

# *Confronting Commercialization of Health Care*



*Towards the People's Health Assembly Book—5*

# *Confronting Commercialization in Health Care!*

*A brief introduction to the ethical and professional  
dimensions and quality of care implications of the  
growing thrust to privatize all health care services.*

*Prepared and Published by  
The National Coordination Committee  
for the*

## *Jan Swasthya Sabha*



*Towards the People's Health Assembly Book-5*

*Confronting Commercialization in Health Care!*

First Edition July 2000

Authored and Published by :

**National Coordination Committee, Jan Swasthya Sabha**

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## **National Coordination Committee Members**

- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- All India Women's Conference (AIWC)
- Bharat Gyan Vigyan Samithi (BGVS)
- Catholic Health Association of India (CHAI)
- Christian Medical Association of India (CMAI)
- Forum for Creche & Child Care Services (FORCES)
- Federation of Medical Representatives  
Associations of India (FMRAI)
- Joint Women's Programme (JWP)
- Medico Friends Circle (MFC)
- National Alliance of People's Movements (NAPM)
- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Ramakrishna Mission (RK)
- Society for Community Health Awareness,  
Research and Action (SOCHARA)
- Voluntary Health Association of India (VHAI)

## **Participating Organizations**

Over 1000 organizations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Sabha campaign as participating organizations.

# About the Jan Swasthya Sabha

Governments & international agencies have forgotten the goal of **Health for All by 2000 A.D.** But we, the people, cannot forget it. It is time to strengthen & expand people centered initiatives - to find innovative solutions & to put pressure on decision makers, governments and the private sector.

There is a need to reiterate that attaining **Health for All** means ensuring everyone has access to affordable quality medicare, safe drinking water and sanitation, adequate nutrition, clothing, shelter and employment and no one is discriminated against on the basis of class, caste, race or gender. People need to be made aware of the links between globalization and the worsening health of the people. When structural adjustment policies work to undermine the vision of Alma Ata, renewing the **Health for All** call is an imperative.

With this understanding a large number of people's movements across the country have jointly initiated a national campaign called the Jan Swasthya Sabha. This has three broad objectives:

- ☛ To re-establish health and equitable development as top priorities in policy making with primary health care as the strategy.
- ☛ To forge a local, national and global unity of all democratic forces to work towards building long term sustainable solutions to health.
- ☛ Reinforce the principle of health was a broad inter-sectoral issue

The campaign has a four-ties structure. 2000-3000 blocks in 200-300 districts mobilize people on **Health For All - Now!** and conduct block level enquiries into the state of health services. These enquiries culminate in block seminars highlighting the findings & helping formulate people's initiatives for primary health care. Then, each district has a district level mobilization culminating in a District Seminar. All this builds up to the Jan Swasthya Sabha to be held in Calcutta from Nov 30th - Dec 1st 2000. Four trains with representatives from various parts of the country will arrive at the National Assembly. The Jan Swasthya Sabha - with over 2000 representatives - will call for a reversal of structural adjustment policies and a renewal of the *Health for All* pledge. The assembly will also send its representatives to the international People's Health Assembly being held at Dhaka from Dec 4<sup>th</sup> - 8<sup>th</sup>, 2000 where similar representatives from other countries will gather. Following the Jan Swasthya Sabha, each interested block or district follows up with health intervention and advocacy.

The Jan Swasthya Sabha is being coordinated by a National Coordination Committee consisting of 18 major all India networks of peoples movements and NGOs. This book is the fifth book in a 5 book series brought out by the NCC for guiding the block, district and state seminars.

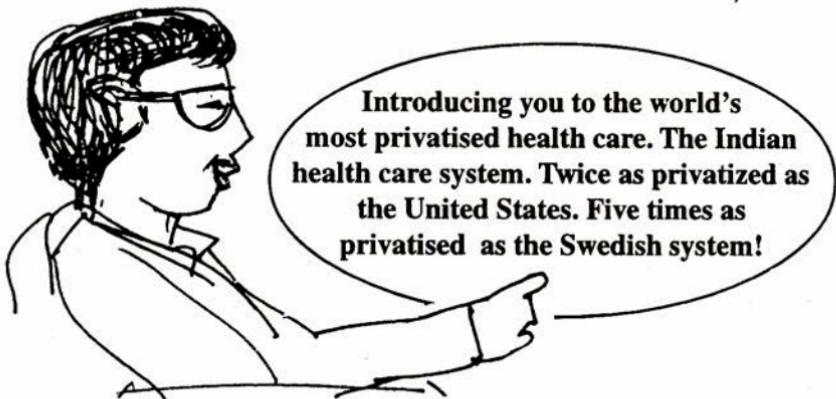
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## Chapter 1

### *Introduction*

# THE INDIAN HEALTHCARE SYSTEM

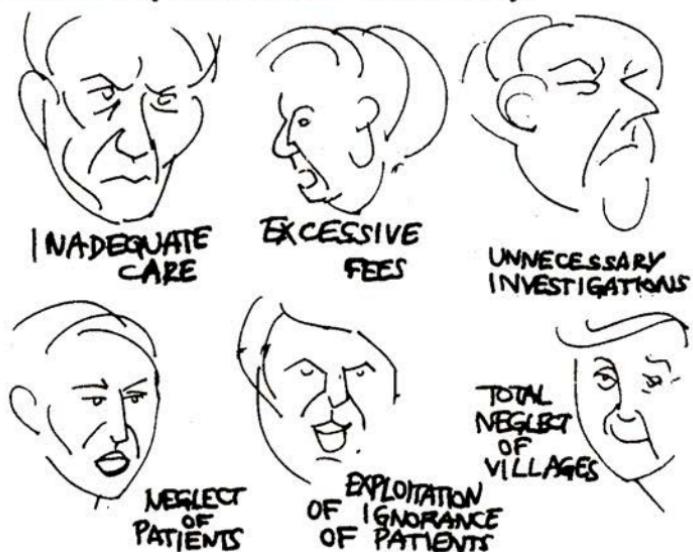


Only 22% of the the health expenditure is public funded in India as compared to 44% in the US, or 95% in countries like Sweden or 75% in all the market economies of the west taken together.

**AND NOW WE ARE TOLD :**



But there are lots and lots of problems with this simple solution:  
What are the popular causes for dissatisfaction against doctors  
and the delivery of health care in India today?



These causes are leading to an increasing alienation of the community from the Medical profession, which is a very unhealthy trend. Cautionary warnings by professional bodies are also not uncommon showing that the malaise is deeper.

**"Eternal vigilance is required to ensure that the health care system does not get Medicalised, that the doctor-drug-producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill-health."**

**-ICSSR / ICMR Report on Health for All**

While many doctors are sincere and committed to the ethical and scientific framework of their profession and vocation, in today's increasingly corruption influenced socio-economic-cultural political milieu, many are not and this is an increasing area of concern.

The public, the judiciary, the media and civic society are losing confidence in the professional disciplining mechanism and peer group controls which have failed to redeem the situation and hence the move to bring doctors under the Consumer Protection Act in spite of arguments to exclude them.

In the first half of this century the image of medical care was largely.

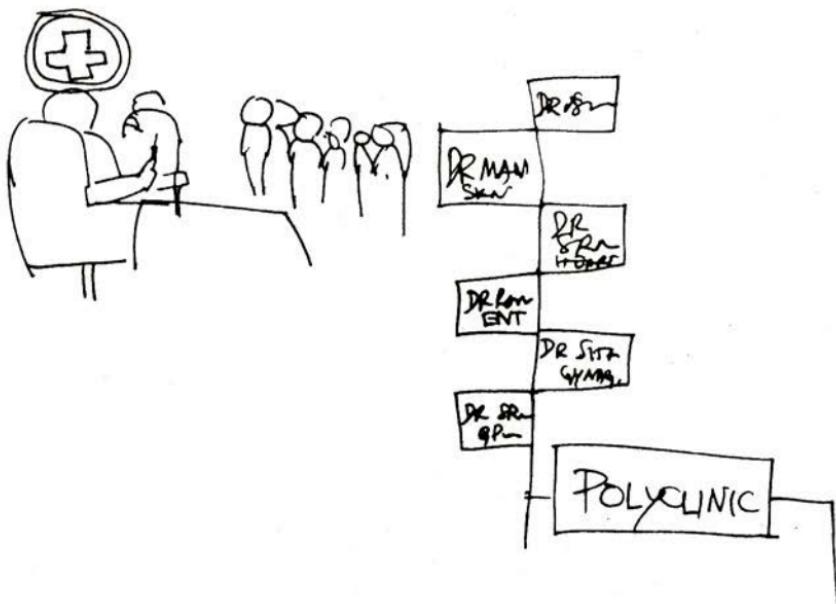


The image of the general practitioner was :



Family doctor and family friend;  
would come to our homes;  
flexible payment often deferred;  
few prescriptions - the compounder  
made up much of these.

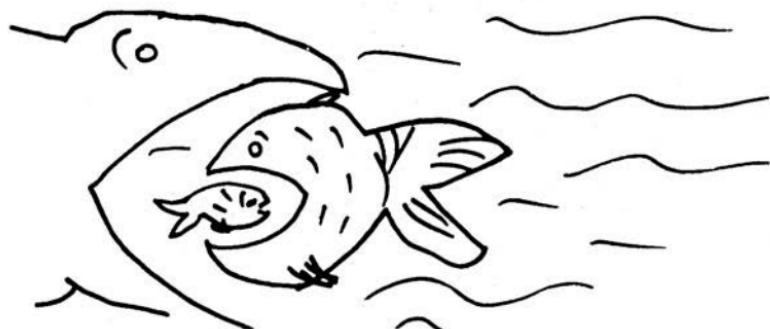
## TODAY:



### Fiercely competitive private practice

- ◆ threatened by numerous nursing homes and polyclinics
- ◆ swallowed up by corporate hospitals and insurance companies
  - and for those who can not pay or are drained of their money a very weak public sector

Picture at the bottom of a big fish swallowing a small fish swallowing a yet smaller fish



The Ordinary General Practitioner today has his problems:



I CANNOT CLOSE THIS CLINIC  
FOR A SINGLE DAY



I HAVE TO GIVE INJECTIONS,  
SHOW QUICK RESULTS



I HAVE TO PAY COMMISSIONS...



THE PATIENT'S  
DEATH WAS NOT  
MY FAULT, BUT  
THEY BEAT ME UP



Look ALL THESE QUACKS AROUND...

**But still wherever available  
he or she is the most preferred  
health professional.**

## At the corporate hospital it is another story.

Let us buy this scan  
worth Rs. 4 crores.

### THE BREAK EVEN ANALYSIS:

We can repay the loan  
in two years at 24% interest.

That means a  
repayment schedule of  
Rs.20 lakhs per month.  
If we earn 25 lakhs per  
month we will earn Rs.2  
lakh profit per month  
after Rs.3 lakh running  
costs.

Let us make an agreement with  
30 doctors. If they give us one case per day  
we will pay them Rs.1000 per patient!

Anything more is welcome.

That means we need 30 patients  
per day from each of whom  
we charge Rs.3000 plus Rs.1000  
to give the doctor, i.e. Rs.4000 per  
scan.

A corporate hospital is run like an industry! It is run to maximise returns on investment. The number of people who need investigation will invariably be less than that needed to break even - especially as more and more hospitals will open. Where there is a high return of investment in any sector in a market economy, more units of that type develop. However this will not push down costs or promote efficiency. It will rather promote more unnecessary investigations, unnecessary hospitalization, unnecessary surgeries and unnecessary referrals. Some of these are done as malpractice. But a greater trend is to shape modern medical science so that there is more and more 'need' for investigations, hospitalization and surgery. For any other commodity if there is competition the price will stabilize around its value. But since no value is too high for human life, the ability to price is limitless. It is limited only by the ability of the consumer to pay

## But should we get worried about corporate hospitals? After all only the rich pay?

The culture of such hospitals redefines medical sciences, shoots up costs leaves patients dissatisfied and often pauperized without improving their health. Since it is mostly senior professionals who work here, the way they redefine medical science is the single greatest threat of these hospitals.



(Tomorrow when the husband dies, the family is on the street.)



“A disproportionate share in decision making and public opinion is contributed by the elite from these hospitals due to the prestige they command - though they have little or no experience of health planning or even working with the poor.

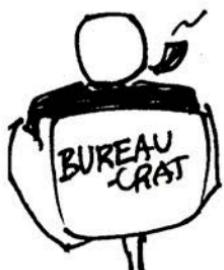


The question is are we individually and collectively helpless?



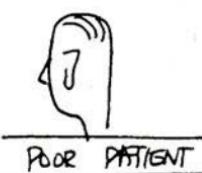
WHEN EVERYONE IS GIVING INJECTIONS  
AND TONICS I HAVE TO FALL IN LINE

WHEN I GO TO A DOCTOR, HOW CAN  
I QUESTION HIM?



LOOK THE PUBLIC HEALTH SYSTEM  
IS EVEN WORSE...

PERSONS WITH NO KNOWLEDGE  
OF MEDICINE CANNOT REGULATE  
THE MEDICAL PROFESSION...



... VERY VERY POOR  
RECORD OF SELF REGULATION.

## Or are there ways to confront commercialization of health care?

The six components of checking commercialization:

1. Strengthen public sector in health.
2. Patient education - on rational medical care and demystifying doctor-patient relationships.
3. Reorient medical education to meet people's needs; to make medical practice more ethical and holistic.
4. Regulation of private medical sector.
5. Dialogue with professional bodies to catalyze, strengthen and support profession's internal initiatives for reform
6. Dialogue with all sections of society including professionals for evolving ethical codes, norms of care and for more open profession.

*This book is an effort to identify the key issues related to confronting commercialisation in health care. The articles for this book are based on papers written for this purpose by some of the most experienced medical and legal professionals in this area. We especially thank Dr. K.R. Sethuraman (JIPMER), Dr. Ravi Duggal (CEHAT), Dr. Ravi Narayan (CHC), Dr. N.R. Madhava Menon and Dr. Frances - for their contributions. This book must be seen as part of the process of initiating a dialogue rather than of asserting dogmatic positions.*

country. Yet, ironically, barbiturate combinations can be freely purchased even over the counter. They are commonly combined with anti asthma drugs. This is a dangerous practice as barbiturates can depress respiration — which can be life threatening in asthma patients.

**Combinations of Antibiotics:** A large number of combinations of two different antibiotics are available in the market. Two categories of these are rational - combination of trimethoprim and sulphamethoxazole as co-trimoxazole and combination of anti T.B. drugs. These are the only two combinations mentioned in the WHO list of Essential drugs. Most other combinations carry the risks and disadvantages associated with combination products related earlier. In the case of antibiotics the disadvantages are greater, one because the side effects tend to be more pronounced; two because the increase in cost is greater; and three because of the added risk of developing antibiotic resistance. The commonest irrational combinations available is a combination of Cloxacillin with Amoxycillin or Ampicillin.

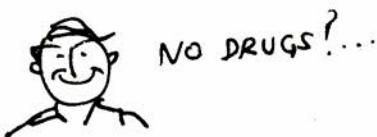
**Combination of Drugs from Different Systems:** Today there is a new trend in the marketing of combination of drugs from the allopathic system along with drugs from other systems viz. ayurveda, siddha, unani and even chinese and Korean systems. It is obvious that such combinations are grossly irrational as each of these systems have differing approaches to disease and therapy. Further, no practitioner is likely to have the knowledge of all these systems to be competent to prescribe such combinations on the basis of his scientific knowledge. These products need to be immediately banned.

### **Irrational Prescribing**

It needs to be understood that the problem is not limited to just a question of irrational or useless or harmful drugs. Rational, or even life saving drugs can be used in an irrational manner. The

commonest problem is the unnecessary use of drugs. Thus, often we see expensive antibiotics being used for trivial infections. Moreover this is often accompanied by wrong dosage schedules. Another problem is the prescription of a large number of drugs for a simple ailment, when one or few drugs would have sufficed. doctors, in many cases, when they are not sure of the diagnosis prescribe a large number of drugs to cover for all the possibilities. Thus a patient coming with fever may be given some antibiotic, a drug to treat malaria, a drug to treat typhoid, etc. It may turn out that the patient was just suffering from a viral fever, which could have been treated with some paracetamol tablets only. Such prescription practices increase the cost to the patient, unnecessarily exposes the patient to potential side effects, and in the case of antibiotics leads to drug resistance, i.e. a situation when these antibiotics become useless when they are really required.

Patients must also realise that if a doctor advises no drugs, he is giving as valuable (or in some cases more) advice as someone who prescribes a large number of drugs. All illnesses do not require drugs — in fact a large number of illnesses are “self limiting”, i.e. the body cures itself without the use of drugs. So patients should not be impressed by a doctor who prescribes a large number of expensive drugs: in most cases the doctor is just hiding his inability to reach a correct diagnosis by trying to cover for all eventualities.



Some other common irrational practices that need to be mentioned. One is the preference among patients and doctors alike for injections. Under normal circumstances injections are not required to be given, except in the case of drugs that can be given only by injection, like insulin, some penicillins, streptomycin, etc. Most drugs are available in both forms: that which can be given by



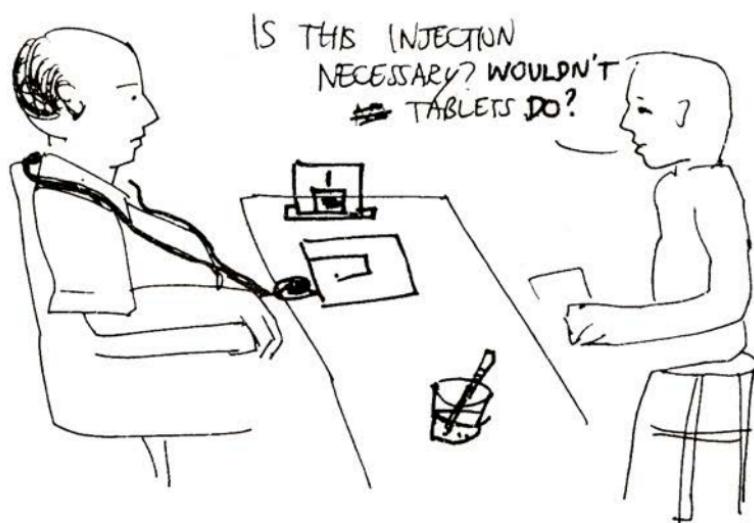
injection, and that which can be taken by mouth. A drug that is taken by mouth may take from 15 minutes to two hours to start acting, while an injected drug may take only a few minutes. Otherwise, usually, the effect of both are similar. So injections are required only when the patient is very seriously ill, i.e. when one cannot afford to wait for half an hour before a drug starts acting. On the other hand, injections have many disadvantages: they are always more expensive, they can cause more severe side effects (even life threatening ones), and when sterile precautions are inadequate they can cause infection and abscess formation at the site of injection, and they can transmit deadly diseases like Hepatitis B and AIDS.

Another prevalent practice is the use of intravenous solutions of glucose, saline, etc. to treat a wide range of ill defined ailments like "exhaustion", "weakness", etc. Such intravenous solutions are necessary only in cases where the patient cannot take water and ailments by mouth, viz. unconscious patients, patients who have been recently operated, patients who are extremely weak and

unable to swallow, those with continuous vomiting, etc. They may also be necessary in severely dehydrated patients, or patients in shock, where the fluids inside the body have to be replaced very fast. But if a person is conscious and not severely dehydrated, and is able to drink fluids, intravenous fluids are a gross waste of money. Practitioners are known to charge 100 to 200 rupees for administering one bottle of such solutions. These solutions contain about half a litre of water and some salts and sugar. The total cost of the same ingredients, if taken by mouth, will come to only one or two rupees. And the benefit would be the same as in the case where it is given by intravenous injection!

When a patient is treated by a medical practitioner, the practitioner is legally bound to provide the patient with a prescription which must contain at least the following things: 1) Name, age and sex of the patient; 2) Findings made by the practitioner on examining the patient, viz. pulse rate, blood pressure, condition of the chest

### ASK YOUR DOCTOR

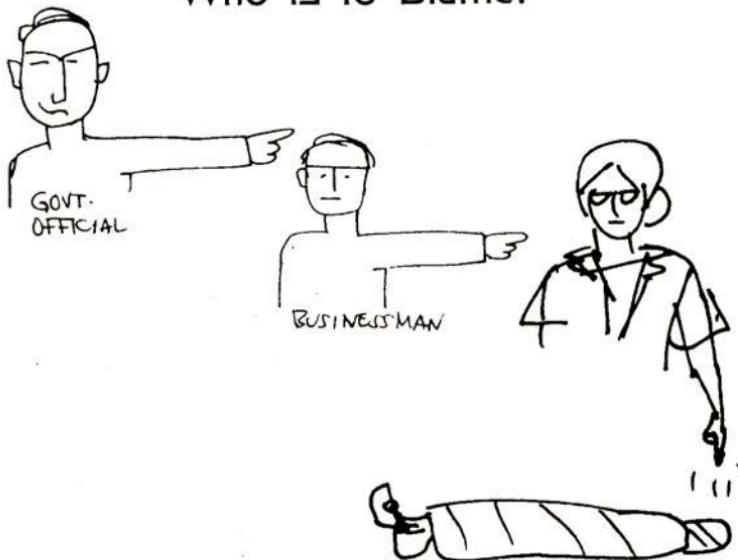


abdomen, cardiac system, etc.; 3) Diagnosis arrived at by the practitioner (even if it is provisional); 4) List of drugs prescribed with the dosage schedule and duration of use advised (this is required even if the practitioner himself dispenses the prescribed drugs); 5) Signature and name of the practitioner. In a large number of instances patients are not provided with prescription at all or with incomplete prescriptions. This is a dangerous practice as a patient is not left with any record of the treatment given and an assessment of the illness he is suffering from. In future, in case of an emergency (due to the disease worsening or due to the side effect of a drug) it becomes impossible to determine the real cause of a patient's worsening condition. Lack of a proper record is also a handicap if a patient decides to switch doctors or if he falls ill again.

Finally, another dangerous practice is that of making drugs available "over the counter", i.e. directly by chemists, without a doctor's prescription. Most drugs can legally be sold by a chemist only if the buyer produces a prescription. There are only a few simple drugs which can be sold without a prescription, viz. paracetamol, aspirin, etc. All other drugs are marked: "To be sold on the prescription of a Registered Medical Practitioner only". It is dangerous to buy drugs without a prescription as all drugs can have side effects, and have very specific do's and don't's.

All these irrational practices continue to flourish because the five actors in this drama: the government as a regulatory authority, the drug companies as producers of drugs, the doctors as prescribers of drugs, the chemists as sellers of drugs, and the consumers as users of drugs, at some level or the other do not fulfil the required obligations and are unmindful of the potential harm that inappropriate use of drugs can cause. Drugs can save lives, but their inappropriate use can also take lives. It is estimated that 20-30% of illnesses — especially in the aged and in children are caused by use of drugs.

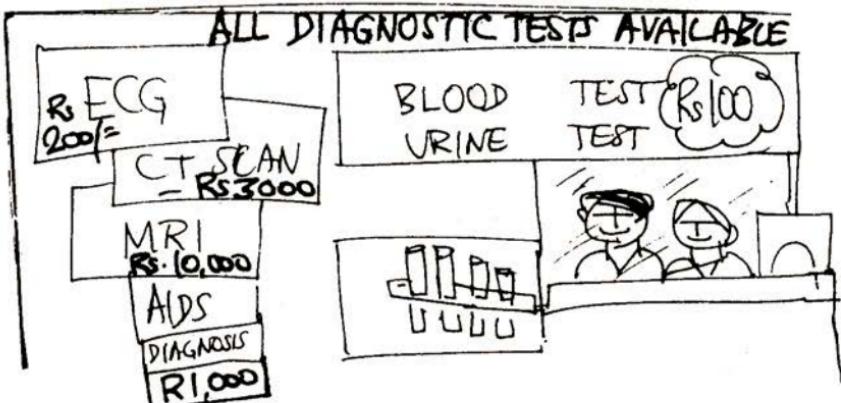
## Who is to Blame?



### Rational Use Of Diagnostics

Using WHO definition of irrational drug therapy as the basis, irrational use of diagnostics (including laboratory tests of blood, urine, sputum, etc.; X-Rays; scans; etc.) may be defined as: "a diagnostic test is irrationally used when the expected benefit is negligible or nil or when it is not worth the potential harm or the cost."

While there is some awareness about irrational drug usage, almost no enough attention has been focused on irrational use of diagnostics. If one realises that an irrational CT-Scan is equivalent in wastage to about 100 bottles of an irrational 'tonic', then the importance of rational use of diagnostics will be apparent. One reason for this neglect may be that most medical professionals are not aware of the need to selectively and critically use the diagnostic tests and avoid the "tar baby syndrome"



All enlightened health care providers and seekers must be aware of the 'tar-baby syndrome'. Scientists first discussed this phenomenon in the New England Journal of Medicine in 1986. They described a cascading process that, after a triggering event, progresses inexorably to its inescapable conclusion, much like an avalanche. They called it the "Tar Baby syndrome" based on an old children's folk tale called "*Brer Rabbit and the Tar Baby*".

**The Story:** One day Brer Fox got hold of some tar and made a Tar Baby. He put a hat on it and set it in the middle of the road. Then he hid behind a bush to see what would happen. Presently, along came Brer Rabbit. He politely wished the Tar Baby good morning. When it did not respond, he wished it again and then yet again. Finally, thinking the tar baby was being deliberately rude, he punched it in the face and of course, his hand got stuck in the tar. He punched it with the other hand and that hand too got stuck. When he tried kicking it, his legs got stuck. He could not free himself.



How does a clinical cascade begin? A physician or at times, a patient, may be goaded by anxiety and frustration, the same stimuli that provoked Brer Rabbit to kick the tar baby. Desire to allay anxiety, to feel in control and to overcome uncertainty prompt the order of some tests -- a seemingly benign and safe action. However it may turn out to be a misstep that sets in motion a cascade of chain reactions that get progressively more risky and more expensive.

The myth of "laboratory proof" has to be realised by all, especially the professionals. Most doctors unfortunately use laboratory tests for support rather than illumination.

Very few tests can make or break a diagnosis by giving absolute proof that a disease is present or absent. Most tests only affect the probability of a disease being present or absent (the likelihood ratio).

Typically 95% of normal people will conform to the range of “normal value” of a test because that is how “normal range” is defined when the test was designed.

*It also means that 5% of normal population will have values beyond what is considered normal for a test.* They are “false positive” cases. If a disease is so rare as to affect one in a million of the population, blind screening for the disease using such a test will pick up 5000 normal persons (5% of one million) as false positives for every single case detected! That is a real-life needle-in-the-haystack situation!

Mindless screening tests thus initiate clinical cascades. It has been estimated that a battery of 12 biochemical tests done by auto-analyser will produce at least one false positive “abnormal” result in 46% of healthy persons. *A 20-test battery will produce abnormal (false positive) results in about 64% of healthy persons;* this will lead to further tests to clarify the issue. It is good for health care industry but may be risky or ruinous for the patients.

The plain truth is that clinical practice is a treacherous pathway lined with potential tar babies. It is indeed quite easy to “kick the tar baby” and initiate a clinical cascade of further tests. Beware of “tar baby syndrome” whenever you go for a battery of diagnostic tests. *With clinical testing, more is not necessarily better.*

### **Prudent Use of Diagnostic Tests**

Before requesting an investigation, the clinician should ask himself/herself the following queries:

1. Will the test result help me to -
  - a) Confirm/establish diagnosis,
  - b) Rule out a diagnosis,
  - c) Monitor therapy,
  - d) Estimate prognosis, or
  - e) Screen for and detect a disease?

2. Can the abnormality I seek in this case -
  - a) Exist without any clinical evidence of it?
  - b) Even if present, be in any way harmful to the patient?
  - c) Be treated or controlled? and
  - d) Be worth the cost and the risk for this patient?
3. Is there no safer and more economical alternative?



If, after careful thought, the answer to all these questions is a clear 'No', then there is no need to do the test. If the answer to any one of them is 'Yes', the test may need to be performed depending on its availability, predictive values and affordability.

### **Rationality and Cost-Risk-Benefit Analysis**

Any health care option can be analyzed in terms of benefits, risks and cost. Benefits have to be weighed against risks and against cost. An enlightened health care seeker can cope with difficult decision making process through analysis. Doctors should encourage such patients to take decisions instead of being paternalistic and talking down to them.

Cost-benefit and risk-benefit can be simplified into four categories:

Category 1:

- a) Low risk - Low benefit
- b) Low cost - Low benefit

These are mostly rituals in health care that are routinely done. "Why not try it? After all there is no harm" or "It does not cost much" are some arguments put forth to promote these options.

Category 2:

- a) Low risk - High benefit
- b) Low cost - High benefit

These are ideal options to be avidly accepted. "It is safe and dramatically improves outcome" or "It is a steal" are some arguments put forth to promote these options.

Category 3:

- a) High risk - High benefit
- b) High cost - High benefit

Many modern miracles of health care belong to this category. Some examples are transplantation, assisted reproduction, foetal surgery and cancer chemotherapy. Quite often, the benefits are highlighted and the risks and costs are understated in the media and by health care providers. Care seekers may mistake these options to be of low risk or low cost. If they burn their fingers due to unaffordable cost or adverse outcome, they may react badly and seek redress.

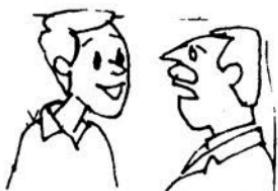
Much health care litigation in court arises from mistaking a category 3 option as a category 2 option. Proper pre-treatment counselling is the only effective solution.

Category 4:

- a) High risk - Low benefit
- b) High cost - Low benefit

These options should be weeded out from rational health care.

Some researchers wanting to be the first to prove a point pursue high risk-Low benefit options. High cost-low benefit options are pursued by 'health industry' that looks for new ways of making profits.



T.S. Eliot has warned us against action taken 'not for the good it will do but that nothing be left undone'. "What other chance do you have" is the question put to the care seeker to justify category 4 options. This pursuit of the margin of the impossible has become "technological brinkmanship" in health care (W.A. Silverman: Perspectives in Medicine and Biology, 1995; 38: 480-95). This leads to the offensive practice of the so-called 'defensive medicine'. In the name of ruling out possibilities, a large number of tests are performed. Tests should be critically selected to 'rule in' a disease rather than 'rule out' all other possibilities.

### **FACTORS THAT PROMOTE IRRATIONAL MEDICAL CARE:**

Why is it that despite so much training, irrational medical care is so widespread? And what can be done to restore the rational practise of medicine? Below we discuss six factors that favour irrational medicine and then go on to discuss factors that could promote rational medical care.

#### **1. Medical Fashions Erode Rationality**

Health care providers, episodically push certain disease labels and treatments because everyone else is doing the same, and it would be unfashionable not to do so. Dr. Buram listed some examples of 1987 in the New England Journal of Medicine (317: 1220, 1987).

- 1. Treatments of fashion:* The use of third generation cephalosporin for community acquired pneumonia (unwarranted and irrational).
- 2. Disease of Fashion:* Chronic fatigue syndrome which was known by many other names earlier.
- 3. Fashions in Surgery:* Historically, tonsillectomy, stomach-freeze for peptic ulcer, gastric balloon inflation for obesity are some humbling examples of fashion. The current craze for - and uncritical acceptance of - all complementary and alternate medical practices

is an example of a fashion born of collective gullibility of the post-modern society. This too shall pass.

## 2. Monetary Compulsion Erodes Rationality

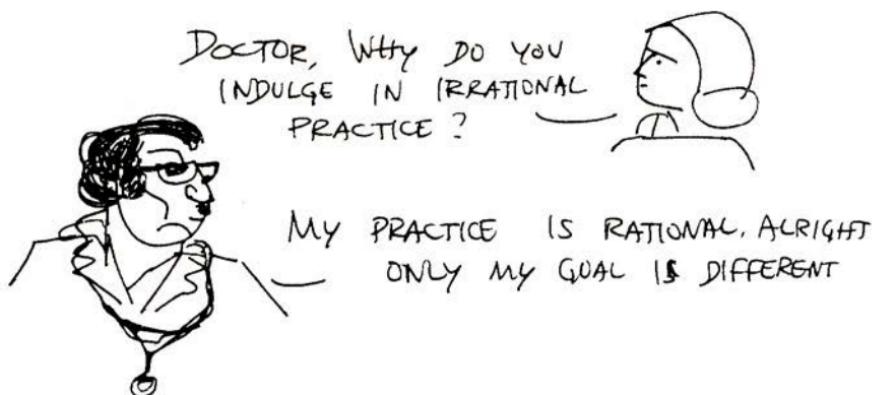
Bernard Shaw had an uncanny insight into the working of doctors' minds when faced with the dilemma of choosing between ethics and monetary compulsions. In 1906 he wrote thus in the preface to a piece called "*Doctor's Dilemma*":

"As to the honour and conscience of doctors, they have as much as any other class of men, no more and no less. And what other men dare pretend to be impartial when they have a strong pecuniary interest on one side?"

"It is simply unscientific to allege or believe that doctors do not under existing circumstances perform unnecessary operations and manufacture and prolong lucrative illnesses."

The pressure to bring in income by unethical means is much higher in hospitals run for profit by non-technical financiers. Dr.Sethuraman, Professor of Medicine in JIPMER, Pondicherry, reports a story related by a junior doctor, who was his former student, and who worked in such a place later. He said this about his hospital: "No mother had a chance of normal delivery during the second half of every month because money had to be generated to pay back the next monthly installment to the bank. Similarly, any one with a chest symptom will be put into the intensive care and kept for five days unless they run out of money and ask for discharge." When he raised ethical queries, he was simply told to 'join in or get out'. He chose to get out.

Doctors in the private sector argue, "The patient is happy getting the maximum attention, we are happy collecting our fees and the health care industry is happy generating income and wealth for the



shareholders. *It is an all-win situation.*" This is a vicious argument and can attract the reply, "A drug dealer or a pimp will also use the same logic and say it is an all-win situation. Can you or society accept it then?"

The harsh reality is that two-thirds of our rural families are in debt because of health care expenditure. If the chain of rural indebtedness has to be broken, planners and health activists have to squarely address this issue and find some lasting solutions. For the conscientious doctor, there is an ethical self test that can be used as a guide: "Would I like myself or my near and dear to be treated thus?"

### 3. Advertising and Corruption Erode Rationality

Irrational practices are often initiated and maintained by marketing techniques of the advertising industry. The drug industry spends 20% of its annual sale or about Rs. 3,000 crores in advertising; this works out to about Rs. 50,000 per doctor per annum and each doctor prescribes drugs worth Rs. 250,000 per annum. Fashions in diagnostics are maintained by a well established kick-back scheme all over India. It is of great concern that what started in Mumbai in the 70's has spread through out the country and is the most important

cause for unnecessary health care interventions. PHA 2000 must address these growing and cancerous developments in health care industry.

### What are commissions :

When a doctor asks a patient to take a CT Scan, the patients is charged say about Rs. 3000. Of this rupees 1000 is paid to the referring doctor so as to encourage him to send more referrals to him. Now this practice has spread to many other investigations and referrels - even for simple blood test. In many countries such payments are illegal. In all countries they are unethical.



### 4. Case Dumping and Case Grabbing Erode Rationality

Some for-profit hospitals engage health care workers, transport workers and others as touts to fetch cases for surgery and other procedures. These touts can be spotted in and around other hospitals offering unsolicited "helpful advice" to prospective clients. Doctors in the know, working in the private sector say, "Cases admitted for

surgery are discharged against medical advice and transferred to another hospital. Insiders are involved and get a good commission for doing this."



If case grabbing is rampant in private sector hospitals, case dumping is equally rampant into the public sector hospitals. In USA, over 250,000 emergencies were shifted from 'for profit' hospitals to public hospitals because they cannot pay. About one in ten, i.e., 25,000 cases die, mostly due to delay in transit (reported in the Lancet 1991; 337: 38). In India, the situation of patient dumping is far worse. The release of Citizens Charter of Health Care Rights in Government hospitals (see annexure 3 & 4) is a step in the right direction; but who will implement it? When?

##### **5. Gullibility Promotes Quackery and Fraud**

There are a number of gullible persons who fall prey to doubts and fears raised by proverbs, house-lizards, black cats, astrologers, palmists and numerologists. They abuse modern medical science

to pander to their fears and phobias; many medical practitioners are only too happy to oblige them as 'it is good for the business'. The dividing line between trust and gullibility is a fine one. When some one is ill, there is pressure to "do something" and it may be tempting to try unproven remedies. Health care quackery is big business even in the developed countries. Unethical advertising, uncritical media hype and human gullibility help propagate it. When the truth about "the miraculous cure" becomes apparent, the stakeholder shifts the focus to protect the health care business interests.

"The capacity of human beings for self-delusion should never be underestimated; conviction profoundly affects observation. If you think you are right and can convince the patient that you are right, then whether you are right or not makes very little difference" (R. Asher: Talking Sense. Pitman Medical Publishers, 1972).

Asher also made a telling comment on hope prevailing over reason. "It is better to believe in therapeutic nonsense than openly admit therapeutic bankruptcy." In the case of AIDS, during the 80's, modern medicine made the 'fatal error' of admitting therapeutic bankruptcy. This led to mushrooming of quacks and charlatans in USA and Mexico who made wild claims of cure to make 'quick bucks' and then vanish. Similar quackery is going on in India today in treating many viral diseases. Informed and enlightened consumers should break the shackles of age-old myths and superstitions. Health and consumer activists have another area that needs urgent intervention to prevent exploitation of the gullible. Some tips are listed below.



## **Ten Tips to Detect possible Quackery or Fraud in health care**

Like politics, health care has also become the last refuge for many scoundrels.

J.H. Young, a professor of history has compiled the following guidelines:

1. Exploitation of fear and phobias or of hope for a miracle.
2. Claims of miraculous scientific breakthrough
3. Promise of painless safe treatment with excellent chances of "cure".(in a condition that has resisted treatment by one or more other health care providers.)
4. Reliance on anecdotes and testimonials.—They don't separate facts from opinions or cause and effect from a mere coincidence.(for example—"I can tell you of a person who took this drug and right away was cured")
5. Heavy promotion by advertising.
6. Large sums of money payable by clients for achieving cure.
7. The use of Simpleton science (one-size-fits-all type of dogma): diseases have one basic cause and one way of treatment takes care of all diseases. For example, water is the basis of all diseases and hydrotherapy cures them.
8. The 'victim of scientific establishment' theory: "the establishment is blind, I am far ahead of times and will be a hero to future generations"(lots of AIDS cures of this sort can be found flourishing at present).
9. Shifting theory to adjust to changing circumstances.
10. Distortion of "freedom of informed choice" to "freedom of choice" to end up with "freedom to be foolish".

## **6. Non-compliance Eclipses Rationality**

Doctors tend to overestimate compliance of their patients (Norrel SE: Soc Sci Med 1981; 15E: 57-61). They often presume that all the patients diligently follow all their advice and do not even check. But patients may feel burdened by treatment advice especially the life style changes and unpleasant procedures or medications.

“You must take it. It is for your own good”, is all that most doctors can say to coax their patients to comply with the treatment.

Some common reasons for non-compliance include:

1. Misunderstanding of the nature of the disease: Patients with diabetes or high blood pressure may assume that one course of treatment will cure the disease. Many chronic health problems need life-long monitoring and follow up. Effective counselling on the nature of illness may reduce this form of non-compliance.
2. Wrong assumption that “control is cure”. This is an extension of the previous fallacy. The patients take medicines till the blood pressure, blood sugar, etc., normalise. Then they stop all treatment thinking that the disease is cured. Proactive advice - “when values reach normalcy, you have to go on to maintenance therapy” - may help avoid such non-compliance.
3. Misunderstanding of name of drug or its dosage or duration of treatment: Effective communication, especially when written in a language that the patient can read, reduces this form of non-compliance. Patients should not feel hesitant to clarify all doubts regarding treatment.
4. Fear of “addiction” and fear of powerful drug: Media reports of the panic-mongering type are followed by an epidemic of this form of non-compliance! Patients must openly discuss their fears with their doctors and get clarified on risk-benefit, potential for addiction or adverse reactions.

5. Mistaking “illness” for “disease”: Though the terms disease and illness are interchangeably used in the health profession, medical anthropologists make a clear distinction. Disease is what is diagnosed by the health professional. It is the abnormality of the body or mind. Usually, though not always, there is a lesion (alteration) of organs or tissues, that can be detected. Illness is what the person with or without a disease perceives. It is subjective. In many diseases like high blood pressure, diabetes and early cancers, a patient may not feel ill at all. On the other hand, in benign conditions like tension headache and irritable bowel syndrome, the patients may perceive severe illness but their doctors may say, “You do not have any disease; all the tests are normal”.

It is important that health care seekers and providers understand the concept of “illness-disease” and the possible paradoxical relationship between them. It is the only way to reduce non-compliance among those with a “chronic disease without illness”. It is also the only way to reduce ‘doctor shopping’ by those with a “chronic illness without disease”. ***This is an area for health activists to run a major campaign.***

6. Social-cultural-religious barriers: Social events disrupt the schedule of an otherwise compliant person. Happy events like a wedding as well as sad events like death of a near and dear result in temporary non-compliance because “taking treatment did not seem terribly important then”.



NO, MY CHILD  
CANNOT HAVE  
SUCH AN  
(INCURABLE DISEASE).  
LET ME TRY  
SOMETHING ELSE.

Dr.Sethuraman reports the case of a Muslim diabetic who thought all insulin is extracted from pigs. He never verified this suspicion with any one else. After nearly two years of non-compliance, he finally confided in Dr.Sethuraman. There are many such deep-rooted social, economic, cultural and religious barriers to compliance.

7. Non-compliance by denial: Denial is one of the coping mechanisms that results in non-compliance. Denial refers to a patient refusing to accept a diagnosis, usually one with a poor outcome. This is the most difficult to manage. Unless the provider-client relationship is strong, mutually respectful, and is able to address deep most concerns of the client, the barrier of denial cannot be breached.

### **FACTORS THAT PROMOTE RATIONAL MEDICAL CARE**

#### **Holistic Care Promotes Rationality**

“Holistic is a buzz-word today - different persons interpret it in different ways. It is not a mix and match of various systems of medicine as being interpreted now. Ancient physicians like Hippocrates and Charaka have advocated truly holistic perspective in medicine.

Hippocrates said *“I would like to know what kind of person has a disease rather than what disease that person has.* Just think about it! Even today, it is difficult to improve upon this simple and yet accurate view of holistic perspective. Consider the diseased person as a whole - his/her personality, attitude to life, knowledge, and socio-economic and cultural standing etc.- in order to understand the illness from a holistic viewpoint.

If Medicine had such a ‘holistic’ view, then when and how did it degenerate to be a dehumanised profession? As medical sciences

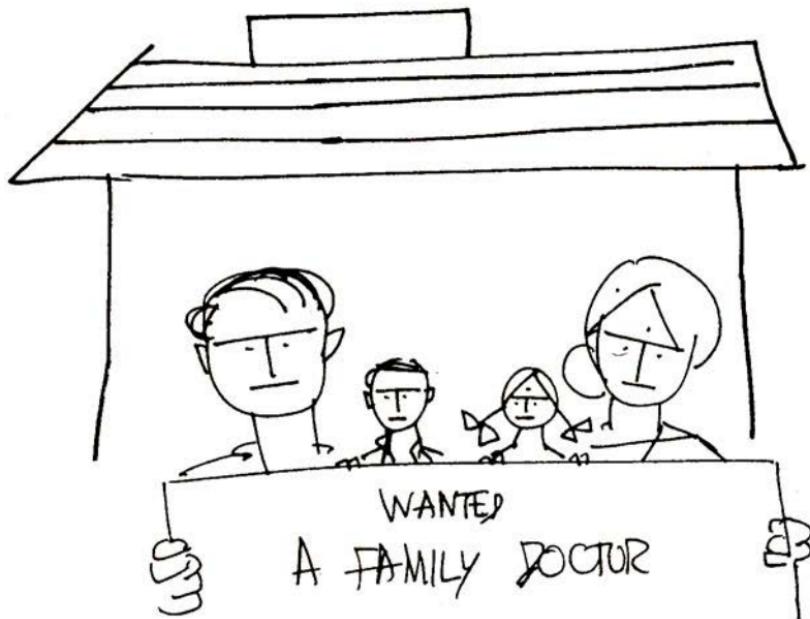
advanced, we could understand more and more about the causation of diseases - revolutionary discoveries and progress were made in the field of medicine and therapy.

Our attention shifted more and more to the biological sciences at the expense of behavioural sciences. In order to cope up with the advances, specialisation became order of the day. As a cynic had said it, "Specialist doctors learn more and more about less and less until they know *everything about nothing*". Dr. K. White has coined the term *Ignorant Savant* for this breed of specialist doctors who are well informed in their own limited fields but are ignorant of patients life-world. T.S. Eliot lamented thus: "Where is the knowledge we have lost in information? Where is the wisdom we have lost in knowledge?"

### **Primary Care Can Promote Holism**

Just as stomach and bowels have a primary non-glamorous job of breaking down complex food, primary care provider has to have a holistic view of a patient's illness and sort out his/her various problems. Sorted out health problems have to be specifically referred for specialised treatment.

During the 70's and 80's, USA went for specialist treatment in a big way. It was a disease oriented, procedural, piece-meal approach that was ruinously expensive and soon controlled by insurance industry. Now advanced societies have realised this folly and are trying to revert back to a primary care approach that is patient-oriented, holistic, continuous and comprehensive. Unfortunately, the third world countries are caught in this quick sand now. *Empowering "just an MBBS doctor" to shed his/her diffidence and practice rational primary care will go a long way to rectify the depressing scenario.*



Primary care physicians need to develop into "health care advocates" for their patients. They must reverse the current trend and help patients to avoid inappropriate entry to specialist care; not merely because it is costly, but because it wastes everybody's time, incurs unnecessary risks and diverts attention from rational, more appropriate and effective solution (Hart JT: Lancet 1992; 340: 772-775).

### **Synergy Fosters Rational Health Care**

Health care providers, care seeking public, industry (diagnostic, therapeutic and insurance) media, activists and governmental machinery are all key players and stakeholders in health care delivery system. If they cooperate and stand together to achieve the goal of "ethical and effective health care for all", then the system will be strong and functional. But if each player sets his own agenda forgetting the common goal, then the system will be weak and dysfunctional. Some examples are:

- Ignorant, unethical or corrupt health-care provider.
- Foolish, non-compliant or deviant behaviour by the care seeker.

- Exploitative health-care industry.
- Biased media that glorifies or vilifies a health care issue.
- Activist with one track mind resulting in a stand off among key players.
- A government that puts profits before peoples welfare.

***The bottom line is not profit or high technology but rational care based on provider-seeker trust.*** If the basic trust is undermined, as has happened in the USA, the health care system will be in jeopardy and every player will be a loser. Trust is the glue that keeps the system together. Without that, it will fall apart like Humpty Dumpty and we may not be able to put it together again.

How far can an economic system that is based on the quest for personal profit and competition allow a system based on trust and altruism to grow? Can a medical profession shaped only by market forces ever be a noble profession? These are some basic questions we need to think about.

### **Other Strategies to promote Rational Care**

Many target groups need to be addressed and multi-pronged action is required. *All bad practices and drugs need weeding out by the government while rational management practices are to be promoted by the health care providers, seekers and other interested groups.*

1. Governmental regulation could remove all irrational formulations and help curb exploitative health care. We need a strong drug-control authority with enough teeth to implement whatever policy they announce from time to time.
2. The health care and drug industry could be coaxed by pressure of the consumer groups and by the medical lobby. But the medical fraternity treads gently in this regard as "*You do not bite the hand that feeds you*". It therefore becomes largely a task of

consumer groups and public opinion to curb the industry's unethical policies.

3. The medical profession needs to reorient towards rational care at all levels. This means two things: periodic updates for those in practice and curricular reforms for those in the medical schools. Educators of Rational Drug Usage (ERDU-group) initiated by CI-ROAP, Penang is an example of this approach:

A Lancet editorial lamented thus: "The treatment has deteriorated. In consequence of cramming science down men's throats, they had very little idea of GOOD practice". The year was not 1985 but 1885!

In real life situations, life is complex and rational decision making much more exacting. The doctor ought to know the social, cultural and anthropological reasons of the health seeking behaviour of the person sitting in his/her consultation room.

Medical curricula have shown benign neglect of these "soft sciences", resulting in the training of 'hard boiled' medicos bristling with scientific information but unable to apply it well. Later in their practice, things only get worse because, "One of the things the average doctor does not have time to do is catch up with the things he did not learn in school. If medicine is a mystery to the average man, nearly everything else is a mystery to the average doctor" (Milton Mayer).

Behavioural sciences module needs to be introduced in medical education, not as a transplant from the West, but evolved in the context of the realities of the third world.

4. Finally, consumer education and people mobilisation *to insist on and get quality and rational health service as a matter of right*. This will not only be the most effective socio-political strategy but the most difficult and daunting one too. ***PHA-2000 is an ambitious attempt in this direction.*** There are two types of intervention to

achieve this. One type like "the 12 questions to a doctor" are measures to help the patient to cope better with the doctor-patient relationship. The others are institutional and organizational measures - like making information easily available in books or on the Net, or by creating a statutory medical board that would give a second opinion when needed. Now is the time for all those concerned with the current crisis in health care to actively support its mission. Come on, let us all act!

### **Eight hints to Detect an Uncaring (irrational) Doctor**

The following are some warning signs that indicate that your doctor may not be doing his/her best to help you.

He/She:

1. Does not listen to what you are saying.
2. Does not probe into your symptoms and complaints. (usually it is essential for a doctor to ask more questions regarding your complaint before he can reach a conclusion).
3. Does not examine you completely or forgets to examine the organ or body system about which you have raised some doubts.
4. Seems to be forgetful and peculiar in behaviour, either smiles inappropriately or is short-tempered.
5. Acts in a paternalistic (fatherly) manner; is all-knowing and tells you "the only way" to manage your problem.
6. Does not educate you on the nature of illness and the rationale of tests ordered and treatment advised.
7. Does not discuss risks and benefits of the tests, procedures and medicines advised.
8. Gets upset or reacts defensively when you suggest seeking a second opinion.

## **What every intelligent patient should ask his/her doctor?**

If you want to be an informed seeker of health care, discuss with the doctor the following points before agreeing to undergo any procedure.

1. What is actually wrong with me?(you can ask for the name of the disease -if any, that you have)
2. How serious is this disease/condition?
3. What may happen to me if I leave it untreated?
4. What kind of procedure are you planning to do?
5. Is the procedure done for diagnosis, for treatment or for both?
6. What are the risks of this procedure?
7. What are the chances that the proposed procedure will be successful in my case?
8. Will the success be a long term or short-term benefit?
9. What alternative procedures/treatments are available?
10. Of these, which do you think would be the best for me? Why?
11. Could you suggest any source of information on this disease that I could read or watch?

## **PEOPLES INITIATIVES FOR RATIONAL MEDICAL CARE:**

- The Kerala Shastra Sahitya parishad has conducted widespread public awareness programmes against irrational and hazardous drugs. Some of the major hazardous drugs on the Kerala market experienced a sharp drop in sales as a result of the campaign.
- CEHAT, Maharashtra has initiated, with district NGOs, public campaigns against misuse of intravenous saline infusion by putting up posters in all private nursing homes and clinics

decrying the practice. This has provoked a response from the local medical association, which however conceded that the issue raised was correct even if such posterizing was not the desired approach!

- Member organisations of the ALL-INDIA-DRUG-ACTION-NETWORK have been active in researching and working up lists of banned and bannable drugs on the Indian market which have been published and widely circulated. The failure to ban many of these drugs have also been addressed by a number of public interest litigations in the Supreme Court which has forced the drug controller to take some action on many of these drugs. Neither policy makers nor health professionals and their associations have seldom addressed rational health care issues. One can rightly claim that going by past experience it is only alert coalitions of non-governmental organisations that have addressed these issues. This essential watchdog role of the non-governmental organisation needs to be emphasised.

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## *Private Health Sector in India: A Critical Review*

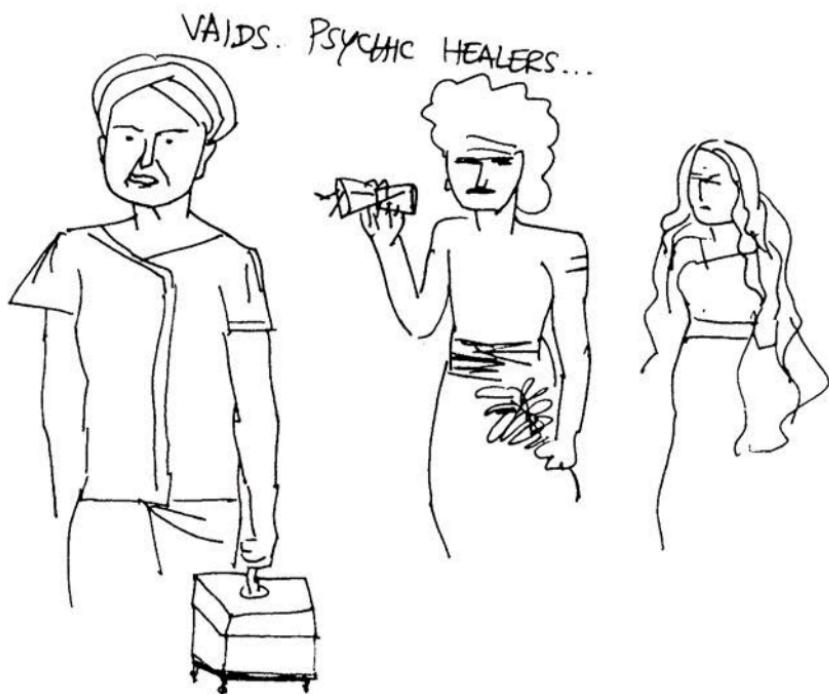
### **A Historical Introduction**

The way we perceive and understand the health sector today is shaped largely by the social and economic setting of the day and its critique and contradictions. Health care, as we know it today, evolved as an institutional system under capitalism, like any other sector of the economy. In pre-capitalist times the health care provider was an independent producer who catered to the local market. His/her skills were acquired through personal contact, usually within the family; ofcourse, there were institutions which provided knowledge and practice skills, especially for higher levels of learning and often under state patronage. The average producer of health care then was not dependant on any external inputs, whether in training, formulation of medicines etc.. The story today is very different. Health care has today become a commodity and is fully commercialised thanks (sic) to the dominant private sector in health care.

### **Before the British came**

From as far back as the Indus valley civilisation, there is evidence, to suggest that State patronage for both public health as well as medical care was common - well planned urban centres, universities, medical texts of ayurveda, siddha and later unani. While there is vast documentation and discussion on the systems of medicine, the philosophical context etc.., literature on health care provision, health care providers, health care spending, organisation of health care services etc.. is conspicuous by its absence. Oral history and

folk traditions, however, do indicate that a large variety of individual practitioners existed - vaidas, herbal healers, snake-bite specialists, birth attendants, abortionists, psychic healers, faith healers etc.. During this period, which coincides with the pre-colonial period, structured health care delivery had clearly established three characteristics. Firstly it was considered a social responsibility and thus State and philanthropic intervention were important. Secondly the services provided were free of cost to all who could avail them or had access to - ofcourse, caste, class and other such biases were there. And thirdly most of these facilities were in towns thus showing a neglect of the countryside.



### **Under British rule....**

Under colonialism Indian medical science declined rapidly. Ayurveda, both due to its unwillingness to become open and adapt to changing times, and due to reduced patronage with Unnani-Tibb becoming dominant in the medieval period, had already suffered a set back. With the coming of the Europeans even Unnani medicine got reduced patronage. The impact of colonialism was far reaching. The gradual destruction of the local economy also destroyed local medical practices. However, the diffusion of modern medicine which was emerging was poor, especially in the rural areas. Hence, people living in these areas had to resort to whatever remained of what was now called folk and/or traditional medicine.

The Indian Medical Service (IMS) set up in 1864 catered mostly to the needs of the armed forces. However, by early 20th century hospitals for the general population were established in chief moffusil towns, besides the Presidency headquarters. The expansion of the medical facilities followed the devolution of the imperial government, especially after 1880 with the setting up of municipalities and district boards.

However, these medical facilities had a distinct racial and urban bias. Separate provisions were made on employment and racial grounds, though in some places non-official Europeans might be allowed access to hospitals designed for civil servants. In General Hospitals, wards for Europeans and Eurasians were separated from those for the rest of the population. The rural areas had to wait till the Government of India Act 1919 whereby health was transferred to the provincial governments and the latter began to take some interest in rural health care. However, this interest was confined to developing for the rural areas a structure of only preventive health care and not hospitals and medical clinics, that is the rural areas were to be given “public health” and not medical care. There was a romance attached to leaving the rural areas to their folk traditions and practices for their medical care but intervention was needed to

maintain public health so that epidemics could be controlled ! The result of this was that medical care activities of the State were developed mainly in the urban areas, and rural areas were deprived the devolution of medical care within their reach. This is an important historical fact to note because this same differential treatment for urban and rural areas has continued even in the post-colonial period, and the international actors, now many more in number and more aggressive at that, provide for its continuity both financially and ideologically.

## Before Independence

It had been terrible years. Famine and epidemics swept the land. Between 1890 and 1920 it is estimated that over 20 million died of plague, small-pox, cholera and malaria alone - not to speak of other fevers and tuberculosis.



That is why  
you need us.  
Because you are  
dirty and diseased.  
We will civilise you.

The worst Famine in Indian history:  
The Great Bengal Famine :

over

**4 million  
dead!**

Not because of our dirt. But  
because you have ruined our  
peasants and our industries.  
Go home we will take better  
care (we've got the Bhore  
report!).



This dualism underlies the history of development and underdevelopment and without keeping this in context the analysis of the health sector will have little meaning. Further, the imperial government in India adopted measures that were totally inadequate to deal with the problems at hand. Apart from the racial and urban bias in developing public health infrastructure they also ignored the way the private health sector was developing. No concern whatsoever was shown at regulating the private health sector. As a consequence the number of unqualified practitioners kept increasing. While those concerned with colonial administration and

living in the enclaves had access to the modern health care services which were evolving, the remaining ("natives") were left to the mercy of these private practitioners most of whom were either "traditional" practitioners trying to integrate with modern medicine or outright quacks. By Independence the qualified allopaths had reached 50,000 and others 150,000. (See Annexure 1)

The health sector world-wide is perhaps the largest subsector of the economy. No other sector of the larger economy has a reach as much as the health sector, its market being assured, whatever the odds. Given this basic feature, modern medicine under capitalism has exploited fully the opportunities for making a profit through provision of health care. Historically, provision of health care services has moved away from the traditional, non-institutional trained and home-based petty-commodity producer, to the sophisticated, institutionally qualified, market and commodity dependent service provider on one hand and the completely corporate, institution-based service on the other hand.

### **Changes with Independence**

Independent India has not as yet seen a radical transformation in provision of health care services for its majority population, especially the masses in the rural areas. This despite a National Health Plan available on the eve of Independence. The detailed plan set out by the Bhore Committee was both well studied and comprehensive and designed to suit Indian conditions. It sought to construct a health infrastructure which would require an increase in resource allocation by the state of about three times that existing then. These state health services would be available universally to all free of cost and would be run by a whole time salaried staff. The

Bhore Committee plan was biased in favour of rural areas with the intention of correcting the wide rural-urban disparities in the shortest possible time. When implemented fully in 25-30 years the level of health services would improve ten-fold (of that existing in the early forties) to 567 hospital beds per 100,000 population, 62.3 doctors per 100,000 population and 150.8 nurses per 100,000 population spread proportionately all over the country. This development would make the private health sector dispensable. This level of health services would have been about three-fifths that of World War II Britain.

#### **On Independence Year : 1947.**

Population : 344 Million  
Life expectancy : 33 years..  
Infant Mortality : 149 per 1000 -  
Under 5 mortality : 246.  
Malaria : 70 Million cases and 2  
Million deaths per year.  
TB : 2.5 million cases : 5 lakh  
deaths per year.  
Smallpox : 70,000 deaths per  
year : 15% of all infant deaths.  
Cholera : 1,17,000 deaths in  
Madras province alone!  
Leprosy : 1 million cases.

#### **India Today : 50 years later**

Population : 900 million  
Life expectancy : 61 years  
Infant Mortality : 74 per 1000  
Under 5 mortality : 115  
Malaria : 9 Million cases  
deaths : over 10,000  
TB : 12.7 million cases  
5 lakh deaths/year  
Smallpox : Nil - Completely  
eliminated.  
Cholera : Almost eliminated but  
now rising again. Gastroenteritis  
rampant.  
Leprosy : Decreasing.

But this is nothing to be happy about.

Viewed historically the post-Independence state health financing and health services development was not very different from the colonial period. The same pattern of a focus on elite groups continued. What changed was the proportion of medical institutions and facilities in the private sector. Especially, the last two decades have witnessed a very high growth rate of private hospitals and dispensaries. (See Annexure 2)

Today health care has become fully commodified and the private sector is the dominant provider of health care globally, as well as in India (though not necessarily in financing, and especially in the developed countries where public financing is the dominant mode). New medical technology has aided such a development and the character of health care as a service is being eroded rapidly.

Provision of routine medical care for a wide range of diseases and symptoms is mostly in the private sector. While government health centres exist across the length and breadth of the country they have failed to provide the masses with the basic health care which the latter expect. It will suffice to say that a fairly large investment by the public sector in health care is being wasted due to improper planning, financing and organisation of the health care delivery system - the national public sector health expenditure today is Rs.20,000 crores (1999-2000), being spent on 5000 hospitals and 550,000 beds, 11,100 dispensaries, 23,000 PHCs, 140,000 subcentres and various preventive and promotive programs, including family planning. The State employs 140,000 doctors and also runs 103 medical colleges. But the services provided by the state do not meet the expectations of people and as a consequence the latter are forced to use private health care whatever be its quality and / or effectiveness.

## **FEATURES OF THE PRIVATE HEALTH SECTOR**

Private general practice is the most commonly used health care service by patients in both rural and urban areas. While this has been known all these years, data in the eighties from small micro studies as well as national level studies by the National Sample Survey and the NCAER, provided the necessary evidence to show the overwhelming dominance of the private health sector in India. These studies show that 60-80% of health care is sought in the private sector for which households contribute out-of-pocket 4% to 6% of their incomes. This means a whopping Rs.60,000 to 80,000 crores private health care market in the country at today's market

prices. This includes the hospital sector where the private sector has about 50% of the market share.

There is a close relationship between the failure of the public sector and the growth of a private sector. First, the former justifies the latter. Second, there exists, perhaps the only place in the world, a private sector that lies well-entrenched within the public sector, a sector that has fully utilized the public sector for its growth, and has never been called upon to repay it. This trend continues to this day.

### How big is it?

Our estimate is based on indirect extrapolation using the assumption that all doctors (compiled from lists of the various medical councils) minus government doctors is equal to the private sector. Today there are about 12,00,000 practitioners registered with various system medical councils in the country and of these 140,000 are in government service (including those in administration, central health services, defence, railways, state insurance etc..). This leaves 10,60,000 doctors of various systems of medicine floating in the private sector and one can safely assume that atleast 80% of them (850,000) are economically active and about 80% (680,000) of the latter are working as individual practitioners. Apart from this there are as many unqualified practitioners according to an estimate based on a study done by UNICEF/ SRI-IMRB in Uttar Pradesh, and if we accept this estimate then the total medical practitioners active becomes about 14,00,000, that is one such practitioner per 700 population! Even if we count only qualified, active practitioners, the ratio is one for about 1160 population - not bad at all.

### Where is it?

Urban concentration of health care providers is a well known fact - 59% of the country's practitioners as per 1981 census (73% allopathic) are located in cities, and especially metropolitan ones. For instance, of all allopathic medical graduates in Maharashtra 55% are located in Bombay city alone which has only 12% of the

state's population! This selective concentration of health care providers then becomes a major concern to be addressed, especially since the health care market is supply induced and when people fall ill they are wholly vulnerable and forced to succumb to the dictates of such a market. The consequence of this is that access to health care providers gets restricted to those living in urban and developed pockets and the vast majority of the rural populace have to make do with quacks or travel to the urban areas for satisfying their health care needs. Infact, studies have shown that those living in rural areas spend about as much on health care as those in towns and hence relocation can become economically viable for qualified private practitioners.

### **What systems constitute it?**

Medical practice in India is a multi-system discipline. Some of the major recognised systems are allopathy or modern medicine, homoeopathy, ayurveda, unani, and siddha. Apart from these there are others like naturopathy, yoga, chiropractic etc.. as also a very large number of practitioners who do not have any qualification from any recognised system. All this creates a complexity which makes information management, recording, monitoring etc.. a daunting task and it is this very diversity and complexity which is in part responsible for the chaos and lack of regulation and quality control. Thus, a major question which needs to be addressed is how do we view practitioners of different systems of medicine, how should they be distributed in the population and what type of care should each group be allowed to administer. We strongly feel that this is an important issue of concern for policy makers. If some steps in the direction suggested are not undertaken with due seriousness then the existing system hierarchies (with allopathy as dominant and homoeopathy and ayurveda qualifications serving as a legitimacy to practice modern medicine or as alternate to allopathy for the patient when the latter fails to cure) will continue and quality care or care with basic minimum standards will never be achieved.

## **How are they licensed to practise?**

Legally speaking registration gives the qualified practitioner the right to practice medicine and it is the duty of the concerned authority to assure the consumers of such health care that no practitioner without appropriate registration is treating patients. It is well known that the various medical councils have been lax and negligent and have not been performing their statutory duties. As a consequence of the latter the medical practitioners have also become lax and a large number of them are practicing today not only without proper registration but also without the requisite qualifications. All this then becomes a threat to the patient who is thrown at the mercy of doctors who may not have the necessary skill and who practice with half-baked knowledge. Thus, even something for which there is a law and an authority to administer it, it is being neglected.

## **What types of care does it give?**

When people fall ill the first line of contact is usually the neighbourhood general practitioner (GP) or some government facility like a dispensary or primary health centre or a hospital. That the GP is the most sought after health care provider has been confirmed now by a number of studies, and this ranges from 60% to 85% of all non-hospital care which patients seek. In a small proportion of patients, about one in ten, the GP may need to refer the patient to a specialist. While modern medicine has simplified treatment of most illnesses and symptoms to a few drugs (even making many of us self-prescribers) its commercialisation has brought in more problems than the benefits it has created. The pharmaceutical industry and the medical equipment industry have both caused much harm to the character of the medical profession. Their marketing practices have lured a large majority of medical professionals (and not the unqualified quacks alone) to increasingly resort to unnecessary and irrational prescriptions of drugs, the overuse of diagnostic tests, especially the modern ones like CAT

Scan, ultrasound, ECG etc... and uncalled for references to specialists and superspecialists (for all of which a well organised kickback system operates - the givers and beneficiaries calling it commission!).

## **PATTERNS OF GROWTH-FROM PRIVATE TO CORPORATE**

The Ministries of Health have shown little concern for planned development of the health sector in India. The Planning Commission's concern was with only the public sector inspite of knowing that the private health sector is the dominant one and such planning has no meaning if the private sector is left out of the ambit. As a consequence of this the availability of data on the private health sector is a major problem. The only definitive set of private sector data is on the number of hospitals and beds and that too is an underestimate as various micro studies have revealed. Another set of data on the private health sector which is somewhat definitive is pharmaceutical production where 90-95% of formulations are manufactured in the private sector.

In India the limited data we have shows that this process of rapid increase in the number of private hospitals and their capacity began in the mid-seventies and has advanced progressively, increasing from a mere 14% of hospitals in 1974 to 68% in 1995. This period of rapid private sector expansion in the hospital segment also coincides with newer medical technologies being made available as well as large scale increases in the number of specialists being churned out from medical schools.

The private hospital sector is presently in the process of making another transition in its rapid growth. This is the increased participation of the organised corporate sector. The new medical technologies have made the concentration of capital possible in the medical sector. These new technologies are increasingly reducing the importance of the health care professional. S/he is no

longer the central core of health care decision making and corporate managers are increasingly gaining control of the health care sector. New medical technologies have opened new avenues of corporate investment that is going to bring about far reaching changes in the structure of health care delivery. With private insurance also on the anvil health care too will soon make its way into the big league of monopoly capital.

**Production and Growth of Medical Human Power :** The training and education of doctors of the modern system is predominantly in the public sector. Until the last decade the private sector showed little interest in medical education and the entire burden of producing doctors and nurses was on the state. But in recent years private medical colleges are increasing in numbers rapidly, many without getting the necessary permission of the Medical Council of India because they lack the necessary facilities essential for imparting such education and training. This trend has been largely due to lack of any regulation on the growth of the private sector, the states unwillingness, and rightly so, to increase the number of medical seats in the public sphere and the large demand of doctors in mid-east and western countries. It must be noted that inspite of various restrictions outmigration of allopathic doctors remains very high with about 4000 to 5000 doctors leaving the country every year which at today's prices means a loss of Rs.400 - 500 crores, assuming Rs.10 lakhs as the cost of production of a doctor.

In contrast, production of doctors under ayurved, homoeopathy, unani, siddha etc.. is largely in the private sector with very limited subsidies from the state. Even these doctors are largely produced for the private market. And with lack of any regulation of medical practice most of them indulge in whole-scale crosspractice, especially allopathy. Infact it is an open secret that the non-allopathic qualification is a via media for setting up the more profitable practice of modern medicine.

The story about nurses is a little different from that of doctors. Firstly, we do not produce enough nurses and what is produced is either absorbed by the state or more often by outmigration. It is funny, but we produce more doctors than nurses in India! Secondly, the demand for qualified nurses in the private sector in India is very small because the private hospitals and nursing homes do not follow any standard practices and prefer to employ nursing personnel who are trained only as auxiliaries or worse still are trained on the job. Neither the Nursing Council or Medical Council or the State have shown any interest in regulating this aspect of private care.

Today with an estimated 700,000 qualified practitioners of various systems and an equal number of unqualified practitioners in individual private practice we have the largest private health sector in the world and one which is completely unregulated. This segment of the private health sector is providing only curative services on a fee-for-service basis.

**Production of Drugs and Medical Equipment :** With a turnover of over Rs.16,000 crores and more than 90% of this being in the private sector the private pharmaceutical industry is the engine of the private health sector in India. It has penetrated the remotest of rural areas and has not deterred from using even the large unqualified segment of practitioners to expand its market. If someone has any information on private medical practice it is the pharmaceutical industry. Its well organised network of medical representatives know the private medical sector in and out. The nonallopathic drug industry, mainly ayurveda and homoeopathy, is also fairly large but organised information on it is not available. Also there are no known complete estimates of turnover or drug production. However, there are a number of ayurvedic drug manufacturers whose turnover is in hundreds of crores, and again mostly in the private sector.

For the consumer the major concern is the rapid increase in drug prices. During the last two to three years prices of many essential

drugs have doubled and this makes seeking of health care more expensive not only in the private health sector but also in the public health sector because the latter's drug budgets have not increased with the increase in drug prices.

The medical equipment industry in India is much smaller than the pharmaceutical industry and India still has to rely heavily on imports, especially of hitech equipment. But there is every indication that it is on the verge of growing very rapidly.

## THE PUBLIC AND THE PRIVATE

One of the myths that we need to question is that the private sector grows by its merit and its industriousness, while the public sector collapses due to lack of motivation and public support. In reality, it is state policy that undermines the public sector and builds the private sector. Direct and indirect support to the private health sector by the state is the main form which privatisation takes in India. Some instances are as under :

- medical education as indicated above is overwhelmingly state financed and its major beneficiary is the doctor who sets up private practice after his/her training -the government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals. It provides incentives, tax holidays, subsidies to private pharmaceutical and medical equipment industry. It manufactures and supplies raw materials (bulk drugs) to private formulation units at subsidised rate/low cost. It allows exemptions in taxes and duties in importing medical equipment and drugs, especially the highly expensive new medical technology.
- the government has allowed the highly profitable private hospital sector to function as trusts which are exempt from taxes. Hence they don't contribute to the state exchequer even when they charge patients exorbitantly.

- the government has been contracting out its programs and health services selectively to NGOs in rural areas where its own services are ineffective. This will further discredit public health services and pave the way for further privatisation.
- the government has pioneered the introduction of modern health care services in remote areas by setting up PHCs. While the latter introduces the local population to modern health care, but by being inefficient it also provides the private sector an entry point to set themselves up. Often it is the same doctor employed in the PHC who opens up practise in private.
- construction of public hospitals and health centres are generally contracted out to the private sector. The latter makes a lot of money but a large part of the infrastructure thus created, especially in rural areas, is inadequately provided and hence cannot meet the health care demands of the people.
- The government also acquires land for corporate hospitals under land acquisition acts which are meant for the public good, and gives it to the corporate sector at well below market rates but in return the corporate hospital has no commitments. The government also allows large corporate hospitals to import over crores worth of equipment, free of all import duties, on the grounds that they are providing free care for over 40% of their patient. But then conveniently forgets to implement the later. The governments loss is estimated at over 500 crores on this alone.
- medical and pharmaceutical research and development is largely carried out in public institutions but the major beneficiary is the private sector. Development of drugs, medical and surgical techniques etc.. are pioneered in public institutions but commercialisation, marketing and profit appropriation is left with the private sector. Many private practitioners are also given honorary positions in public hospitals which they use openly to promote their personal interests.

- in recent years the government health services have introduced selectively fee-for-services at its health facilities. This amounts to privatisation of public services because now utilisation of these services would depend on availability of purchasing power. Increasing private sources of income of public services would convert them into elitist institutions, as is evident from the functioning of certain speciality departments of public hospitals.
- the government has allowed the private health sector to proliferate uncontrolled. Neither the government nor the Medical Council of India have any control over medical practice, its ethics, its rationality, its profiteering etc..

The above are a few illustrations of how the state has helped strengthen the private health sector in India. In today's liberalised scenario, and with World Banks advice of state's role being restricted to selective health care for a selective population, the private health sector is ready for another leap in its growth. And this will mean further appropriation of people's health and a worsening health care scenario for the majority population.

## **REGULATING THE PRIVATE HEALTH SECTOR**

The private health sector is responsible for nearly three-fourths of all health care in the country and yet it is not regulated in any significant manner by any authority even when there are Acts established for that purpose. For instance the Councils of the various systems of medicine are supposed to assure that only those having the appropriate qualifications and those registered with them may practice the particular form of medicine. But evidence shows that this does not happen in practice and hence unqualified persons set up practice, there is rampant crosspractice, irrational and other malpractices are common, there are no fixed schedules of charges for various services being rendered, hospitals and nursing homes do not follow any minimum standards in provision of services, practice may be set up in any place etc. Whereas the public health

sector due to bureaucratic procedures is forced to maintain atleast some minimum requirements, (for instance, they will not employ nonqualified technical staff) will carry out tasks only if minimum conditions or basic facilities are available, and is subject to public audit, the private health sector doesn't pay heed to any such thing.



Private medical practice has now existed too long without any controls and regulation. In the last decade or so an increasing pressure is being exerted on the private health sector to put its house in order. Patients, consumer bodies and other public interest groups are targeting malpractices and negligence in the private health sector and demanding compensation, accountability, setting up of minimum standards etc.. Apart from getting the concerned authorities to implement existing Acts, laws etc... there is a need to bring in an entirely new range of comprehensive regulations as existing in countries which have near universal health care provision with predominantly privately managed care. This means drastic changes in health policy and reorganisation of the entire health care system. We recognise that privately provided health care has come to stay but we also believe that it needs to be organised in an appropriate manner to evolve a public-private mix which provides universal health care coverage.



# PRIVATIZE..

REGULATE IT ALSO...



The new strategy should focus both on strengthening the state-sector and at the same time also plan for a regulated growth and involvement of the private health sector. There is a need to recognise that the private health sector is huge and has cast its nets, irrespective of quality, far wider than the state-sector health services. Through regulation and involvement of the private health sector an organised public-private mix could be set up which can be used to provide universal and comprehensive care to all. The need of the hour is to look at the entire health care system in unison to evolve some sort of a national system. The private and public health care services need to be organised under a common umbrella to serve one and all. A framework for basic minimum level of care needs to be spelt out in clear terms and this should be accessible to all without direct cost to the patient at the time of receiving care. It is interesting to note that though World Bank has pushed privatization forcefully, the pressure to regulate it is so muted. Yet every Western country does have such regulation.

Today we are at the threshold of another transition which will probably bring about some of the changes like regulation, price

control, quality assurance, rationality in practice etc.. This is the coming of private health insurance that will lay rules of the game for providers to suit its own for-profit motives. While this may improve quality and accountability to some extent it will be of very little help to the poor and the underserved who will anyway not have access to this kind of a system. Worldwide experience shows that private insurance only pushes up costs and serves the interests of the have. If equity in access to basic health care must remain the goal then the State cannot abdicate its responsibility in the social sectors. The state need not become the primary provider of health care services but this does not mean that it has no stake in the health sector. As long as there are poor the state will have to remain a significant player, and interestingly enough, as the experience of most developed countries show, the state becomes an even stronger player when the number of poor becomes very small!

### **Immediate Policy measures needed**

While reorganisation of the health sector will take its own time, certain positive changes are possible within the existing setup through macro policy initiatives.

These are

- a) the medical councils should be directed at putting their house in order by being strict and vigilant about assuring that only those qualified and registered should practice medicine
- b) continuing medical education (CME) should be compulsory and renewal of registration may be linked to it
- c) medical graduates passing out of public medical schools must put in compulsory public service of atleast five years of which three years must be at PHCs and rural hospitals (this should be assured not through bonds or payments but by providing only a provisional license to do supervised practice in state health care institutions and also by giving the right to pursue postgraduate studies only to those who have completed their three years of rural medical service)

- d) regulating the spread of private clinics and hospitals through a strict locational policy whereby the local authority should be given the right to determine how many doctors or how many hospital beds they need in their area (norms for family practice, practitioner : population and bed : population ratios, fiscal incentives for remote and underserved areas and strong disincentives and higher taxes for urban and overserved areas etc.. can be used)
- e) regulating the quality of care provided by hospitals and practitioners by setting up minimum standards to be followed
- f) putting in place compulsory health insurance for the organised sector employees (restructuring the existing ESIS and merging it with the common national health care system where each employee has equal rights and cover but contributes as per earning capacity, for example if each employee contributes 2% of their earnings and the employer adds another 3% then nearly Rs.100 billion could be raised through this alone), special taxes and cesses for health can be charged to generate additional resources (alcohol, cigarettes, property owners, vehicle owners etc.. are well known targets and something like one percent of sales turnover for the products and a value tax on the asset could bring in substantial resources)
- g) allocation of existing resources in public sector can be rationalised better through preserving acceptable ratios of salary : nonsalary spending and setting up a referral system for secondary and tertiary care. For specialist, diagnostic services and hospital care a referral system must be put in place and such care must be available only on reference from a general practitioner, except in an emergency.

These are only some examples of what can be done through macro policy initiatives.

## **What should a Comprehensive Legislation seeking Regulation include?**

The following suggestions on regulation encompass the entire health sector. However, they are not an exhaustive list but only some major important areas needing regulation.

### ***1. Nursing Homes and Hospitals :***

- Setting up minimum decent standards and requirements for each type of unit; general specifications for general hospitals and nursing homes and special requirements for specialist care, example maternity homes, cardiac units, intensive care units etc.. This should include physical standards of space requirements and hygiene, equipment requirements, humanpower requirements (adequate nurse:doctor and doctor:beds ratios) and their proper qualifications etc...
- Maintenance of proper medical and other records which should be made available statutorily to patients and on demand to inspecting authorities.
- Setting up of a strict referral system for hospitalisation and secondary and tertiary care
- Fixing reasonable and standard hospital, professional and service charges.
- Filing of minimum data returns to the appropriate authorities for example data on notifiable diseases, detailed death and birth records, patient and treatment data, financial returns etc..
- Regular medical and prescription audits which must be reported to the appropriate authority
- Regular inspection of the facility by the appropriate authority with stringent provisions for flouting norms and requirements
- Periodical renewal of registration after a thorough audit of the facility

## **2. Private Practitioners :**

- Ensuring that only properly qualified persons set up practice
- Compulsory maintenance of patient records, including prescriptions, with regular audit by concerned authorities
- Fixing of standard reasonable charges for fees and services
- Regulating a proper geographical distribution
- Filing appropriate data returns about patients and their treatment
- Provision for continuing medical education on a periodic basis with licence renewal dependent on its completion

## **3. Diagnostic Facilities :**

- Ensuring quality standards and qualified personnel
- Standard reasonable charges for various diagnostic tests and procedures
- Audit of tests and procedures to check their unnecessary use
- Proper geographical distribution to prevent over concentration in certain areas

## **4. Pharmaceutical industry and pharmacies :**

- Allowing manufacture of only essential and rational drugs
- Regulation of this industry must be switched to the Health Ministry from the Chemicals Ministry
- Formulation of a National Formulary of generic drugs which must be used for prescribing by doctors and hospitals
- Ensuring that pharmacies are run by pharmacists through regular inspection by the authorities
- Pharmacies should accept only generic drug prescriptions and must retain a copy of the prescription for audit purposes

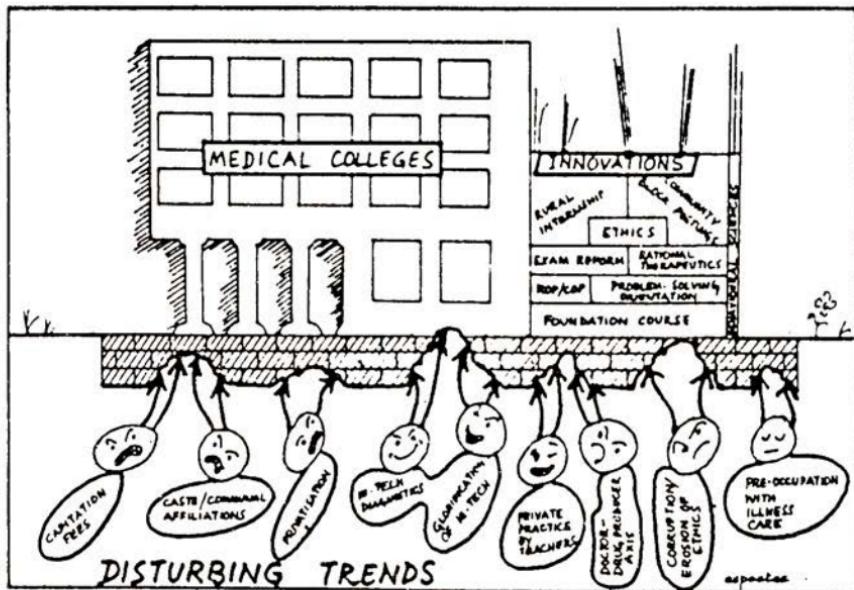
## **Who should regulate professional practise?**

A regulatory authority will have to be set up at national and state levels to monitor, audit and assure that the health sector functions in a reasonable manner and as per agreed and accepted norms. Such a body will necessarily have qualified and reputed health professionals, but neither will it be exclusively health professionals, nor will the professionals on the body be chosen only by other professionals. Both the state apparatus, responsive to a political process and institutions of civil society who have a track record on working for professional reform and for more equitable health systems need to be part of its composition.

## Chapter - 4

# *Medical Ethics, Medical Education and Health Care*

## **Concerns and Challenges from a Peoples Health point of view**



### **1. What are the popular causes for dissatisfaction against doctors and the delivery of health care in India today?**

- ◆ There are complaints of inadequate care and demand of excessive fees for giving attention.
- ◆ Doctors are charged with recommending unnecessary investigations and prescribing avoidable treatments.
- ◆ There are reports of exploitation of the ignorance of patients and of acting in violation of the autonomy of patients.

- ◆ There are reports of overwhelming emphasis on therapeutic medicine to the total exclusion of preventive and social medicine.
- ◆ There is concentration of health care services and doctors in the urban area and near total neglect of village and rural tribal areas.
- ◆ There are frequent reports of neglect of patients by doctors and hospital staff and sometimes even maltreatment and unethical and sometimes even criminal behaviour.

While many doctors are sincere and committed to the ethical and scientific framework of their profession and vocation, in today's increasingly corruption influenced socio-economic-cultural political milieu, many are not and this is an increasing area of concern.

One approach to tackling this is legal and administrative. We have discussed this in the earlier chapter. But bringing them under consumer protections act and other such laws is no end in itself. It brings its own problems (defensive medicine, burgeoning legal costs etc.) and though acceptable as an immediate measure is no solution to the basic problems.

The question that needs to be asked is - what is wrong with medical education that all this is happening. Are not doctors trained to serve the rural areas and the poor-at least to practice ethically.

And other than education what are the professional bodies doing about it.

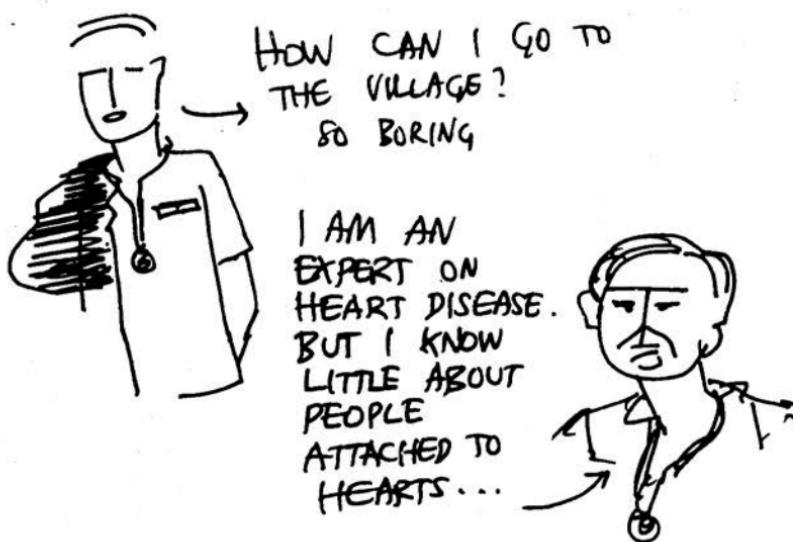
Who guides the doctors on ethical and social concerns?

The present uneasy truce is neither conducive to the promotion of trust and professionalism in medical practice nor a healthy environment in which an ethical and conscientious medical practitioner can seek to practice his vocation. We have to examine what are the main problems in medical education and what can be done about it. We have to look at how ethical guidelines are created and promoted and how they can reflect public concerns better. We

also have to note recent trends that are worsening the situation rather than improving it.

**2. What are the disturbing trends in the institutions that train and produce doctors and nurses and other health professionals for the health care delivery system in India?**

- ◆ The major problem of medical institutions have been that they largely draw students from the more urban and affluent sections of society who culturally are not attuned to serving the needs of the poor or serving in rural areas. The other major problem with these institutions are the preoccupation of medical educators with disease care in tertiary care centres and low priority for primary health and community health care. These two factors by them selves are adequate to lead to the production of doctors who are inappropriate for our needs.



- ◆ It may also be stated that aspects like behavioral sciences, ethical concerns, an understanding of economic pressures that distort medical science; cultural gaps that impeded doctor -patient communication are all almost completely missing from the syllabus. The doctor emerges with a fragmented and technocratic vision of disease and health, rather than a holistic perspective.

In the last two decades the above problems have got seriously exacerbated by a number of factors. The most important of these are:

- ◆ The growth of private capitation fee colleges, which are increasingly commercialising all aspects of medical education.
- ◆ The mushrooming of institutions based on caste and communal affiliations & the mushrooming of private high technology diagnostic centres and the concurrent glorification of high technology, through high-pressure advertising in the media and in medical education.
- ◆ The unresolved and probably increasing problem of private practice among full time teachers of medical colleges;
- ◆ The increasing 'doctor-drug producer axis' with 'vested interest' in 'abundance of ill health' which includes all sorts of gifts and perks from pharmaceutical companies for doctors - a process that starts from the medical college hospital onwards.
- ◆ The rampant corruption that seems to be accepted as routine practice and the increasing erosion of norms of medical ethics, with resulting increase in medical malpractice even among faculty of medical colleges.
- ◆ The increasing trend to flout norms for admission/ selection procedures and sanctioned numbers by State Governments and universities that have to be regularly challenged by judicial activism.



Taken together, they are beginning to have 'an insidious but definitive eroding effect on the focus and orientation of health service development in the country as well as the nature of the human power education investment of the State'. Even more disturbing is the fact that young doctors in formation are exposed to unethical practices during the formative years, which influence their knowledge, attitude and practice of medicine in the future. While all the above trends are increasingly widespread in medical colleges - the canker is spreading to nursing, pharmacy, dental and all other institutions training health human power development in the country.

### ***3. What's wrong with 'Capitation Fees Medical colleges for health professionals?***

Among all the above trends, the one that is most insidious is the growth of capitation fee medical colleges and various other related trends including NRI quotas which are commercialising the whole medical education scene.

Many people ask what's wrong with private medical colleges allowing admissions by students whose parents are willing to pay large amounts of capitation fees to ensure admissions? Is this not a good example of self-financing colleges? Is there not a need for increasing involvement of private sector in higher education? If people are willing to pay more for special food, clothes, shoes, consumer good what's wrong with buying seats in a medical college?

Of Course the capitation fee for our medical course includes charges for a passport, visa and emigration formalities...



- ◆ First it's important to note that the Supreme Court judgement in a special writ petition from Andhra has established that capitation fees are:

Wholly arbitrary,

Unconstitutional according to article 14-equality before law and are evil, unreasonable, unfair and unfit,

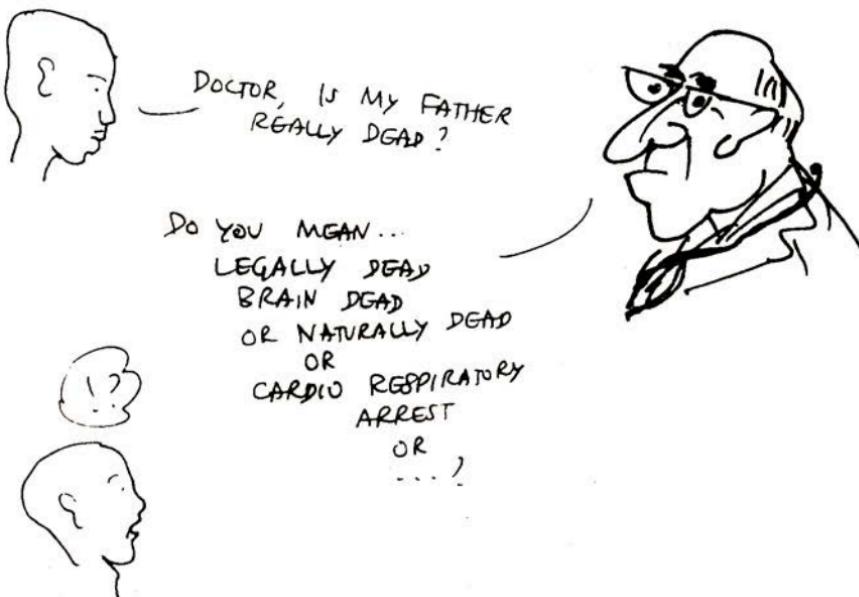
Enables the rich to take admissions where as the poor have to withdraw due to financial inability and

Therefore are not permissible in any form.

- ◆ From reports in the media and anecdotally in Medical professional circles there is increasing evidence that the capitation fees ethos is contributing to a fall in qualitative standards. The selection of students and their initial orientation, the quality of facilities available in many of these centers, the emphasis given to medical education and the power of money and influence at the time of examinations all adversely affect the outcome. While these are increasingly problems even in government colleges, in the private sector the levels of deterioration are enhanced and overt.
- ◆ The mushrooming and totally unregulated growth of capitation fees colleges and the fall in teaching ad ethical standards is even more disturbing because this is going on inspite of stated policies against this type of commercialisation by Central and State Government and professional associations and Councils, as well as Supreme Court guidelines.
- ◆ While in recent years some judicial activism has set some controls in this matter, in the medical college sector it is still totally unregulated in nursing, pharmacy, dental and other institutions. The controls set by the judiciary in medical education, especially as regards the ceiling amounts for charging fees, are also observed mainly in the breach.
- ◆ The problem is further worsened by the active involvement of medical College and professional leadership - seniors in the medical profession - many of whom by virtue of being compromised personally are unable to take a public stand against the issue. Even if they do so, it is often a blatant double standard.

#### 4. Are there Human Rights issues in health care?

The enormous strides in modern medicine, diagnostic techniques, surgery and health care systems have raised problems in respect of standards of care, extent of human rights protection and adequacies of systems of accountability. Time tested standards; ethical norms, conventions and practices are being questioned in the light of new knowledge and better understanding of health care.



- ◆ The determination of whether a person is medically or legally dead is full of intricate problems relating to ethics, morality and law.
- ◆ Keeping a body functioning with a respirator, pacemaker, intravenous feeding, renal dialysis etc now invites a variety of legal issues concerning homicide, negligence claims, insurance claims, transplantation of organs, probate law and so on.

- ◆ The development of artificial insemination and surrogate parenthood raises problems to the established laws of rape, adultery, legitimacy of offspring apart from issues of ethics and morality.
- ◆ Amniocentesis and abortion are medical practices, which have led to lot of concern around basic human rights issues. Sex selective abortion is a specific example of an immoral practice, clearly made illegal by legislative action, that nevertheless continues to flourish and spread.
- ◆ There are new legal and ethical issues in the care of mentally ill; those in prison and other custodial institutions; and even the use of drugs and psychotropic substances by medical and health personnel.

Ethical issues and dilemmas for the doctor and hospital staff are constantly increasing.

- ◆ Should 'a terminally ill patient be kept alive indefinitely by costly life sustaining apparatus or medicine when there are no chances of recovery '
- ◆ Should a deformed foetus be allowed to be born alive?
- ◆ Should a doctor make some of those decisions himself or should others be consulted?
- ◆ Can he be guided by the informed consent of the patient alone?
- ◆ What is expected of him as a professional bound by the Hippocratic oath?

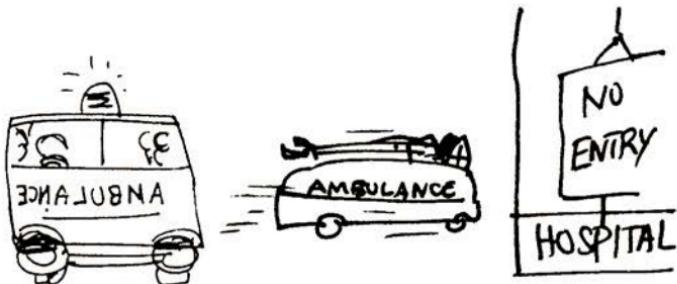
As science progresses more and more human rights issues and ethical dilemmas will emerge.

There is another set of issues of ethics that relate directly to privatization of health care;

If an emergency case is brought to a private hospital can the patient be turned away for lack of inability to pay. Even if immediately attended to who decides when to send them off. The Supreme Court



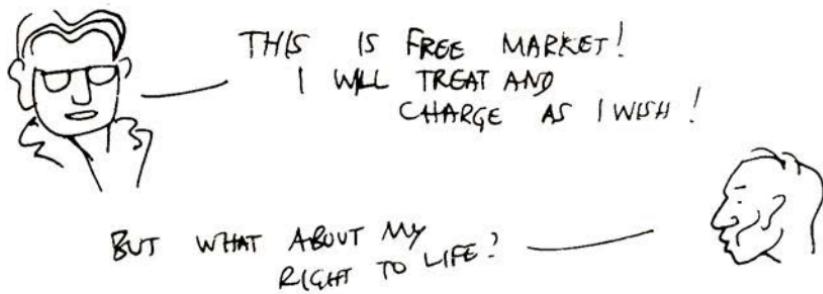
has ruled that if a sick patient cannot be handled by a health institution for lack of facilities then it is their duty to arrange for the transport of the patient to the nearest place where such facility exists. (see annexure 4) But this does not happen. And the private sector has never accepted such a responsibility. Rather providing ambulance services is often an especially lucrative part of running a nursing home.



How far does the responsibility of the state lie. Most would hold for example that the state must be able to provide services for child-birth in complicated cases —irrespective of the ability of the patient to pay for it. It would be a denial of the right to health if this were not available. But could we so insist that the state should provide for chronic hemodialysis or transplantation for kidney failure for all cases — as is provided in many countries of the west.

The central question that emerges is who decides today and what factors influence the decision?. And how do we think such decision-making ought to be shaped?

**5. How can these issues in Medical Ethics, Medical Education and Health care be tackled?**



The problems discussed so far are complex and the situation is changing all the time, due to not only technological progress but also due to new economic policies of Liberalization, Privatization and Globalization. The so-called LPG policies distort health care systems and affect doctor-patient relationships. In essence they lead to less and less regulations and tend to legitimize anything that makes more profits for investors in health industry while all other considerations are of secondary importance. The assumption is that since consumers will assert their choice the best and most people-friendly options will grow. But as we have seen from the earlier considerations this has not happened.

To understand the problem comprehensively and suggest alternatives, one needs a very thorough socio-economic-political-cultural and philosophical critique of not only the evolving medical/health care system but also the social context and milieu in which they are changing and evolving. That is beyond the scope of this book. However there is a consensus that some regulations are essential to ensure that such concerns are responded to.

***6. How should regulation be organized? Should the regulatory reins required be punishment led or ethics driven?***

Regulations are inevitable for any public activity.

But any sort of regulatory regime raises a basic dilemma ?

Should the regulation be through legislation and legal measures, which are essentially punishment driven? Or can there be there be alternative approaches.

The earlier section on regulating the private sector has discussed the various aspects of regulations. The issues discussed include the question of who should regulate, and how to regulate ?

But we now consider the aspect that any regulatory approach has some inherent problems. So even as we ensure minimum regulations

to safeguard the public concerns we need to build on complementary measures to ensure ethical practices.



The regulatory regime now in place is largely a legal-cum-bureaucratic mode. The traditional principles of common law liability are superimposed with a statutory arrangement of consumer protection procedures. However if things are allowed to develop only in this structure, it is feared that we will soon have escalation in costs of health care and lots of unnecessary investigation and intervention as 'defensive practice' i.e. doctors protecting themselves against further cases by patients for malpractices by subjecting them to all sorts of tests and procedures. Only insurance business will benefit, neither the doctors nor the patients.

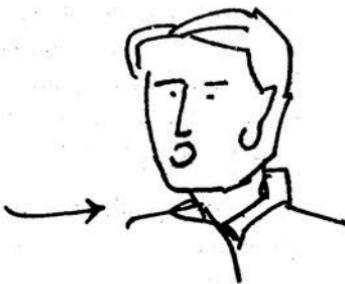
It would be much better if we could intervene in medical education and medical training to ensure that ethical values are internalized. It would be much better if we could build institutions that would ensure that ethical practice is proactively promoted.

Father:  
‘My son was all right till yesterday. Then he dies during a minor eye surgery. I demand an eye for an eye!’



Father:  
‘But you told me you are the best center in the world!’

Doctor:  
‘But mistakes can happen!’



## So what is to be done?

### At the level of help to the individual patient:

- ❖ Bringing Medical service under the preview of the Consumer Protection Act has been the first of these required changes.
- ☛ One can also talk of setting up medical boards where patients are not seeking redressal but at least can get a reliable second opinion when they are in doubt about the correctness of treatment in a given case.



“Doctors, I have been advised to go in for an interns removal operation. Is it really needed?”

### **At the level of civic action:**

- Promoting public debate, review and scrutiny of existing codes, a regulation and practices and planning dialogues for reform and reorientation has to be the next step. This would be brought about by the involvement of peoples / consumers representatives at all levels of the system-be it service, training or research.
- Promoting public involvement in the evolution of clinical guidelines:

*Are there treatment protocols available?*

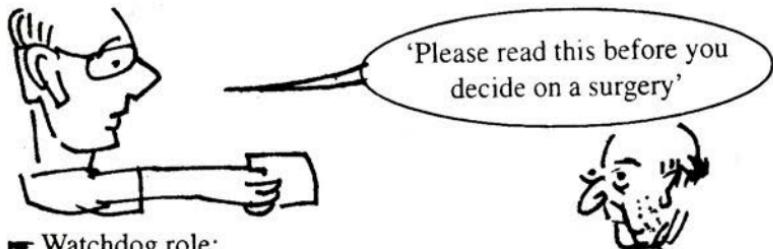
*Are there guidelines available on when it is expected for a doctor to order investigation?*

*Are there clear ethical guidelines available regarding in controversial areas or newly emerging technologies:*

*Are such guidelines drawn up at the level of a hospital or state or central government or at the professional body after adequate discussion where different sections of society, especially those representing women and the poor, are heard.*

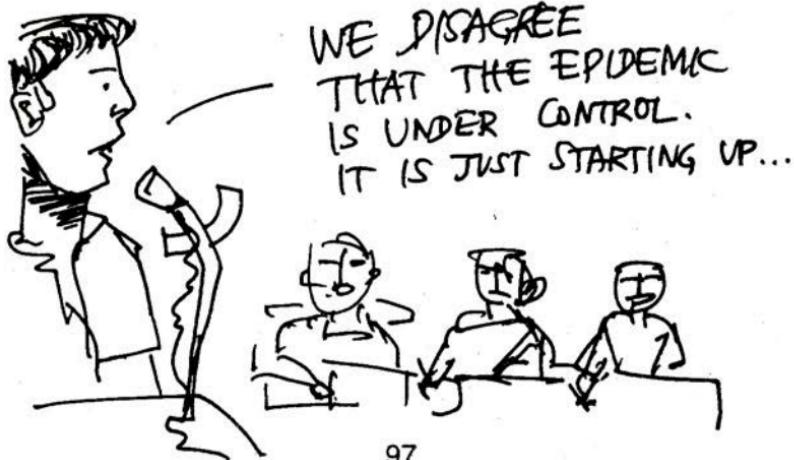
Such guidelines help the doctor to avoid the practice of defensive medicine.(that is taking investigations or procedures just to keep himself safe from possibility of misguided legal action though medically speaking this was not needed.)"

- Are there adequate patient information material available? (this enables informed consent decision making and lessens room for litigation)



- Watchdog role:

Civic society in close collaboration with the ethical sections of the health professionals should increasingly play a watchdog role in Health Care in the country. What are the levels of health and health care? How do they relate to existing and proposed policies? Many issues need to be looked at and monitored, quickly bringing to public scrutiny transgressions or even areas of confusion where a social consensus is called for or more social debate is required. For example in the introduction of genetically modified foods.



- Social mobilization for medical reform: Given the pressures for commercialization of medical care with all its attendant problems, what is needed in a strong countervailing movement by health and development activists, people science movement activists, consumers organizations not-for-profit health care providers and peoples movements that will bring medical education and their ethical orientation, high on the political agenda of the country -as part of the effort to ensure an adequate healthcare for all its citizens.

### **In summary:**

The thrust areas or central concerns which need to be addressed by people's movements and institutions of civil society are:

- ◆ To make health planning base itself on the intricate relationship between poverty and sickness . At the root of ill health is an iniquitous and unjust distribution of the means to health. All health programmes must therefore be an integral part of human development and poverty alleviation programme. Only constant pressure from the representatives of the poor can ensure that this focus is retained.
- ◆ The growing commercialisation of health care and the growing market economy related distortions in health care options and health care responses need to be countered carefully. We have to fight for more comprehensive solutions evolved socio-epidemiologically and not allow top down, selective technological fixes promoted by an international market economy in health
- ◆ Health human power development institutions and colleges should be challenged to be less ivory towered; less high technology centered; and become more community oriented and primary health care inspired. This can only be done if faculty and students are exposed and involved in primary care and community health situations within the curriculum framework.
- ◆ Strengthening the university and Medical Council regulatory structures and countering the nexus between the capitation fees

college lobby and the political system through active lobbying must counter the commercialisation of medical education.

- ◆ There is urgent need to study the trends in privatization and in private sector health care to ensure that they contribute to Health care and medical education and not distort them further through the promotion of an unregulated market economy.
- ◆ There is urgent need to change the focus from Doctors to nurses, health workers, traditional birth attendants to establish a sense of priority and focus on Primary Health care and to give serious considerations for quality enhancement of these grades of health workers and their training programme.

The Peoples Health Assembly at Dhaka, the Jana Swasthya Sabhas in all the states and finally the National Sabha in Calcutta and all the district level meetings need to include these issues on their agenda.

The focus of the Peoples Health Assembly is on

- ◆ Recommendations to Government and professional bodies on measures - legal and administrative needed to check this commercialization and keep medical practice effective, safe, cheap and holistic.
- ◆ On peoples initiatives and mass mobilization to educate the people on their rights, help them with strategies to cope individually and as communities with the problems due to commercialization of healthcare and to build up public awareness for reform of the medical sector.

All those concerned about Peoples Health needs and Peoples Health will have to take on this emerging challenge as we begin the new millennium. Our efforts will determine whether in the years to come, health care and medical education will primarily respond to the peoples health needs and aspirations or will professional expectations and market phenomena continue to distort the process.

**Market or People? What will be our ethical choice?**

Annexure - 1

**HEALTH CARE INFRASTRUCTURE AND FINANCING 1880 - 1940**

|   | 1880 | 1890  | 1900  | 1910  | 1920  | 1930  | 1940  |
|---|------|-------|-------|-------|-------|-------|-------|
| 1.Hospitals & Disp. (only state financed)   | 1212 | 1736  | 2313  | 4262  | 5067  | 6448  | 7441  |
| i)Percent State Owned   | na   | na    | na    | 68.5  | 72.2  | 72.0  | 87.3  |
| ii)Percent State Financed   | na   | na    | na    | 74.5  | 78.0  | 81.9  | 92.4  |
| iii)Total Beds  | na   | na    | na    | 45639 | 55772 | 67245 | 74111 |
| iv)No. of Patients Treated (millions)   | na   | 12.98 | 20.49 | 35.06 | 45.53 | 67.87 | na    |
| v)% treated in state financed institutions  | na   | na    | na    | 80.4  | 82.7  | 84.6  | na    |
| 2.Total Public Health Expenditure, includes local govt. (Rs.million annual avg. of last decade) | 18.5 | 23.3  | 38.8  | 53.5  | 76.3  | 143.4 | 145.3 |
| -percent spent by local govts.  | 43.8 | 45.1  | 51.8  | 58.3  | 61.6  | 63.7  | 60.8  |

|   |       |       |      |        |       |      |      |
|---|-------|-------|------|--------|-------|------|------|
| -percent public health expenditure to total govt. expenditure | 3.14  | 2.92  | 3.78 | 4.23   | 4.54  | 5.35 | 5.47 |
| 3.Medical Practitioners as per census                         | 91607 |       |      | 304544 |       |      |      |
| -percent qualified (only allopathy)                           |       | 14.51 |      |        | 25.58 |      |      |

Sources : Expenditure Data - Roger Jeffery: The Politics of Health in India, Univ. of California Press, Berkely, 1988

Hospital Data - Statistics of British India, Part V - Area, Population and Public Health, Directorate General of Commercial Intelligence, GOI,

1909 (upto 1900) and Statistical Abstract for British India, GOI, relevant years (for other years),

Practitioner data: Census of India 1881 vol.III, GOI and 1931 vol.I Part II, GOI, includes Burma etc...

Annexure - 2

**HEALTH INFRASTRUCTURE DEVELOPMENT IN INDIA 1951-1998**

|   |                  | 1951        | 1961   | 1971   | 1981   | 1991   | 1995   | 1996   | 1997  | 1998   |
|---|------------------|-------------|--------|--------|--------|--------|--------|--------|-------|--------|
| 1 | Hospitals        | Total       | 2694   | 3054   | 3862   | 6805   | 11174  | 15097  |       |        |
|   |                  | % Rural     | 39     | 34     | 32     | 27     |        | 31     |       |        |
|   |                  | % Private   |        |        |        | 43     | 57     | 68     |       |        |
| 2 | Hospital beds    | Total       | 117000 | 229634 | 348655 | 504538 | 664135 | 870161 |       |        |
|   |                  | % Rural     | 23     | 22     | 21     | 17     |        | 20     |       |        |
|   |                  | % Private   |        |        |        | 28     | 32     | 36     |       |        |
| 3 | Dispensaries     |             | 6600   | 9406   | 12180  | 16745  | 27431  | 28225  |       |        |
|   |                  | % Rural     | 79     | 80     | 78     | 69     |        | 43     |       |        |
|   |                  | % Private   |        |        |        | 13     | 60     | 61     |       |        |
| 4 | PHCs             |             | 725    | 2695   | 5131   | 5568   | 22243  | 21693  | 21917 | 22446  |
|   |                  |             |        |        | 27929  | 51192  | 131098 | 131900 | 13493 | 136379 |
|   |                  |             |        |        |        |        |        | 1      |       |        |
| 5 | Sub-centres      |             |        |        |        |        |        |        |       |        |
|   |                  |             |        |        |        |        |        |        |       |        |
|   |                  |             |        |        |        |        |        |        |       |        |
| 6 | Doctors          | Allopaths   | 60840  | 83070  | 153000 | 266140 | 395600 | 459670 | 47578 | 522634 |
|   |                  | All Systems | 156000 | 184606 | 450000 | 665340 | 920000 |        | 0     | 503950 |
|   |                  |             |        |        |        |        |        |        |       |        |
| 7 | Nurses           |             | 16550  | 35584  | 80620  | 150399 | 311235 | 562966 | 56570 | 115500 |
|   |                  |             |        |        |        |        |        |        | 0     |        |
|   |                  |             |        |        |        |        |        |        |       |        |
| 8 | Medical colleges | Allopathy   | 30     | 60     | 98     | 111    | 128    |        | 165   | 165    |
|   |                  | Out turn    | Grads  | 1600   | 3400   | 10400  | 12170  | 12086  |       |        |
|   |                  | P. Grads    |        | 397    | 1396   | 3833   | 3139   |        |       |        |

|    |  |                                      |           |                |                |                   |                   |                      |
|----|--|--------------------------------------|-----------|----------------|----------------|-------------------|-------------------|----------------------|
| 10 | Pharmaceutical production                | Rs. in billion                       | 0.2       | 0.8            | 3              | 14.3              | 60.5              | 160.0 (1999)         |
| 11 | Health outcomes                          | IMR/000                              | 134       | 146            | 138            | 110               | 80                | 74/69 72 71          |
|    |  | CBR/000                              | 41.7      | 41.2           | 37.2           | 33.9              | 29.5              | 29 25 24             |
|    |  | CDR/000                              | 22.8      | 19             | 15             | 12.5              | 9.8               | 10 9 9               |
|    |  | Life Expectancy years                | 32.08     | 41.22          | 45.55          | 54.4              | 59.4              | 62 62.4 63.5         |
|    | Births attended by trained practitioners | Per 1000 live births                 |           |                | 18.5           | 21.9              | 28.5              |                      |
| 12 | Health Expenditure Rs. Billion           | Public Private@ CSO estimate of pvt. | 0.22 1.05 | 1.08 3.04 2.05 | 3.35 8.15 6.18 | 12.86 43.82 29.70 | 50.78 82.17 82.61 | 101.65 113.13 126.27 |

② Data from - 1951:NSS 1st Round 1949-50; 1961: SC Seals All India District Surveys,1958; 1971: NSS 28th Round 1973-74; 1981:NSS 42nd Round 1987; 1991 and 1995: NCAER – 1990 and 1994.

Source : 1. Health Statistics / Information of India, CBHI, GOI, various years

2. Census of India Economic Tables, 1961, 1971, 1981, GOI

3. OPPI Bulletins for data on Pharmaceutical Production

4. Budget Papers of Central and State Governments, various years

5. National Accounts Statistics, CSO, GOI, various years

## **MODEL CITIZEN'S CHARTER FOR GOVERNMENT HOSPITALS**

*(Extract of letter No. Z28015/131/96-H, dated 13-12-1996 from the  
Ministry of Health and Family Welfare, Govt. of India, New Delhi)*

### **1. Preamble**

Government hospitals exist to provide every citizen of India with health care within resources and facilities available. Such care is to be made available without discrimination by age, sex, religion, caste, political affiliation, economic and social status. This Charter seeks to provide a framework which enables citizens to know what services are available, the quality of services they are entitled to and to inform them about the means through which complaints regarding denial or poor quality of service will be addressed.

### **2. Objectives :**

- 2.1 To make available medical treatment and related facilities, for citizens who seek treatment at the hospital.
- 2.2 To provide the appropriate advice, treatment and support that would help cure the ailment to the extent medically possible.
- 2.3 To ensure that treatment is based on well considered judgement, is timely and comprehensive and with the consent of the citizen being treated.
- 2.4 To ensure users are aware of the nature of ailment, progress of treatment, duration of treatment and impact on their health and lives, and
- 2.5 To redress any grievance in this regard.

### **3. Components of service at hospitals :**

- 3.1 Access to hospital and professional medical care to all.
- 3.2 Making provision for emergency care after main treatment hours, whenever needed,
- 3.3 Informing users about available facilities, costs involved, and requirements expected of them with regard to treatment as well as use of hospital facilities, in clear and simple terms,

- 3.4 Informing users of equipments out of order,
- 3.5 Ensuring that users can seek clarifications on and assistance in making use of medical treatment and hospital facilities,
- 3.6 Collecting fees and charges that are reasonable and well known to public, and
- 3.7 Informing users about steps to be carried out in case of most of the common deficiencies in service.

**4. Commitments of the Charter :**

- 4.1 To provide access to available facilities without discrimination,
- 4.2 To provide emergency care, if needed, on reaching the hospital,
- 4.3 To provide adequate number (to be defined) of notice boards detailing location of all facilities,
- 4.4 To provide written information on diagnosis, treatment being administered, and costs that will be recovered, each day in case of in-patients,
- 4.5 To provide a receipt of all payments made for medical care,
- 4.6 To record complaints round the clock, and designate Medical Officers who will respond at an appointed time the same day in case of in-patients and the next day in case of out-patients.

**5. Grievance redressal :**

- 5.1 Grievances that citizens have will be recorded round the clock.
- 5.2 There will be a designated medical officer to respond to requests deemed urgent by the person recording the grievances.
- 5.3 Aggrieved users would, after having their complaint recorded be allowed to seek a second opinion from within the hospital.
- 5.4 Have a Public Grievances Committee outside the hospital to deal with grievances that are not resolved within the hospital.

**6. Steps that will be taken :**

- 6.1 Hospital staff, Department of Health and citizens representatives will discuss the utility and content of the Charter before it is formulated.
- 6.2 The areas on which standards are prescribed will be selected on the basis of feedback from users of problems and deficiencies, collected by an independent body.
- 6.3 Systematic efforts will be made to create wide awareness that a Charter exists, among the users of the hospital, and

- 6.4 Performance in areas where standards have been specified in the Charter will be compiled and displayed publicly.

**7. Responsibilities of the Users :**

- 7.1 Users of hospitals would attempt to understand the commitments made in the Charter and demand adherence,
- 7.2 Users would not insist on service above the standards set in the Charter, particularly because it could negatively affect the provision of the minimum acceptable level of service to another user;
- 7.3 Instructions of the hospital personnel would be followed sincerely, and
- 7.4 In case of grievances, the redressal machinery would be used by users without delay.

**8. Feedback from the users :**

- 8.1 The perceptions of users on the quality of service of hospitals would be systematically collected and analysed by an independent agency, and
- 8.2 The feedback, would cover areas where standards have been specified as well as other areas where standards are proposed to be set up.

**9. Performance audit and Review of the Charter :**

- 9.1 Performance audit may be conducted through a peer review every year or every two years.
- 9.2 The audit would look at user feedback, records on adherence to committed standards, the performance on parameters where standards have not yet been set, and other indicators of successful goal realisation.
- 9.3 Identify areas where standards can be introduced, tightened, etc., opportunities for cost reduction, and areas where capacity building is required, and
- 9.4 Through re-assessment of the contents of the Charter every five years.

## EMERGENCY SERVICES IN HOSPITALS

*(Extract of letter No. Z28015/131/96-H, dated 13-12-1996 from the Ministry of Health and Family Welfare, Govt. of India, New Delhi)*

The Honourable Supreme Court in their judgement dt 6-5-96 in SLO (C) No. 796/92 - Paschim Banga Khet Mazdoor Samity and others Vs State of West Bengal and another suggested remedial measures to ensure immediate medical attention and treatment to persons in real need. The State Government of West Bengal alone was a Party in the proceedings of the case. The Hon. Court has given directions that other States though not parties should also take necessary steps in the light of recommendations made by the Enquiry Committee which was set up by the State Government of West Bengal and further directions as given by the Court.

The following guidelines may also be kept in view while dealing with emergency cases in addition to the existing guidelines :-

- i) In the hospital, the Medical Officer in the Emergency/Casualty services should admit a patient whose condition is morbid/serious in consultation with the specialist concerned on duty in the emergency department.
- ii) In case the vacant beds are not available in the concerned department to accommodate such patient, the patient has to be given all necessary attention.
- iii) Subsequently, the Medical Officer will make necessary arrangement to get the patient transferred to another hospital in the Ambulance. The position as to whether there is vacant bed in the concerned department has to be ascertained before transferring the patient. The patient will be accompanied by the resident Medical Officer in the Ambulance.
- iv) In no case the patient will be left unattended for want of vacant beds in the Emergency/Casualty Department.
- v) The services of CATS should be utilised to the extent possible in Delhi.
- vi) The effort may be made to monitor the functioning of the Emergency department periodically by the Heads of the institution.

- vii) The Medical records of patients attending the emergency services should be preserved in the medical record department.
- viii) The Medical Superintendent may coordinate with each other for providing better emergency services.

3. With regard to maintenance of admission register of patients, following may be kept in view :-

- a) Clear recording of the name, age, sex, address and disease of the patient by the attending Medical-Officer;
- b) Clear recording of the date and time of attendance, examination/admission of the patient;
- c) Clear indication whether and where the patient has been admitted, transferred, referred;
- d) Safe custody of the Registers;
- e) Periodical inspection of the arrangement by the Superintendent;
- f) Fixing of responsibility of maintenance and safe custody of the Registers.

4. With regard to identifying the individual medical officer attending to the individual patient approaching OPD/emergency department of a hospital on the basis of consulting the hospital records, it has been directed by the Court that the following procedure should be followed in future :-

- a) A copy of the Duty Roster of Medical Officers should be preserved in the Office of the Superintendent incorporating the modifications done for unavoidable circumstances;
- b) Each Department shall maintain a register for recording the signature of attending medical officers denoting their arrival and departure time;
- c) The attending medical officer shall write his full name clearly and put his signature in the treatment document;
- d) The Superintendents of the hospital shall keep all such records in safe custody.
- e) A copy of the ticket issued to the patient should be maintained or the relevant date in this regard should be noted in an appropriate record for future guidance.

It is appreciated the Hospital Superintendent/Medical Officers-in-charge may have difficulty in implementing these guidelines due to various constraints at the ground level and as such, feedback is vital to enable Government to refine and modify the order as it will ensure a valid working plan to regulate admission on a just basis. Detailed comments are, therefore, requested with constructive suggestions.

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