Sustaining for-profit emergency healthcare services in low resource areas

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Abstract

The Bawaskars in their Comment "Emergency care in rural settings: Can doctors be ethical and survive?" raise a context-specific question about the sustainability of emergency care in rural, low resource areas. This could be broadened to "What efforts are needed to sustain emergency care systems run by the private sector in rural, low resource areas without catastrophically affecting patients or healthcare providers?" There are enough constitutional, legal and ethical imperatives to state that all emergency care should be available to everyone irrespective of paying capacity. The State should be responsible for providing emergency care via the public sector or for strategically purchasing it from private providers. Even if that arrangement is not viable, private sector providers cannot expect the community to underwrite the sustainability of such services and the return on investment in their training. Finally, we suggest that the principles of ethics cannot be invoked for justifying the financial viability and sustainability of the private sector in an unequal world.

The issues that the Bawaskars raise though their article (1) are rather contextual and lack universal relevance. They are relevant to the concerns of those physicians working rationally in the for-profit private sector in underserved areas.

The context-specific question they have raised about the provision of emergency care in rural, low resource areas could be broadened to "What efforts are needed to sustain emergency care systems run by the private sector in rural, low resource areas without catastrophically affecting patients or healthcare providers?" There are lots of studies which show that emergency care expenses, especially in private healthcare services push patients' families below the poverty line (2,3)

Achieving a balance between sustainability of private health facilities and ethical practice could only be through the provision of such emergency care services as part of free public healthcare for all, or it would need people to have enough surplus money to access emergency care at the nearest private sector facilities. As a signatory to the UN Declaration on the right to health (4), India has already committed to provision of accessible and affordable healthcare to all citizens.

This question around sustaining privately run emergency care in rural resource-poor settings without catastrophic expenses among people, in fact leads us further to "What is the relevance and space for private healthcare facilities in emergency care in underserved areas?" Ideally, the state should run and provide healthcare to all people for their needs including emergency care, and there should be no compulsion for people to go to private healthcare facilities.

Even in the real world where private facilities arguably provide more than 70% of care even in rural areas (5) due to the poor quality and ineffectiveness of services in public health facilities, can the community be expected to pander to various considerations of private providers? The Bawaskars make a problematic statement that asserts "doctors in small communities are easy prey" to the machinations of the public which they serve. Prey to what - the poverty of the people or their poor paying capacity? Is the community often not a prey to the rapacious private sector physicians who would charge exorbitant fees, carry out irrelevant investigations and often not reach a correct diagnosis, besides advising unnecessary admission and treatment?

However, one wrong does not justify another. Their main thesis is that it is difficult for ethical and rational doctors to survive in rural underserved areas because several people in the community they serve don't fulfil their promises to pay later for emergency care.

Preservation of life and saving life is an absolute constitutional obligation for health systems according to Article 21of the Constitution of India. There is a certain ethic (6) that guides care in emergencies in all shades of health systems, whether state run or dominated by private healthcare providers. Even in the market driven US health system, though 8.6% (7) of people don't have any health insurance, every health facility is obliged to provide free emergency care to all (8). Certainly, in countries that provide Universal Health Care such as Thailand, Canada and Brazil, emergency care is available without the sick person having to pay anything (9, 10, 11) In other capitalist economies such as Germany, France and Spain too, emergency care is provided free, although certain routine services like physiotherapy, speech therapy, medical aids are not even provided to those that are insured (12).

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In India, while we have laws that prevent any health facility from denying emergency care (13) the scope of which is variable, the quality and spectrum of care are poor (14). The proportion of people with a myocardial infarction who reach a hospital and get thrombolytic treatment is 35-50%.(15) Similarly, those suffering a stroke who could reach a hospital within the window of four hours in a metropolitan city like Mumbai is 42%.(16) The proportion of people with snake bite with envenomation who get the required dose of anti-snake venom is less than 50% (17). The situation in most rural hospitals can only be imagined as far worse. It may not be incorrect to say that most rural hospitals, whether community health centres or primary health centres, rarely provide any effective emergency care for most common emergencies that rural folk face except obstetric care, even if they do provide some routine care (18). Apart from providing a modicum of emergency obstetric care, these institutions serve mainly as referring nodes (19).

In the context of this dire state of emergency healthcare services, what is the place of private for-profit health facilities? It would clearly be desirable that all such institutions should get themselves empanelled under the National Health Protection Scheme that the state provides funds for, and could then use the packages specifically meant for emergency care. We agree that there is a need to expand the different packages offered under the health insurance schemes and ensure the inclusion of emergency care. A Law Commission report guides the state to allocate a separate fund to support emergency care expenditure by medical professionals, hospitals and even ambulances (13). Recently the states of Delhi (20) and Kerala (21) have passed orders that all emergency care for trauma and selected emergencies for the first 48 hours will be paid for by the state and this will include care in private health facilities. The West Bengal Clinical Establishments Bill, 2017, recommends that expenses incurred by private hospitals in emergency care for those who are not able to pay will be paid for by the state "in due course" (22). Since the Law Commission's 2006 report categorically suggests that the state has to ensure payment for emergency care, including during childbirth, incurred in the private sector, this provision should be used by individual state governments to ensure adequate emergency care in both public and private hospitals, irrespective of the sick person's ability to pay. Compliance with this is unknown, except in Delhi and Kerala.

A second problematic statement which the authors make is that "the public has the prejudice that doctors overcharge often, and that they don't understand the expectations for the return on investment of time and fees that doctors make". Is overcharging a mere prejudice of the community towards doctors (23)? No. Every year about 7% (63 million) of Indians fall below the poverty line due to catastrophic healthcare expenditure (3, 24, 25). The investment of money that the state makes in the training of physicians both at MBBS and post-graduate levels comes from the taxpayers' money and the community cannot be expected to underwrite the expenses certain physicians make in getting trained in private, paid training institutes.

Finally, how many doctors has anyone heard of slipping down the economic ladder? We would argue that the financial graph of almost all private physicians only moves upwards.

What place does the private sector occupy in the health care services scenario? Clearly, the expansion of private health care services has been in response to the ineffective and inaccessible public health system in rural areas. a process that acquired speed in the 1980s and galloped towards corporatisation after 2000. However, in the unequal society that India is, with large swathes of rural areas being underserved, the private sector would naturally have found its relevance there. However, the formal private sector only thrives in those areas where the public system thrives, even if the quality is variable (26). What then is available to most rural areas is usually informal practitioners whose rationality and effectiveness is often questionable. There are only a handful of voluntary organisations who provide clinical care that includes secondary level emergency care in rural areas. The number of private clinics that provide in-patient and emergency care in the villages is far smaller in our villages than our cities.

To summarise, we opine that there are enough constitutional, legal and ethical imperatives to ensure that all emergency care should be available free for everyone, regardless of their paying capacity. This should ideally be provided by the public services. If the state is unable to make available effective and necessary emergency health care services at all levels, tertiary, secondary and primary, then it could strategically purchase them from the private sector. Even if that arrangement is not viable, the private sector providers cannot expect that the community should underwrite the sustainability of their services plus return on any investment they may have incurred on their training. That would be unacceptable. We should work on arrangements that make the state underwrite emergency care expenses for indigent patients who seek treatment in the private sector. Finally, we suggest that the principles of ethics cannot be invoked for justifying the financial viability and sustainability of the private sector in an unequal world.

References

1. Bawaskar HS, Bawaskar PH. Emergency care in rural settings: Can doctors be ethical and survive? *Indian J Med Ethics*. 2018 May 3 [cited 2018 Jul 15]. Available from: http://ijme.in/articles/emergency-care-in-rural-settings-can-doctors-be-ethical-and-survive/?galley=html
2. World Health Organization/World Bank. Tracking Universal Health Coverage: 2017 Global Monitoring Report. 2017[cited 2018 Jul 15]. Available from: http://pubdocs.worldbank.org/en/193371513169798347/2017-global-monitoring-report.pdf
3. Bhandari L, Berman P, Ahuja R. The impoverishing effect of healthcare payments in India: New methodology and findings. *Econ Pol Wkly*. 2010 Apr 17 [cited 2018 Jul 13];45(16):7–8. Available from: https://www.epw.in/journal/2010/16/special-articles/impoverishing-effect-healthcare-payments-india-new-methodology-and
4. UN High Commissioner for Human Rights, World Health Organization (WHO). The Right to Health Factsheet 31. Report. 2008;31(June):1–52. Available from: https://www.ohchr.org/Documents/Publications/Factsheet31.pdf
5. Ministry of Statistics and Programme Implementation, Government of India.. New delhi:MoSPIHealth in India-NSSO 71st Round. 2014 [cited 2018 Jul 12]. Available from: http://mospi.nic.in/sites/default/files/publication_reports/nss_rep574.pdf
6. Medical Council Of India. Code of Medical Ethics Regulations, 2002.

New Delhi:MCI; 2002. Amended up to Oct 8, 2016. [cited 2018 Jul 14]. Available from: https://www.mciindia.org/CMS/rules-regulations/code-of-medical-ethics-regulations-2002
7. Barnett JC, Berchick ER. Health Insurance Coverage in the United States: 2016 Current Population Reports. 2017 [cited 2018 Jul 27]. Available from: https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf
8. Emergency Medical Treatment & Labor Act (EMTALA), 2012 [cited 2018 Jul 27]. Available from: https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/
9. Government of Canada. Health care in Canada. Modified Jul 11, 2017[cited 2018 Jul 14]. Available from: https://www.canada.ca/en/immigration-refugees-citizenship/services/new-immigrants/new-life-canada/health-care-card.html
10. Ministry of Public Health, Thailand. 11th National Health Development Plan 2012-2016 . 2012 Oct[cited 2018 Jul 13]. Available from: http://www.nationalplanningcycles.org/sites/default/files/country_docs/Thailand/11ththailandnational_health_development_plan.pdf
11. O'Dwyer G, Konder MT, Machado CV, Alves CP, Alves RP. The current scenario of emergency care policies in Brazil. *BMC Health Serv Res*. 2013 Feb 20;13:70. doi: 10.1186/1472-6963-13-70.
12. Institute for Quality and Efficiency in Health Care(IQWiG). Health care in Germany: Health insurance in Germany [Internet]. 2018 [cited 2018 Jul 28]. Available from: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0078017/
13. Law Commission of India, 201st Report on emergency medical care to victims of accidents and during emergency medical condition and women under labour. 2006 Aug [cited 2018 Jul 12]. Available from: http://lawcommissionofindia.nic.in/reports/rep201.pdf
14. Thota D, George CK. Quality emergency medical care in India: Challenges & opportunities. Working Paper 60/2005:1–20. Available from: https://www.ihs.org.in/Publications/wp60.pdf
15. Guha S, Sethi R, Ray S, Bahl VK, Shanmugasundaram S, Kerkar P, et al. Cardiological Society of India: Position state/ment for the management of ST elevation myocardial infarction in India. *Indian Heart J*. 2017 Apr 1 [cited 2018 Jul 12];69(1):S63–97. Available from: https://www.sciencedirect.com/science/article/pii/S0019483217301876?via%3Dihub
16. Khan A, Phadke M, Lokhandwala YY, Nathani PJ. A study of prehospital delay patterns in acute myocardial infarction in an urban tertiary care institute in Mumbai. *J Assoc Physicians India*. 2017 May [cited 2018 Jul 12];65(5):24–7.
17. Kasturiratne A, Wickremasinghe AR, de Silva N, Gunawardena NK, Pathmeswaran A, Premaratna R, Savioli L, Lalloo DG, de Silva HJ. The global burden of snakebite: a literature analysis and modelling based on regional estimates of envenoming and deaths. *PLoS Med.* 2008 Nov 4 [cited 2018 Jul 12];5(11):e218. Available from: http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.0050218
18. Chauhan R, Mazta S, Dhadwal D, Sandhu S. Indian public health standards in primary health centers and community health centers in Shimla District of Himachal Pradesh: A descriptive evaluation. *CHRISMED J Heal Res* [Internet]. 2016 [cited 2018 Jul 14];3(1):22. Available from: http://www.cjhr.org/text.asp?2016/3/1/22/172390
19. Sodani P, Sharma K. Strengthening primary level health service delivery: Lessons from a state in India. *J Fam Med Prim Care* [Internet]. 2012 [cited 2018 Jul 14];1(2):127. Available from: http://www.jfmpc.com/text.asp?2012/1/2/127/104983
20. Citizen Charter of G B Pant Hospital, Government of Delhi. Date unknown [cited 2018 Jul 16] Available from: http://www.delhi.gov.in/wps/wcm/connect/d8ac34004462961b8f39bf75d920f8b7/CitizenCharaterFinal.pdf?MOD=AJPERES&lmod=1347330896&CACHEID=d8ac34004462961b8f39bf75d920f8b7
21. Kerala Emergency Medical Services Project. 2010 [cited 2018 Jul 13]. http://www.arogyakeralam.gov.in/index.php/special-initiaves/kemp
22. The Telegraph Bureau. Consequences of hospital bill . *The Telegraph*.2017 Mar 3[cited 2018 Jul 14]. Available from: https://www.telegraphindia.com/1170303/jsp/calcutta/story_138694.jsp
23. Gadre A. India's private healthcare sector treats patients as revenue generators. *BMJ.* . 2015 Feb 24; 350:h826. doi: 10.1136/bmj.h826.
24. Karan A, Yip W, Mahal A. Extending health insurance to the poor in India: An impact evaluation of Rashtriya Swasthya Bima Yojana on out of pocket spending for healthcare. *Soc Sci Med* . 2017 ;181:83–92. doi: 10.1016/j.socscimed.2017.03.053. Epub 2017 Mar 27.
25. World Health Organization, World Bank. Tracking Universal Health Coverage: 2017 Global Monitoring Report. Geneva:WHO; 2017[cited 2018 Jul 13]. Available from: http://pubdocs.worldbank.org/en/193371513169798347/2017-global-monitoring-report.pdf
26. Personal communication with and presentation by Indranil, Sharma S, Datta P, Selvaraj S. Changing landscape of private health care providers in India: implications for National level health policy. Presented at JSA-OXFAM-PHRN Conference, New Delhi; January 2017.

Response to Jain et al on emergency healthcare in low resource areas

PRABIR CHATTERJEE

"Sustaining for-profit emergency healthcare services in low resource areas" by Jain et al (1) is an excellent reply to the Bawaskars (2). Clearly, the state must prevent both patients from going bankrupt and practitioners from running into negative balances.

However, two points made in the commentary are contestable:

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(i) *"... how many doctors has anyone heard of slipping down the economic ladder? We would argue that the financial graph of almost all private physicians only moves upwards."*

Is there any evidence to support this statement? Probably the income of private doctors in rural areas varies with the number and paying capacity of patients. In Eastern Europe (eg, Romania (3)) and in drought-hit areas—if the number of patients remained constant—the real income of doctors would fall with that of their patients. Any increase in income would be proportionate to that of the economic milieu or the number of patients seen.

(ii) *"What place does the private sector occupy in the healthcare services scenario? Clearly, the expansion of private healthcare services has been in response to the ineffective and inaccessible*