# Time to Act?

Over the last year, discussions have taken place towards amending the 53-year-old Bombay Nursing Home Registration Act in Maharashtra. The new legislation would be called the Maharashtra Clinical Establishment Act. The proposed bill is a significant milestone and the focus of intense debate.

In 1991 the Mumbai group of Medico Friends Circle filed public interest litigation jointly with an aggrieved citizen, whose father died following mismatched blood transfusion in Mumbai. The Court asked the Municipal Corporation to set up a committee to refurbish the outdated and poorly implemented Act. The committee's report and a subsequent in-depth study of private healthcare providers in Satara (1) contained shocking findings: according to the survey, only a quarter of practitioners were qualified; 62 per cent kept no medical records; most nursing homes employed unqualified and poorly paid nurses and lacked the equipment, space and infrastructure to ensure patient safety. Not one hospital was registered with the local authority.

Still, the government slept over the studies for almost a decade. The wake-up alarm appears to have come from a World Bank- funded Health Systems Development Project to standardise private health services in Maharashtra. The state government is likely to table the draft for discussion soon and is keen that the bill is passed. The Andhra Pradesh government has passed a similar bill in March 2002. Private insurance is watching these developments with interest.

The draft proposal was discussed in July 2001 with representatives of consumer health groups, medical professionals, owners of nursing homes, and other organisations concerned with health. These associations, which have a stake in updating regulation of health sector, played an important role in shaping the discussion on the proposal. Many issues were touched upon in the course of these and subsequent discussions. Some of these are: redefining 'clinical establishments'; dealing with their registration and re-validation and appointing competent authority to do so; classifying healthcare establishments with reference to different standards and to require them to conform to the standards regarding staff, equipment, facilities etc; participation in national health programmes; penalties for flouting the rules; requiring clinical establishments to display their fee structure, and ensuring patients' access to their health records.

How does the proposed bill differ from the current Act? One, it covers all healthcare sectors — public, private and non-governmental — and systems (allopathy and alternative) across the state, a commendable step indeed. Second, mandatory registration, re-validation and common minimum standards would improve the quality of health care. Third, patients will be better informed about fees and intervention charges and would have access to their medical records, should they so wish. Fourth, depending upon its final formulation, the amended Act could ensure that private healthcare providers respect the rights of patients with HIV to receive healthcare without discrimination. Finally, the Act, if implemented in the intended spirit, can check the proliferation of poor quality clinical establishments.

The intentions are laudable, but the proposed amendments must ensure that the final Act includes the logistics of implementing it. These logistics have not been worked out adequately in the draft available. The private sector's knee-jerk response is that it will have to pay more for registration, face what it considers intrusive and overbearing regulators and see an increase in its paperwork. It is for the government to ensure that these fears are irrational. The authorities must discharge their duties effectively, involve stakeholders in the decision-making process, and be accountable to them to enable confidence in their performance. Given the government machinery's competence and commitment, perhaps this is asking for too much.

The proposed bill covers traditional and alternative systems of medicine. But how will alternative practitioners be judged? Against the skills of those in the same field or those of orthodox medical practitioners? Some of these systems lack statutory councils and ought to be governed by separate legislation.

The new bill proposes some minimum standards for registering clinical establishments. Experts, not a clinical establishment board, should develop guidelines, which are rational, evidence-based and sensitive to the needs — and realities — of rural health care. The amended Act should link professional standards of practice with registration and revalidation so that individual doctors can be accounted for their competence, performance and conduct.

Identifying a negligent doctor in the private sector is easy. But not so in the public sector. Given the appalling standard of public health care, the government will have to work hard to ensure that public health providers flouting standards and rules do not escape punishment.

Information, autonomy, power – an Act so graced will be an achievement. While the public sector has suffered from excessive bureaucratic controls, the private sector had neither control nor regulations, and for five decades resisted the concept of minimum clinical standards. Tightening regulation could be the first step towards achieving good clinical care. It could provide much-needed teeth to the consumer and the government: it is up to them to use them judiciously. For, regulation alone, as we know from our experience with the MCI and the Consumer Protection Act, is not enough. Nor does it necessarily change doctors' behaviour. It must be backed by an alert citizenry and a proactive government.

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