Situation review and analysis of accreditation system in India.

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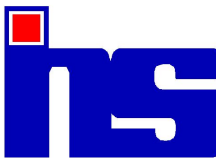

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Situation review and analysis of accreditation system for health care organisations in India.

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I. Introduction:

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

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

II. Situation review of private hospitals and nursing homes (PHN):

In India variations within the spectrum of private hospitals is vast. On one extreme there are the hi-technology, five star corporate hospitals and on the other end there are small nursing homes with 1 to 10 beds functioning from small residential places and sheds. During the last one and a half decades the growth of corporate hospitals has been at very fast pace. Many corporate houses and non-resident Indians have recently joined this enterprise. Several large business houses in addition to their regular business have diversified into the field of health.

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During 1974, 16 % of the hospitals and 21.50 % of the hospital beds in India were in the private sector and the rest in the public sector (CBHI, GOI). This proportion increased in 1990 to 57.95 % of hospitals and 29.12 % hospital beds in the private sector (CBHI, GOI). There are reasons to believe that the number of hospitals in the private sector is much larger than what the available data suggests. A survey undertaken by Directorate of Health, Andhra Pradesh (DHAP) found the existence of 2,802 P.H and 42,192 P.H beds in Andhra Pradesh in 1991. The survey also showed that 67.60 % of the PHN were located in urban areas (which were the state capital, divisional HQ, district HQ, taluka & mandal HQ). The PHN bed population ratio was .637 beds per 1000 population as compared to public hospital which was 0.512 (DHAP 1993). The above data suggests that the size of PHN is much larger than official data brought out by the government. Secondly PHN are mainly concentrated in the urban areas. In many of the metropolitan cities, district head quarters and semi-urban places the majority of the hospitals / nursing homes have a bed size of 15 to 25. There has been very little information forthcoming and documented on the structure, functioning, role and quality of care provided by PHN's in the country. Very often information that is available is through media reports and studies which are far too few.

Recently due to pressure from the judiciary, certain facts are coming out. In Calcutta a petition was filed by an advocate in the Calcutta High Court regarding the conditions of private hospitals and nursing homes. In response to this a committee was appointed by the speaker of the West Bengal legislative assembly in 1985 to prepare a report. This report found that the nursing homes lacked adequate floor space, ventilation, lighting, water, bathroom facilities and qualified doctors and nursing staff (The Telegraph, 1989). In 1991 the Chief Justice of the Bombay High Court directed the Bombay Municipal corporation (BMC), to set up a permanent committee to oversee and supervise the implementation of the Bombay Nursing Home Registration Act (BNHRA), 1949, and make recommendations.

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

Only 15 of them had an OT out of the 22 who were supposed to have it. In 7 of them the OT also served as a labour room. It was observed that in some PHN the OTs and labour rooms were in rooms originally designed as kitchen. Some had OT's that were pathetically as small as 48 sq. ft and leakages were to be found in the OT and labour room with paint from the ceiling and walls peeling off. Seventy seven percent did not have a scrubbing room. Many of the hospitals and nursing homes were ill equipped, especially those providing maternal health services. For instance many of them did not have resuscitation sets in the labour room for new born babies. The availability of emergency supportive services like ambulance services, blood, oxygen cylinders, generators etc. was also insufficient.

Majority of them employed unqualified staff. Out of 24 hospitals and nursing homes studied only 1 hospital had employed a post graduate doctor, whereas 10 of them had doctors trained in other systems who were providing treatment in allopathy. Few hospitals had provision for the doctors to be present round the clock. Majority of the PHNs utilised the services of

visiting consultants. Less than a third had qualified nurses while most of them had employed unqualified nurses.

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

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

The dismal condition of hospitals and nursing homes is because there is practically no monitoring and accountability to the people or the authorities concerned. In fact hardly is there any authority concerned about it. In most of the states in India there are no legislation or regulation for PHN. A study undertaken by Medico Friend Circle (Bombay group) in 1993 on regulatory and monitoring mechanisms existing in various states of India, found that the states of Tamil Nadu, Punjab, Andhra Pradesh, Kerala, Goa Daman and Diu, Mizoram, Gujarat, Orissa, Sikkim and Manipur do not have any rules, laws, regulations or even data of PHN. Added to these states are Madhya Pradesh and Rajasthan. This was found out through visits and discussions with government officials of the respective state governments. To our knowledge Maharastra, Union territory of Delhi and Karnataka have a legislation for private hospitals and nursing homes. In Delhi there is the Delhi Nursing Home Registration Act (DNHRA), 1953, and in Bombay the Bombay Nursing Home Registration Act (BNHRA) 1949 (Nandraj 1994). In Karnataka there is the Karnataka Private Nursing Homes Act, 1976.

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

In Bombay the Bombay Municipal Corporation (BMC) was not enforcing the BNHR Act. The judges in the Bombay High Court in the judgement mentioned elsewhere in this paper observed that "*The writ petition[3] filed in that connection had served the purpose of activating the concerned authorities, who seemed to have woken up and taken certain steps in the direction of implementation of the various provisions of the law*". The Corporation of Bombay during the hearing admitted that the officials had not visited nor taken action against any hospital or nursing home. In fact, one out of four hospitals were functioning without registration. Though the Act was applicable to entire Maharastra, its implementation, albeit with incomplete coverage, was found to be restricted to the cities of Bombay, Pune, Nagpur

and Sholapur. In Delhi , the administration admitted that only 134 out of 545 nursing homes were registered. There is hardly any regulatory intervention or interference of the government in the private sector and on the health care market Even the few existing laws and regulations are either toothless or not implemented at all. People's dissatisfaction with the private sector and their disillusionment with the medical establishment is quite high (Jesani.A & Nandraj. S 1994).

III. Efforts made for evolving standards and developing an accreditation system:

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

Government's Role: As seen earlier the government's role in monitoring the private hospitals has been very dismal. In Bombay and Delhi, where there is legislation, no minimum requirement and guidelines have been laid down in the Act regarding space, sanitary conditions, personnel, equipment, fees to be charged etc. Very surprisingly in Bombay the public health department of BMC which grades restaurants in the city on the basis of hygiene and facilities is also responsible for PHN. Only recently the Delhi administration has started evolving certain minimum standards for private hospitals. These are that the doctor-patient ratio should be 1:10, the nurse patient ratio should be 1:5 in a general ward, and 1:1 in intensive care areas. The doctor holding a recognised degree should be present round the clock. A separate labour room and OT, each having minimum floor space of 180 sq.ft. should be available. The new rules also make it obligatory for the nursing home to display the charges to be levied for various services provided at a prominent place.

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

In the recent past a study was conducted by the National Institute of Health & Family Welfare (NIHFW), New Delhi for the purpose of drawing up norms of equipment for hospitals. It

undertook a review of literature on the various standards existing for hospitals. The study mainly concentrated on government hospitals. It came up with guidelines on norms for essential and major equipment for 50, 100 and 500-750 bedded hospitals. These were for basic diagnostic, therapeutic, supportive and other services and for the medical and surgical departments of the hospitals. The norms laid down included specifications of equipment, their quantity and approximate price (Anand T R, Agarwal AK, 1992).

The Bureau of Indian Standards (BIS) have developed standards for basic requirement for hospitals upto 30 beds (IS:12433 Part-1, 1988) and standards on the classification and matrix for various categories of hospitals (IS12377). The standards cover basic requirement for planning a 30 bedded general hospital in respect of functional programme, functional and space requirements, manpower requirements, instruments and equipment and essential requirements for building services and environment. The classification and matrix for 5 categories of hospitals (30,100,250,500 and 750 bedded) and according to the functions (BISa,b 1988).

IV. Role of consumer and non-government health organisations:

The credit of focusing attention of the people regarding standards for private hospitals and nursing homes should go mainly to the consumer groups. This is due to the fact that these groups have been working on various aspects of the private health sector. Along with the consumer bodies, groups of health professionals and hospital organisations were also involved for drawing up standards and to develop an accreditation system. These efforts though at an infancy stage show a potential for developing in the near future. These efforts were undertaken primarily by consumer and non-governmental organisations based in the cities of Bombay, Pune, and Hyderabad.

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

Meanwhile in Pune the Health-Committee of the Lok-Vignyana Sanghatana (the People's Science Organisation in Maharashtra) took the initiative in preparing minimum standards.

After intensive discussions the committee for check-up for anaesthesia before surgery came up with 'Routine Preoperative investigations for 'Minor surgery' in ASA Grade 1 patients.

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

V. Hospital owners and other professional bodies:

There have been efforts to promote a voluntary accreditation system by the Indian Hospital Association (IHA) both at Bombay and Delhi. In Bombay the IHA along with the Bombay Management Association joined hands to promote the scheme in the city. The scheme visualised that PHNs would be given accreditation according to the degree to which they conformed to the minimum standards laid down by an accreditation committee comprising prominent members of the medical and legal fraternity. The accreditation fees varied from Rs. 2000 for a 15 bed hospital to Rs.15000 for one with more than 300 beds and the accreditation would be valid for two years. The organisers reason that they would depend on persuasion and the doctors self scrutiny and not have a policing role. The scheme was envisaged with the idea that the PHNs would get accredited voluntarily (The Independent, 1993). The response to the scheme has been very luke warm. To the best of our knowledge the organisers did not lay down the basis for gradation and only three hospitals had come forward. Many of the private hospital and nursing home owners felt that the move was in the right direction but regarded it with scepticism and suspicion. It was felt that the committee should tone down the minimum requirements for areas such as space allocated per bed and the number of trained nurses. Many of them were hesitant to shell out the amount every two years.

The response of private hospitals and nursing homes for having minimum standards and to participate in an accreditation scheme has not been encouraging. Among the problems put forward were that the proposed standards were unreasonable and impractical for them to follow. Nurses were not available since majority of them joined the government service and many went to the middle east. Private hospitals and nursing homes did not want to be monitored and be accountable. Nowhere in the world including the dogmatically pro-market USA, there exists an unregulated health care market as in our country.

VI.Issues in developing an accreditation system:

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

Standardisation will benefit both the patient as well as the doctor / owner of the hospital / nursing home. Patients will benefit because today there is a lot of arbitrariness in the modalities for diagnosis and treatment of various health problems. For the doctors / owners, once standards are laid down, there will be a better chance that the judiciary will also accept it as reasonable standards.

Many issues need to be addressed for developing an accreditation system. Firstly certain minimum standards and guidelines have to be laid down. Secondly the accreditation system, if it has to be implemented in an effective manner, has to have some kind of legality and

legitimacy. Efforts made for a voluntary system have not produced results. The private hospitals and nursing homes have been very defensive for a system of monitoring and accountability. Experience shows that, especially in the service sectors, unless persons delivering the services are directly accountable to people, a lot of dissatisfaction and indifference is generated. Thirdly the organisation launching the scheme should be accepted by both the hospital owners and consumers. It has to have impeccable credentials.

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

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VIII.End notes:

[1]Utilisation of health care facilities reported in selected studies. All figures in %.

Study		Area	Public Hospital	PHC	PHN	Practi-tioner	Drug Store	Traditional	Self care	Other	Total
	Out patient	Rural	17.7	7.9	16.2	53	-	-	-	5.2	100
		Urban	22.6	4.6	18.1	51.8	-	-	-	2.9	100
	Inpatient	Rural	55.4	4.3	38.6	-	-	-	-	1.7	100
		Urban	59.5	0.8	38.5	-	-	-	-	1.2	100
NCAER-1990 All India		Rural	28	9.9	44.4		10.8	-	-	6.9	100
		Urban	31.2	7.9	44.8		13.6	-	-	2.5	100
KSSP-1987 Kerala		Rural	23.0		53.0	-	-		12	12	100
FRCH-1987 Jalgaon District		Rural	11.1		84.6	-		1.7	2.6	-	100
		Urban	16.9		77.5	-	-	3.7	1.9	-	100
FRCH-1990 Madhya Pradesh two districts		Rural	2.8	14.8	73.9		1.3	1.0	6.2	-	100
		Urban	14.8	0.3	71.9		3.2	0.8	9.4	-	100

Sources: NSSO, 1989; NCAER, 1992; Kannan, Thankappan, et al. 1991; Duggal R.S.Amin, 1989; George A et al., 1993.
PHN = Private hospitals and nursing homes; PHC = Primary health centres

[2]Estimates of total health expenditure in India for the fiscal year 1990-91 are as under:

Channel	Crore rupees
Ministries of Health & Family Welfare	6,000
Other Ministries (Railway, Defence, P&T, Mining etc.)	500
Corporate sector, public and private, assuming 60% of employees of organised sector get benefits of ESIS.	650
Municipal bodies (Net of grants from Ministries & health)	2,050
Employees state insurance scheme (ESIS)	300
Personal household burden calculated at Rs175 per capita.	14,500
Total Health Expenditure	24,000

[1] Note: The Total works out to 6% of Gross National Product:

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