Private Sector Accountability for Maternal Health: Findings From A Study From Seven Districts In India

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Private Sector in India

The private health care system forms the bulk of the healthcare provisioning in India[i]. It is understood as fairly large and heterogeneous in nature[ii,iii,iv], and includes beyond the for-profit private sector, the not-for profit sector encompassing for example faith-based or NGO healthcare provisioning Although, the for-profit sector is primarily dominated by individual practitioners, there is an ever-burgeoning institutional and corporate interest in private provisioning of health services.[v] The sector also includes a wide array of systems, allopathic, homeopathic, *ayurvedic, unani, tibbi, siddhi* as well as many informal practitioners like faith healers and traditional birth attendants. In addition to this there are the cross practitioners who include those prescribing medicines without any formal training and those with training in one discipline prescribing medicines of another discipline. It is also empirically established that most qualified practitioners are based in urban centres while unqualified providers cater to the health needs of the poorer populace in both rural and urban areas.[iv] In rural settings, apart from unqualified allopathic practitioners, the other providers accessed are traditional healers, traditional birth attendants, herbalists and shamans or priests.[ii] A recent trend since the nineties, is the growing trend of Public Private Partnerships, or inclusion of private players in the public sector through a variety of partnerships, which has been documented and researched. Such public-private partnerships have taken the form of contracting, private management of public facilities, incentivising private entities by providing subsidised land for their facilities etc.[ii] The key challenge thus far has been ensuring regulation in private provisioning and partnerships, owing to the huge diversity of private groups and entities involved in the sector. Researchers also highlight that steadfast resistance to regulation by private actors has been a great obstacle in the way of ensuring standard quality and affordable health services with accountability. [iv]

Private Sector and Maternal Health

Private sector regulation of maternal health services is crucial to ensuring safe motherhood in the country. In the last two decades, utilisation of private services for maternal health has increased considerably, both directly as well as through public-private partnerships. As of 2015-16, one in four (26 percent) births occurred in a private facility (NFHS 4, 2015-16) and women delivering in private facilities incur costs amounting to 16,522 INR as opposed to 3,198 INR in the public sector. Notwithstanding the costs incurred, the quality of care remains questionable. The private sector in health care in India is so far entirely unregulated. Provisions and quality of care in private hospitals has been studied in the recent past to reveal that there is severe shortfall of qualified staff and the poor standards of care in these facilities[vi]. Basic and essential services such as ambulances and blood banks were found to be available in very few hospitals.[vi,vii] Further, C-sections are particularly

[1] SAHAYOG, Lucknow (http://www.sahayogindia.org/)
[2] National Alliance of Maternal Health and Human Rights (http://namhhr.blogspot.in/p/about-namhhr.html)
[3] Centre for Health and Social Justice, New Delhi (http://www.chsj.org/)

common in private sector health facilities (41% of deliveries), an increase from 28 percent in 2005-06 (NFHS 4, 2015-16).

Despite the dismal state of regulation of this sector, there is a policy interest in building public private partnerships for better maternal health care in emergency obstetric care and diagnostics. This was a popular strategy during the National Rural Health Mission and continues even today with the stated purpose of increasing access and quality of services while reducing out-of-pocket expenses. However, there is a dearth of evidence to prove that PPPs actually contribute towards increasing access and quality of care.[viii] Studies conducted on the impact of these partnerships, reveal that partnering with the private sector could fail to serve its intended purpose, as shown in a study on the Chiranjeevi Yojana in Surat district which found questionable the claims that the scheme has been able to reduce maternal mortality, as all complications which need Emergency Obstetric Care are being routed to public institutions. Another study of the a PPP scheme Aarogyasri in Andhra Pradesh found that found that following the introduction of the scheme, the proportion of hysterectomy cases among women aged 25-40 increased by 20 percent; as women were told by the doctors that they would die if they did not opt for this surgery. Even so, the National Health Policy 2017 endorses "strategic purchasing" from the private sector and publicly financed, privately provided, insurance schemes ostensibly in the effort to realize universal health coverage.

The central government enacted the much-awaited Clinical Establishment Act in 2010 for the regulation of all clinical establishments in the country - whether private and public in nature and/or run by trusts, corporations or even a single doctor[4]. Currently, the act is applicable in Arunachal Pradesh, Sikkim, Mizoram, Himachal Pradesh and all the seven Union Territories. Other states seeking to take up the Act are required to pass a resolution in their respective state assemblies. As of now, according to the Ministry of Health and Family Welfare, only six additional states viz. Uttar Pradesh, Uttarakhand, Rajasthan, Bihar, Jharkhand and Assam have adopted the Act.

Methodology:

This submission draws on a study conducted across **4 states in India – Uttar Pradesh, Jharkhand, Odisha and West Bengal**, covering maternal death reviews of **139 cases from 7 districts** across these states. Among these, while several women accessed private services during pregnancy, a total of **58 women** across all 7 districts utilized some form of private services (through formal, informal or traditional providers) during or after labour, until their eventual death. These reviews were conducted between **April 2013 and November 2015**, with the objective of documenting maternal deaths from the family's perspective, through a **verbal autopsy method**, and identifying maternal health care violations. The sampling method employed was purposive as the study focused on extremely marginalized populations (mainly tribal, Dalit, Muslim women). The study sought to explore *to what extent was the design of the existing health system and maternal health programme effective in responding to the complications in maternity, given the special vulnerability of these marginalized groups.* The ultimate aim was to build a non-adversarial approach to CBMDR among frontline workers, providers, managers towards identifying health system gaps.

Findings

Diversity of private providers:

[4] Excepting establishments covered by the armed forces

As discussed above, India's diversity of private providers was also reflected in our field sites; including not-for-profit trust hospitals, smaller doctor owned hospitals and nursing homes, individual practitioners (qualified and unqualified), chemists, and traditional healers. In the state of Uttar Pradesh that has a dysfunctional system for managing maternal emergency care, a significant number of women went to small local nursing homes some of which were run by unqualified practitioners. On the other hand, in our study districts located in Odisha, Jharkhand and West Bengal, the presence of private health facilities appears to be comparatively far less, perhaps owing to the evident poverty in those sites, which made the existence of private clinics non-viable. However, in these states community-based traditional healers including traditional birth attendants (*Dais*, *domburi*) and Shamans were accessed for delivery and pregnancy care. Additionally, the local presence of informal untrained providers was ubiquitous and women often approached them in case of complications or for abortion services.

Reasons for using private facilities:

Private providers were accessed by women in these districts for varied reasons:

i) In remote and hard-to-reach areas of Jharkhand and Odisha, informal untrained providers and traditional providers were the first point of contact as they were easily accessible.

ii) Gaps in the public health system - Across the districts, during the ante-natal period, women sought care and check-ups in the private clinics, especially for certain services that may not be available in public health centres like Ultrasonography (USG). In addition it was observed that even District Hospitals tend to refer out patients for USG and blood tests to a private lab. In the case of obstetric complications, there appears to be an unspoken consensus that private hospitals will ensure the care as the public system is functioning poorly. Sometimes, women across the districts, accessed private hospitals as a last resort after trying the public hospitals several times. Thus families are compelled to spend unaffordable amounts on treatment that may end up being ineffective.

iii) Trust deficit - In the districts of UP especially, women were forced to go to private providers when government facilities turned them away without providing treatment. Further although maternal health services are supposed to be provided free of cost in public facilities in UP, providers often demanded informal payments. Such experiences led to an erosion of trust in the public health system; for example,the mother-in-law of a young women remarked: *"Who would want to go to a government hospital?"*, indicating her dissatisfaction with the services that prompted her to go directly to a private provider. The trust deficit is so strong in some districts in UP (Azamgarh for instance) that although the ASHA worker counsels women to call the ambulance and to go to government health facilities for institutional childbirth, 10 out of 18 women chose to go directly to informal providers or private hospitals during labour.

This trust deficit was also evident among the public providers themselves – the sub-centre ANM herself referred one woman to a private hospital indicating that the health workers themselves are aware emergency obstetric services will not be given by the public health system.

Deliberate diversion of patients from the public into the private sector

There is a worrying 'leaking out' from public into private facilities which leads to unaffordable expenses for the poor families that are seeking treatment. Public providers encourage the women to seek care in other private hospitals or in clinics where they privately practice. In Banda and Mirzapur

(Uttar Pradesh, UP), it is a matter of concern that the ASHA workers (frontline workers who are trained and appointed by the public health system to register women for ANC and accompany them for treatment), may refer women to the private sector for commissions.

Another observation is that government-employed doctors are openly doing private practice, sometimes right next to the public hospital. In Godda, Jharkhand and in especially in Azamgarh (UP), private hospitals run by government employed doctors, are seen as providing better care than the government hospitals

Questionable quality of care in the private sector

Although the private sector is widely accessed, it was found that across the study districts but especially in UP, the treatment was very medicalized, extremely costly and sometimes of doubtful standards failing to save women's lives. Sometimes the private hospital also referred women into the Medical Colleges (public tertiary health facility), especially when the cases deteriorated into a critical condition. Thus, it was seen that, private doctors and hospitals whose services were used for serious pregnancy complications did provide treatment but took no responsibility for the woman, sending her away whenever they felt things had gone wrong, or when the family had no more money to spend.

> In case, in UP, a private doctor conducted a C-section surgery without setting up an IV line; the woman probably died during the surgery, but the private doctor told the family that her condition was serious, and gave them Rs 500 to immediately take her away to the Medical College

Further, referrals to formal private establishments from informal providers were seen to occur in Azamgarh, where the informal providers referred women into expensive private hospitals when they detected complications. The treatment in these expensive private hospitals, was often irrational, unreliable, and of very poor quality, with unsupported referral and often callous behaviour - private sector providers did not hesitate to turn out women in a critical condition just before she is about to die to prevent a death in their facility.

Cost of Care in Private Facilities

Despite the questionable quality of care in private facilities, the costs were still exhorbitant. In Azamgarh (UP), families reported going through enormous lengths to raise the money needed for such private healthcare, such as selling all their assets or taking loans at exorbitant rates of interest. This is also reflected in large survey data which shows that women delivering in private facilities spend on an average INR 16,522 as compared to INR 3,198 in public facilities (NFHS 4, 2015-16).

Recommendations

I. The **National Clinical Establishments Act** should be effectively and immediately implemented in all states without exception.
II. Maternal health services provided by **other practitioners should be recognised and regulated**. Within this, AYUSH practitioners must be engaged in provision of services, after appropriate capacity building. Also, informal providers who are omnipresent must be

recognised. The potentially harmful practices of these practitioners must be understood and modified. Informal providers should to be mapped, and the package of services that they can offer must be clearly delineated.

III. **Traditional providers** especially traditional birth attendants play an important role in providing delivery services to the most marginalized and vulnerable women. They are the only source of support for domiciliary deliveries, which are currently unattended by skilled providers. The practices of these providers must be studied, strengthened, and appropriate linkages with the formal health system created.

IV. **Standard Treatment Protocols** for maternal health must be laid down and adherence to it must be secured. This is essential to reducing the possibility of irrational procedures and malpractice. Professional bodies such as the IMA, IAP, NNF and FOGSI have an important role to play in ensuring that guidelines are followed.

V. There should be a **Proper Referral System** established especially for referrals from public facilities to private ones which should be made only if the required services are not available at the public facility.

VI. **Cost of services** must be fixed and the list of available services with prices should be displayed prominently in all facilities along with the **Patients' Rights Charter**.

VII. Patient feedback should be collected in a confidential manner using ICT mechanism and should be fed into monitoring reports made by teams comprising of civil society representatives, users, PRI members,

VIII. The **Renewal of Accreditation** should be reviewed by District Accreditation Committees based on the monitoring reports. **CSO representatives, especially women** should be ensured in the District Accreditation Committees.

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[i] Jain N et al (2015) NSSO 71st round: Same data Multiple Interpretations. Economic and Political Weekly, 50(46&47), 84-87.

[ii] Nandraj, S et. al. (2001) Private Health sector in India.Cehat, IIT Madras and CSMCH-JNU.

[iii] Baru, R and Ramila Bisht (2010) Health Service Inequities as Challenge to Health Security. Oxfam India

[iv] Baru, R (2013) 'Challenges for Regulating the Private Health Services in India for Achieving Universal Health Care', Indian Journal of Public Health, Volume 57, Issue 4, 2013.

[v] Ibid.

[vi] Deosthali, Padma et. al (2011) 'Poor standards of care in small, private hospitals in Maharashtra, India: implications for public–private partnerships for maternity care' Reproductive Health Matters 2011;19(37):32–41

[vii] Deosthali, Padma and Ritu Khatri (2011)'Private Health Sector in Maharashtra: A study of private hospitals', CEHAT, Mumbai

viiiChiranjeeviYojana is an exception, however studies done on this scheme also show that it has not been able to reach out to the most vulnerable, although its stated purpose was to increase access to these groups. T. K. SundariRavindran (2011) Public-Private Partnerships in Maternal Health Services. Economic and Political Weekly, Vol - XLVI No. 48.