INDIAN MEDICAL ASSOCIATION - HOSPITAL BOARD OF INDIA

HOSPITAL HEALTH

BI-MONTHLY NEWS BULLETIN FROM IMA HBI

Volume : 1 Issue : 1 JULY - AUGUST 2025

Why this Bulletin?

Operating a Private Healthcare Establishment is a challenging endeavour that demands dedication, resilience, and a commitment to continuous improvement. Healthcare providers face numerous obstacles daily—from managing operational complexities and regulatory compliance to addressing patient needs and adopting evolving medical technologies. In this dynamic landscape, consistent encouragement and robust support are essential to not only sustain these establishments but also to foster their growth and optimize the quality of care delivered.

Recognizing these challenges and the vital role private healthcare providers play in our communities, the Indian Medical Association – Hospital Board of India (IMA HBI) is proud to announce the launch of its bi-monthly bulletin, HOSPITAL HEALTH. This publication is curated with the aim of supporting, empowering, and inspiring healthcare professionals and administrators alike by providing timely insights, expert guidance, and best practices tailored specifically to the private healthcare sector.

We look forward to embarking on this meaningful endeavour with you.

Dr K.M. Abul Hasan, Chairman, IMA HBI **Dr. Sanjay Patil,** Secretary, IMA HBI **Dr. Anil Kumar Patil,** Treasurer, IMA

IMA Successfully lobbied and got Hospitals less than 50 beds changed to Green Category from Orange Category

CENTRAL POLLUTION CONTROL BOARD Green Category Incentives

Provides:

Less Consent renewal fees
Less environmental surveillance / compliance burden
More validity period for consents/ authorizations.

Consent Management

SPCBs / PCCs may grant consent to Operate (CTO) to red, orange and green categories of industries for validity up to 5 years, 10years, and 15 years respectively.

Inspection Frequency:

SPCBs / PCCs may prioritize their environmental surveillance programs based on the categories of sectors. SPCBs / PCCs are required to ensure inspection of red, orange, and green category of industries at least once in six-months, one-year, and two-years, respectively.

Siting criteria:

The categorization may be used as a tool for deciding the location/siting of an industry in a particular location.

Red category sectors are generally prohibited in ecologically sensitive arrears.

Orange category sectors, have specific siting requirements depending on the region.

Green category sectors are generally allowed in most areas.

Development of cluster:

The classification will help in planning of sector specific cluster, based on scoring of various pollutants and development of adequate environment management infrastructure facility.

NATIONAL INSURANCE SUMMIT

Organised by IMA HBI & NHB of IMA TNSB

ALL ARE Welcome

Date : 17.08.2025 at 9:30 AM - 5:00 PM

Venue : IMA TNSB HQRS Building, Chennai

IT'S A PROBLEMS & SOLUTIONS SUMMIT

IMA HBI had an interactive meeting with office bearers of THANA at Hyderabad arranged by Telengana state IMA with the objective to form a federation of all hospital's associations in the country. That exercise was fruitful, and we are going to all the stakeholders of Hospital industry.

Current status of our case in Supreme Court Challenging to Rule 9(ii) on rate determination.

Note Sent by our respected Advocate Mr. Prabha Bajaj, Delhi

W.P (C) 262/2024

The Indian Medical Association (IMA) has raised several key points regarding the Clinical Establishments (Registration & Regulation) Act, 2010 (CE Act, 2010) and the Clinical Establishments (Central Government) Rules, 2012 (CE Rules, 2012), particularly focusing on Rule 9(ii) of the 2012 Rules.

ISSUE RAISED	ARGUMENT BY IMA	CURRENT STATUS
Challenge to Rule 9(ii) on Rate Determination	The IMA is challenging the validity of Rule 9(ii) of the CE Rules, 2012, which empowers the Central Government to determine the range of rates for procedures and services charged by clinical establishments in consultation with State Governments. The IMA contends that the CE Act, 2010, neither in letter nor spirit, grants the Central Government jurisdiction to frame rules for restricting or determining rates. They argue that the Act's objective is solely to prescribe "minimum standards" of facilities and services, which cannot be stretched to include "rates". Therefore, Rule 9(ii) is considered ultra vires (beyond the powers of) the 2010 Act and should be struck down. **Pg B para 1, Pg G para 19, Pg 9 para 25,26,27, Pg 6 para 15**	The present petition i.e W. P (C) 262/2024 has been tagged with Writ Petition (Civil) No. 214 of 2024(**Order dt. 03.05.2024)** In terms of the order dt. **14.05.2025 in W.P. (C) 214/2024** along with W. P (C) 648/2020, 289/2021, 262/2024, , 285/2024, ,505/2024, 573/2024, 409/2024 The Learned Attorney General was asked to indicate which of the matters are to be taken first for adjudication and disposal and also the sequence of hearing the other writ petitions since some writ petitions challenge the implementation of the Rules and some support the Rules. This Hon'ble Court also appointed Ms. Srishti Agnihotri, Adv to represent the Petitioners and Mr. Ameyavikrama Thanvi, Adv to represent the Respondents for collection, preparation and filing of common compilations and written submissions. During parliamentary debates on the 2010 Act, the Minister of Health and Family Welfare, Shri Ghulam Nabi Azad, acknowledged concerns about rate fixation. He stated that fixing rates is challenging due to the complexity of the health sector and the lack of standard treatment guidelines. However, he assured that rules would be formulated to determine a "range of costs" that hospitals could charge for different procedures after categorization, and that accountability for quality of services would be ensured. He also indicated that penalties would be in place for charging beyond the fixed range. **Pg 182 para 2 onwards , 183, 184**
Unconstitutionality of Rule 9(ii)	The IMA argues that Rule 9(ii) is unconstitutional and violates fundamental rights, including Articles 14, 19, and 21 of the Constitution of India. They contend that imposing a standardized rate or formula is impractical due to countless factors affecting clinical establishments, such as infrastructure, faculty size, and geographical location. Such restrictions would infringe upon the fundamental right of medical professionals to practice their profession. The IMA also states that the Rule provides unregulated discretion to the government without clear guidelines for determining rates.**Pg I para 27,28,29, Refer to Challenged Rule, Article 14, 19, 21.**	
Impact on Private Healthcare Sector and Medical Tourism	The IMA submits that the private sector contributes significantly to healthcare infrastructure (2/3rds of spending) where the State has failed to provide adequate medical facilities. Rates charged by private establishments are used for infrastructure, skilled personnel, R&D, and advancing modern medicine. Curtailing these rates would deter further investment and development of world-class facilities. India's "medical tourism" thrives on affordable medical facilities compared to other countries, a fact recognized by NITI Aayog's 2021 report. Restricting rates would negatively impact this sector. **Pg R, 25,26,27 para 51,52,53,59 60,61,62 Annexure P-9 WHO Report pg 201 to 416 ANNEXURE P-10 NITI AAYOG REPORT 417-460.**	The parliamentary debates indicate a recognition of the private sector's role in healthcare. The Minister stated that imposing "very hard legislation" or a "licence raj" could deter private hospitals from developing, creating more problems than solving. **Pg 183 last 3 paras Pg 184 para 1 onwards**
Parliament's Jurisdiction (Public Health as State Subject)	Public health, hospitals, and dispensaries fall under the State List (List 2, Seventh Schedule) of the Constitution. Parliament generally lacks jurisdiction to legislate on this, except for Union Territories or when states adopt the Act under Article 252(1).**Pg 4 para 10 13, Refer to Seventh Schedule, Article 252.**	The CE Act, 2010, explicitly states its applicability in the first instance to Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim, and Union Territories, and to other states that adopt it by resolution under Article 252(1). The Minister confirmed that other states would need to adopt the law after its enactment, and he had written to Chief Ministers, with many responding positively. **Pg F para 15-18**

IMA HBI Membership Fee

Affiliation Fee (One Time):- Please **ADD** the GST amount (as applicable as per Govt. rule) **in the 'Total Fee'**.

No. of Beds	HBI HQs. Share	State Chapter Share	Local Sub chapter Share	Total Fee
0-25	₹ 2500	₹ 1000	₹ 1000	₹ 5000
26-50	₹ 3750	₹ 2250	₹ 1500	₹ 7500
51-100	₹ 5000	₹ 3000	₹ 2000	₹ 10000
101-200	₹ 7500	₹ 4500	₹ 3000	₹ 15000
> 200 Beds	₹ 17500	₹ 10500	₹ 7000	₹ 35000

Please Note: - 1) Please **add in 'Total Fee'**, collect & pay the GST amount (as applicable as per Govt. rule) & send the GST challan along with this application form. **2)**Affiliation application form must be sent through IMA local branch only. **3)**Please attach true copies of **i)** Regi. Certificate Under State Nursing Home Act, **ii)** IMA Life Membership Certificates of Doctors Who Are IMA Members & **iii)** State Medical Council Regi. Certificates of All Doctors. **4)**In case the local branch HBI subchapter or state chapter does not exist, the clinical establishment should pay through the local IMA branch and state IMA branch. Affiliation of minimum 15 hospitals to form a local subchapter and 50 hospitals to form a state chapter is necessary. **5)**Please attach an additional sheet, if necessary.

CLICK HERE TO DOWNLOAD LIFE AFFILIATION FORM

ADVISORY FOR CLINICAL ESTABLISHMENTS IN THE COUNTRY REGARDING COMMON EMPANELMENT DRIVE

IRDA has declared a Common Empanelment Drive with a goal to empanel 4000 hospitals in the few months. Through this drive, hospitals will be brought under cashless structure with cost strategies aligning with the government health schemes (PMJAY) Insurers, under the guidance of the General insurance council, are actively onboarding hospitals, particularly eye and general hospitals. Common Empanelment Drive shall prove detrimental for hospitals.

Scientific Rates & Packages are must before accepting common empanelment. Healthcare Delivery cannot be compelled at pre-decided rates. With Current rates, the clinical establishments will be unable to sustain for long pressed with cashless at par. IMA Hospital Board of India has repeatedly requested for scientific rates derived by costing studies. The insurance company rates, government health schemes rates are baseless & lack scientific costing as back up. The various committees which were utilized to conclude the rates & packages did not have factual representation of clinical establishments in the country.

In "Cashless Everywhere" model, the claim will be admissible as per the terms of the insurance policy and the insurer. This is indicative of Continuation of unilateral bias by insurance companies towards patients as well as hospitals. Cashless everywhere is impossible without scientific costing-based rates & shall not be accepted at any cost. In an insurance-based model, cashless is beneficial only to business center insurance companies & not for hospitals or people of the country. All issues in the current cashless model have been raised categorically by IMA HBI past many years and these all issues stand unresolved.

Government health schemes - only voluntary in nature. These cannot be forced on clinical establishments in the country. Hospitals, the most important stakeholders responsible for actual healthcare have not been consulted before any such decision.

Till we get clarity and the rate list revision on scientific cost analysis, it is advisable to refrain from signing the MoU.

RECEPTION MANAGEMENT IN HOSPITALS

Reception management in hospitals is crucial because it's the first point of contact for patients and their families, significantly impacting their overall experience and perceptions of the hospital. Effective reception management ensures smooth patient flow, accurate information dissemination, and a positive first impression, contributing to patient satisfaction and the hospital's reputation.

Here's a more detailed breakdown of its importance:

1. **First Impression and Patient Experience:**

The reception area is often the initial point of contact for patients and visitors, making it vital for creating a welcoming and efficient environment.

A positive first impression can reduce patient anxiety and build trust in the hospital's ability to provide quality care.

2. **Streamlined Patient Flow:**

Efficient reception management helps in registering patients, managing appointments, and directing them to the appropriate departments.

This reduces waiting times, minimizes confusion, and ensures patients are seen by the right healthcare professionals promptly.

3. **Accurate Information and Communication:**

Reception staff are responsible for providing accurate information about hospital services, procedures, and policies.

They handle inquiries, answer phone calls, and relay messages, ensuring clear and effective communication between patients, staff, and visitors.

4. **Security and Safety:**

Reception management plays a crucial role in maintaining security and safety within the hospital.

This includes screening visitors, managing access control, and implementing visitor management systems to track who enters and exits the facility.

5. **Data Management and Record Keeping:**

Reception staff are often responsible for maintaining patient records, including demographic information, medical history, and insurance details.

Accurate record-keeping is essential for providing proper care and ensuring compliance with healthcare regulations.

6. **Emotional Support and Empathy:**

Reception staff are often the first point of contact for patients who are anxious, stressed, or in pain.

They need to be empathetic, understanding, and able to provide emotional support to patients and their families.

7. **Efficient Resource Management:**

Reception management can also involve managing hospital resources, such as supplies and equipment, and coordinating with other departments to ensure smooth operations.

8. **Building Reputation and Loyalty:**

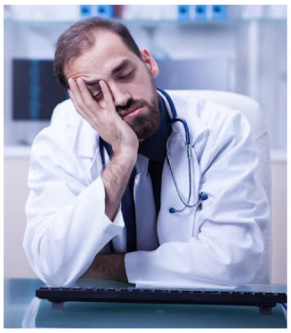
Effective reception management contributes to a positive patient experience, which in turn can lead to increased patient satisfaction and loyalty.

A good reputation is vital for attracting new patients and maintaining a strong presence in the community.

9 TIPS TO REDUCE ELECTRIC USAGE IN HOSPITALS & HEALTHCARE:

- Switch to energy-efficient lighting and upgrade lighting systems, especially in areas needing continuous illumination.
- Shut down or put unused electronics on standby.
- Use automated settings for heating and cooling, especially in unoccupied spaces.
- Integrate renewable energy sources such as solar, wind, or water.
- Install occupancy sensors in rarely used areas like bathrooms to control lighting and water usage.
- Explore alternative and more efficient laundry methods, such as cold-water washing and recycling water and heat.
- Consider cogeneration systems to reuse and recycle energy within the facility.
- Turn off lights when not needed, using timers or occupancy sensors.
- Regularly maintain and upgrade HVAC systems to ensure optimal and energy-efficient operation. HVAC stands for Heating, Ventilation, and Air Conditioning. It's a system designed to control the temperature, humidity, and air quality within an enclosed space, like a building or a vehicle. Essentially, it's a climate control system that provides thermal comfort and good indoor air quality.

Are we sleeping adequately?



Prevalence of Sleep Deprivation among Doctors

- A significant proportion of young doctors, including those in India, regularly get less than the recommended 7 hours of sleep. One study found that over 80% of doctors surveyed were sleep-deprived during night shifts, averaging just 5.4 hours of sleep.
- Another survey indicated that 89% of doctors felt sleep-deprived at work at least some of the time, with about 22% experiencing this daily.

Physical and Mental Health

- Chronic sleep deprivation among doctors increases the risk of lifestyle diseases such as obesity, type 2 diabetes, and cardiovascular diseases.
- Sleep-deprived doctors report higher rates of mood disorders, including depression and burnout, as well as ongoing feelings of fatigue and irritability.
- There's evidence linking sleep deprivation to decreased DNA repair and increased DNA damage, which could predispose young doctors to more severe health problems over time.

Professional Performance

- Sleep loss impairs critical cognitive skills. Even a small reduction in sleep (2–4 hours less per night) can lower psychomotor performance to levels comparable to the legal intoxication limit for alcohol.
- Doctors with poor sleep demonstrate reduced attention, impaired judgment, slower reaction times, and diminished memory—factors that increase the risk of clinical errors.
- Sleep-deprived doctors are also more prone to accidents, with a notable portion experiencing car crashes after overnight shifts.

Long-Term and Lifestyle Impact

- Prolonged lack of restorative sleep is associated with gastrointestinal problems, visual disturbances, elevated stress hormones, and higher incidence of burnout.
- Many young doctors experience "micro-sleeps"—brief, uncontrollable episodes of sleep—that can be dangerous during clinical practice or when driving

PATIENT SAFETY

Global Burden

- Occurrence of adverse events due to unsafe care is likely to be one of the 10 leading causes of death & disability.
- 70 Lakhs* surgical patients suffer significant complications each year, resulting in the death of 10 Lakhs such patients
- 1.7 Lakhs* admissions annually in the USA due to Patient harm
- 15% of hospital expenditure on treatment of safety failure in OECD countries
- 50% of such harm is preventable.

Indian Scenario

- In India, around 5.2 million injuries occur due to medical errors, resulting in around 3 million preventable deaths every year.
- For every 100 hospitalizations, approx. 12.7 Adverse events occur.
  (Ashish Jha, BMJ Quality & Safety, Sept 2013)

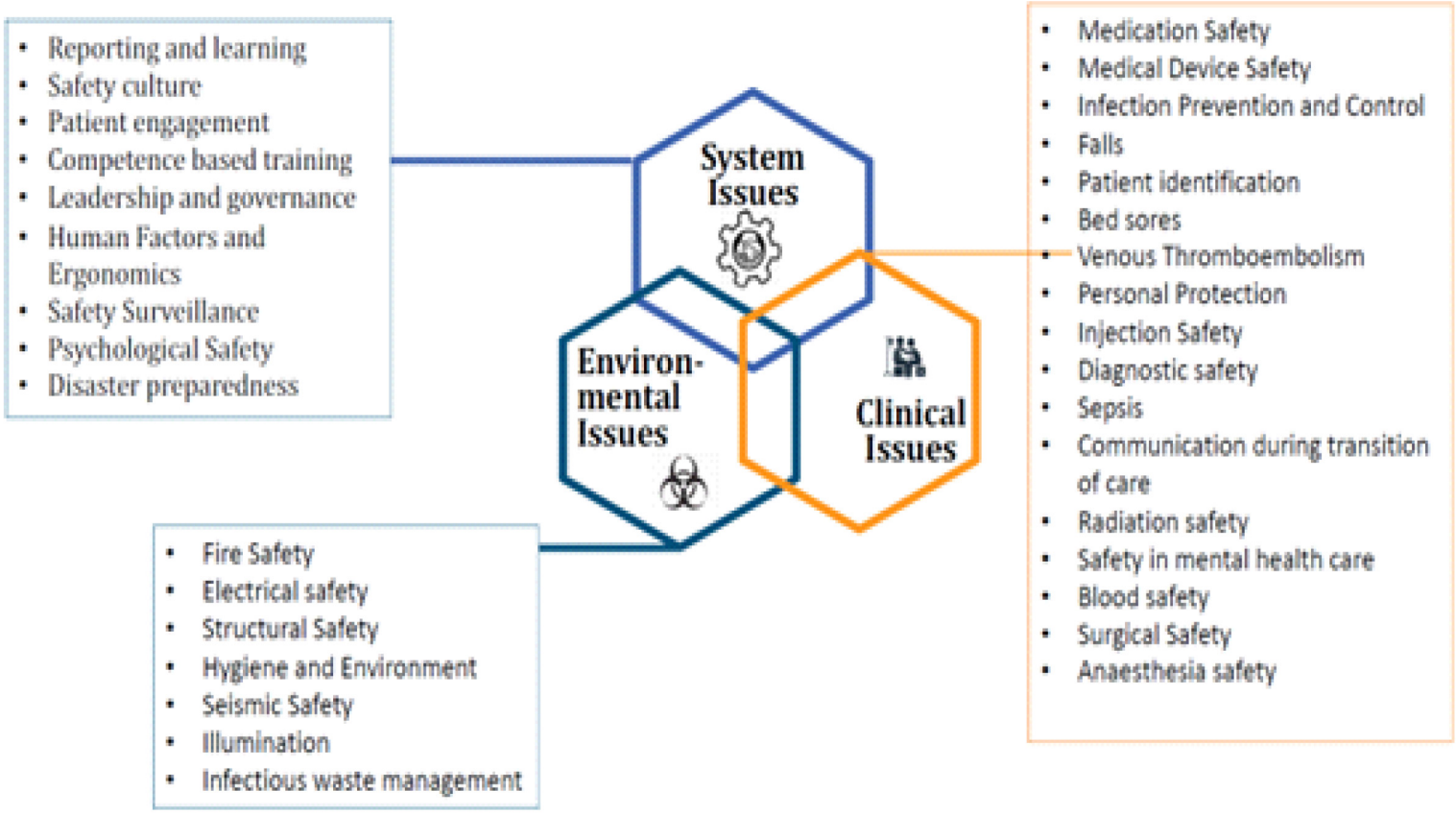
Three Common Safety Incidents

- Related to Surgical Procedures (27%)
- Medication Errors (18.3%)
- Healthcare Associated Infections (12.2%)

Existing Initiatives supporting Patient Safety

- National Quality Assurance Standards
- 'Kayakalp' Initiative – Infection Control, Needle Stick Injury
- National Patient Safety Implementation Framework
- Pharmacovigilance Programme of India – Medication Safety
- Haemovigilance Programme of India – Blood Safety
- Health Management Information System (HMIS) – SSI, Needle Stick Injuries, Performance
- of Health Facilities (ALS, BOR), Audits, etc.
- Facility Level Audits – MDR, CDR, Death Audits, Prescription Audits

Patient Safety-Multiple facets



(Sources: National Patient Safety Implementation.)

Innovations in Paediatric Practice

Innovations are improving on or adding on new dimensions to your practice. A new idea or method incorporated in your routine, improve your practice and increase the clients. Choose your area of interest and expertise. Work on it to improve the delivery of your day today interactions.

Treating children is an integral part of family practice. children present to us in different ages, problems and sizes. Treating a small child is akin to travelling in a difficult mountainous terrain. From the relatives get the history, check the mental status, Bowel bladder habits, sleep, appetite and play gives clue to the diagnosis apart from the presenting problem.

1. Reception Training of the outpatient assistants in identifying Sick children is of utmost importance. A child presenting with fits, high fever or severe dehydration can be identified by anyone. But to pick up a child who has drowsiness or breathing difficulty and acute severe deterioration needs training. You can do it with videos available online. Any fitting child can be managed by giving intranasal midazolam spray. One spray per 4 kg to be given alternatively in both nostrils after putting the child on the left lateral position

2. Emergency room: Any acutely ill in child, be it fits, asthma, dehydration needs checking of ABC -airway breathing and circulation. Keeping a ready reckoner with details on vital parameters according to the age and sex will help immensely. Do not hesitate to supplement oxygen in a sick child. Never ever nebulize the asthmatic child without oxygen. use oxygen to deliver the nebulization or supplement it along with the Nebulisation. Remember always that oxygen is a respiratory system drug. If you do not have a oxygen source or oxygen cylinder in your clinic you can use MDI inhaler with spacer depending on the age of the child.

3. Salbutamol delivered through a metered dose inhaler is 1/20 of nebulized solution. So, no sudden drop in spo2 while using the broncho dilatory medication. Give four puffs of salbutamol every 20 minutes for 3 times and review the child afterwards for any improvement. You can continue with inhaler if already on or oral medication. This is equivalent to nebulization without the hassle of finding out or using oxygen sources.

4. Many children need intravenous fluids due to inadequate intake. Raised body temperature, altered taste, inflammatory markers reducing the appetite are the reasons. Alternate to intravenous re-hydration is by giving oral Re-hydration salt mix in appropriate quantity of water or homemade re-hydration fluids like kanji,(rice, dal, wheat), tender coconut water and rasam rice. Giving fruit juices without adding sugar may be fine in conscious non diarrheal babies but avoid diarrhea. continuing breast feeding in a breast feed child is a must. avoid extra milk, biscuits, bread and drinks like Horlicks (too much salt) boost etc.(sugar) non-WHO ORS brands.

5. ORS is one of the 10 best inventions of the 20th century. But the salty taste is not liked by many children. To make it tasty ORS may be added to kanji 200 ml (when using 4.5 gm) or made as popsicle or mixed with cold water or sprinkled on food (unpublished observation). Give slowly as 2-3 teaspoons every 10 to 15 minutes. Vomiting is another disturbing symptom for many. Children having needle phobia use ondansetron as mouth dissolving tablet on strip which can be placed on or under the tongue.

6. Per rectal medications: Children with difficulty in swallowing or vomiting can use per rectal medication. Paracetamol is available as a suppository in different strengths for all ages fulfill this need. Other medications are Dulcolax for constipation, diclofenac for orthopedic conditions and ibuprofen as anti-inflammatory suppository.

(Will continue...)

Dr Selvan, Paediatrician Erode