Episode 2: Exploring Healthcare in Maharashtra

TRANSCRIPTION

Speakers:

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Vivek Divan:

This is Status of States, where we explore health and healthcare across India's diverse regions with a particular focus on policy, programs, and ground realities. The Indian Constitution lists public health as the responsibility of states. Join us as we speak with health experts from different states, understanding the unique contexts, challenges, and innovations shaping public health.

I'm Vivek Divan, your host for this episode of Status of States, brought to you by the Center for Health Equity Law and Policy at the Indian Law Society in Pune. Let's dive right in.

In this episode we explore the state of Maharashtra. We're pleased to have Dr. Abhay Shukla speaking with us today. Abhay is a public health physician whose work has focused on improving community health and patient rights in Maharashtra for nearly three decades.

He currently serves as a Senior Consultant at SATHI Pune and is a national co-convenor of Jan Swasthya Abhiyan. He has been a champion in advocating for the Right to Healthcare and developing patient-centred initiatives, including the drafting of the national Patients' Rights Charter.

Abhay has authored and co-authored various publications on the health system in India. His book "Dissenting Diagnosis" exposes concerning practices within the private medical sector. He has been instrumental in facilitating community-based responses to COVID-19 in Maharashtra and large-scale audits to address overcharging by private hospitals at that time.

Abhay let me start by throwing the bigger question to you, which is - if you were to describe the state of healthcare in Maharashtra in general, how would you do so?

Dr. Abhay Shukla:

Thanks Vivek for including me in this series. When we talk about Maharashtra, it is a really paradoxical state. I describe it as a rich state with a poor health system.

Another way of describing the situation is like a few islands of prosperity amidst a sea of poverty. Maharashtra has huge inequities. Huge inequities overall and also huge inequities in healthcare and access to healthcare. And we have one of the most privatised healthcare systems in the country. So if you look at the NSS (National Sample Survey) data, 78 percent of hospitalizations are in the private sector, which is like the second highest among all major states of India.

And Maharashtra also has the largest number of, you know, insurance and panel private hospitals per lakh population among the larger Indian states. So it's a very privatised healthcare system. and a very low spending on public health. If you look at the 2022-23 figures, Maharashtra has the lowest spending on public health as a percentage of the state budget among all 28 Indian states.

This is a kind of paradoxical situation. As a result, I mean, most people do not have access to quality health care. Nutrition indicators, anaemia indicators are quite poor. Maharashtra has the highest levels of child wasting among all states of the country, despite the fact that it is a relatively prosperous state. So what we have in Maharashtra is poor health at high cost.

Vivek Divan:

Thanks for that. I think in stark terms, you have described the situation of, as you said, one of the wealthiest states in the country with little excuse, really for finding ourselves in a place where there are these few islands, but vast poverty and in the context of healthcare too.

You know, I remember growing up in what was then Bombay where there was a pride actually in the public provisioning of healthcare through the hospitals which are associated with medical colleges, very good quality in KEM, JJ, Nair and many others. Let's look at the issue of public provisioning for a second, and I'm wondering maybe you have some perspectives on whether public health provisioning has weakened as you suggest it has in your response just now and what the reasons were for that weakening.

Dr. Abhay Shukla:

So as you said, until the 1980s, Maharashtra had a reasonably well functioning public health system. Mumbai especially has, of course, several large and well functioning public hospitals, even if they may be overcrowded and so on. But this situation changed from the 1990s onwards, and we have seen complete neglect of the public health system by the political leadership of the state under various different governments and, on the other hand, rapid expansion of the private health care sector.

And this became very, very obvious and stark during the COVID 19 pandemic when we saw, you know, on one hand, there were some positive features, especially in cities like Mumbai, where the public health services, they reached out to people, showed basic outreach, testing, vaccination, and even treatment to whoever they managed to, you know, admit.

But on the other hand, we saw the public health system was completely overstretched during the COVID-19 pandemic in Mara because of its limited capacity of beds and services. So, for example, the Pune Municipal Corporation, when the pandemic started, the corporation in Pune did not have a single ICU bed among all of its hospitals. Pune is the second largest and a very large city of Maharashtra. Not a single ICU bed.

That was a similar situation we had in other large cities of Maharashtra with the exception of Mumbai, which is a kind of an outlier. In fact, I have calculated that many, many lives could have been saved in Maharashtra if we had a better public health system and well functioning public health services, especially in urban areas.

Maharashtra has the largest urban population of India. But if you see the number of urban public hospital beds, Maharashtra ranks seventh in the country, which is really striking. It's very insufficient.

If Maharashtra had the public health services and a case fatality rate similar to Kerala or Tamil Nadu at least around 60, 000 lives lost to COVID would have been saved if we had a better functioning public health system. So this underfunding, under resourced public health services in Maharashtra, people have paid a very huge cost for this, especially during the COVID pandemic.

Vivek Divan:

So on the one hand, while there's this weakening, lack of investment, a lack of political will to support clearly also some sort of interest in privatising healthcare, despite that COVID hit, It was the public hospital system, which actually came to the aid of people. Could you tell us a little bit about what were the factors that enabled that to happen and where the private sector was in that context?

Dr. Abhay Shukla:

In terms of Mumbai, I said that Mumbai is an outlier regarding health services because BMC, the corporation in Mumbai, has a much larger budget than any other city of Maharashtra in per capita terms.

So BMC spends almost 5, 000 rupees per capita on public health, which is much higher than any other city of Maharashtra. So Mumbai has a much better public health budget. And also historically, there are a much larger number of public hospitals, not just big hospitals like KEM and JJ and Nair, but also secondary hospitals.

Mumbai had secondary hospitals providing COVID care or had COVID beds during the pandemic. Better funds, a better state of overall public health infrastructure kept Mumbai as a kind of outlier. But on the other hand, in many other cities and districts of Maharashtra, the situation was quite different.

Vivek Divan:

So, tell me I'm assuming that this creates iniquity, huge iniquity. We've heard about the fact that privatisation of healthcare has created concerns around out of pocket expenditure, driving people into poverty, etc. I'm assuming that with this shift in Maharashtra from the 1990s, that has also been the case.

Could you describe how it has played out in Maharashtra for people who are trying to access healthcare in the last two decades, let's say?

Dr. Abhay Shukla:

So one of the main impacts of this privatisation has been that out of pocket spending on healthcare for ordinary people has gone up hugely. So again, if you look at the recent NSS data from the 75th round, you'll see that among major states of India, per hospitalisation expenditure in Maharashtra is second highest among all the major states of India, after Punjab.

Almost 27, 000 rupees is the cost of an average hospitalisation. If a person goes to a private hospital in an urban area the cost of a hospitalisation averages at about 42,500 rupees, which is huge. That is the average. This is what we have seen you know, in terms of overall increase in out of pocket spending and during COVID this went up even further.

Actually at SATHI, we did an analysis of hospital bills of patients who had sought care for COVID in private hospitals across the state, a hundred patients and about 120 hospitalisation episodes. And we saw that, while according to the regulated rates, the expenditure should have been about 8, 000 rupees per day, which is quite high, that is the expected level. But the actual level of spending in large private hospitals was above 40,000 rupees per day. So you can imagine 40,000 rupees per day is a huge amount for an average family. And COVID means they have been hospitalised for 15 days, 20 days, more than that also.

This out of pocket spending is one of the major consequences of privatisation and another associated consequence has been irrational care and unnecessary care, which is driven by the private sector, which wants to, you know, basically maximise its profits. So unnecessary caesarean sections, unnecessary hysterectomies, also a more complex problem, but also there is a large number of sex selective abortions.

These are all consequences of this kind of unregulated and irrational health care being provided by the private sector in Maharashtra.

Vivek Divan:

So let’s come back to talking about the private sector in a bit. I want to return to the public sector and the description you've given of how it has been weakened over time largely in urban Maharashtra, but also in smaller districts.

Recently, we've seen the incident of several deaths at a government hospital in Nanded district, and later a fact-finding team from Jan Arogya Abhiyan investigated the situation. Can you tell us a little bit about what JAA found and what it has recommended to urgently change things for the better?

Dr. Abhay Shukla:

In Nanded on 1st of October, 2023, in the main medical college hospital, there were 24 deaths of patients in 24 hours, which is a huge number for a hospital. It's more than twice, perhaps almost thrice of what is the average. After these deaths took place, the political leadership in the state was trying to scapegoat some of the hospital staff or the dean, saying that there is some kind of local problem.

But Jan arogya Abhiyan, which sent a Fact Finding Team, and I was a part of that team we went there immediately and interviewed a very wide spectrum of people who are associated with the health system in Nanded. And we found that the reason for this huge spike in deaths was related to an overload of patients in the medical college hospital and the reasons for that had to be sought outside the boundaries of the medical college hospital.

In Nanded district, there are 20 other public hospitals, various rural hospitals, sub district hospitals, women's hospital, a civil hospital, which all should be taking care of a lot of the load for secondary care across the district and only selected patients who have some health problem, which requires specialised care, tertiary care, only they should mostly be coming to the medical college, but out of the 20 public hospitals in Nanded, 19 do not even have a paediatric ward. They have no facilities for treating neonates, newborns, which means that all sick babies, all sick children, they just get directly referred to the single medical college hospital. And in this medical college hospital, there's also a shortage of basic staff, including nurses and resident doctors.

So for example, there's a neonatal intensive care unit, which has. 20 cradles, which means 20 babies can be admitted, but at any point of time, 60-70 babies are actually admitted because they're just being referred from all over the place.

So we saw that there were 2-3 babies on one cradle because that's the only way that they could manage those children. Now, this is obviously not a satisfactory situation. And there are only 2-3 nurses in that entire neonatal intensive care unit, which is something like one-fifth of the actual requirement, similar for resident doctors.

So there's a complete mismatch between the patient load across the district and the capacity for giving specialised care, which is only concentrated in one medical college hospital, which gets completely overwhelmed in certain situations and then excess deaths tend to occur.

So weak public health services, almost non existent specialised care outside the medical college and under resourcing of the medical college hospital itself. These are the systemic factors which led to the excess number of deaths in the Nanded Medical College Hospital last year.

Vivek Divan:

So before we get to your response to what needs to change, I wanted to ask you, would you say this is representative of other districts in Maharashtra?

Dr. Abhay Shukla:

Absolutely. We call the Nanded incident as the tip of an iceberg, which means that similar situations, which are less visible, are prevalent in many other districts, probably most of the districts of Maharashtra.

In fact, even at that time, you know, October 23 there were similar incidents of excess deaths of children and babies in other cities of Maharashtra also. So there was a similar incident in Thane in Aurangabad, in Nagpur and these excess deaths were taking place because the system was getting overwhelmed.

There was a long weekend at that time, which means that other private hospitals were not functioning. Probably other hospitals were not treating patients and all the patients were getting referred to these large public hospitals, which were completely overwhelmed. And even in Nashik, previously we have seen a similar kind of incident taking place - a large number of infants dying in a short period of time.

So the main problem is insufficient primary and secondary services and under-resourced tertiary hospitals. And in this combination, the number of patients which have to be treated overwhelms the single specialised hospital, which is there in the district.

The hospital bed to population ratio actually is quite unfavourable in Maharashtra. So we should have about 2-3 hospital beds per thousand population, but Maharashtra has just about 0.5, that is half public hospital beds per 1000 population. So this is quite insufficient and this is a situation across almost the entire state of Maharashtra with the partial exception of Mumbai city, which is a kind of an outlier, but it has its own set of problems.

Vivek Divan:

I'm curious to know, what do you think is the reason for such a weak kind of situation to persist? Is it because there is genuinely no political will or health is really not an issue which people kind of go to the polling booth thinking about? Or is it something else around the political class on understanding why public health systems are vital to a healthy society, or is it to do with the fact that there is a belief that privatisation will solve these problems?

I'm just curious, in your experience, have you engaged with people in positions of making policy? And what are their perspectives on this? Because it sounds like an utterly hopeless situation. And I wonder since the incident and since your fact finding report What has been done to rectify things?

Dr. Abhay Shukla:

Firstly, what we see in Maharashtra is not totally unique. Many other states of India also have this kind of under-resourced and politically neglected public health services with few, of course, important positive exceptions.

The reason for this starts from the 1980s and the early 1990s. In the 1980s, we saw a huge increase in the number of medical colleges and the starting of a large number of private medical colleges across many states, and Maharashtra was one of them, which started turning out large numbers of specialist doctors, MD and MS doctors and these MD and MS doctors, actually, they should have been absorbed into an expanded public health system, but that did not happen, at least definitely not in Maharashtra.

So instead, because of the prevailing entire new policy framework from the early 1990s of liberalisation - privatisation in a larger global climate, it was decided that the government will not invest in expanding public health services. Rather people should be encouraged to basically seek healthcare from the private sector in the market.

From then onwards, the public health system stagnated. It was not given political attention. Many politicians themselves were involved in setting up private medical colleges. So they had a vested interest in not strengthening public health services,

one can say. And obviously with a large number of postgraduate doctors, MD, MS doctors turning out, they started setting up their own nursing homes, their own small or medium sized hospitals. Probably people in the state also initially did not realise what was going on, and the middle class perhaps welcomed it to some extent.

By the time we reached the current situation we had landed up with a highly privatised healthcare system. So now both social kind of mobilisation and political will, will be required to change this situation. It's not a hopeless situation because after the Nanded incident. Jan Arogya Abhiyan launched a Right to Healthcare campaign and we visited 8 different districts of Maharashtra and organised health rights assemblies in each of these districts.

Everywhere, large sections of people came forth with the saying that we need to improve public health services, we need to regulate the private health sector in Maharashtra. So there is, I think, some amount of social recognition of the fact that this situation needs to change, but it's going to be an uphill task.

Vivek Divan:

Were there immediate rectification steps taken in Nanded to deal with the situation as it was then?

Dr. Abhay Shukla:

It's interesting that it is the High Court of Bombay which took a cognizance on a suo-moto basis of the Nanded incident, and the High Court started asking questions from the state government and the state health department and medical education department about what they're doing.

And I would say that largely because of the media coverage and the pressure from the High Court, that some sort of partial steps were taken, but actually very little has improved in Nanded itself, unfortunately. There have been some contractual appointments in the medical college. Some human power has been increased, which is not enough, but the situation of the secondary public health services in the rural hospitals, the sub district hospitals, et cetera. It remains more or less the same. There is very little improvement or almost no improvement until now. And that's because of the policy framework. There needs to be a change in the policy framework at the state level itself, and which has to be also logically supported from the national level.

It's not just a local problem of one medical college in one district.

Vivek Divan:

It’s an interesting argument you have made Abhay. Let’s look at the public provisioning of healthcare a little closely here. In an international context, India is committed to the Sustainable Development Goal of universal health coverage. The Pradhan Mantri Jan Arogya Yojana has been implemented to bring this into effect. It is a well intended programme, but there is now data revealing some of the challenges with it.

There are concerns around how the private sector will feature in such a programme. Being a proponent of strengthening the public healthcare system, what do you think it will require for Maharashtra to really elevate public healthcare in the context of programmes like PMJAY to ensure that genuine access to universal health care actually takes place?

Dr. Abhay Shukla:

Vivek, let me reiterate that in any country of the world or any state of India, there is no substitute for well functioning public health services. And public hospitals can function very well if they are provided the funds and given adequate political attention. I am myself a graduate of AIIMS (All India Institutes of Medical Sciences) in Delhi. And as you might be knowing, AIIMS is a public hospital and AIIMS for a long time was probably one of the best in the country and it still is because it gets an adequate amount of funds and also is being based in the national capital, it gets political attention. But not just that, even in states like Kerala, Tamil Nadu, Goa, we have examples of quite well functioning public health services right down to the PHC level. So, if there is political attention, if there are adequate resources, public health systems will function well. But the converse is also true, that if they're starved of essential resources, if, you know, human power is not provided, other systems are not well in place, then they will languish.

But the point is that we also need to understand that the public health services are called a system because there is a system there. The private sector has no system. It's a sector of just individual providers who are all competing among each other and who have no coordination among themselves. So if you want a system, the public system has to be central.

It's the only entity which can organise the larger system and even bring the private sector under some kind of regulation and proper. rational management which will never be happening if you leave it to the private sector on its own. So this is a very important point that we need to underline. And it's only the public sector which has a system. The private sector does not have a system per se.

And if we only go for schemes like PMJAY and other insurance schemes, these actually leave the larger market forces intact. These do not touch upon rationalisation of care or rates of care being made, you know, more logical on any other kind of improvements or regulation of the private sector. And they just hand out public resources to private providers on a case to case basis, which does not actually lead to a genuinely universal kind of system.

It just leads to some patients getting some partial care. for some of the diseases. It's not a solution. It's at the most a very, very temporary sort of measure. What we need for universal health care is basically a system of right to health care, which is focused on the public health system, anchored by the public health system, but can involve, of course, private providers in a rationalised and regulated manner. And what I say is that, you know, there are five components of this right to healthcare based on the public health system.

What are the five things we require in the public health system: A, B, C, D, and E. So A is an act, a right to healthcare act. B is the budget. There has to be an adequate budget, at least 8 percent of the state budget should be spent on health and something like At least around you know, 1.5- 2 percent of the GSDP should be spent on public health. B is budget.

C is community accountability, community monitoring, and responsive governance and curbing of corruption. That is C in the public health system.

D is doctors and drugs, which means basically staffing and medicines, which are also critical. And it is possible to have a very efficient system of procurement and distribution of medicines as Tamil Nadu has shown. And not just Tamil Nadu, but even states like Kerala and Rajasthan have also implemented. So that is essential for the public health system to function well.

E is expansion of the public health system. To meet the population needs right from the sub-centre and PHC (Primary Health Centre) levels up to the tertiary hospital levels.

So with an act with the budget, with community accountability, with doctors and drugs and with expansion, all these ABCDE, if they are in place, we can have the right to healthcare in any state, including in Maharashtra. Maybe I'll touch upon this a little later about how Maharashtra actually has all the prerequisites for universal health care except the political will, which is what is required.

Vivek Divan:

Yes, let's revisit this point. I think it's a wonderful way in which you've actually described the components, but let's come back to that in a bit. Abhay, you have spoken about the idea of universal healthcare. There is also this idea of a patient's charter of rights in the context of health care that has been proposed by the union health ministry.Could you talk a little bit about Tell us a little bit about that.

Dr. Abhay Shukla:

Yeah, sure. A system for universal healthcare, it's an idea or it's a kind of a model which has been implemented in many countries across the world, which have essentially realised that healthcare should be at least partially removed from the market.

It should not just remain like a commodity. In fact, everyone who lives in that country should have access to reasonably good quality healthcare, which is free of cost and not dependent on your capacity to pay. So, of course, there are many such models in developed countries, but also in countries like Thailand from the global south, they have also implemented a well functioning universal healthcare system.

So, in a state like Maharashtra or in any other state of India we can also at least start the process of developing universal healthcare services, which should be essentially based on three components. One is expanded, strengthened and accountable public health services, which will be the bedrock of such a system.

The second is regulation of the private health care sector and sort of insourcing private hospitals and private providers to provide certain kinds of care which are not available in the public health system. It should be free of cost for the people who access the care, but will be paid for by the government. But of course, their rates will be rationalised, their treatment practices will be regulated, and they will be part of such a system.

And the third that over on this system will be based on a system of rights so that people are not denied care and also it's held socially accountable as, for example, in Thailand, there is a system of health assemblies which are organised every year or in Brazil, they have these health councils which are multi stakeholder. So it has to be strongly held and socially accountable.

So this kind of system of universal health care should be actually on the agenda, even in the context of India and Maharashtra.

Coming to the patient's rights charter, as we know that there's a huge asymmetry of knowledge and also of power between an ordinary patient and a hospital. The patient is much more powerless and the hospital and the treating doctor often has a certain kind of inherent power, which can be either used well or it can be abused. So to prevent any abuse of this kind of power, across the world, there's this concept of patient's rights. And basic elements including right to information, right to confidentiality, seeking a second opinion, knowing about the rates of services, right to privacy, various records and reports, etc. These are basic patient's rights.

In India, I was part of a committee of the National Human Rights Commission which developed the first national level patient's rights charter in 2018 which was then sent to the Union Health Ministry; not much progress was there initially by the ministry. After that, as Jan Swasthya Abhiyan, we organised a demonstration at Jantar Mantar in February 2019, asking for, among other things, implementation of the patients rights charter.

After this in June, 2019, the ministry released the first circular on patients rights, which included 13 patients rights and some set of patient responsibilities also. This was actually not completely sufficient, but after the COVID experience and some of our efforts in 2021, in August, 2021, An updated and expanded charter of patients rights has been released by the Union Health Ministry to be implemented in all states across the country, which has 20 patients rights.

And these are very important rights. As I mentioned, some of them, no hospital can detain the dead body of a patient, No hospital can force the patient or the family to buy medicines only from the pharmacy which is there in the hospital or which is dictated by the hospital. If they are involved in clinical trials, they have an entire range of rights, etc.

This patient's rights charter now needs to be very widely known. It needs to be very widely publicised, and it needs to be implemented as a part of the larger regulatory framework, whether it is the Clinical Establishments Act at the centre level or other state level regulatory acts. It needs to be implemented everywhere.

I would urge all the listeners of this podcast to become acquainted with these patient's rights so that whenever it is required, they can demand them. Or they can also advise others about how to, you know, ensure these rights, which should protect them in any kind of clinical situation.

Vivek Divan:

Okay, I want to now focus back on private healthcare. As you say, it's not a system but a sector. It is a largely unregulated sector, and you have advocated for regulating it.

It has been powerful in Maharashtra for several years now. What would be your key proposals about regulating the private sector based on the experiences of people over the last few decades?

Dr. Abhay Shukla:

Quickly, if we just see what happened during COVID in Maharashtra. Maharashtra had the largest number of COVID cases as well as COVID deaths among all Indian states. Even according to official figures, it's about 1.5 lakh deaths out of the total national figure of a little more than 5 lakh deaths. And that is an underestimate.

So, in Maharashtra, what we saw in the first wave was initially denial by many private hospitals who were turning away patients. And then they started admitting patients. And by the time of the second wave, there was huge overcharging and including a lot of irrational care or less rational care, which was going on in many private hospitals.

During the COVID pandemic, because a large number of women, they lost their husband's COVID as the so-called COVID widows, where women who had lost their husbands to COVID, number in tens of thousands in Maharashtra. So they were saddled with a double burden. First of all, they had lost their husband and their partner. And secondly, they were, you know, saddled with these huge private hospital bills after the death, which range in the 15 lakhs, 20 lakhs, 25 lakhs per family, which is almost unpayable.

So given this situation, because of the private sector overcharging. Jan Arogya Abhiyan and a network of, you know, COVID affected single women, we organised the Samta Sabhas in some parts of Maharashtra and where people came and started recounting their stories of overcharging. And SATHI also documented some of these stories.

As I already mentioned, probably the rates of hospitalisation care in large private hospitals were above 40,000 rupees per day. So this is the scale of huge overcharging which people because of a lack of regulation of private hospitals. Although the government tried to regulate the rates, it was not very effective.

Actually, even during COVID, in January 2021, the government of Maharashtra, they enacted a new set of rules for the Maharashtra Nursing Home Registration Act. It's a very old act, but they tried to bring in some rules. For example, some provisions include that every private hospital should display at least the indicative rates, a set of 15 rates and in a rate chart. Every hospital should follow the patient's rights, every city and every district of Maharashtra should have a grievance register cell for patients to approach in case they have a problem in a private hospital.

These rules were passed in January 2021. But now we're in 2024. Actually, we have seen that there was not much political will for implementation of these new rules. So our immediate demand is that these rules should be adequately implemented across the state, which is something that doesn't require any new law.

Then we also need a more comprehensive Clinical Establishment Act or CEA for Maharashtra, which also includes standardisation of rates.

So transparency of rates, observance of patients rights, functioning of grievance adjusted cells and moving towards standardisation of private hospital rates. These are all key components of the kind of regulation that we require in Maharashtra, of course, along with standard treatment protocols to rationalise the care of these private hospitals.

To oversee this kind of regulations, we also have asked for multi stakeholder bodies, which include civil society, patients groups, women's groups so that it's not just a bureaucratic implementation, but rather there's a larger social oversight. Otherwise. We'll have a regulatory escape or expert regulatory capture and nothing much will change. So we need regulation, but it also needs to have a social component.

Vivek Divan:

The suggestions that you mentioned, have you made these to the state government? And in a broader sense, for instance, I know that you are involved in a Public Interest Litigation in the Supreme Court about the regulation of private healthcare. Can you tell us about these different strategies through which you seek reform of the law to reflect a more egalitarian health system?

Dr. Abhay Shukla:

These are primarily political decisions. And therefore in the Right to Healthcare campaign, In late 2023 and early 2024 we had a campaign across 8-10 districts of Maharashtra where we organised these assemblies, as I've already mentioned. And we tried to dialogue with political parties also.

And in February 2024, we had a state level convention, a health rights convention, where we invited representatives of various political parties to also respond to these issues. That was an attempt to put the issue on the political agenda in Maharashtra. We are going to continue this process even before the assembly elections in Maharashtra, which are later this year.

Coming to the Supreme Court PIL. Yes. Jan Swasthya Abhiyan has filed a PIL in the Supreme Court, which was accepted in early 2021. The hearings on that PIL and another related PIL, which has been filed by an organisation called Veterans Forum have started. Our PIL, we have asked for implementation of the Clinical Establishments Act in the 12 states, which have adopted the act, which means rate transparency, which is there in the rules, must be implemented. All hospitals should display their rates. Standard should be notified and the process of standardisation of rates, which is mentioned in the rules, but pendings since 2014, from 2014 to 2024, even the basic standards have not been notified in 10 years down the line. And the process of standardisation of rates has also been completely suspended. So these have to be restarted and taken forward and implemented.

These are some of our main pleas in the PIL and also the fact that other states which may not have adopted the central CEE, they also should have some similar regulatory processes, keeping in view the fact that we cannot discriminate among people across states and the patient's rights charter should be immediately implemented, grievance redressal cells should be initiated. These are all core pleas which are there in the PIL.

The Supreme Court has started taking up these issues but unfortunately the union government has been rather sluggish in responding. But even more worrisome is the fact that in the last hearing, the private hospitals lobby came in with some of the top and most expensive lawyers of the country to argue that the government has no mandate to standardise rates. The Supreme Court should completely keep out of this entire process of standardising rates. They very vehemently argued against any kind of regulation.

This is the kind of situation that we are in right now. Basically much larger public awareness and public support for regulation of the private healthcare sector is required and even rational-ethical doctors are now coming forth and saying, yeah, we, you do the, some sort of standardisation and basic regulation to avoid this complete commercialization and irrational kind of healthcare, which is not good for people, but it's not even good for, you know, rational ethical doctors.

We have been asked, is it possible for hospitals to standardise rates? The answer is - Already tens of thousands of hospitals in India are following CGHS (Central Government Health Scheme) rates. They're observing CGHS rates. They're

providing services at standardised rates. There's more than 15,000 private hospitals that are part of PMJAY and every day they're treating hundreds of patients at standardized rates. Insurance companies also standardise rates at a certain level.

So already we have partly standardised rates for private hospitals. We just have to take it forward and standardise whatever is possible to be standardised. There may be some particular situations which are exceptional, but still by and large it is something which is technically possible.

What is required is basically the political will and adequate social support for this.

Vivek Divan:

Okay, that gives us a vivid picture of the actors who influence these issues. It also gives us an idea of where the case is right now. I imagine that there will be renewed momentum once the court reopens and sets some dates for hearings.

I want to take a step back now, as we have been focusing considerably on hospitals and tertiary care. Let’s talk about the idea of strengthening primary health care. The clear logic is that by strengthening primary health care, the burden on secondary and tertiary care will be reduced, a lot of health complications can be addressed at a very early stage, which in turn will lead to a healthier populace. Yet over time we have seen primary healthcare weakening.

What is your view on the current state of primary healthcare systems in Maharashtra and what needs to change?

Dr. Abhay Shukla:

Yeah, Vivek, you're absolutely correct. Primary health care is extremely important in any health system because it's the base of the entire healthcare system.

Primary health care is not just about providing some kind of primary treatment. It's also related to preventive, promotive services, immunisation, antenatal care, outreach services, disease surveillance, all these link with primary healthcare. And also it's very much about involving communities, involving, frontline health workers like ASHAs and Anganwadi workers.

It's an entire system which basically bases the healthcare services in the community and reaches out to and ensures that not only that people take care in a timely manner, but also that to the extent possible diseases are prevented or at least detected at an early stage and managed in an effective manner so that maybe 80 percent of health problems can be managed through the primary health care system.

So therefore, its strengthening is extremely important and also can deal with some of the social determinants of health, like safe water supply, sanitation. Nutrition, food security, et cetera, and also linked with primary healthcare. That's why it's so important.

But in Maharashtra, what I would say is that, I mean, there is a kind of a basic sort of very skeletal infrastructure in place. And now we have these health and wellness centres where the sub-centres and the primary health centres are being upgraded, which is a positive step. And we should definitely welcome that. But the kind of human power that is required, the kind of resources that are required to strengthen these health and wellness centres is still not adequate.

So some steps have been taken, which is positive, but much more needs to be done. And also the community structures surrounding the you know, these health and wellness centres like the Jan Arogya Samitis. They have mostly remained on paper in many areas. In several areas, SATHI and its partner organisations have actually built up these Jan Arogya Samitis, activated them, and those have led to remarkable positive results in terms of improving the utilisation of the PHCs and the sub-centers in terms of improving people's engagement with the health system.

So that community involvement and community action component is also very important to improve primary health care. And I think if that is done, with resources from the top and community engagement from below and good management within the system, all these components together definitely primary healthcare can be improved and it's very important.

Vivek Divan:

So I want to touch on the theme of community. You mentioned it a few times and you've also spoken about the need for multi-stakeholder bodies to oversee implementation of things like the Clinical Establishments Act or any other law which comes into force. You've spoken also about social auditing as it were,, which I imagine is the same idea.

Could you tell us a little bit about what actually it would look like for community monitoring and social auditing to take place to ensure that the mechanisms, government, private healthcare are actually being implemented in an equitable way?

Dr. Abhay Shukla:

This is an area which is still emerging and we need more sort of social experimentation to develop this, but we have some tentative or preliminary experiences.

So for example, during COVID, because of the overcharging by private hospitals, Jan Arogya Abhiyan organised a public hearing on private hospitals in early 2021. This is probably unique, probably the first time that there was a public hearing on private hospitals. It had to be done in a hybrid mode because of the COVID situation and all that.

But there was a huge response that we got, and the concept was sort of established that even private hospitals have some social accountability, especially during a pandemic, but even otherwise. At least they cannot completely, grossly overcharge or engage in grossly irrational care or malpractices. That is something which is not socially acceptable. And therefore society has some role in monitoring and making accountable the private health care sector and the private health care sector also should respond.

This kind of social oversight was also then displayed during the process of this participatory survey of hospitalizations of patients and their families which was done in September 2021, where, you know, 75 percent of the COVID cases they reported that they have been overcharged and more than 2,500 such cases were surveyed.

This entire campaign for a participatory audit of private hospital bills during COVID was something unique, which happened in Maharashtra from roughly November, 2021 to March, 2022. And during this campaign for participatory audit, the government actually responded to this demand that people who have been grossly overcharged, their private hospital bills should be re audited, and if they have been charged excessively, the excess amount should be refunded. And this actually happened in Maharashtra.

So about 500 complaints were lodged. Out of these 500 complaints in about more than 100 complaints, the private hospitals gave some kind of informal refund to the family. And in 63 cases, they formally received refunds of amounts ranging from 25,000 to 50,000 to more than a lakh rupees from the private hospital. This is unprecedented, which shows that if people are activated, if there is a social mobilisation, even private hospitals can be held accountable.

Given this experience we think, especially in countries like India, the regulation needs to have an element of social accountability. So if something is happening in a private hospital which is not appropriate from the patient's point of view, people should have a say, at least in pointing out these problems and monitoring the situation, in informing the local regulatory authorities so that proper action is taken.

Otherwise, the regulators can be bought off, they can be corrupted, they can be captured by the private sector, and that will not serve the purpose that we are expecting. So therefore, we need social audit processes, not just for the public health

system, but of course, they're very important through community monitoring. Which we have done in Maharashtra on a large scale, but also for the private sector and also for public private schemes like the PMJAY, which also need to be brought under the lens of social audit and accountability, without which, you know, all kinds of distortions, denials, and double charging tend to take place.

Vivek Divan:

As I'm hearing you speak, I'm visualising that if this is legislated on, it will be a great tool to ensure accountability and transparency. It has been attempted in other social sector legislations like the NREGA, and has had some success. So there are lessons to be learned from other models.

As we move to the end of our conversation I want to bring back the five components that you discussed earlier, Abhay - the A B C D E, an Act, a Budget, Community, Doctors and Drugs, and Expansion.

You mentioned Maharashtra has all the prerequisites for this to be implemented. Tell us a little bit about that and also in an ideal situation, what would that system look like?

Dr. Abhay Shukla:

Maharashtra has all the resources to ensure universal health care for its residents. If you actually look at it carefully, Maharashtra is the highest GSDP among all Indian states.

It has the seventh highest per capita income among Indian states, large Indian states. So we have enough financial resources. Maharashtra has the largest number of billionaires in India. 38 out of the top richest Indians are from Maharashtra, mostly from Mumbai. Maharashtra of private hospitals empaneled by insurance companies. So we have a huge private sector.

We also have the second largest number of medical colleges, we are turning out or rather churning out doctors in large numbers everywhere. So there's no shortage of doctors. There's no shortage of hospitals overall. Or even if there is some shortage, it's basically because of inequitable distribution. But otherwise, there is a large number.

Maharashtra has the largest number of pharma production clusters in the country. So medicines are being produced. And we also are paying the highest amount of health insurance premiums. So 30 percent of the entire country's health insurance premiums are paid in Maharashtra more than any other state.

So people are paying out of their pockets, basically to scope with the privatised healthcare sector because of the set task situation. So people are already paying a lot, but not getting good quality care. But I said in the beginning, we have poor health at high cost. So we have all these resources, but they are locked into a completely privatised and inequitable system.

The large majority of Maharashtra's population, especially in rural areas, tribal areas, and even among the urban poor. They are not able to access these resources. So the solution to that is basically moving towards a system of universal healthcare and right to healthcare. And this would have probably two steps or two stages.

The first step is what I call basic right to healthcare or right to public healthcare services. Where the state needs to say that, okay, we will ensure all public health services are adequately delivered in all parts of the state based on certain minimum standards, like Indian public health standards there are certain norms for human power, every sub centre, every PHC etc , will have adequate staff and including specialist doctors, etc. And also there's a mandatory level of financing. You know, something like at least 8 percent of the state budget will be dedicated to health services. Which will mean doubling of the health budget in Maharashtra. But as I said, we have enough resources. It's a rich state. So we have to tap into those resources.

Budgets and the human power and standards all have to be part of this right to healthcare process. So the first stage would be basically ensuring that people at least get basic public health services in an assured manner, of course, with some kind of grievance reduction mechanisms and social oversight.

Once that is in place, then we can move towards the second step of tackling the private sector and bringing it under a larger umbrella of universal healthcare, but where the public health system already has gained a certain level of capacity to deliver and also to regulate. And then we can move towards universal health care where people can even walk into a private hospital, which is regulated and empanelled and get free services, which are paid for by the state.

It's this kind of a two step process which needs to be thought about to implement the right to healthcare in a state like Maharashtra.

Vivek Divan:

One fundamental thing that comes to mind is that you need a legislative framework to enable all this. I imagine that there must have been conversations within the ecosystem of public health activists and experts to consider what role the law should

play. Do you see momentum building in that direction? And, do you see conversations possible with elected representatives on this front?

Dr. Abhay Shukla:

Yes, that is an important point.

We have had quite a bit of discussion within Jan Swasthyaya Abhiyan about what kind of legal framework will be appropriate to ensure the right to healthcare. Now India has a federal system regarding health services under the constitution, they fall under the state list. Besides this, there is huge diversity across Indian states. So what will work in Punjab will not be applicable to Tamil Nadu. What is appropriate for Gujarat will not work in West Bengal and so on. I mean broadly. Therefore, what we have demanded in the People's Health Manifesto, which was released recently before the Lok Sabha elections, is that all states should adopt Right to Healthcare Acts and this should be supported in a major way through financial and other administrative support by the central government.

This would be an appropriate way to ensure that federalism is maintained. It's not a completely centralised system, but it is supported by the centre in an adequate manner. And talking of these kinds of state level right to healthcare acts, Rajasthan did attempt an act last year, and it was a notable and commendable initiative. At least it had the potential to ensure the right to public healthcare services, which is an important first step that at least people get basic public health services in an accountable and assured manner. But because of a lot of resistance from the private healthcare sector, the final act got somewhat diluted. But still, this is like a first round or a first sort of phase of experience.

We can build upon the learnings from the Rajasthan experience and design such state level right to health care acts for other states across the country, including Maharashtra, which will be, as I said, initially focused on legally assured health services from public health facilities with the obligation on the state to properly fund and deliver these services and accountability mechanisms, which will ensure that if somebody is denied the essential care, then they can activate a grievance redressal system and get a redress for that in some form.

If this is done, it will restore people's trust in public health services, which is very important. If you know that you go to a PHC and you'll get at least basic services there, people always prefer free and good quality services, which are assured and they would shift back to the public health system in significant numbers.

This will help to roll back privatisation and create the basis for the next step, which would be universal healthcare, where people can even go to private health care providers.

Vivek Divan:

In my mind's eye, when you spoke just now, I visualised the path to equitable health being paved with both the will to change the status quo but also the idea of building bottom-up pressure to convince people in positions of power.

It's been a really enlightening conversation with you Abhay, and I'm sure we have given our listeners a good glimpse of the state of health and healthcare in Maharashtra and considerable food for thought. Thank you so much for your time and sharing your experience and expertise.

Dr. Abhay Shukla:

Thanks a lot for giving me this opportunity.

Vivek Divan:

Thanks for joining us for this episode of Status of States. Stay tuned for more such conversations.

This is your host, Vivek Divan, signing off.