REPRESENTATION SEEKING ISSUANCE OF DIRECTIONS/GUIDELINES BY THE UNION GOVERNMENT TO STATE GOVERNMENTS AND UNION TERRITORIES UNDER THE DISASTER MANAGEMENT ACT, 2005 REGARDING CHARGES OF COVID-19 TREATMENT IN PRIVATE HOSPITALS IN PURSUANCE OF THE DIRECTIONS OF THE HON'BLE SUPREME COURT VIDE ORDER DATED 14.07.2020 IN "*SACHIN JAIN VS. UOI*" [WP (C) 10918 OF 2020]

All India Drug Action Network & Jan Swasthya Abhiyan- Mumbai

17 July 2020

TABLE OF CONTENTS

LIST OF ABBREVIATIONS	
AB-ARK	Ayushman Bharat-Arogya Karnataka
AB-PMJAY/ PMJAY	Ayushman Bharat Prime Minister Jan Arogya Abhiyan
AMC	Ahmedabad Municipal Corporation
CBC	Complete Blood Count
CGHS	Central Government Health Scheme
CT Scan	Computerized Tomography Scan
ECG	Electrocardiogram
EWS	Economically Weaker Section
GIC	General Insurance Council
GoM	Government of Maharashtra
HBsAg	Hepatitis B surface antigen
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic Social and Cultural Rights
ICU	Intensive Care Unit
IL-6	Interleukin 6
MJPJAY	Mahatma Jyotiba Phule Jan Arogya Yojana
MoHFW	Ministry of Health & Family Welfare
MRI	Magnetic Resonance Imaging
NDMA	National Disaster Management Act, 2005
NPPA	National Pharmaceutical Pricing Authority
PET Scan	Positron Emission Tomography Scan
PPE	Personal Protective Equipment
USG	Ultrasonography

Representation seeking issuance of Directions/Guidelines by the Union Government to State Governments and Union Territories under the National Disaster Management Act, 2005 regarding charges of COVID-19 treatment in Private Hospitals

All India Drug Action Network & Jan Swasthya Abhiyan- Mumbai

17 July 2020

The All India Drug Action Network (AIDAN) and Jan Swasthya Abhiyan -Mumbai (JSA-Mumbai) have been impleaded as intervenors in the matter titled "*Sachin Jain Vs. Union of India*" (WP (C) Diary Number 10918 of 2020) (hereinafter *Sachin Jain*) being heard by the Hon'ble Supreme Court of India vide its order dated 05.06.2020. This representation is being submitted in pursuance to the order of the Hon'ble Supreme Court dated 14.07.2020 in the above said matter.

Preface & Outline

The main aim in the present document is to provide a brief overview of regulatory powers that ought to be exercised in the present circumstances, and the necessity and duty to exercise such powers. This is brought out through examples of ways in which patients are effectively denied treatment, or charged so heavily as to cripple them, which have been encountered by our organisations during their work with COVID-19 patients. We have laid down the issues that need to be brought under regulation and an analysis of best practices and shortcomings of various state policies. In this background, we have laid down our suggestions, a non-exhaustive outline of which is as follows :-

1) Direct the state governments to maximise provisioning of free COVID-19 treatment by requisitioning capacity in private hospitals and reimbursement of charges by the government at pre-determined rates.
2) Where this is not possible, direct states to take steps to fix maximum ceiling rates for COVID-19 treatment in private hospitals on all COVID beds

3) Inclusion of all aspects of treatment under price caps, including but not limited to investigational therapies, medicines, investigations, PPE, management of co-morbidities, interventional procedures, diagnostics, etc.

4) Applicability of fixed rates should also extend to those paying through insurance so as not to lead to exhaustion of insurance policies.

5) Oversight mechanisms for monitoring and enforcement of Orders as well as time bound patient grievance redressal system.

6) Disclosure and display of information in real-time relating to occupancy and availability of rate capped beds in each category of bed (isolation bed, high dependency unit, ICU without ventilator, ICU with ventilator); and monitoring the utilisation of free beds under various Central and State sponsored insurance schemes through the oversight mechanism must also.

7) Reporting requirements of private hospitals

8) Wherever state laws/policies mandate provision of concessional/ free treatment to underprivileged sections, directions to states must ensure that these are implemented in letter and spirit.

9) Wherever national or state-level public-funded insurance schemes are operating to provide free treatment for COVID-19, they must be fully implemented to the fullest - benefit must be given to all.

10) COVID-19 suspected cases must also be eligible to be covered in the fixed rates.

11) Charges of private ambulance services must be fixed by the government.

12) Pre-Admission Deposits/ Advances

13) Transparent billing practices and regulation of COVID-related medicines, medical devices and consumables etc.

Power and Duty to Regulate

Pursuant to the Hon'ble Supreme Court's order dated 14 July 2020 in *Sachin Jain* we had participated in a Video Conference with officials of the Ministry of Health and Family Welfare (MoHF&W), and pursuant to directions in that hearing we are making the following written submissions/ representation to enable the issuance of directions/ guidelines to the States and Union Territories under Section 10 of the Disaster Management Act, 2005 read with Sections 62-

64 of the Act by the National Executive Committee/ Union Govt., to regulate the charges for COVID-19 health goods, services and facilities, hereinafter treatment, in private hospitals. The necessity for provision of treatment in the present case is to control the epidemic and mitigate the disaster for the people at large, as well as ensuring the Right to Health of all Indian Citizens. Thus, the power to regulate is also coupled with a duty to act in face of the ongoing situations demanding action. In this regard, further reference in this regard may kindly be made to the Affidavit filed by AIDAN dated 13.07.2020 before the Hon'ble Supreme Court.

The power to regulate also flows from the obligation under Article 21 of the Constitution read with the obligation under Article 12 International Covenant on Economic Social and Cultural Rights (ICESCR) as elaborated in General Comment 14 to make treatment affordable and accessible and to protect the right from being infringed by private parties by profiteering. It is settled law that private hospitals cannot profiteer at the expense of the right to health and life. Moreover, the Hon'ble Supreme Court has also held the same in its aforesaid order dated 14th of July, 2020, which also makes the same clear.

Unaffordable cost of accessing treatment of COVID-19

With the number of COVID-19 cases rising in India, the public health system is overwhelmed, strained and working beyond its capacity. Accessing care in the private sector is no longer a 'choice' but a compulsion. Moreover, a significant number of critical care facilities necessary for life-saving treatment are only available in large private/corporate hospitals where the treatment is out of reach for most due to the high prices. Newspapers and social media are replete with stories about excessive charges from private hospitals which are indulging in profiteering in many creative ways, such as :-

- PPE Billing Practices - For example, inflation of charges for PPE, medicines and ambulance charges in the medical bills of patients; multiple billing of full cost of same PPE and other equipment to every patient in a ward/ hospital; and even forcing patients to pay for unrealistic quantities of PPE which cannot be practically utilized on a single patient. Patients have been billed even thousand of rupees per day on account of PPE.

- Consumables and Medicines - Consumables and medicines account for huge expenses and together are often the largest components of the bill, particularly as the duration of hospitalization increases. This is not surprising in light of the analysis previously undertaken by the National Pharmaceutical Pricing Authority (NPPA), Department of Pharmaceuticals, Ministry of Chemicals and Fertilizers. In February 2018, the NPPA published analysis of the bills from four prominent corporate hospitals exposing huge unethical hospital margins for medicines, consumables and medical devices, over the cost at which these products were procured by the hospitals. Hospitals were found to favour the use of brands of medicines and medical devices that would provide the highest commissions to them. For example, the margins over the hospital procurement price were found to be exorbitant in the range of 158-1192% for medicines, 344-1737% for consumables, 372-1271% for medical devices. This practice of charging exorbitant amounts and profiteering has not changed even during the COVID-19 pandemic.

- Deposits - Apart from the above, patients are also being forced to pay hefty deposits as a precondition of admission, and corporate hospitals are reportedly indulging in financial "cherry picking" patients to admit only patients with a high ability to pay.

- COVID-19 packages - Many private and corporate hospitals have developed COVID-19 packages for different categories of beds. The packages are excessively priced and cannot be justified on the basis of the medical services or components included in the package. The rates are exclusive of procedures, investigations, high-end medicines, etc. which are charged additionally. Bills are therefore far higher than the package rates which in and of themselves overpriced. Margins are particularly high for isolation ward beds.

The above-mentioned billing practices, apart from others, cause undue financial hardship/ strain on families of patients at a time when people have fewer resources due to lockdown and restrictions severely impacting jobs and incomes. Treatment charges can vary widely depending on whether the patient has co-morbidities, and the need for critical care support and interventions. Scheduled rates of hospitals for ICU admission are so steep that it is unaffordable for the majority of families beyond the initial few days of admission. Unfortunately, the COVID-related panic, coupled with lack of government accountability/oversight mechanisms has emboldened the private sector players to operate with impunity.

In this regard, we have already attached various bills, letters and newspaper reports as part of annexures of our impleadment application and Reply Affidavit dated 13.07.2020 to show the existence of the above mentioned exploitative practices leading to unaffordable costs of treatment. You are requested to kindly go through the same, as the same are not being repeated herein for the sake of brevity and conciseness. Various other examples in the form of bills, etc. are also readily available with the present intervenors, copies of which can be provided if deemed relevant.

Financial Interests of Private Hospitals - Further, much stress has been laid by the private hospital associations regarding their profitability and cash flow, on the basis of certain industry funded/ dominated reports. The Hon'ble Supreme Court has held time and again that matters relating to the larger public interest, the private interest must take a back seat; and that saving a human life and health is of paramount importance, and there can be no competing interest where the life and health of a human being is involved. Notwithstanding, the reports themselves are unreliable being based on vague and anonymous projections based on incomplete and self-reported data, and the same has been dealt with in detail in the intervenor-AIDAN's Reply Affidavit dated 13.07.2020.

Ayushman Bharat-PMJAY Scheme

It is respectfully submitted that the utilisation of Ayushman Bharat (AB-PMJAY) (as per figures available in the public domain) for COVID-19 treatment was low. The National Health Authority had publicly shared (via twitter) that as on 14 June, 2020, 7,477 free tests and 5,464 free treatments have been provided to beneficiaries under AB-PMJAY through 1109 empanelled designated COVID hospitals, of which only 470 were private hospitals. Further AB-PMJAY provides a limited coverage of Rs. 5 lakh per family. This is insufficient to meet the cost of care for an entire family, particularly if specialised or critical care is required. The majority of large corporate hospitals with critical care facilities needed for COVID-19 treatment are not empanelled under AB-PMJAY, and AB-PMJAY empanelled hospitals are not evenly distributed regionally. Regions with lower per capita incomes where a large number of people in need of coverage are concentrated, have fewer empanelled hospitals. Thus, the Ayushman Bharat scheme

fails to address the need of the hour, which extends not only to persons beyond the traditionally covered beneficiaries of the scheme, but also demands coverage beyond what is offered under the scheme.

Insofar as price fixation under the scheme is concerned, even under the existing scheme, no rates have been fixed for the entire nation, and states have been permitted to fix their own rates. However, as pointed out hereinafter, this endeavour has failed to yield the required result. In this regard, copy of the Office Memorandum issued by the National Health Authority dated 08.04.2020 permitting states to fix their own rates is annexed herewith as **ANNEXURE-A**.

Efforts of State Governments to provide affordable for COVID-19 treatment

We appreciate that the Ministry of Health and Family Welfare (MoHFW), taking cognisance of scarcity of beds as well as reports of overcharging by private healthcare providers, issued a letter dated 15 June 2020 to State governments and Union Territories to encourage them to enhance bed availability and critical care health facilities and fix the rates for treatment of COVID-19 in private hospitals. We note that following the letter, several state governments have responded by issuing Orders to fix maximum package rates for COVID-19 treatment. However, it is respectfully submitted with deepest regard for this office that in the present situation, recommendatory letters are not sufficient to guide states in tackling the ongoing spread of the virus.

While different State governments have issued Orders to make COVID-19 treatment accessible and affordable by applying different schemes and policies, much variation exists across the states. Moreover, these efforts are constrained by inadequacies, loopholes, or ambiguities in the policies and regulation, thus failing to achieve the objective of ensuring affordable and accessible treatment for all COVID-19 patients. Thus, it is contingent upon the National Executive Committee under the Disaster Management Act to issue directions to States relating to cost of treatment and billing practices for COVID-19 in private hospitals, and **to provide a uniform and watertight framework for States and Union Territories to follow. It is necessary that any such framework has due oversight mechanisms and operates with transparency,**

accountability, and due precaution to close loopholes. In this regard, a chart comparing the different rate capping orders/ policies passed by various state governments is annexed herewith as <u>ANNEXURE-B</u>, along with copies of the relevant orders of different states.

ISSUES WHICH NEED TO BE ADDRESSED THROUGH CENTRAL DIRECTIONS/ GUIDELINES

1. **<u>Provisioning of free treatment</u>:** Some states have made a provision of free treatment in designated COVID-19 government and private hospitals. **Given the situation of a public health emergency due to global pandemic, and the backdrop of economic hardships faced by people, it is imperative that the provision of free treatment is made by requisitioning capacity from the private sector at pre-determined rates to be reimbursed to private hospitals by the government. These pre-determined rates should be based on Standard Treatment Guidelines as well as fixed, cost-based inputs.**

   This is necessary not just to secure our citizens' constitutional right to life and right to health, but the removal of financial barriers to COVID-19 treatment is also prudent public health policy to control the pandemic and mitigate the hardships flowing from it. Due to its nature, COVID-19 illness can entail extended hospital stays. Severely-affected patients in particular will require lengthy admissions of several weeks combined with critical interventions like oxygen and ventilator support. Mere restriction of treatment rates in private facilities is not sufficient to protect against financial distress as even at prescribed rates, the cumulative cost over several days could make treatment unaffordable for many families. Families can easily be devastated by the costs of treatment, particularly as often several members of a family are affected. We know of many families who have had to borrow huge sums of money from relatives and friends and sold off gold and other assets to pay off medical bills. Patients are having to pay huge amounts for a range of experimental treatments (plasma therapy, remdesivir, tocilizumab, itolizumab etc.) which are being used rampantly, even in non-compliance

with the protocols. Since this step is essential in mitigating the effects of a disaster, the National Disaster Mitigation Fund (NDMF) should be mobilised towards this end.

In addition to this, it has been observed that various states have also sought to merge these directions within existing policies and schemes to increase access to and affordability of COVID-19 treatment. Several states have adopted a mixed model of assuring free treatment to some segments of the population through government-run insurance schemes and additionally imposing rate caps on treatment accessed in private hospitals by people who are not covered under free treatment. One such example is that of the State of Maharashtra, a summary of the policies is annexed herewith as **ANNEXURE-C**.

These models allow for governments to supplement the shortages of beds in the public sector and harness the critical care facilities available in the private sector, and also improve affordability of treatment. However, these measures leave out large sections of society who were not originally envisioned to benefit from such schemes, but who are now in a dire situation owing to ailing economic condition. Thus, it is imperative that the guidelines/directions be issued to the state government to implement inclusive policies that maximise the benefit of free treatment.

2. **No limitation of rates on number of beds - Rates fixed for COVID-19 treatment in private hospitals by state governments should be applicable to all COVID-19 beds available in hospitals, without any limitation on the number or percentage of beds to which fixed rates apply.**

Several states have limited the applicability of COVID-19 treatment caps to a specific percentage of beds. In Maharashtra, rate caps have been applied to 80% of beds in the private sector. In Delhi, the rate caps are limited to 60% of the total hospital bed capacity. Private hospitals in Delhi that are treating COVID-19 patients in beds above this threshold, after accounting for any EWS beds, are permitted to bill as per their own schedule of charges.

The above limits cause the following issues and concerns :

a. Create inequities in that someone who cannot afford the hospital charges would still be forced to pay a higher cost of treatment only because of non-availability of beds on which price caps apply. The order therefore creates an unconstitutional distinction between two classes of similarly situated patients and treats them unequally by arbitrarily conferring privileges to one group and liability on the other.
b. Patients at the time of admission are not informed by hospitals about schemes for free/ concessional treatment or price capping imposed despite being mandated to, and patients are therefore billed as per market rates.
c. Create a reasonable apprehension that the patients paying higher costs would receive better quality treatment. This has already been observed to be a problem with hospitals empanelled under various state funded health insurance schemes and this is only likely to worsen with high demand for COVID-19 beds. Several instances of differences in quality of services being offered by hospitals under different 'panels' have already emerged.
d. Patients who are admitted under government schemes/referrals are often lured with the promise of 'better' care if they pay more. Patients desperate for treatment are powerless to negotiate with private hospitals and may end up getting forced to pay higher costs. At a time when hospitalisation capacity is limited, patients do not have the power to refuse to pay full charges in return for treatment. Consent given by patients/ attendants in such circumstances would be out of coercion rather than free will, and therefore serves no purpose.

In one instance, a patient's family was not informed about the COVID-19 treatment rates fixed by the Delhi Government at the time of admission at Saroj Superspeciality Hospital and was misled into signing a consent form for billing according to the hospital's own charges. When after a few days the family became aware of the government rates and brought to the attention of that hospital management that it should comply with the Delhi Government's orders and bill them as per the price caps, the quality of care deteriorated. The patient developed painful bed sores as a consequence of the poor care and neglect. Similarly, in another case involving Shanti Mukand Hospital, the family was not informed about the rates fixed for COVID-19 treatment by the Delhi Government. They

were told that the hospital had a COVID-19 package for ICU admission and a family member's signature was taken as consent for the same. In both cases, “consent” would be void because it was taken without complete information being provided to the patients. In this regard, the grievances of the patients’ families filed with Delhi Government along with enclosures are annexed herewith as **ANNEXURE-D** and **ANNEXURE-E**, respectively.

3. **Inclusion of all aspects of treatment - The fixed rates should not exclude critical components of COVID-19 treatment such as those listed in points 3a- 3g.**

   State Government fixed package rates often have unreasonable exclusions and do not comprehensively cover all costs of COVID-19 treatment. Common exclusions are:

   a. Investigational therapies (plasma therapy, remdesivir, favipiravir, tocilizumab etc.)
   b. High-end medicines (expensive antibiotics, like immunoglobulins, meropenem, parenteral nutrition, tocilizumab etc.)
   c. High-end investigations including CT scan, MRI, PET scans etc
   d. Personal Protective Equipment (PPE) used by healthcare workers
   e. Management of co-morbidities - costs involved in treatment of diabetes, hypertension, dialysis etc.
   f. Interventional procedures - Central Line insertion, Chemoport insertion, bronchoscopic procedures, biopsies, ascitic/pleural tapping etc.
   g. Diagnostics - COVID-19 test, IL-6, Blood gas analysis etc.

   These components of treatment form a significant share of bills. - Not including all components of care under the fixed rates allows hospitals to invent new charges/ inflate costs of existing charges. For example, hospitals have been found to be conducting unnecessary investigations multiple times to drive up the cost of care for patients, charge multiple times for PPE, etc. Moreover, PPE and other consumables are often not covered

by insurance and therefore patients end up incurring out of pocket expenditure for the same.

Patients who are most at risk in COVID-19 are those with comorbidities. - The bills for patients with co-morbidities are often the highest because of more severe manifestations of COVID-19 illness which may require critical care interventions such as oxygen and ventilator support, high-end medicines and extensive stay in hospitals. Non-inclusion of comorbidities under the package rates will lead to additional expenses for private patients.

4. **Fixed rates should be applicable even to those who are paying through private insurance.**

Some states have chosen to exclude persons with private health insurance coverage from the fixed government rates altogether, (e.g., See the attached policy of Karnataka Government under Annexure-A). Other states have instead chosen to remain silent whether the rates are available to insured individuals**,** which leads to ambiguities exploited by private hospitals in their favor (e.g., due to lack of specific guidance by the Delhi Government in this regard, some Delhi private hospitals have denied insured persons from availing the government rates). In both these situations, without applicability of the fixed rates, patients run the risk of insurance cover being exhausted, forcing them to incur out of pocket expenditures. For patients who are already suffering from pre-existing conditions like cancer, etc., depletion of insurance cover leaves them vulnerable in the future.

Unfortunately, private hospitals have been charging excessively high COVID-19 packages to insured patients as a consequence of perverse incentives operating. An added financial burden on patients arises because insurance companies are also unwilling to cover the high hospital charges in the current situation, and also deny payment for costs of consumables like PPE which patients are then forced to pay on their own. To protect

patients from out of pocket expenditure the fixed rates should apply to patients covered by private insurance as well.

The Delhi Government's Order is silent on whether the price capped rates are applicable to patients who are privately insured and hospitals are therefore setting their own rules. A patient admitted at Moolchand Hospital was denied government rates apparently because the insurance provider did not bring the Delhi government order to the hospital administration's notice during admission. The insurance company initially refused to reimburse costs beyond the government rates, but after much negotiation, agreed to cover some additional amount. Despite this, the patient paid an out of pocket charge of Rs. 73,348. In this regard, the grievance of the patient's family filed with Delhi Government along with enclosures is annexed herewith as **ANNEXURE-F**.

5. **Oversight mechanisms for monitoring and enforcement of orders as well as time-bound patient grievance redressal system.**

We have come across numerous instances where hospitals have refused to comply with government orders and have issued bills at hospital package rates to patients, despite being eligible for fixed rates. At the time of a pandemic where the family members of the COVID-19 patient are usually quarantined and when financial resources are restricted, it is extremely difficult to resort to grievance redressal mechanisms. Family members are afraid to complain when patients are undergoing treatment, out of fear that treatment quality may be compromised if the hospital is antagonised with a complaint. Thus, relying on a complaints-based redressal mechanism is not sufficient to ensure compliance of hospitals with government orders. States must put in place a mechanism to monitor compliance through regular auditing of bills of COVID-19 patients[1] with strict enforcement measures. All grievance redressal mechanisms must also be time-bound with clear protocols laid out. These protocols must also be clearly disseminated so that patients and their families know how to access them.

[1] as done in Mumbai https://mumbaimirror.indiatimes.com/mumbai/other/auditors-slash-134-inflated-covid-bills-by-rs-23-4-lakh/articleshow/76540807.cms

Pertinent examples of flouting of orders include the case of Nanavati Hospital, Mumbai, against whom an FIR was lodged by BMC due to overcharging and other malpractices[2]. This clearly shows the manner in which state governments too are finding themselves without effective remedy, and are having to resort to the criminal justice machinery, which is subject to lengthy procedures.

In the aforementioned case relating to Moolchand Hospital where the patient's family raised a grievance and challenged the billing from the hospital, despite non compliance with the Delhi Government's Order, the hospital consistently refused to revise the bills. Despite a family member complaining to the competent government authority, no action has yet been taken against the hospital to ensure that the family is reimbursed the excess payments that they were forced to make. In the case of the patient admitted to Shanti Mukand Hospital, in spite of repeated requests, the billing has not yet been revised and brought in line with the government rates.

Specific suggestions for oversight mechanisms in the form of Ombudsperson and auditing of hospitals is given in **ANNEXURE-G**.

6. **Disclosure and display of information in real-time relating to occupancy and availability of rate capped beds in each category of bed (isolation bed, high dependency unit, ICU without ventilator, ICU with ventilator); and Monitoring utilization of free beds under various Central and State sponsored insurance schemes through oversight mechanism.**

   In states where a limited percentage of beds have been reserved under treatment rate caps, lack of transparency allows private hospitals to conceal the availability of rate capped beds and forces patients to avail treatment at full rates. Non-availability of this information restricts the right of citizens to avail the fixed rates.

[2] https://mumbaimirror.indiatimes.com/coronavirus/news/bmc-files-fir-against-nanavati-hospital-for-overcharging-covid-19-patient/articleshow/76753756.cms; https://www.indiatoday.in/india/story/fir-against-nanavati-hospital-in-mumbai-over-rs-17-lakh-bill-on-covid-patient-1696605-2020-07-03

Centralized systems for bed allocation must be set up in every district and city. In cases where the patients are expected to pay any amounts towards COVID-19 treatment in the absence of policies mandating free treatment or effective price caps, at the very least, bed allocation must be based on the economic profile of the patient to the maximum extent possible.

Government authorities must proactively monitor utilization of beds under various state schemes. Centralized database/ dashboards of available beds in various hospitals for COVID-19 care and treatment can also identify the various schemes that they come under for purposes of transparency and to give patients and their families an informed choice when accessing treatment services.

7. **Reporting requirements** - One major lacuna in all the orders passed by the various state governments is that they do not provide for any reporting/ monitoring mechanism for the government to ensure that hospitals comply with the fixed rates. It has been observed that there is a general reluctance in state governments to enforce their own orders. On numerous occasions, non-compliance by hospitals is not met by any action by the concerned state government(s). In order to bring greater transparency and accountability in the regime, there is an urgent requirement that hospitals regularly report on the number of persons treated under government fixed rates and this information is made publicly available.

8. **Wherever state laws/ policies mandate provision of concessional/ free treatment to underprivileged sections, directions to states must ensure that these are implemented in letter and spirit.** Moreover, state governments must proactively advertise these schemes through print and social media so that people get to know about the same. Moreover, hospital admission must not be denied for want of income proof. Patients should be given a reasonable amount of time to submit income proof as often family members are also quarantined at the same time. In this context, as per the

judgment dated 26.06.2020 of the Hon'ble Bombay High Court in "*Abdul Shoeb Shaikh and Ors. vs. K.J. Somaiya Hospital and Research Centre and Ors.*" [WP-LD-VC 54 of 2020], self-attested affidavit suffices as an income certificate to avail beds under EWS category. This logic must be extended to those availing free treatment during COVID-19 pandemic. Copy of the judgment dated 26.06.2020 is annexed herewith as **ANNEXURE-H**.

We have found that private and charitable hospitals are often not conforming with mandated requirements to provide free/ concessional treatment. By way of an example, in Mumbai, data from the Charity Commissioner's Office has shown that a majority of free/ concessional beds available to EWS and indigent patients remain unutilised, while patients are struggling to find beds. A Table showing the utilisation of free and concessional beds as per BPT Act published by the Mumbai Charity Commissioner, as on 11.06.2020 is as follows :-

	No of indige-nt beds	**No. of unoccu-pied indigent beds**	**No. of weaker section beds**	**No. of weaker section unoccu-pied beds**	**Total No. of reserved beds**	**Total No. of unoccu-pied beds**	**Total % of unoccu-pied beds**
Mumbai City	459	390	459	448	918	838	91.2%
Mumbai Sub-Urban	332	288	332	304	664	592	89.2%
					1582	**1430**	**90.4%**

9. **<u>Wherever national or state-level public-funded insurance schemes are operating to provide free treatment for COVID-19, they must be implemented to fullest</u>** - State insurance schemes must be accessible to all residents of the state - temporary and permanent, and should not be limited to patients who have a domicile status. Ration cards must not be a condition for accessing social insurance schemes and other entitlements, especially as the most vulnerable often do not have access to such documents. As portability is inherent in the Ayushman Bharat Scheme, it must be utilized to ensure that migrant labourers and others who have access to the scheme are able to use the same for obtaining free health care for COVID and non COVID treatment in destination states.

10. **<u>COVID-19 suspected cases must also be eligible to be covered in the fixed rates</u>. -** States have not accounted for COVID-suspect patients in their policies. These patients exist in a so-called "no-man's land". States policies fail to consider the costs involved for patients during the period when COVID-19 is suspected but not yet confirmed. We have come across cases of huge treatment costs (in lakhs) for treatment at private hospitals which are not treating COVID. Even in private hospitals providing COVID-19 treatment, the fixed rates are only applicable only once the patient has been confirmed to be a COVID patient.

    A patient underwent admission to Memorial Hospital, Sonipat and Saroj Medical Institute, Delhi for the duration of time when he was experiencing symptoms but was not confirmed to be positive for COVID. In these two hospitals, the patient incurred expenses of Rs.53,000 and Rs.1,33,644 for 6 and 4 days of stay respectively before being admitted at a third hospital, Saroj Super Specialty Hospital for COVID-19 treatment. A copy of the grievance of the patient against Saroj Super Speciality Hospital to the Delhi Government, which contains the details of charges incurred for COVID-suspected treatment is already annexed hereinabove.

In this regard, it is pertinent to mention here a best practice from the State of Maharashtra, wherein even COVID-19 suspected cases have been made eligible for fixed rates, and this may be adopted pan-India.

11. **Charges of private ambulance services must be fixed by the government**. - There is a lot of profiteering happening in this regard with patients and their families having to pay even Rs.5,000 to transport a single patient for short distances such as 2-3 kms in cities like Mumbai. In this regard, Mumbai has capped the private ambulance rates, which must also be extended to other metropolitan cities, at the very least, if not to all cities.[3] The Central Government must issue a directive to all states to regulate prices of private ambulance services and augment capacity of the '108' ambulance services - a publicly funded scheme so that patients and their families do not have to pay unreasonable prices when desperately seeking care.

12. **Regulation of pre-admission deposits/advances by private hospitals** - We have found that many patients are unable to gain access to healthcare due to demand for pre-admission deposits or advances, often ranging Rs. 50,000-Rs. 4 Lakhs. In such circumstances where the public healthcare system is proving to be inadequate, and citizens have no option but to access private healthcare institutions, it is highly unfortunate that citizens who cannot afford to pay such high deposits are virtually thrown out on the road. It is essential to ensure that hospitals do not charge pre-admission deposits from patients, and in any case, do not refuse admission on this ground, which is particularly important for emergency patients. As mentioned hereinabove, having a centralised real-time hospital bed database is essential to ensure compliance in this regard.

    In a case before the Hon'ble Gujarat High Court ["*Suo Moto vs. State of Gujarat & 2 other(s)*" [Order dated 29.05.2020 in WP (PIL) NO. 42 of 2020], the Hon'ble Court had directed that :-

[3] https://timesofindia.indiatimes.com/city/mumbai/maharashtra-now-civic-bodies-collectors-can-hire-private-ambulances-at-fixed-cost/articleshow/76635220.cms

"*We make it clear that if any patient is referred by the Civil Hospital or the S.V.P. Hospital to any private / corporate hospital, then there shall be no predeposit, but, if any patient directly comes to the private / corporate hospital for being treated for COVID-19, then in such circumstances, it shall be open for the concerned hospital to demand for a reasonable pre-deposit and thereafter, raise the demand in phases as and when need arises. It should not happen that because of the financial constraint, the patient remains without any adequate medical treatment. If such a thing occurs, then that would be the worst scenario.*"

We consider it essential that such a model be put in place, where at the very least, patients being referred by the Government machinery should not be subjected to any pre-admission deposits, and any deposits being charged from any other category of patients is strictly within the realm of reasonableness. In order to achieve this, a firm ceiling on the maximum allowable deposit must be fixed at the state level, and orders to this effect directing the state governments must be passed by the Central Government.

Further, provision must be made that in case of persons who cannot afford to pay such deposits immediately, they may be allowed to take admission to the hospital on the basis of an undertaking, or it may be recovered from them later on. Without such an essential provision, there is no hope for gaining access to healthcare for the majority of our citizens.

13. **Transparent billing practices and Regulation of COVID-19 medicines, medical devices and consumables** - State Governments need to be supported in making COVID-19 treatment in private hospitals more affordable through actions that lie in the realm of the National Executive Committee under the Disaster Management Act. Therefore, we are taking this opportunity to request you to take immediate action in respect of COVID-related medicines, medical devices and consumables. **We urge that the Government, through the National Executive Committee under the Disaster Management Act or**

through the National Pharmaceutical Pricing Authority (NPPA) where appropriate, must urgently step in to:-

a. Mandate that all COVID-related devices, consumables and medicines must be billed separately by hospitals (along with MRP, brand name, company name, quantities) in order to bring about transparency and uniformity in billing practices **In this regard, a compilation of excerpts of bills from various private hospitals containing the charges of PPE kits and PPE components (such as N95 masks) is annexed herewith as <u>ANNEXURE-I</u>**. The bills reflect wide variations in the charges for PPE kits and PPE components as well as intransparent and improper billing practices.

b. Cap the prices of PPE kits and components, including face masks; infrared thermometers; pulse oxymeters etc. In order to prevent black marketing, hoarding and to effectively regulate prices, PPE and critical devices should be regulated under the *Drug Prices Control Order, 2013* or by bringing them under the purview of the *Essential Commodities Act, 1955.*

c. Cap the prices of medicines used in COVID-19 treatment and/or make provisions for government procurement and provision of medicines to healthcare facilities, particularly highly priced experimental therapies like remidesivir, tocilizumab, itolizumab, favipiravir or convalescent plasma therapy.

d. As many of the drugs/ treatments for COVID-19 mentioned above are still largely in the experimental realm, it is seen that often private hospitals are administering expensive therapies/ drugs to patients rampantly which result in high charges. In this context, where, if the above suggestions regarding provision of free medicines/ treatment are not considered to be implementable for any reason, **<u>at the very minimum</u>**, the cost of such expensive experimental drugs/ treatments **<u>must</u>** be reimbursed to economically vulnerable persons. This is also true for all COVID-19 patients admitted in government quota beds in private hospitals too, but should not be restricted to only such patients.

Conclusion

We hope that you shall treat this representation favourably in the interest of the life and limb of the citizens of India and pass necessary directions/ orders in exercise of the powers vested in the Central Government.

We are available to aid your office in any manner within our means in case of any doubts, concerns or clarifications. In case of any ambiguities or concerns over sources of the facts and observations in this representation, kindly allow us an opportunity to address the same.

In case of any further information/ queries, please contact :-

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