and owned by doctors themselves. This was in contrast to the earlier trend where hospitals were housed in rented premises. This shows that this is/was a profit making venture for doctors who largely belong(ed) to the higher class and are/were able to invest private capital in setting up such enterprises. The easy access and choices available for taking loans too had/has made it easier for individual doctors to set up their own hospitals and support entrepreneurship.

- ***Standards of Care***

The physical infrastructure in the hospitals with 0-30 beds, in terms of basic facilities such as electricity, ventilation, water supply and so on may have increased over the years, but private hospitals fall short of specific services that are critical indicators of quality like emergency services, maintaining patients' records, mechanism to redress grievances and following other regulations like BMW or Universal Guidelines for HIV/AIDS prevention. A functional plan that ensures demarcated space for essential services was found to be present in large hospitals and those located in developed districts. Doctors were/are indulging in multiple facility practices whereby they are able to increase their earning capacity even if it were at the cost of the patients' health.

- ***Inadequacy of Human Resources***

The data related to human resources in these hospitals suggests that there is an overall non- availability of qualified staff in private hospitals. It is alarming that the basic staff, doctors and qualified nurses are so poorly available across hospitals. Amongst these, the hospitals in developed regions and those that were large in size fare (d) better in terms of availability of human resources. Additional services such as laboratory and x-ray were/are being provided by untrained staff. It emerges that the shortage of qualified nursing staff is acute and there is a need to deliberate on the same. More than fifty percent of the nursing staff in these hospitals are/were trained in-house. In-house training essentially means on-the job training. Therefore, there is a need for the state, medical association, nursing association and hospital owners to focus on this and provide options for certified courses which are accredited and also look into the need for setting up of additional nursing colleges if necessary.

- ***Violation of Patients' Rights***

The study found gross violation of Patients' Rights. The hospitals did not provide emergency care, privacy, consent or information to patients. This showed the complete apathy of the medical profession to respecting patients' rights even while they had no qualms in demanding a law for their own protection. The findings related to the absence of an independent grievance redressal mechanism assume significance in the context of the ordinance passed by the GoM for the protection of doctors. This ordinance calls for all health establishments to set up a mechanism for responding to grievances/medical negligence/problems with management and to aid and advise the patient.

- ***BNHRA: Law for mere Registration without any Regulation***

The study brings out the poor attainment of basic minimum requirements of standards of care by small hospitals as compared to the draft BNHRA rules. It gives an idea about the gap that will have to be bridged when these draft rules are approved and become operational. The registration is obviously being seen as a mere formality and paper work. Neither the state

nor the doctors are taking this seriously. Mumbai is an excellent example to highlight the complete apathy on part of both parties towards adherence to any norms. Despite the fact that the law has been functional in Mumbai for over 60 years; the non-attainment to minimum requirements is inexcusable. The analysis further calls for a better monitoring of registered facilities and stringent penalties for non-compliance on an ongoing basis. The study brings forth the fact that the standards of care, including availability of infrastructure in hospitals and the adherence to minimum requirement under the law is determined by market rather the status of registration.

▪ *Awareness about BNHRA and Accreditation*

The study sought the opinions of hospital owners on the regulation of the private sector. Information was also collected on the awareness and understanding of the BNHRA amongst doctors and their perceptions towards self regulation. The study found that the awareness regarding BNHRA Act is 76.2% in the sample. The awareness about the BNHRA act is low in less developed regions. Almost 50% of the hospitals especially from the developed areas and bigger hospitals had no objection to the Act, whereas some smaller sized hospitals located in less developed areas were struggling with infrastructure problems, especially human resources. The awareness about accreditation was high in large hospitals and those located in Mumbai and developed districts similar to BNHRA. Hospitals located in less developed districts and those that were small in size expressed concern that costs would rise with self-regulation. There is need for training and orientation of the medical profession on law, ethics and regulations.

▪ *Bringing all Laws Governing Private Hospitals Under One Umbrella*

Private hospitals are governed by several laws: Medically Terminated Pregnancy (MTP), Pre-conception and Pre-natal Diagnostic Techniques (PCPNDT) Act, BMW, BNHRA, CPA , etc., and each of these are implemented by different departments of the state. In addition to these, private hospitals also need to conform to Universal Guidelines for Management of HIV/AIDS. We found that hospitals were violating many other laws in addition to not being registered under BNHRA which is compulsory now for all private hospitals. This rampant flouting of laws is because there is no department to monitor the functioning of private hospitals. All the committees formed for the implementation of various laws should be brought under one umbrella so that minimum standards are defined and there is better accountability

on the part of these hospitals.

RECOMMENDATIONS

1. Gross violation of patients' rights and serious non-compliance to minimum requirements under the law demands immediate attention from the state. The state must also set up grievance redressal mechanisms for patients' accessing private health services and also legalise Patients' Rights so that they are justiciable. The GoM's recent ordinance (March 2009) states that assault on doctors is a non-bailable offence and makes it mandatory for health facilities to set up mechanisms for the redress of patients' grievances. This caveat for setting up grievance redressal mechanisms recognizes that assaults on doctors can be prevented by ensuring better communication between the provider and the client. While assaults on doctors cannot be justified on any grounds, the reasons for such assaults lie solely in the poor quality of health services provided by private hospitals.

2. The problem of non-availability of qualified nurses needs to be debated. The genuine shortage of qualified nurses should be taken up and more nursing colleges should be instituted. In-house training of nurses which is rampant needs to be standardized through developing a systematic curriculum, and certification or accreditation of such courses.

3. The state must put in mechanisms for the implementation of the BNHRA and to monitor of the same. Mere registration has no influence on the standards of care and there is need for better monitoring of registered facilities and stringent penalties for non-compliance on an ongoing basis.

4. The minimum requirements itself require a massive overhauling as they are insufficient to ensure any standard of care to patients. There is a dire need for setting up a board consisting of various stakeholders to evolve minimum standards of care for private hospitals and also to enforce them.

5. The draft rules under the amended BNHRA 2005 submitted to the Government of Maharashtra in June 2006 have included both minimum standards of care as well as patients' rights. There is a crying need for the immediate implementation of these by the state.

6. Hospital owners should be trained in various laws and universal guidelines governing their sector.

Endnotes

[1]Private hospital for this study is defined as any hospital that is providing in-patient services and is less than 30 beds. In Maharashtra, all such hospitals are registered under the Bombay Nursing Home Registration Act (Amendment), 2005 which defines such institutions as a Nursing Home where

"the premises are used or intended to be used for the reception of persons suffering from any sickness, injury or infirmity and the providing of treatment and nursing for them and includes a maternity home …."

[2]*Baru, Privatization of Health Services:* A South Asian Perspective, EPW, October 18, 2003

[3]In India, there has been an increase in the number of private hospitals from a mere 14% hospitals in 1974 to 68% in 1995 (Baru 1998)

[4]NSSO rounds (60th and 52nd rounds)

[5]*Review of Health Care,* CEHAT, 2005

[6]*Bulletin of World Health Organisation.* "Private sector health care in developing countries needs better stewardship, researchers say," 23 April 2002.

[7]Nandraj, Duggal (1997), Muraleedharan (1999), Baru (1998).

[8]Qualified nurses were ANM or B.Sc

[9]Consent and counselling have no meaning when there is compulsory testing!

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Parliamentary Panel Slams Health Ministry for Hampering Vaccine PSU Revival

The Parliamentary Standing Committee on Health and Family Welfare has come down heavily on the Health Ministry for its delay in resuming the operations of the three closed public sector vaccine units and called for immediate revocation of the suspension of licenses.

The panel headed by Amar Singh, in its recent report, has not minced words in slamming the Ministry for its alleged attempt to create hurdles in reopening the three units – Central Research Institute (CRI), Kasauli; the Pasteur Institute of India (PII), Coonoor and the BCG Vaccine Laboratory, Chennai – which were closed in January 2008 on the grounds of non-compliance of Good Manufacturing Practice (GMP) norms.

"The sequence of events since the suspension of manufacturing licenses of the three units in January 2008 clearly establishes the fact that their revival is not envisaged by the Government in the near future. Rather, every attempt has been made to create hurdles so as to ensure that the process of making them GMP compliant continues for long and the manufacturing process of major vaccines of Universal Immunization Programme (UIP) at these age-old PSUs remains suspended," the report said, after going through an Action Taken Note (ATN) prepared on its earlier recommendation for resuming operations at these units at the earliest....

... "The Committee has also been informed that the first phase of the IVC project focusing on formulation facilities is expected to start in January 2010 and is to be completed in December 2012. The second phase of bulk production units is expected to start in September 2010 and to be completed in December 2012. The Committee can, therefore, only conclude that at least for the next three years, supply of vaccines as per the requirements of the entire country will be met mainly by the private sector. Not only this, the quantum of manufacturing of UIP vaccines like DPT (100 million doses), TT (200 million doses), BCG (100 million doses), Measles (100 million doses), Hepatitis B (40 million doses) and Pentavalent combination vaccines (100 million doses) establishes the fact that the fate of the existing PSUs is sealed," the report said.

"Committee's worst fears are confirmed by the assessment about the three units given by the Ministry. According to the Ministry, what these units are going to produce is to be determined by a vaccine policy, yet to be formulated by the Government. Secretary, Health Research has been requested to organize a discussion with all concerned. Only thereafter, the policy on what the three units should manufacture for ensuring vaccine safety would be developed. It has also been pointed out that the three units, given their heritage status have inherent capacity constraints to undergo the requisite modernization. Consequently, their product mix can never be as dynamic as envisaged in the case of IVC," it said.

"The Committee is deeply disturbed by the conflicting signals emerging from the Government's side on the status of the three existing vaccine -- producing PSUs. On the one hand it is being emphasized time and again at different fora that Government is determined for the revival of the three units and every effort is being made to ensure their becoming GMP compliant, on the other hand it is also being categorically pointed out that their fate is to be decided by a vaccine policy yet to be formulated and they can never equate with the proposed 'state of the art' IVC project," the report said.

Source: December 28, 2009. *Pharmabiz.com*

Perspective Paper on Health Financing

- Ravi Duggal[1]

The health financing strategy of any country is critical for the character and nature of the health system that evolves in that country. If we look at countries where citizens have universal access to healthcare then it is clearly evident that public finance is the predominant mode for provision of healthcare services. Thus in such countries between 45 to 80 percent of health expenditure is accounted for by publicly generated sources like taxes and social insurance. Examples of such countries include all OECD countries with the exception of USA. These include Canada, UK, Sweden, Germany, Japan, Australia and Italy, among others. A number of developing countries have also moved towards universal or near-universal access to healthcare for their population. These include Sri Lanka, Thailand, Malaysia, Brazil, Costa Rica, Cuba, Chile, Mexico, among others.[1]

When countries move closer towards universal access through predominantly public financing a very clear shift in out-of-pocket payments takes place – from being predominant they become insignificant. Mexico and Thailand are the most recent examples of this trajectory. Similarly, when countries reduce public financing for healthcare then OOPs (Out Of Pocket) increasingly accounts for a larger share and inequities start surfacing. Sri Lanka, because of a budgetary crunch is facing this kind of crisis and its predominantly tax financed system is under threat, especially so because World Bank is now coming with its classical prescriptions of the government limiting its role to primary care or selective care and allowing the private sector to take charge of the rest and that too in a scenario in Sri Lanka where the private sector has been very weak and unregulated and most of it is anyway government doctors doing legally permitted private practice. The Sri Lanka government has been resorting to giving fiscal incentives to private hospitals which are clearly inefficient, ineffective and inequitable amounting to not only subsidizing the high-income patients and private providers but also impacting resource availability to public hospitals.[2]

In contrast, most developing countries of Africa and Asia have levels of public financing which is less than 40% of total health expenditure and this constrains public financing in healthcare provision and puts a larger burden on households to pay directly for accessing healthcare most of the time. WHO has

estimated that 5.6 billion people, mostly the poor, across the world spend out-of-pocket for over half their healthcare needs and this is often financed through debt or sale of assets[3]. And this is also often one of the primary causes for poverty in such countries. Table 1 provides very clear evidence at the global level of the linkages between income, public financing of healthcare, level of health expenditure and health outcomes.

Table 1: Linkages between Income, level of Health Expenditure, Source of Health Financing and Health Outcomes

Issue	Low income	Middle income	High income
Public Health spending %	25	50	70
Per capita health expenditure $	10	100	2000
OOPs %	70	40	15
Social insurance %	1	20	30
Tax: GDP ratio %	15	25	35
U5Mortality/ 1000	126	45	7

Source: compiled from WHO 2007: *World Health Statistics 2007*, WHO, Geneva; TAX:GDP Ratios from World Bank 2006: *World Development Indicators*, World Bank, Washington DC.

While public financing is critical to healthcare access and equity, what Table 1 also tells us is that in order to have a reasonable level of public finance commitment to healthcare we also need adequate revenues accruing to the public exchequer. Thus tax: GDP ratios also become a critical element for public financing of healthcare. Again, most countries which have universal or near universal healthcare access have tax: GDP ratios which are above 30%, that is of the total income of that country the government is able to net in over 30% of it as tax revenues. The latter is critical for social sector expenditures because in most countries around 8 -10% of GDP goes towards what we call non-development expenditures like public administration, law and order, defense, governance structures, and so on. And most developing countries usually have a tax: GDP ratio of between 10-15%. Thus if 10% goes to non-development spending then what is left for social sectors is grossly inadequate. Thus if we have to meet the globally accepted norm of 5% GDP for health and 7% GDP for education then a tax: GDP ratio closer to 30% becomes critical.
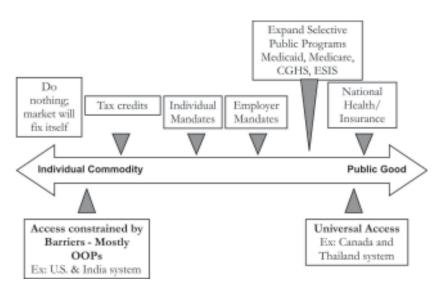
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[1]*Email: <rduggal57@gmail.com>*

However tax:GDP ratios are closely linked to the structural dynamics of the larger economy, and often political will with a strong social-democratic leaning is the underlying determinant for realizing reasonable levels of revenues for governance. Thus a sense of public good must prevail strongly within governance structures. Hence countries which have high tax:GDP ratios also have a social democratic character and therefore commit larger resources to the social sector or public goods and are able to achieve reasonable levels of equity in access to basic social and economic needs. The schematic in Figure 1 demonstrates the above political economy and its criticality for health financing, universal access and equity.

Figure 1: The Importance of Healthcare as a Public Good with Public Financing

Source: Adapted from American Medical Students Association, <www.amsa.org>

Thus what we conclude from the above is that a healthcare system which has universal access as its goal will emerge only when healthcare is recognized primarily as a public good and consequently receives the necessary resources from public sources.

The other problematic that confronts us in the understanding of health systems and financing is the provision of healthcare. This is an arena of conflict and debate with people taking strong sides in favour of the public or private sectors. The crux of the debate and conflict is that the supporters of private sector criticize the public system for its inefficiency, red-tape, callousness, and mindset and attitude problems. The supporters of public sector blame the private sector

as being exploitative and profit-oriented, unethical, and inducing unnecessary demand. Both are correct as well as wrong. Correct because the descriptors mentioned above are indeed quite common and wrong because if the public sector is inefficient then the contrary that the private sector is efficient may not be always true or if the private sector is exploitative that does not mean the public sector is not exploitative and so on. Most countries providing universal access have overcome these problems through organization of systems and regulation. That is the healthcare system is modeled around the financing strategy and the latter is used as the fulcrum to organize, regulate and control. Thus it does not matter whether the provider of services is from the public sector or from the private sector. The financing mechanism which is under public domain defines in detail the structure and nature of services needed and develops a payment or buying mechanism of those services which are regulated and audited. There is no fixed formula across countries. While we see that financing mechanisms tend to be very similar across countries – mostly a combination of two or three modalities, provision of services is much more varied with different kinds of a public private mix, mostly a consequence of their historical position. Thus, for example, when UK adopted the NHS, the hospital system was largely public-owned and hence hospitals under NHS are overwhelmingly in public sector. In contrast, ambulatory care was mostly in the private sector and hence the ambulatory care system under NHS devised a mechanism to contract in private providers through a capitation payment system. Similarly, when Canada adopted its Health Canada Act hospitals were equally owned by public and private sector and hence under Health Canada there are hospital providers both in public and private sector. The key here is that the healthcare system is organized, regulated and controlled through a financing mechanism which is managed publicly irrespective of whether services are provided privately or publicly.

If India has to move towards a universal access healthcare system it will have to adopt the above principles though its structures and mechanisms may be different. That is, India will have to organize,

restructure, regulate and control the healthcare system through a publicly mandated financing mechanism which would be some mix of a social insurance and tax based system, similar perhaps to Thailand's financing strategy. But given India's historical position the larger challenge would be the provision of healthcare, especially the reining in of the huge private sector in both ambulatory and hospital services. I say that this is a larger challenge because no country in the world which has achieved universal access to healthcare was in a historical position like India, that is having a completely dominating private health sector which is also completely unregulated and lacks ethics in practice.

So what are the options for India? Not an easy question to answer. India spends around Rs. 3000 per capita on healthcare which is around 6% of its GDP. Huge indeed, but of this only Rs.450 comes from the public exchequer or a mere 15%. Of the rest 96% is out-of-pocket and only about 4% is insurance. The 15% of the expenditure which goes to the public sector accounts for 15% ambulatory care and 55% hospital care and the 85% of private expenditure takes care of 85% ambulatory care and 45% of hospital care. The public sector is plagued with a severe human resource problem especially doctors and nurses as well as supplies and maintenance which has led to a virtual collapse of the public health system over the last decade and a half, though in the last 5 years the NRHM has put in substantial efforts to try and revive at least the rural public health system. Their efforts have not been very successful as the above said problems continue to plague the public health system[1] and somewhere the health financing strategy in the public sector is to blame because the demands at the unit level where care is delivered are not used as the basis of developing the financing framework but some age-old top-down mechanism which is not only ad hoc but bureaucratically suffocating.

In the urban areas while more resources are committed, especially for the hospital sector, the problems of human resources, supplies and maintenance are probably more severe because the numbers using the urban public health system are huge unlike the rural public health system which has very low levels of utilization. This shows that urban health systems, especially from the perspective of the poor have a large demand but it remains unfulfilled again because of a poor and inadequate financing strategy. Overcrowding in hospitals because of a lack of a robust primary care system in urban areas and consequently a lack of a referral system creates havoc with the urban

healthcare system rendering it ineffective and inefficient as well as financially unsound. Hospital systems are best served with a global budgeting strategy which implies that funds are allocated on the basis of effective costing of services which are translated into per bed cost for effective delivery of care and budget levels thus determined. This does not happen in India and hence the urban health care system in India fails to deliver despite its high level of utilization atleast in numbers.

Where the private health sector is concerned it functions completely on supply-induced demand which fuels unnecessary procedures, prescriptions, surgeries and referrals, leading to its characterization as an unethical and mal-practice oriented provisioning of healthcare. This has huge financial implications on households, inflating costs of healthcare, spiraling indebtedness and pauperization and being responsible for the largest OOPs anywhere in the world.

The challenges across the country differ due to different levels of development of the public and private health sectors in the states. For instance a state like Mizoram, a small and hilly state, already has an excellent primary healthcare system functioning with one PHC per 7000 population and one CHC per 50,000 population and since it has virtually no private health sector, the demand side pressures are huge and hence the public health system delivers. Each PHC has two to three doctors on campus available round the clock with 15-20 beds which are more or less fully occupied and 95% of deliveries happen in public institutions. So Mizoram has indeed realized the Bhore dream. The problem in Mizoram is that there are very few specialists available and hence higher levels of care become problematic – the CHCs are however run by MBBS doctors who have received some additional training. Mizoram does not have a medical college but it does have reservations in other state medical colleges. While the state cannot provide tertiary care it has a budget to send people elsewhere to seek such care. And Mizoram does this with 2.7% of its NSDP and has the best health outcomes in India. In some senses, Mizoram is like Sri Lanka – a statist model. There are few other states in India which can do a Mizoram because they too do not have a significant private health sector but to do that they have to demonstrate the political will of Mizoram.

Even though extremely successful Mizoram cannot be the national model because the reality across most other states is very different, the reality of an entrenched private health sector which is unethical

and unregulated. The private health sector has to be reined in and this can only happen with a strong political will which declares healthcare to be a public good and which takes on the private sector to get organized under public mandate. Under NRHM sporadic efforts towards this end are being undertaken in the name of public-private-partnerships like Chiranjeevi in Gujarat, Yeshasvani in Karnataka, Arogya Rakshak in AP, Rajiv Gandhi Hospital in Raichur (Karnataka Govt and Apollo Hospitals) etc.[2] They may have achieved limited success but then healthcare systems cannot be built by segmenting it into programs and one-off initiatives like PPPs. There have to be serious efforts at building a comprehensive healthcare system and it goes without saying that given India's political economy of healthcare the private sector will have to be a significant partner in this process. So states have to think beyond the Chiranjeevis and Yeshasvanis and learn from the recent experiences of Thailand, Mexico and Brazil to invest in an organized healthcare system and with booming economy resources will not be a constraint.

So the challenge is enormous demanding huge restructuring of the healthcare system in the country through strong regulatory mechanisms both for the public and private sectors, education of professionals in ethics of practice, pushing the politicians for creating a strong political will to make healthcare a public good as well as generate and commit adequate resources to realize universal access. The restructuring of the healthcare system and its financing strategy, given the price advantage of India and economies of scale it offers, will actually reduce nearly by half the healthcare spending in the country and reduce substantially the household burden to access healthcare. The calculations that I have done show that for universal access to healthcare across India we need less than 3% of GDP[3] provided we show the political will to shift healthcare from the domain of the market to the category of a public good. This will indeed do a lot of public good!

Endnotes

1 WHO 2007: *World Health Statistics 2007*, WHO, Geneva.

2 Ravi Rannan-Eliya and Ajantha Kalyanaratne, 2005: Fiscal Incentives for the Devlopment of Health Services in Sri Lanka, National Commission on Macroeconomics and Health – Sri Lanka, MoH, Govt. of Sri Lanka, Colombo.

3 WHO 2008: *World Health Report 2008 - Primary Health Care Now More Than Ever*, WHO, Geneva.

4 SATHI 2008: *Report of First Phase of Community Based Monitoring of Health Services under NRHM in Maharashtra*, SATHI, Pune. Such monitoring is happening across 10 states and all are reporting more or less similar results that show that NRHM on the ground is not sailing smoothly.

5 A Venkat Raman and James Warner Björkman 2008: *Public/ Private Partnerships in Healthcare in India,* Routledge, New York.

6 Ravi Duggal 2005: Financing the NRHM,   <http:// phm-india.org/
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Cervical Cancer Ad Campaign shifted to FM Radio after DCGI's Notice to GSK

An ad campaign advocating medical consultation and treatment for cervical cancer continues to be aired on FM channels in Mumbai. The campaign has avoided mentioning the two brands of cervical cancer vaccine marketed in the country by GlaxoSmithKline (GSK) and Merck.

GSK was recently pulled up by Drugs Controller General of India (DCGI) for carrying a major ad campaign in leading national dailies on the dangers of cervical cancer in young girls and women and its prevention. A show-cause notice was issued to GSK by DCGI and the company undertook the task of withdrawing its advertisements from the media.

After running the ads in several national newspapers for almost a month, the GSK had given an assurance to the DCGI that it is unilaterally withdrawing the ads.

 "I am not aware of the ads being aired on FM Radio by these companies after the show-cause notice. I had issued a show-cause notice against the GSK a few days ago and the company has been given 10 days time to provide an explanation. If they continue to promote advertisements, I will consider the next line of action," DCGI's Dr Surinder Singh said. Similar incidents have been taking place in India, and it would take some time to eliminate them all together, he added.

DCGI had issued a show-cause notice to the GSK last week for launching an advertisement blitzkrieg in the national media on cervical cancer vaccine without taking prior approval from the drug authorities.

The DCGI's notice asks the GSK to provide an explanation within 10 days for such the advertisement campaign, failing which the DCGI will proceed to take action against company. DCGI sources indicated that the action includes withdrawal of licenses issued to the GSK's cervical cancer vaccine Cervarix, which the company has launched in the Indian market recently.

According to the notice, GSK has violated Rule 106, Schedule J of the Drugs and Cosmetics Act, 1940 under which the drug company cannot advertise any drugs. Launching advertisements requires prior permission from the DCGI, and GSK was not given no such permission.

Source: December 31, 2009. *Pharmabiz.com*

Community Monitoring in NRHM:
Improving Public Accountability of the Health System

-S.Ramanathan, Renu Khanna and Rajani Ved[1]

I. Introduction

The National Rural Health Mission (NRHM) implemented since 2005 is intended to bring about fundamental changes in the delivery of health care in India. One of the key elements of NRHM is its emphasis on accountability. NRHM introduced the concept of "communitisation" – a process where the "community is …empowered to take leadership in health matters." The communitisation process is expected to usher in accountability. Accountability is perceived as a core of good governance, though, there are different views on the concept of accountability. One view of accountability is that it involves two processes – engagement and responsiveness.

In the NRHM, community monitoring is one the three prongs in the accountability framework. The communitisation process, in which community monitoring is a key element, is intended to place the community at the centre of health interventions.

II. Community Monitoring and Accountability

From 2007 to early 2009, NRHM supported a pilot initiative in community monitoring in nine states. The purpose of the pilot was to pool available expertise through active participation of civil society organisations, to steer the process of community monitoring and to garner lessons learnt to ensure a successful roll out across the country. The states in which the pilot was done were: Assam, Chattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu. In these nine states, the pilot phase was implemented in 36 districts. In each district, three

blocks each were chosen (108 blocks) and in each block, three PHCs were chosen (324 PHCs) and in each PHC, 5 villages were chosen (1620 villages). An evaluation of the pilot phase was undertaken in early 2009.

The evaluation showed that the pilot phase was effectively implemented for about 18 months. In this period, one cycle of monitoring could be done. While it was too early to assess the outcomes of the process, significant gains were seen. These were:

- Preparation of national and state level resource materials and their availability in the public domain.
- Formation of over 2000 Village Health and Sanitation Committees (VHSCs) in nine states.
- Preparation of report cards in all VHSCs.
- Organisation of Jan Samwads.

The gains reflected the commitment and passion of all stakeholders - GOI, State Governments, NGOs and communities. The crusader approach and the spirit of volunteerism were abundantly evident in the way community monitoring was implemented in the nine states. The review indicated that with the implementation of community monitoring, the promise of communitisation, articulated in the NRHM framework, was beginning to be fulfilled.

The review also showed that few states had already begun the process to include community monitoring in their State Project Implementation Plans (PIP) for the next year. Karnataka had committed Rs 25 crores for implementation of community monitoring in 2009-10. Maharashtra, Orissa, Rajasthan, and Tamil Nadu had also initiated steps for the inclusion of the community monitoring in the next year's plan.

Did the community monitoring lead to an engagement with and responsiveness of the health department?

Despite the short implementation time, the most significant gain from community monitoring was the active engagement between the community and

the health department. Community monitoring was beginning to enable the community to be in centre-stage and was making them a significant stakeholder in the management of the public health system. The VHSCs were giving a sense of identity and voice to the community, thereby leading to empowerment. The VHSCs and the various committees above the village level, reflected a significant social capital and the reviewers felt that they should be strengthened, nurtured and sustained to contribute to the communitisation process in NRHM.

There were gains from an equity perspective too. The process involved the excluded and the marginal groups. There was an affirmative approach to ensure that Dalits, Scheduled Tribes and women headed the VHSCs in some states. Community mobilisation, a key element of the community monitoring, led to increased knowledge about entitlements and rights in the community. It also enabled a better connect between the front line service providers and the community, and in some instances community members had begun to appreciate the constraints of the front line providers. There were instances where, the community had begun to address some of the constraints faced by the front line workers. The sharing of the report cards in villages, besides empowering the community paved the way for need based village-level planning. Importantly, the health department responded too – the Jan Samvaads or public hearings facilitated a significant degree of responsiveness by the health department.

To reiterate, the community monitoring began to initiate the process of ensuring accountability – engagement and responsiveness – in the health system in the country. It is important though to mention that there were variations across states and within states as well, depending on the propensity of the officials to accept the process.

III. Institutionalisation and Scaling Up

Community monitoring has enabled the beginning of an accountability mechanism in the health department. However, the experience reveals that in order to monitor, the community needs access to information (reliable and structured) on their entitlements, the status of service delivery and

organisational capacity to undertake the monitoring. The provision of information alone is not adequate unless people know how to use it.

There is also the danger of the elite capturing the monitoring process. To enable the facilitation and to prevent elite capture of the process there is need for a large number of committed and quality local facilitators. In the pilot phase, the crusader spirit of the civil society organisations enabled this. However, when the process is scaled up this may not be feasible.

One way could be to anchor this as a part of the larger communitisation effort of NRHM and within an existing arrangement in the health department. At present, there is no significant convergence with other communitisation processes (for example, the ASHA) and there is a need to build this in, especially when the process is scaled up. Involving Panchayati Raj Institutions (PRI) has been a challenge in the community monitoring process, particularly where capacity building of PRI has been weak. In order to scale up and ensure that the process is rooted in community structures, community monitoring requires strengthening of the PRI to demand accountability from the heath system. Also, to ensure that information management is not overwhelming for the community, the tools for community monitoring need to be simple and user friendly for the community. The process of monitoring should have an incremental approach – the issues to be monitored should be gradually increased to ensure that the capacity of the community is built and there is acceptance from the health department. The Jan Samwads should gradually become a community led process to enable engagement between the community and the health department and the responsiveness of the latter to the community.

The accountability process initiated by the community monitoring needs to be continued to enable a better health status of the people. The Government of India should support the process to ensure that it is scaled up in the pilot states and initiated in the remaining states.

India's Health Providers - Diverse Frontiers, Disparate Fortunes

- Kabir Sheikh and Asha George

Frontline health providers are caught at the core of the many contradictions which characterize India's diverse health sector and complex development profile. While India is at the forefront of global trends in medical tourism, rural areas remain dependent on informal health providers with no recognized training. The Indian government employs a vast network of health workers, but this system is dwarfed by a dominant and largely unregulated private sector. While policy efforts to regulate medical training and practice from the many health traditions move at a glacial pace, health providers react in varied ways to the contextual pressures that influence their government service and/or private practice. These contemporary dynamics are informative and emblematic of larger developmental processes, yet remain poorly explored and understood.

An Inchoate Body of Knowledge

What do we know about frontline health providers in India? Some issues relating to health providers are subject to much popular speculation and discussion. The availability of good health care, or lack thereof, is a matter of universal concern to all segments of society. The growth of the private medical sector, doctors' pursuit of commercial interests, quackery, apathy and corruption in government services, and complicity of doctors in organ theft and sex-selection are topics widely covered by the news, fuelling debate and opinions among all walks of life. Yet these representations remain only the tip of the iceberg, no more than the most visible fragment of the vast inchoate body of knowledge on the subject. Many areas are poorly explored or understood.

Note: This is an extract from the introductory chapter of the volume: Health Providers in India: On the Frontlines of Change, *edited by Kabir Sheikh and Asha George, and published by Routledge Books, New Delhi, forthcoming in 2010. The volume consists of twelve contributed chapters including essays and empirical research studies on different groups of frontline health providers (doctors, nurses, public health workers, counsellors, traditional practitioners and homecare providers), and a selection of poems by Gieve Patel. Authors who have contributed include Akhila Vasan, Anagha Pradhan, Asha George, Bharati Sharma, Bhargavi Davar, Darshan Shankar, Dileep Mavalankar, Jayashree Ramakrishna, John Porter, Kabir Sheikh, Karina Kielmann, Korrie de Koning, Kranti Vora, Lokesh Kumar, Madhura Lohokare, Paramita Chaudhuri, Pritpal Marjara, Rajendra Kale, Rama Baru, Renu Khanna, Risha Hess, Saswati Sinha, Sheela Rangan, Shilpa Karvande, Unnikrishnan PM, V Venkatesan and Vidula Purohit.*

Furthermore, much of the lay speculation around health providers is unsound. For instance, reducing the professional motivations of private doctors to pursuit of self-interest and money is at best an incomplete commentary, and at worst one that is not constructive. As Hess and colleagues relate in Chapter 5, private practitioners have the agency and ability to contribute to public health programmes, and well-informed collaborators can assist them in actualizing these public roles. When we dismiss traditional practices as quackery and fit for abolition, we neglect that traditional practitioners serve important social as well as medical functions in communities which have little access to qualified physicians.

Formal scholarship on the subject of Indian health providers is also limited. Analyses and commentaries tend to focus on problems of regulation and critique unethical practices in the private medical sector, while the policy literature, dominated by economists and development scientists, tends to view health providers as little more than resources or instruments to be manipulated in the fulfilment of policy objectives. Substantive writing on cadres of health workers other than doctors is particularly hard to come by. Traditional health practitioners is a neglected area altogether, save for a small body of writing by anthropologists. Commentaries on the health sector and systems tend to focus more on structural aspects, and not on the actors who comprise the systems.

Why is so little known, or at least so little published about the worlds of India's health providers, given the importance of the tasks they are entrusted with by society? Doctors in India alone total over a million, the population of a small country, and other groups of health providers match that number and more. Many questions can and should be asked about the individuals and communities that make up these numbers. What are the worlds that providers live in? What roles do they play and what drives them? How do they respond to change in policies, systems and societies? What relationships do they have with their patients and their peers? What personal and professional struggles do they face?

Original research and reasoned, well-contextualized analysis is needed to better understand the communities and individuals who embody our health sector. While scholars as Taylor (1976), Kirkpatrick (1979), Venkataratnam (1979), Madan (1980),

Chandani (1985), Jeffery (1988) and Rohde & Vishwanathan (1995) initiated sociological interest in understanding the worlds of Indian health providers, these landmark contributions are now several years out of date. Considering the immense transformations that have affected India's health sector since these publications, it is time for a volume to bring together reflections on the varied realities of the individuals who are at the forefront of health service delivery in India today.

This volume consists of twelve essays by a diverse group of contributors including health researchers, policy advocates, programme managers and a journalist, and poems by poet, artist and physician Gieve Patel. The contributions are based either on empirical research or on the authors' experiences of working with or as providers, and each presents a distinctive view of a particular group of health providers. The ideas and themes that emerge in the following pages provoke us to re-examine many preconceptions, and as such we hope that the volume will be a significant step in a more informed understanding of providers' roles as actors in the health systems and societies of contemporary India.

The Contributions

The issues that confront us when we think about the diverse world of health providers are multifarious and it was a daunting task to pre-determine topics for the volume. We chose to be guided by the contributions of our authors in selecting ideas and themes that were of relevance. Resultantly the volume embraces multiple perspectives and is interdisciplinary. Since each of these chapters is derived from field level experiences and interactions, the volume can be said to encapsulate a "grounded" perspective of concerns that emerge. Each chapter is a case study; hence the concentration of the volume is on depth, not breadth of enquiry. Important universal themes still connect the different chapters.

Among the foremost emerging themes was that of government health workers' experiences of negotiating their often unstable working environments. In the first chapter, George details the reflections of Rural Health Assistants on the challenges faced in providing primary health care in rural communities. In doing so she makes a persuasive case for viewing these workers in the social contexts that shape their actions. She details how health assistants perceive and negotiate gendered norms, curative hierarchies, market pressures and community scepticism with varying success. Despite their privileged positioning in rural economies, their

reflections reveal their vulnerabilities, forbearance and adjustments in carrying out vital yet poorly supported public health mandates.

Mavalankar and colleagues, in Chapter 2, add to the literature on Auxiliary Nurse Midwives (ANMs) by examining how the ANM's role has mutated over time from that of a midwife supporting childbirth, to that of a paramedical worker whose activities are limited to family planning, immunization and superficial antenatal care. They explore past shifts in policy and programmes and how this influenced the organizational context that ANMs work in, their training and career paths. As researchers concerned about India's maternal mortality and the need to ensure skilled attendance at birth, they conclude with reflections on more recent policy developments and their implications for strengthening the midwifery role of ANMs. Further research is required to examine more critically whether ANMs themselves see midwifery as central to their professional stature.

Vasan and Ramakrishna explore a revitalized profession – counselling. Counsellors have found renewed interest in their practice in recent years with the advent of the HIV epidemic, and the demand for counsellors to staff testing centres. Paradoxically, as they inhabit the world of HIV/AIDS which is built around a lexicon of rights and respect, these counsellors often work in contexts of discriminatory hierarchies and widespread inattention to employee and patient rights. The authors examine the counsellors' struggles to integrate into hospital environments, their negotiations with managements and the impact of a capricious policy environment, and underline the importance of ensuring counsellors' welfare for the success of future HIV/AIDS programmes.

In Part II of the volume, four chapters on medical practitioners bear on the tension between doctors' instincts to further their own interests or fulfil their traditional function of serving the public good. In the first of these chapters, Baru emphasizes the importance of situating the behaviour of providers within the broader context of structural changes in the national polity and society. She documents the erosion of the morale of doctors in a premier government hospital, which she contextualizes within a set of distal factors – the lack of political commitment to social welfare, the changing character of middle class India and private sector growth. She asserts that poor services in the government health sector need to be understood in the context of the devaluation of their contributions to society, a natural corollary

of a wholesale political shift to the right.

Presenting a converse picture of private sector enthusiasm for public health are Hess and colleagues (Chapter 5) who relate the experiences of Population Services International (PSI), a non-profit social franchising organization, in engaging private practitioners in a public health initiative. PSI's strategy for promoting evidence-based care for sexually transmitted infections involved close contact and attention to the practitioners' needs from the collaboration, strict quality control, and a practical approach to problem solving at field level. The programme reported qualified success in aligning doctors' practices with standardized norms, but many aspects of practice remained unchanged where they conflicted with local cultural norms and with doctors' primarily curative objectives. The need for stronger regulations in the private sector is still critical, caution the authors.

Sheikh and Porter take an empathetic view of everyday decision-making by doctors working in highly contingent environments in both government and private hospitals (Chapter 6). Using an issue case study (HIV testing), they microscopically delineate practitioners' mental maps or "appreciations" - bases for decisions in practice which balance their role-perceptions, pragmatic considerations and closely held beliefs. The practitioners are often well-intentioned, the authors observe, but work within distinct world-systems of meaning and purpose which do not always coincide with the rationales of established public health programmes. Through this lens the authors highlight the phenomenon of Indian doctors' intellectual seclusion, and suggest that conceptual gaps need to be bridged to allow doctors to better actualize their public roles.

Venkatesan draws our attention outside the clinic to the wider arena of political action. He documents a sequence of events in which sections of the medical community organized to agitate against the government's affirmative action policies, and highlights key elements which set this agitation apart from other social protest movements in the country (Chapter 6). The assurance with which parliamentary authority was challenged, the indulgent response of the judiciary and patent yet unquestioned caste biases in the framing of arguments by the agitators, underline the ideological power that elite doctors deploy in contemporary India, with troubling consequences for a democratic society.

Unlike Venkatesan's agitating doctors, Gieve Patel –

himself a doctor – doubts and questions medical dominance. In the first of his poems at the end of this volume, entitled "Public Hospital", Patel reflects on the ephemeral nature of the power that doctors appear to hold. The final poem, "The Multitude Comes to a Man" speaks profoundly about the unspoken bonds of trust that underlie the health care encounter.

The multitude sees its own power
Accumulate before
The healing man, and exchanges
Willingly power
For power.

Trust between provider and patient draws its strength from the magic of healing knowledge, yet is fragile in its susceptibility to abuse. It is this same undercurrent of trust that also runs through Lohokare and Davar's accounts of encounters between faith healers and their clients with mental health infirmities in small-town Maharashtra (Chapter 8). The accounts reveal a healing approach which is not dissimilar to contemporary psychotherapeutic approaches, but is couched in a language and context more accessible to the sufferers. In this, the third part of the book, two chapters (Lohokare and Davar; Unnikrishnan et al.) focus on traditional practitioners, and one on home-care providers (Karvande et al.). These providers are distinguished by their closeness to people and communities most in need of health care, yet lie on the peripheries of our consciousness. Rich local traditions of health are facing extinction and in this process of erosion, opportunities are lost to bridge the divide between household / local healing cultures and formal medical science. The struggle for legitimacy and acceptance is an important part of these providers' existence.

Even as debates around marginalized *populations* have found their place in public health discourse, the positions and contributions of these subaltern groups of *providers* remain widely unaddressed. Many of these subgroups of health providers are poorly researched, and indeed their presence, in many instances, has not been adequately quantified. Attempts at quantification are often problematic - marginal groups of health providers blur our perceptions of the scale of the health sector, of what is public and private care provision and indeed of the very nature of health care provision - one reason why we do not commence this volume with a conventional delineation of India's health sector in numerical terms of demographic composition.

The chapters on traditional providers in this volume contribute two-fold – in documenting the scale and profile of these sectors, and in highlighting their importance to communities through the common languages and values that they share. Unnikrishnan and colleagues' analysis of the demographic profile of traditional orthopaedic practitioners in two South Indian states reveals the gradual decline of a transgenerational tradition. These practitioners' futures are balanced precariously between two important but often conflicting policy agendas – promotion of traditional practices, and better regulation of health care quality. Karvande and colleagues (Chapter 10) narrate four stories about people living with HIV/AIDS and their family care givers. From these complex human narratives of loss, familial compassion and the struggle for survival important lessons for policy materialize. In India much of care for the sick is provided by families, yet their caring role and the internal dynamics between individuals who constitute family structures and relations is hardly acknowledged. Mechanisms to support the neediest families fail to recognise the heterogenous needs of individuals within families and are largely inaccessible to them.

Finally we look at the question of personal experience – the grey zone where individuality overlaps with the performance of professional roles. Sexual harassment is among the most adverse of personal experiences in the workplace. Chaudhuri analyses the experience of women who were subjected to sexual harassment in the public and private hospitals they worked in, the mechanisms they adopted to cope, and the role of administrators and co-workers in addressing the issue. Despite the ways in which sexual harassment is normalised and the challenges in reporting the problem, colleagues are not necessarily apathetic to the problem. The views and nuances that emerge provide insights for more effective implementation of the Supreme Court guidelines on sexual harassment in the health sector and also in other workplace contexts.

Pradhan et al tell the story of the efforts of a NGO to train male Multi-Purpose Workers in gender sensitive practices, and the processes of realization and change encountered by both sets of actors – trainers and trainees (Chapter 12). The interventions kick-started a process wherein health workers began reflecting on how gender norms are systemically ingrained, how their masculinities are constructed and on the effects of gender issues on reproductive and sexual health. In the exchange, trainers also became aware of the vulnerabilities of male health workers, in the context of increasing workloads and a lack of investment in their development. The appreciation and trust that evolved helped to support a cadre, often seen problematically, into valued human beings and agents of positive change.

Gieve Patel's poems conclude the contributions in this volume. The poetic medium is most suited to capture the depth of the personal experience of being a health care provider. Patel reflects variously on the transience of power, on the strength of the sick and on the violence of medical intervention. The poems speak of the pain of witnessing human suffering and the doubts that beset a thinking practitioner, but through each one also runs a subtext of dynamism and possibility. It is this possibility, of colluding in the achievement of good health, that sustains and inspires health providers in their working lives.

Charting Frontiers and Fortunes

In enacting their roles as healers and carers, and in seeking personal fulfilment and professional success, Indian health providers face encumbrances and obstacles from many quarters. Career and educational opportunities are often narrow, competitive and increasingly uncertain. Professional livelihoods and self-confidence at times conflict with the rapid changes that are coursing through economies and health systems. Reforms are not always designed with frontline providers in mind, adding to their frustration and disillusionment. Within this background there are many deterrents to positive action, from the vicissitudes of unregulated markets to fossilised bureaucracies and prejudiced public perceptions, each distorting the processes particular to health care provision. In their complex, changing environments health providers can take little for granted. They struggle simultaneously on many frontiers – social, systemic, and internal – and each step they take must be negotiated carefully. The chapters in the volume record some of their varied and difficult journeys in traversing these different frontiers. As members of a work-force engaged in a critical developmental activity, health providers' travails reflect those of the youthful country they inhabit, and as such this volume is also a document of the growth pangs of India's development.

The social dimension is an important but often hidden factor shaping providers' worlds. Gender emerges as an important theme across several chapters (George, Pradhan et al., Chaudhuri), but elements of other intersecting social characteristics, namely class and caste, and their implications for professional life are

also examined by Baru and Venkatesan. The stories of indigent families, neglected by health planners in their struggles to care for their sick, exemplify the fundamental social inequities that beset the country (Karvande et al.).

Formal health systems and structures support providers in performing their functions, but too often they are also found to be resistant to innovation and unsupportive of those in their lower echelons (Vasan and Ramakrishna, George, Sheikh and Porter). For groups such as traditional health providers, the rules of the mainstream health sector may be little more than instruments of exclusion and discrimination (Lohokare and Davar, Unnikrishnan et al.). Uncontrolled health care markets and their irregularities affect not just private practitioners but also government health workers and practitioners, striving to maintain respect and standing among their clientele (George, Baru).

The challenges confronting medical practitioners' differ qualitatively from other categories of health providers. Paradoxically, their elite status and ability to resist authority also serve to isolate and distance them from new ideas and from broader processes of social change and development (Venkatesan, Sheikh and Porter). For doctors, even as they resist the limited external challenges to their dominance, the true frontiers lie within. Doctors and the collective medical fraternity must introspect, reach out beyond the insular boundaries of their profession, and reinvent themselves if they are to regain the respect they once had in society.

We hope that this book will serve as a resource and assist those engaged in health policy-making and planning, in India and globally, to be better informed by perspectives from the street, the clinic and the home - where health care encounters are enacted, and which form the settings for the twelve chapters which follow. We aim to promote an approach to policy-planning which is grounded in field level processes and on prevailing realities of societies, organizations and markets. We are also invested in advancing a nuanced understanding of providers' roles in health systems and in society, not just as instruments but also as instigators of change. Finally, we hope that the book may facilitate a revitalized understanding of, and focus on health providers as a distinct subject of sociological enquiry. We are optimistic that the volume will contribute to a renewed appreciation of this ancient and essentially human occupation and its protagonists – health providers – in the diverse contexts that make up the reality of modern India.

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Doctors Can't Endorse Drugs, MCI Introduces New Code

PTI 1 January 2010

NEW DELHI: Endorsing or participating in private studies on efficacy of drugs and accepting any kind of hospitality from pharma companies might be a thing of the past for doctors with the Medical Council of India coming out with a fresh code of conduct for medical practitioners.

The MCI via amendment to the "Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulation 2002", has brought out the code of conduct which includes not accepting any gifts or travel facility from any pharmaceutical company or the health care industry.

According to the new rules, a medical practitioner may carry out, participate in or work in research projects funded by pharmaceutical and allied health care industries, but has to ensure that the particular project has due permission from the competent authorities.

He also has to ensure that the research project gets clearance from an institutional ethics body.

Making the Case for Community Health Insurance

- Denny John[1]

1. Introduction

The current healthcare delivery system in India is more skewed towards private healthcare utilization. Studies[1,2] on utilization patterns and household health expenditures in India show that 50% of people seek inpatient care and around 60% to 70% of those seeking out-patient care go to private health facilities. This has also been exacerbated by the fact of dwindling public health expenditures[3] by various governments from 1.2 % of GDP in 1986 to 0.9% in 2001, resulting in inadequate and poorly functioning public health facilities. A recent World Bank[4] (2001) study on India concludes that out-of-pocket medical costs (estimated to be more than 80% of the total medical expenditure) alone may push 2.2% of the population below the poverty line each year. Although attempts have been made by government in terms of health financing coverage in terms of ESIS, CGHS, UHI Scheme etc, these have failed to cover the vast number of populations. It is mainly due to the reason that schemes such as ESIS, CGHS etc are for formal employment sector whereas 70% of India's employed are in the informal sector, thus keeping them out of any "safety net" mechanism. Social security schemes such as UHI Scheme have failed due to lack of awareness about the scheme among the poor, inadequate social marketing efforts and its usage through reimbursement rather than "cashless" transactions.

Table 1: Household Expenditure on Health Care Services

Type of payment by household	Expenditure (in Rs 000)	% Distbn.
(1) Out of pocket payments for healthcare	748,783,126	98.4
(2) Health Insurance Premiums		
CGHS	417,588	0.1
ESIC	5,442,614	0.7
GIC Companies	5,358,800	0.7
Private Insurance Companies	31,837	0.0
Total (2)	11,250,839	1.5
(3) Donations in kind to NGOs	905,142	0.1
Grand Total (1)+(2)+(3)	760,939,107	100.0
Ref: NHA Accounts 2001-02[5]		

[1]*The author is Faculty, Institute of Public Health, Bengaluru. This paper was earlier presented at Insurance Summit 2007, Mumbai.*

1.1   *Household Expenditure on Health Care Services:* The total expenditure incurred by households on health care activities is Rs 760,939 million[5]. Out of this 98 percent is out of pocket expenditure on health services. This includes household payment made for utilizing health care services delivered by government, private sector and NGOs (See Table 1).

2. Need for Equitable Health Systems

In public health finance, equity is usually defined in terms of the ratio of payments to income.[6] Equity in health care has also been conceived in terms of access, finance, expenditure, and outcomes, and additionally one can find reference to a distinction between horizontal and vertical equity. (See Table 2 below)

Horizontal equity generally refers to the distribution of costs and benefits across groups of similar socioeconomic or health status; vertical equity refers to the distribution of costs and benefits across groups of differing status. The underlying assumptions are that unequal health outcomes are unjust, that health services should be provided (or guaranteed) socially, and that distribution of costs and benefits should somehow be related to health and wealth status. Health insurance, whether public or private, for-profit or community-based (definition cited elsewhere in this paper), must strike a balance between economic efficiency and equity.

3. The Main Issues in Health Insurance in India

3.1 *Barriers to entry into the market of insurance:* In the early 1990s, the Indian government established the Insurance Regulatory and Development Authority (IRDA), which has been responsible for developing the framework for de-monopolization of the insurance market. One of the severe barriers to entry into this market is the requirement to deposit Rs. 100 Crore as a precondition for being granted an insurance license.[8] Not only is this amount out of reach for smaller insurers, but as this deposit does not bear a return, insurers must compensate for this lost yield by raising insurance premiums.

3.2. *Insufficient pooling of healthcare expenditure*: According to WHO figures[9] (2002 data), total health expenditures represent 6.1% of India's GDP, but most of this amount, representing 4.8% of GDP is the share of private expenditures and only 1.3% of GDP is public expenditure. Of the 4.8% private expenditure, 98.5% are Out-of-Pocket-Spending of users (OOPS). In other words, 77.5% of total expenditure for

Table 2: Definition of Equity in Health Policy

		Concept of equity	
		Horizontal	Vertical
Dimensions of equity	Access	All those with similar needs have similar access to services	Those with greater need have access to more or more intensive care
	Finance	Those in equal socioeconomic positions pay the same for care	Wealthier households pay more than poorer households
	Expenditure	Those in equal socioeconomic positions, or those in similar health receive the same value of publicly-funded services	Poorer households, and households with more illness, receive more than wealthier and healthier households
	Outcomes	All households experience similar health outcomes, regardless of socioeconomic status	

Source: Lundberg and Wang, 2005, pg 4.[7]

healthcare costs must be paid by single individuals or households[10, 11] and this huge flow of funds does not pass through any pooling mechanism. Without health insurance, and under the existing paradigm of (i) a very low share of public expenditure, and (ii) a very high share of unpooled expenditure, poor households are exposed to risk of impoverishment due to the cost of healthcare, and enjoy low access to healthcare due to its high cost. The same devastating effect occurs also in households that do not face a catastrophic hospitalization but must bear the aggregate cost of multiple episodes of less severe illnesses. Health insurance is therefore an urgent anti-poverty measure.

3.3. Limited possibilities to buy health insurance: Of those who do have health insurance in India at present, many (if not most) are covered by employer-sponsored schemes. These insurance products are designed for those with a steady and relatively high income, namely mainly men in formal employment in large urban areas. People wishing to buy health insurance as individuals (outside the framework of group policies) may encounter difficulties in doing so. These difficulties are virtually insurmountable in rural areas, or if the insurance product should be very cheap, both because the pure risk premiums are high and because there is insufficient pressure to reduce the administrative costs.

3.4. Administrative loading to fees: Some insurers use the services of intermediaries (TPAs), whose role is to administer claims and maintain business books. TPAs and other intermediaries do not influence the cost of underwriting the pure risk, but they add to the cost of premiums due to the higher transaction costs. These transaction costs are generated by search and information costs, negotiation and decision costs, monitoring and implementation costs on the market side, as well as increasing transaction costs inside the insurance company due to growing size and complexity[12] . It is claimed that the role of TPAs increases because they can operate for-profit activities, whereas health insurers are supposed to be not-for-profit. However, the fees of TPAs increase the administrative cost of the insurance, which translates to higher premiums. Higher premiums reduce the likelihood that poorer people would be willing or able to buy health insurance from commercial insurers. One can thus conclude that the present methods of administering insurance business interfere with extension of coverage to poor segments of the population.

3.5. Insufficient supply of medical services: On the service delivery side, it is self evident that health insurance can be attractive only if the insured can access sufficient supply of good quality healthcare services. In India, most of the medical facilities are located in urban areas, and therefore the urban population has a better option to access good healthcare providers. This is all the more important since there is almost no regulatory control of the quality of care provided by medical providers. Insurers are also not very active in ensuring the quality of care that the insured can get; in fact, there is relatively little information on links between providers of care and providers of insurance (the "managed care" model). Mediclaim, which offers mainly an indemnity product, has been criticized that its benefit package was not comprehensive enough, and that it was responsible for undue delays in claim settlements. In summary, health insurance is for the time being mainly sold in urban areas where there is ample supply of healthcare services. People living in rural areas have a more

restricted choice, and often may be required to co-pay part of the cost even if they are insured. Therefore, poorer people, women, and those living further away from urban centers are much less likely to be interested in commercial health insurance.

4. Community Health Insurance (CHI)

CHI[13] can be defined as "any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management." CHI schemes involve prepayment and the pooling of resources to cover the costs of health-related events. They are generally targeted at low-income populations, and they cover a diverse group of communities such as: people living in the same town or district, to members of a work cooperative or micro-finance groups. Most often, the schemes are initiated by a hospital, and targeted at surrounding populations in the area. As opposed to social health insurance, membership is almost always voluntary rather than mandatory.

4.1 Estimates of coverage by community health insurance in India

According to ILO[14], there are 40 documented CHI schemes working mostly among the poor in the country; predominantly based in rural or semi-urban areas with about 10 million individuals as target population, of which many were insured (this has risen to 115 schemes covering more than 12 million population as per current ILO estimates, although no official figures are available yet.) These population ranges from tribal population (ACCORD, Karuna Trust and RAHA), dalits (Navsarjan Trust), farmers (MGIMS, Yeshaswini, Buldhana, VHS), women from self-help groups (BAIF, DHAN) and poor self-employed women (SEWA).
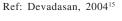
4.2 Organization Structure of these CHI schemes

In India, depending on the insurer (see Figure 1), there appears to be 3 types of organization structures of these CHI schemes. In Type I (or HMO type), the hospital provides both the healthcare delivery and provision of insurance programme. In Type II (or Mutual type) the voluntary organization or NGO is the insurer, and they in turn purchase healthcare from the providers. In Type III (or Intermediate type), the voluntary organization or NGO acts as an agent, purchasing healthcare from providers, and insurance from insurance companies. All the 4 GIC Companies and few private companies such as Royal Sundaram and ICIC Lombard are involved in these CHI programmes.
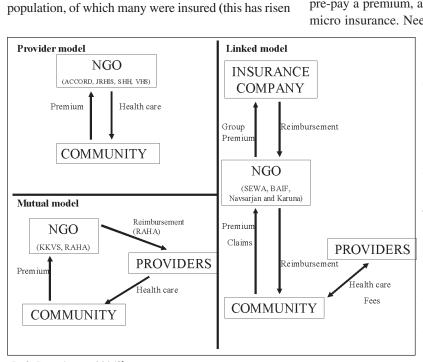
4.3 Relative advantages of the CHI schemes

4.3.1 *Revenue collection and generation*: They are community-based and are able to mobilize social interactions and social relationships to introduce a pre-payment scheme. People who join the scheme must pre-pay a premium, and this generates income for the micro insurance. Needless to say, those who pay the premium trust that the 'insurer' will be around to meet its part of the deal when the time comes. The community is less likely to disappear than an agent of a commercial insurance located far away. Hence the ability of community-based schemes to raise funds where others fail to do so.

4.3.2 Prioritizing local needs: Most of the CHI programmes started as a reaction to increase household health expenditure and government failure in provision of quality health care.[16] As most of these programmes are addressed to the poor; the premiums have been kept low. The providers are

Ref: Devadasan, 2004[15]

mostly private-both profit and non-profit depending on the provision of these; only one scheme i.e. Karuna Trust utilized the government health facilities.

4.3.3 Increase utilization and "for all": Evidence[17, 18] suggests that micro health insurance units are effective in increasing utilization of insured members and that they perform very well in terms of equality of access among members of micro insurance .

4.3.4 Overcome (or reduce) market failure: Insurance market failure arises from adverse selection and moral hazard. One of the most powerful features of small communities is the free-and-frequent flow of information about people. This prevents single individuals from hiding their ailments, so there are less chances of information asymmetry, and much less likelihood of adverse selection. Also since the community will make efforts to keep the premium low with adequate health coverage, thus reducing the aspect of market failure usually associated with commercial health insurance.

4.4 Relative disadvantages of CHI schemes

4.4.1 Limited local capacity: Most of the CHI schemes have been started by local NGOs as part of the health programmes. These health programmes being done at local levels the CHI schemes also tend to be of the same size in terms of coverage of geographical area.

4.4.2 Small group size: As per Devadasan & Nandraj[19] (2006), the membership to these CHI schemes vary from 1000+ to 2 million. Health insurance operates on the "law of large numbers" to spread the risk over a wider population. The small group size in these CHI schemes prevent also minimize the impact of "economies of scale" which is needed to keep the premiums low while still providing adequate health coverage.

4.4.3 Lack of reinsurance facility: This could offer the required financial and technical assistance to the CHI schemes.

4.4.4 Coping with high-cost events: Certain chronic conditions or diseases; such as HIV/AIDS put an internal pressure on the CHI schemes in terms of healthcare cost, which due to low premiums and small group size the CHI scheme is unable to bear.

Conclusion

In recent years, community health insurance (CHI) has emerged as a possible means of: (1) improving access to health care among the poor; and (2) protecting the poor from indebtedness and impoverishment resulting from medical expenditures. The World Health Report 2000[20], for example, noted that prepayment schemes represent the most effective way to protect people from the costs of health care, and called for investigation into mechanisms to bring the poor into such schemes. Based on various evidence available in the field of CHI schemes in India, and in other developing countries, and extensive theoretical evidence, it could be recommended that CHI is a justified and cost-effective method to mitigate burden of healthcare expenditure on poor populations and improve their access to quality healthcare institutions. What is needed for government, health policy planners, insurance companies and other players in its delivery is a four-fold strategy as stated below:

a) Implementation of adequate accreditation mechanisms for healthcare providers at all levels of care (primary, secondary and tertiary) to ensure delivery of quality health services

b) Support to the existing CHI schemes and NGOs willing to start new CHI schemes through adequate training, capacity building and provision of professionals to ensure sustainability and up-scaling of these schemes.

c) The government should focus on initiating social reinsurance (Social Re) schemes which will transfer the risk of these CHI schemes in case of high claim payouts or during disasters.

d) Subsidies to be targeted to poor populations in payments of premium by government and corporate bodies minimizing the premium-cost burden on these communities.

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Document Extract

From the Minutes of Medical Council of India Executive Committee Meeting held on 17th Nov., 2009.
Code of conduct for doctors and professional association of doctors in their relationship with pharmaceutical and allied health sector industry.

... In dealing with Pharmaceutical and allied health sector industry, a doctor and professional associations of doctors shall follow the code of conduct given below:-

1. Gifts : A doctor shall not receive any gift from any pharmaceutical or allied health care industry and their sales people or representatives.

2. Travel facilities: A doctor shall not accept any travel facility inside the country or outside, including rail, air, ship , cruise tickets, paid vacations etc. from any pharmaceutical or allied healthcare industry or their representatives for self and family members for vacation or for attending conferences, seminars, workshops, CME programme etc either as a delegate.

3. Hospitality: A doctor shall not accept individually any hospitality like hotel accommodation for self and family members under any pretext.

4. Cash or monetary grants: A doctor shall not receive any cash or monetary grants from any pharmaceutical and allied healthcare industry for individual purpose on individual capacity under any pretext. Funding for medical research, study etc. can only be received through approved institutions by modalities laid down by law in a

transparent manner. It shall always be fully disclosed.

5. Medical Research: A doctor may carry out, participate in, work in research projects funded by pharmaceutical and allied healthcare industries. But in accepting such a position a doctor shall :

(i) Ensure beyond all reasonable doubts that the particular research proposal has the due permission from competent legal authorities.

(ii) Ensure that such a research project has the clearance

of national / state /institutional ethics committees / bodies.

(iii) Ensure that it fulfils all the legal requirements prescribed for medical research.

(iv) Ensure that the source and amount of funding is publically disclosed in the beginning.

(v) Ensure that proper care and facilities are provided to human voluntaries, if they are necessary for the research project.

(vi) Ensure that undue animal experimentations are not done and when these are necessary they are done in a scientific and a humane way.

(vii) Ensure that while accepting such an assignment the doctor shall have the freedom to publish the results of the research in the greater interest of the society by inserting such a clause in the MoU.

(viii) The doctor shall realize that unless point (i) to (vii) are fulfilled the research project funded by industry would be entirely legal and ethical.

6. Maintaining Professional Autonomy: In dealing with pharmaceutical and allied healthcare industry a doctor shall always ensure that his / her professional autonomy and freedom is never compromised.

7. Affiliation: A doctor may work for pharmaceutical and allied healthcare industries in advisory capacities, as consultants, as researchers, as treating doctors or in any other professional capacity. In doing so, a doctor shall always:

(i) Ensure that his professional integrity and freedom are maintained.

Questions for Discussion

These three sets are meant for 3 separate major sessions/sub themes of the mfc Annual Meet Jan. 8-9, 2010.

I. Financial Barriers to 'Health Care for All'

- Anant Phadke

Government Funding for Health Care

1. What is the relative proportion of various sources of health-care financing in India - Central, State and local governments, public sector institutions, private as well as public firms, NGOs and households themselves? Why public financing has been so grossly inadequate? Compared to other countries is the Indian govt. spending a much lower proportion of its revenues on health-care or is it the case that the govt.'s revenues themselves are very low due to lower tax-GDP ratio or a combination of both?

2. Is the low tax-GDP ratio due to a larger proportion of unorganised, poor agricultural sector or due to effectively low taxation on the rich due to huge tax-concessions, loop-holes or a combination of both? What are taxation rates in other comparable developing countries and developed countries?

3. What is the extent of inequities in health-care financing in public Health?- urban-rural divide, neglect of vulnerable sections, for example, psychiatric illness, women's reproductive (as distinct from maternal) health; neglect of sickle cell anaemia affecting the tribal people etc., etc.?

4. In India, expenditure on medicines accounts for max. 50% of health care expenditure, in the private sector. In the Public Health Facilities, why the budget for medicines as proportion of expenditure for curative/ symptomatic care has been so low? (The govt. accounts for only 2000 crores out of 30,000 crore market of medicines in India).

5. What are the other barriers in increasing the public funding for health-care in India? The contradiction between state governments being the major funders because health-care is a state subject versus the fact that state governments have very little powers for taxation.

6. Any specific suggestions for fund mobilization for health care? Increased taxation on alcohol, tobacco? "Health cess" like the "education cess"? What are the political, ethical implications of this kind of fund-mobilization for health care?

7. Financial sanctions for non-salary expenses of the health dept. come quite late; from October onwards and an important part is released during last couple of months of the financial year. Is this an important barrier in ensuring adequate, regular supplies to the Public Health Facilities?

Other Sources of Funding for Health Care

1. What is the proportion and role of foreign aid and investment in health care financing in India?

2. What proportion of population is covered under co-payment based health-insurance. What has been the performance of various health insurance schemes supported by the govt.?

3. Does the method of financing health care affect the charges levied by doctors? In absence of any control over the content of medical care, Health Insurance tends to inflate doctors' bills. How does this compare with the situation in say USA where insurance companies put pressure on doctors to economise on medical interventions to reduce cost?

4. It has been claimed that levying user charges in Public Health Facilities leads to:

   (a) availability of locally available flexible source of found for more efficient, end-use sensitive use of resources; (b) curtailment of excessive use of facilities by citizens; (c) enhancement of demand from the community for accountability.

   What has been the experience in the West and in India so far about this? Do user chares reduce the utilization of Public Health Facilities by the poor?

5. What has been the experience of 'community financing' of health insurance as regards to access to health care?

II. Questions and Points on Healthcare Provisioning

-Abhay Shukla

Though not exhaustive, these points address some key questions on healthcare provisioning in the current context. They draw upon the concept note (see mfc bulletin, 337-338) of the 2010 annual meet.

A. Overall Availability of Healthcare Resources

1. What are the ideal and 'optimal' norms for public health system? How many health centres, per unit population, are required for sufficient or optimal coverage? How much human-power (which includes specialists, general doctors, nurses, paramedics, health workers) is required? For instance, at present we have one PHC with one or two doctors for population of 30,000. Is this adequate to meet the expected load of patients in the community? If not, what would be an adequate PHC coverage model?

2. What are the gaps in resources and facilities available in the public health system with reference to 1) existing criteria, 2) 'optimal' criteria?

•   A comparative analysis of the availability of resources, across countries and regions, must be conducted in order to measure the gaps. In 1946, standards of National Health Service recommended by the Bhore Committee were half of what was prevalent in developed countries. For instance, one doctor was recommended for a population of 1600 and one nurse for a population of 600. What norms should we take now at the beginning of 21st century in India?

•   What are the disparities between urban and rural areas in the current distribution pattern, regarding doctors and beds for patients, for every 1000 people?

3. Based on standard (e.g. WHO) population based norms, what is the current status/shortfall concerning total availability of specialist doctors, family or general doctors, nurses, paramedical personnel and other types of health related human power? Which are the critical gaps?

4. Which kind of spaces may be optimally addressed by CHWs in both rural and urban areas? What is the likely impact of ASHAs as regards availability of health services at the community level and what changes are required in this programme to make it effective?

5. What is the existing (mal) distribution of private medical resources? For instance, how many qualified private doctors/private hospital beds per 1000 population exist in rural vs. urban areas? In developed vs. less developed regions of states?

6. When do we define a situation as 'over-concentration' of medical resources? (E.g. very large number of ultrasound clinics per lakh population in certain talukas of South Maharashtra which cannot be justified by any rational requirement; large number of MRI scanners in South Mumbai).

7. What kind of possible norms for the private medical sector may we specify towards a 'Certificate of need' regulation? (i.e., beyond what point should licenses be restricted for certain medical facilities in an area, based on already existing adequate resources)

B. Production and Deployment of Health Care Resources

Issues of production and deployment of medical human power

1. Linked with A.3 above, what is the total annual production in India (colleges in public and private sector) of MBBS doctors, BAMS and BHMS doctors, graduate nurses, ANMs, pharmacists, Lab technicians etc.? What is the level of shortfall in production?

What kind of systems are required for upscaled, good quality training of CHWs (with involvement of NGOs) and with such systems, what would be the time scale required for putting in place generalised CHW programmes?

Regarding gaps in availability of doctors what is the direction, dynamics concerning these gaps, barriers? For example, there is major shortage of postgraduate, specialist doctors in Rural Hospitals, district hospitals and in rural, poor areas. Though the number of such doctors passing out of medical colleges has increased substantially, many of them pay huge sums of money to graduate from the private medical colleges and their fees have galloped. A substantial proportion of post graduates go abroad for greener pastures. Given this dynamics, what are the possible mechanisms of inducing doctors, especially specialists, to work in rural areas and smaller towns?

What is the record of measures for better deployment of doctors in the Public health system (compulsory service/bonds, incentives) and which measures are likely to work?

(There is of course linked to a large, related debate on medical education – access and costs of medical education, content of education, type of doctors being produced etc. How do we approach this entire area?)

What proportion of practitioners engages in 'cross-practice' (practicing a mode of treatment in which they are not formally trained) and what are the health consequences of this? How do we deal with the large pool of cross-practicing doctors in a rationalized and planned framework? What is our stand regarding the move of having AYUSH doctors in charge of PHCs with very little supply of Ayurvedic medicines and virtual absence of homeopathic drugs in stock?

What proportion of patients currently access 'informal' or non-qualified 'doctors' in both rural and urban areas? What are the health consequences of such treatment? What should we do with this large but somewhat questionable 'health human power'?

Issues regarding production of medicines

Is the total scale of production of essential medicines in India adequate to meet the entire range of health care needs? If not, where are the gaps? Does India have the capacity to produce all essential medicines to serve the entire population?

What proportion of medicines produced in India is used irrationally or unnecessarily (could be based on updated and expanded Satara study type data)? What scale of funds would be saved by a rational pharmaceutical production and use policy? What about adequacy of production of necessary vaccines? Does production of unnecessary vaccines or their irrational use affect the availability of the genuinely required vaccines?

C. Access to Health Care Services

Although the existing public health system in rural areas is nominally a 'universal access system', what is the actual accessibility and quality of services being provided? When we say provisioning of services (from institutions especially) what really happens, how many PHCs actually often have dais conducting deliveries? How many PHCs have pharmacists or paramedics often functioning as the doctors, or no doctors at all on certain days or during certain hours?

Dealing with issues of physical / geographical access esp. in tribal, hilly, remote areas; what are the modified norms required to deal with physical access barriers?

Is there any justification for mobile clinics, medical trains and other special mechanisms to improve physical access? If not what are the alternatives?

What are the major issues of information / knowledge access concerning Health care and how can these be tackled? What is the potential of using the revolution in communication technology to improve access to health services? Within the context of broader Health system changes, can telemedicine enable the PHC doctor or family physician to consult an expert and reduce the current gap in availability of expert opinion?

Given the dominant, unregulated and often unaffordable private medical sector, how do we analyse present financial access/lack of financial access to Health care? (e.g. catastrophic spending, indebtedness or selling assets to meet health care expenses, proportion of total income spent on health care) (Related with session on health care financing)

D. Quality, Rationality and Patient Choice in Health Care

What parameters do we use to assess quality of care being given presently by say PHCs or small (less than 10 beds) private hospitals? By larger public and private hospitals?

The quality of care may be a complex combination of various factors, including the following:

a.   Timely and equitable access to services

b.   Technical competence of providers

c.   Availability of necessary infrastructure, equipment and supplies

d.   Effectiveness of care (obtaining desired results with minimal risk)

e.   Rational and optimal nature of care (opposed to excessive / irrational interventions)

f.   Interpersonal relations and responsiveness, promotion of users rights

g.   Continuity and safety

h.   Non-clinical amenities

Currently most standards for Health care facilities (e.g. IPHS, BIS standards for private hospitals) focus on availability of technically qualified providers (b) and physical standards (c). How do we properly assess and ensure the more complex but extremely important

other parameters of quality of health care?

We are aware of the large scale of irrational medication, investigations, surgeries etc. in the private medical sector leading to major overcharging and waste of resources, besides adverse effects on patient's health. In quantitative terms, what proportion of resources could be saved if all health care were delivered rationally and wasteful interventions were eliminated? What would be the effective mechanisms for ensuring such rationalization, esp. in the private sector, and what would be the limits to standardizing treatment protocols (provider preferences, differences in judgment, variation between situations and levels of resources).

In any system of Health care we must provide for patient choice – particularly in terms of choice between various systems of medicine (modern medicine, AYUSH systems, self care and natural remedies etc.). Further, within any system also there must be some scope for choice of provider (which particular doctor one would like to consult) and for modes of treatment to patients (e.g. aggressive vs. palliative care in cancer), based on full information to patients about the consequences of various types of choices. What is the current situation regarding choice of providers in the Public health system, how can these issues be addressed in a Better Organized System?

E. Alternatives and Future Options

To achieve Universal Access, we will need to harness and regulate the large scale private medical sector to serve the health needs of the population in an equitable manner. However, what is our assessment of various existing publicly funded, private sector provided schemes (often categorized under 'PPPs')? What have been the key problems with various major models? If these piecemeal attempts have failed to meet the desired objectives, then what will need to be done differently to ensure that future arrangements (in a changed system framework) would be effective? These questions relate not only to provisioning, but to all sectors – including financing and regulation / monitoring.

On the basis of answering such questions, in our future deliberations we would need to look at possible models of publicly managed and funded comprehensive health care systems, based on an appropriate mix of public and regulated private health care provisioning, integrated with effective public regulation and community-oriented monitoring.

III. Questions on Governance and Accountability
-Rakhal Gaitonde

Presented below are a set of questions that came up during the scan of the literature on the subject of governance and accountability in India. The questions seem to fall broadly into three categories. The first is a set of questions on macro/policy issues, the second set deals with so called meso level issues and the last set will deal with more micro level questions.

Macro Level

The government seems to have adopted a changed role based on the recommendations/pressure of International Financial Organizations. There is a shift from being the fundamental provider/ensurer of services, making sure the "last person" receives all services etc. to being the facilitator (protector?) of market forces and "enabling" the market to provide these services. Of course it is still a complicated picture in India – but the government in India certainly seems to be moving there steadily. In addition are the related macro level factors of the power of the corporate/pharma/industry complex wrt the common person and her/his concerns. Moreover the health system itself with the 'God like' doctor and the medical technological paraphernalia has inbuilt power hierarchies. Under these circumstances,

1. How do we analyse and promote the all-important factor of 'political will' in health system governance? Why is Health/Health care a prime political issue in some countries, and a low political priority in other countries like India? How do we 'generate' political will for Health in the Indian situation?

2. The National Rural Health Mission through the Community Monitoring and Planning program sought to 'set right the balance of power between the system and the people'. What have been the lessons learnt during the implementation over the last 3 years? What are some of the successful interventions that have enabled a more balanced power equation? How do we enable these at a larger scale?

3. There is increasing evidence of the harmful effects of the current model of corporate led neo-liberal policies, as well as the negative impact of pharma industries on health practices and policies. How are we going to use this evidence to influence a radical restructuring of the health policy making arena? How has the experience of decentralized planning in India as well as other

countries (especially Latin America) contributed to this debate? How can the concept of the Village Health Plan, the District health plan, etc., contribute to this re-orientation?

4. What key lessons can we learn from the processes of community based monitoring of public health services? How can these processes be made more effective, can extend their reach to higher level health facilities and policy making structures, and can be generalised on a large scale? How do we move towards 'communitisation' of health services and social control of health policy making?

5. How do we deal with the all pervasive issue of corruption - in management of public health systems and in regulation of the private medical sector? How can community accountability mechanisms contribute to this?

Meso Level

In this level I formulate a few questions with regards linking the above larger issues to actual actions at the micro / individual / community level. The key aspects of this level of thinking are the legal framework as well as the institutions to implement / assure the legal guarantees. This includes institutions for monitoring / evaluation as well as planning and mechanisms for redressal. These will include those institutions within the system / profession as well as those which are more participatory and include community participation.

1. What is the consensus for an appropriate legal framework for the assurance of Health for All? What are the learnings from the formulation of the public health acts recently introduced like the Gujarat Public Health Act, The Bombay Nursing Homes Registration Act and the draft National Health Bill?

2. What are the international examples (especially the Brazilian and South African experience)?

3. What has been the experience of implementing acts / bills such as ESI Act, Workmen's Compensation Act, PCPNDT act, Consumer Protection Act etc. in the field of health?

4. What are the experiences of evolving legal frameworks and their implementation in other fields like education (Right to Education Bill), Right to food (Food Security Act), forest rights (the recent legislation regarding forest rights etc)?

5. What structures, mechanisms, processes would be required to regulate standards, quality of care and to ensure patients rights in the private medical sector today? How can this regulation be made participatory (and not bureaucratic or inspector raj type)?

6. Why has self-regulation by the medical profession in India been so weak and ineffective? How can an element of self-regulation be integrated in the system of private medical sector regulation indicated in the previous question?

7. What has been the experience of the institutions like 'jan sunwai' and 'social audit' in the field of health as well as in other fields like Right to Information, NREGA, PDS, etc.?

8. What has been the experience of involving the Panchayats/the process of Village Health Plans etc. to ensure the reflection of community priorities and contributing to the overall governance and accountability mechanisms?

Micro Level

At the micro level we grapple with the issues of 'capacity building' of the communities, increasing their ownership of these various structures, making these structures more representative of the communities needs etc. We also need to grapple with issues like the training and sensitization of individual physicians both in the public sectors as well as in the private sector.

1. What is the experience of the ASHA as an activist to increase the patronage of the public sector services as well as increase accountability? What are the positive experiences? How can these be scaled up? What are the blocks for the activist role of the ASHA? How have these been overcome? What can we learn from these about the system and the establishment of accountability mechanisms?

2. What is experience of choosing the Village Health and Sanitation Committees? Their orientation and their ability to perform monitoring activities over the long run without the support of NGO facilitators? What are the resources required to reach this state of functionality? How are these to be mobilized in the long / medium term?

3. What is the experience in creating awareness/demand/ownership for these structures among the people?

4. What is experience in increasing sensitivity as well as acceptance of an altered balance of power among the medical professionals as well as the bureaucracy? What have been some of the experiences? What have been the learnings form the various experiences?

[Contd. from Pg. 26]

(ii) Ensure that patients interest are not compromised in any way.

(iii) Ensure that such affiliations are within the law.

(iv) Ensure that such affiliations / employments are fully transparent and disclosed.shall be done in a transparent manner and item wise disclosure shall be made to the members and sponsorers.

(iv) The organisers shall ensure that sponsorers have no influence on the subject, content, presentation, choice of lectures and programmes, choice of speakers, proceedings and publication of results.

8. Endorsement: A doctor shall not endorse any drug or product of the industry publically. Any study conducted on the efficacy or otherwise of such products shall be presented only on appropriate scientific bodies or published in appropriate scientific journals in a proper way. ....

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