INSTITUTE OF PUBLIC HEALTH

To 19/07/2017

Chairman,
Joint Select Committee on the Karnataka Private Medical Establishments (Amendment) Bill, 2017
Room No 143, Vidhan Soudha,
Bengaluru.

Respected Sir

Sub: Submission to the Joint Select Committee on the Karnataka Private Medical Establishments (Amendment) Bill, 2017committee

I note with concern the media debate regarding the regulation of the private health sector in Karnataka. The representatives of the private health sector are misleading the public by misinforming them about the key issues. As an academic with 30 years of experience in the medical and health field, and somebody who has done research in the field of governance and regulations as well as health economics, I would like to make the following submissions:

1. **Regulation of the health sector:**
   1.1. In most countries of the world, health care is provided by either the private sector or the government health sector. In all these countries, the government regulates the health sector and especially the private sector (Bennett et al., 1994; Tangcharoensathien et al., 2008).
   1.2. This regulation is in the form of licensing entry into the medical profession, promoting ethical conduct of the professionals, ensuring basic standards of care and controlling the price of health care services (Ensor & Weinzierl, 2007).
   1.3. In India, there are some regulations of the health sector. These include the Medical Council of India (MCI) Act that regulates the licensing of doctors and also prescribes the ethical practices that a doctor needs to follow. The Consumer Protection Act (CPA) can take action against doctors who have committed medical negligence and then there is the CrPC that can be applied to doctors who have caused death of patient due to negligence. Other than this, there are many other acts, but most of these are minor in nature in terms of regulations.
   1.4. Evidence from studies show that neither the MCI nor the CPA are effective in regulating the doctors, the health facilities and the health care services in India (S. Nandraj, 2015; Sunil Nandraj, 2000; Sharma, 2015).
   1.5. There is enough evidence from India to show that the Indian health sector has suffered because of lack of regulations of the private health care sector (S. Nandraj, 2015; Sunil Nandraj, 2012; Peters & Muraleedharan, 2008). In most states of the country, we are not even aware about the number of private health facilities and the services that they provide (De Costa & Diwan, 2007).
   1.6. This is the reason the government has been keen on regulating the health sector. Policy documents have clearly advocated for stronger regulation of the health sector and

especially the private health sector (HLEG, 2011; Ministry of Health and Family Welfare, 2017). Towards this they have introduced various measures including the Clinical Establishment Act, capping the prices of essential medicines and consumables.

1.7. Karnataka has been a pioneer in regulating the health sector. Much before the Ministry of Health and Family Welfare, New Delhi drafted the Clinical Establishment Act, the state of Karnataka introduced the Karnataka Private Medical Establishment (KPME) Act. This has required private health care facilities to register with the government. With time, the government has identified some gaps in the act and have introduced a bill to amend the KPME act. Unfortunately, the private health care sector is opposing these amendments with various false claims

1.7.1. **They claim that the health sector is never regulated** – as stated in the above paragraphs, the world over, the government regulates the health sector through various means. Even in countries like the USA and the UK, there are regulatory mechanisms to protect the patients from the health care industry (Salter, 2001) Most OECD countries have independent regulatory bodies for regulating the health sector (Healy & Sharman, 2006; Marchildon, 2013).

1.7.2. **The private sector claims that regulations will stifle the market economy**. This is a strange argument because regulators are introduced in market economies specifically to prevent market failures. E.g. in the telecom industry in India, we have the TRAI, in the Airlines industry, we have the DGCA, in the stock exchange, we have the SEBI, etc. The role of these regulators is to protect the interest of the various actors.

1.7.3. **The private sector claims that health care services should be left to market forces**. This goes against the grain of existing knowledge and practice. It is well known that markets fail in health care industry because of asymmetry of information. So everybody (including capitalists institutions like the World Bank) promotes MORE regulation in the health sector (Gottret & Schieber, 2006).

Hence, I conclude this section requesting the hon'ble members of the Joint Select Committee to kindly ensure that the health sector (and especially the private health sector) in Karnataka is regulated and that they do not dilute either the KPMEA or the proposed amendments.

2. Costing of services

Here again, I note that the private sector does not want the services to be costed. Their claim is that health care costs are very variable and so the government should not fix these costs. It should be left to the private hospitals to fix the prices.

There are two issues with this argument

2.1. Firstly, prices of health care services can be and are fixed in most middle and high-income countries by either the government or the insurance companies. There are standard ways of costing that are approved by international agencies like the WHO and the World Bank and most health economists use these methods to price the services. It is argued that a surgery is not like a mobile phone and that there are unexpected complications and additional expenses that cannot be factored into the price. But this is exactly what cost accountants do and the extent of complications and unexpected events are well documented in textbooks of medicine and in journal articles. Using these projections, it is possible to estimate the cost of a particular procedure, keeping in mind all the aspects of the cost, ranging from Human resources, medicines and consumables, equipment, infrastructure, depreciation and even a profit margin. A link to an established manual on

costing is provided herewith http://www.jointlearningnetwork.org/resources/costing-of-health-services-for-provider-payment-a-practical-manual

2.2. Due to the asymmetry of information, the patient is totally at the mercy of the hospitals when they are presented with the bills. The patient does not know whether the bill is a real price of the services provided or whether it is an inflated bill to take care of the unreasonable profit margins. They cannot compare the bills with other hospitals, because a) it is usually provided at the end of the stay, when they are pressurized to pay and b) they are not aware whether the bills are high because of the 'better' quality of care that they have received.

It is obvious that such costing exercise will never be undertaken by the private sector as there is no incentive for them. Communities and patients cannot do a costing as they do not have the necessary knowledge and skills. So, it is very important that the government takes the initiative and conducts such costing exercises and fixes the price of various commonly conducted medical procedures. The government is the only hope for the patients and such a move will be well accepted by the citizens of the state. In fact, again Karnataka has been a pioneer in such a move and the Suvarna Arogya Suraksha Trust (SAST) has already conducted such a study on 20 important conditions. They have taken evidence from private, government and NGO hospitals to come up with a document that has been vetted and cleared by the World Bank itself.

One common grouse by the private sector is that an uniform price for a procedure does not take into account the fact that i) hospitals are of different sizes (some large and some medium and most very small with just 20 – 30 beds); ii) hospitals are located in different economic geographies, so the price of land in Bengaluru is very different from the price of land in Bidar; iii) the quality of material used will differ in different hospitals, some will use the latest stents, others will use a basic stent. These are valid points and one way of getting past this obstacle is to do a basic costing. The steps for this are as follows:

- **Step 1** – identify the commonly conducted procedures in the state. Datasets from SAST and from Yeshasvini will easily provide this information
- **Step 2** – for each of these procedures convene a meeting of the concerned professional association, e.g. if cataract is a procedure to be costed, then call the representatives of the Ophthalmologists Association – Karnataka Chapter.
- **Step 3** – ask them to list the basic materials required to conduct a cataract surgery. This will include the medicines, the consumables, the anesthesia, the post op dressing, etc. The details of the lens that will be required (to provide optimum vision post-surgery) will also be spelt out. Additional information will include the type of human resources required (ophthalmologist, nurse, attenders), the number of days of hospitalization required and details of the post discharge medicines.
- **Step 4** - The medicines and consumables will be costed and this will be the minimum cost for doing a cataract surgery of acceptable quality. Additional costs like the bed charges, the operation charges, the theatre charges, the nursing charges are left to the hospital to decide.
- **Step 5** - The patient is informed that the minimum cost of a cataract with quality lens is Rs xxxx. If a hospital then charges Rs yyyy, they will have to explain the price difference to the patient. This way the patient is empowered to make informed decisions as he/she now knows the basic cost of such a surgery. Hospitals will be also careful about inflating their bills as patients now have an idea of how much the cost of materials is and how much the cost of the hospital is.

- **Step 6** – These costs need to be revised every two years at least, as pharmaceutical inflation is one of the highest in the world. This will ensure credibility of the exercise and improve compliance by the hospitals.

I appeal to the members of the Joint Select Committee that we in Karnataka should learn from tried and tested measures (in other countries) and be the pioneers in providing affordable and safe health care services to the citizens of our state. Such a move will also be an unique one and will be followed by other states. Let Karnataka lead the way.

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PS: I declare that I do not have any conflict of interest in producing this submission.

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SHORT CV OF Dr. N. Devadasan

Dr. N. Devadasan is a medical doctor by training and has subsequently done Masters in Public Health and also has a PhD in health insurance from the famous Gent University. He started his career as a community health physician working with Adivasis in the Nilgiris district for 10 years. Subsequently, he joined the WHO and was in charge of the communicable disease cluster. He resigned from the WHO in 2003 and founded the Institute of Public Health, a not-for-profit academic institution that bridges the gap between academics and services through applied research and training. IPH works closely with state governments and has assisted the government of Karnataka in various matters including providing technical support. Currently IPH conducts research in the fields of governance, health financing, urban and rural health services as well as access to medicines. Dr. Devadasan has published more than 88 articles in journals and is the author of 5 books in the field of health financing. He is also a member of various committees, both at the national and state level.