Summary of

The Private Medical Sector in India

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THE PRIVATE MEDICAL SECTOR IN INDIA

(Summary)

The private medical sector in India accounts for 61% to 86% of the total medical expenditure, 73% of allopathic doctors, a much larger proportion of non-allopathic doctors, 56% of hospitals and 30% of hospital-beds. In spite of this dominant share that the private sector occupies, there are hardly any studies barring those covering the drug industry which have looked into its role and functioning.

This lacuna is especially glaring in the context of the recent trends towards further privatization of medical care. In this paper, we have tried to study different aspects of the private medical sector such as general practitioners, consultants, hospitals, laboratories, medical colleges, etc., with a view to analyze how appropriate is this private sector in fulfilling the health care needs of the Indian people and to find out what reforms are needed to make it fulfill its role.

Though the private medical sector in India is more accessible to and popular with those who can easily afford to pay for it, it suffers from a number of features which are inimical to the interests of a rational, affordable, socially desirable form of medical care system. These are - socially inappropriate, costly, sub-standard medical education ; lack of adequate, proper Continuing Medical Education ; gross urban-rural disparity in the availability of qualified medical practitioners ; irrational drug use ; unnecessary and unethical medical interventions; sub-standard quality of medical care ; lack of rationalization of professional charges; paucity of record keeping; lack of preventive measures and health-education; unqualified, poorly paid paramedic staff; lack of professional self-regulation. Many of these features are also present in the public health care system but they are much more pronounced in the private medical sector. Each of these problems is briefly examined below :-

I> Inappropriate Medical Education

Medical education in India is elitist, biased towards curative care, hospital-oriented, wasteful and socially inappropriate. Private medical colleges, barring exceptions, are no solution to these problems. Yet their role has been increasing. The number of allopathic medical colleges in India has increased from 28 to 125 from 1950 to 1987. During this period,

the proportion of private medical colleges has increased from 3.5% to 17%. Twelve out of eighteen new medical colleges opened during 1974-1986 were in the private sector. By 1986, the proportion of private medical colleges in Ayurvedic, Homeopathic, Unani medical systems was 67%, 65%, 75% respectively. This proliferation of private medical colleges is inimical to the interest of rational, affordable medical care for three reasons :

1) There is no need to open new medical colleges anymore. Looking at the current output from the existing medical colleges, by the year 2000 A.D. there will be one MBBS doctor per 2000 population and one doctor of whatever degree, per 1000 population. This ratio is satisfactory for a developing country like India. Secondly, experience shows that merely producing more doctors is not the solution for paucity of doctors in rural areas; MBBS and post-graduate doctors tend to flock to the cities. Use of well-trained, well-supported paramedics is the more appropriate solution to the paucity of doctors in rural areas. Doctors from private medical colleges increase the urban concentration of doctors since it is only in cities that they can earn back their substantial investment in medical education.

2) Private colleges charge from 3-5 lakh rupees per student. As of 1993-94, these fees are now standardized by the state - Rs. 1.72 lakh per year for "paying" students ! Any doctor who has spent so much on education is bound to recover it from his patients. This can only be done by indulging in excessive billing and unnecessary medical interventions, thus further lowering the ethical standard in medical practice.

3) Most of the private medical colleges are sub-standard and are not recognised by the Medical Council of India .

Private medical colleges thus worsen the situation in the field of medical education and hence need to be banned.

II> Lack of Continuing Medical Education (CME)

Unlike in some Western countries, a doctor's registration in India is renewed without undergoing any CME. There are voluntary efforts at CME. For example, many branches of the Indian Medical Association conduct CME - programmes for their members and IMA runs a monthly Journal of Indian Medical Association (JIMA) for its members. But out of 3.5 lakh MBBS doctors in India, less than 25% are members of IMA, and

about 10-25% of the members attend its CME programmes. For the eight lakh non-allopathic doctors (Homeopaths, Ayurveds, etc.) there is hardly any proper CME. Most of them prescribe allopathic medicines ("cross-prescriptions") and depend more or less solely on the Medical Representatives of drug companies for their knowledge of allopathic drugs. As a result, the half-truths and untruths propagated by the drug companies are uncritically accepted by the medical profession.

A National Medical Education Board has to be set-up, which would, through its state branches, deliver compulsory CME to doctors. Renewal of registration of doctors should be subject to satisfactory completion of CME. Cross-prescriptions should be banned or should be allowed strictly in accordance with proper training in the other pathy.

III> Irrational Drug Use

Most of the drugs marketed in India are in the form of drug-combinations and most of these drug-combinations are irrational and some are even hazardous. Yet they are widely prescribed in India, especially in the private sector. In the Public Health Facilities, the health authorities draw up a list of rational, essential drugs and District Health Officers are to buy medicines in accordance with this list. The centralized purchases of drugs in the public sector is therefore mostly of rational drugs. But in the private sector, all kinds of irrational drugs are prescribed. This is confirmed by the results of our study of prescription practices in a typical district in Maharashtra. It was found that prevalence of use of irrational or hazardous or unnecessary drug is far more common in the private clinics than in the Primary Health Centres.

Unnecessary use of injections and intravenous infusions is the most glaring and the most common unnecessary medical intervention. This, again, is quite common in private practice since there is a strong financial incentive in unnecessarily using this costly mode of medical interventions.

To remedy this situation, only rational drugs and rational drug-combinations should be allowed; all others should be banned. Along with continuing education of doctors, there has to be extensive and continuous health education of lay-people so that patients do not ask for injections or "powerful medicines" due to their misplaced faith in them. A practice of paying "examination fees" to a general practitioner has to be instituted

since lack of this practice is partly responsible for unnecessary use of injections.

IV> Unnecessary and Unethical Medical Interventions

Unnecessary surgeries and laboratory tests are on the rise. This is because of increasing urban concentration, increasing commercialization and the rise of the corporate sector in medical care. To the list of unnecessary removal of appendix, tonsils , uterus, etc., are added new high-tech procedures like heart operations. According to a senior heart surgeon in Bombay, 40% of coronary angioplasties and 20% of coronary bypass surgeries done in Bombay are unnecessary! It is quite common for a CAT-Scan centre to offer commissions to doctors for sending their patients for this costly investigation.

The sale of kidneys for transplants; misuse of prenatal diagnostic tests for detection of the sex of the foetus and the subsequent elimination of female foetuses; buying of blood from professional blood donors and the consequent risk of spread of AIDS, Hepatitis - these murky deeds are a special feature of the private medical sector.

These nefarious practices must be stopped with a heavy hand. Standard treatment guidelines should be worked out by medical bodies so that unnecessary medical interventions can be easily singled out.

V> Sub-standard Medical Care

Many private nursing homes neither have adequate floor space, ventilation, cleanliness, or adequate water supply, nor well-trained staff. This was recorded by a Committee of the West Bengal Legislative Assembly in 1985 and members of the Bombay High Court Committee in 1993. The Nursing Homes Act is merely on paper, wherever it exists (as in case of some of the metropolitan cities).

Minimum standards for private hospitals must be laid down and strictly enforced.

VI> Arbitrary Professional Charges

There is no principled basis for the level of fees to be charged by the doctor. The rule seems to be - charge as much as the patient can bear. A pediatrician from a small town may charge Rs.20/- as consultation, as compared to Rs. 100/- in a city like Bombay. Similarly, charges for Caesarean delivery may vary from Rs. 500/- in a small town to Rs.5000/

- in Bombay. Doctors' charges should be standardized since an individual patient is helpless to influence the doctor's fee. Cost of living, knowledge and experience of the doctor, type of surgery - all these should be properly considered to standardize charges.

VII> Paucity of Record-keeping

General practitioners and small hospitals keep (if at all) very cursory and inadequate records of their medical findings, not to mention statistics and proper accounts. The doctor's medical findings are not available to the patients as a matter of right.

There is, therefore, no scope for any medical audit to evaluate the performance of the doctor.

There must be minimum mandatory record-keeping by doctors and it should be available to the patient as a matter of right, when he/she asks for it.

VIII> Lack of Preventive Measures and Health Education

Private practice, by its very nature, is confined to an individualized relation between a patient and a doctor. So long as the patient is relieved of his/her suffering, the job of the private practitioner is considered to be over. But the disease process originates at a social level, e.g. defective water supply to a community or promotion of tobacco. Doctors should therefore participate in the collective action to control diseases because they have the knowledge about these. But private doctors, by and large, do not participate in the National Health Programmes like Tuberculosis, Malaria, Leprosy Control Programmes, etc.

Similarly, curative, preventive, promotive health practices and their rationale need to be propagated through health educational activities. But private practice, by its very nature, tends to neglect these health educational activities, especially on a social scale. This also holds true for the medical profession as a body, although some exceptional doctors, through their individual efforts, do undertake health education activities by writing articles for lay people, giving popular talks, etc. The magazines published by IMA "Your Health" and "Aapka Swasthya" (in Hindi) are not widely circulated; in fact they are hardly known. Notable exceptions are the Diabetic Association of India which, in some places, has been active for years together in educating lay people about diabetes.

The content of health education is also affected by the needs of private practice. On the one hand, aspects of science of medicine are explained to the people. On the other hand, the overall impact of such health education is to narrow down the concept of the disease process to merely its biological aspects while ignoring the broader social causes such as environmental degradation or an unhealthy life-style. Secondly, such health education mystifies medicine and exaggerates the importance of doctors. In short, consciously or unconsciously, such health education serves to expand the market of medical care.

Private practioners must participate in National Health Programmes and in properly conducted health educational activities.

IX> Unqualified, Poorly Paid Staff

Most assistants employed in the private sector, except in big hospitals, are under-qualified. Given their low educational qualifications and the very superficial training given by the doctors, most assistants cannot cope with the responsibilities they have to handle. The quality of care thus suffers. Due to long hours of work (in many small hospitals, the shift stretches to 12 hours) and poor wages, poor avenues of progress, the staff is dissatisfied and this, in turn, adversely affects the quality of their work.

There is a need for proper education and continuing education of paramedics in the private sector: also for some incentive in the form of a share in the prosperity of the hospital or the clinic.

X> Lack of Professional Self-regulation

Medicine is not mere business. It is an honorable profession with its own code of ethics and a statutory body (the Medical Council of India) to uphold the dignity of the medical profession. But in practice, the MCI is quite inactive and ineffective in curbing irrational practices and malpractices. Neither MCI nor the voluntary body-Indian Medical Association-are regulating the quality of medical care or curbing unethical practices in the medical field. Everything is left to the "law of the market".

There has to be some effective mechanism of ensuring professional standards and ethics in the medical profession.

XI> Conclusion

The above very brief survey of the private medical sector in India forces us to conclude that the private medical sector suffers from many

serious problems and hence needs drastic reforms. The nature of these reforms has been indicated above, at the end of the discussion of each of the problems pin-pointed. To reiterate these :

* ban on private medical colleges;
* compulsory continuing education of doctors;
* ban on irrational and hazardous drugs;
* ban on cross-prescriptions;
* standardization of medical interventions, of nursing homes and of professional charges;
* mandatory minimum medical record keeping;
* participation of private practitioners in National Health Programmes;
* proper training of paramedical staff and giving them a proper share in the prosperity of the clinic/hospital;
* tightening of professional self-regulation by doctors' associations.

The State has to take a much more active role in enforcing these reforms. Secondly, if the state pays for the medical care of its citizens, this single, powerful buyer can enforce the above reforms much more effectively. Patients are too vulnerable, powerless and scattered to put any positive pressure on doctors to reform the medical system. Thus a system of Universal Medical Insurance (UMI) in which every citizen is automatically medically insured (the state pays doctors' bills for all its citizens) is necessary to enforce these reforms. Such a system exists in Canada and Australia and is eminently practicable. This publicly financed, privately managed medical-care system would allow private practice and initiative. But, at the same time, it would also regulate it to safeguard the interests of patients, of the nation and of rational, ethical practice in general. A large majority of doctors would benefit from it because of the security and the job-satisfaction it would provide to them. The question is, can we achieve adequate political mobilization and political enlightenment to bring about such a medical care system ?

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This is the summary of an overreview by Dr. Anant Phadke of the private medical sector in India. He identifies the following features of the private sector which are an obstacle to the development of a rational, affordable, socially just medical care system.-- Costly yet sub-standard private medical colleges, which are unnecessary in the first place; lack of Continuing Medical Education of doctors ; irrational drug-use ; widespread " cross-prescription practices" ; unnecessary medical interventions ; lack of regulation and standardization of quality of nursing homes and medical interventions ; lack of preventive measures and health-education ; gross urban.rural disparity ; sub-standard, poorly paid staff, etc.... The author suggests a number of reforms, which can be carried out effectively in the framework of Universal Medical Insurance, as has been done in countries like Canada and Australia. These reforms are :-

* ban on private medical colleges ;
* compulsory continuing education of doctors ;
* ban on irrational and hazardous drugs ;
* ban on cross-prescriptions ;
* standardization of medical interventions, of nursing homes and of professional charges ;
* mandatory minimum medical record keeping ;
* participation of private practitioners in National Health Programmes ;
* proper training of paramedical staff and giving them a proper share in the prosperity of the clinic/hospital;
* tightening of professional self-regulation by doctors' associations.

The author argues that the inclusion of doctors in the Consumer Protection Act 1986, would not improve the quality of medical care if no progress is made in the direction of these reforms.

Though the private medical sector in India occupies a dominant share and position hardly any studies have analysed its functioning. With the trend towards further privatizartion of medical services in India, this critical study of the private medical sector stands out boldly. It should interest anybody concerned with the fate of the medical services in India.