HEALTH CARE SCENARIO IN INDIA

PRESENT AND EMERGING

Dr. C.M. FRANCIS

1. INTRODUCTION

Each civilization – Indian, Egyptian, Babylonian, Greek or Chinese – had its own way of attaining and maintaining health and tackling disease. The Indian Systems of Medicine included Ayurveda (the Science of Life) with the principles and practice of healthy living, Siddha and Unani. And then came Western (Modern) Medicine, with the coming of the Europeans. Western Medicine has been greatly influenced by Greek and Arab Medicine. Next come Homoeopathy. All these systems are flourishing today. Will they be integrated? That is the million dollar question.

Hospitals came into being in India quite early. During the Maurya and Gupta dynasties, there were hospitals for men and animals. Emperor Asoka had built a number of hospitals. Veera Chola Maharaj had built many hospitals and even a medical school. Emperor Akbar had a number of hospitals built, including a large one at Fatehpur Sikhri. All these were free charity hospitals.

The first Western (modern, allopathic) hospital was built in 1510 A.D by Albuquerque – the Royal Hospital – in Goa. The East India Company built hospitals in Madras (Chennai), Bombay (Mumbai) and Calcutta (Kolkota). There were separate hospitals for the Europeans, the Sepoys and the 'natives'. The condition of the hospitals for 'natives' was extremely bad. One visitor wrote : "The Company has a pretty good hospital at Calcutta, where many go to undergo the penance of physic but few come out to give an account of its operation". So much for the quality of care and the outcome!

The twentieth Century saw substantial numbers of doctors, nurses and allied health professionals coming out of the teaching institutions and the establishment

of many more hospitals. There was greater growth after India attained Independence. The major increases were in the Government and Voluntary Sectors. There were also large numbers of private, general practitioners and a few nursing homes, catering for the middle class families. The quality of service (especially nursing care and cleanliness) was much better in the hospitals in the voluntary sector. Towards the last two decades of the last century, there was a spurt in the number of nursing homes and hospitals in the private sector.

There have been qualitative and quantitative changes in health care. Some of the qualitative changes are good, some not-so-good and yet others definitely bad. The health situation in the country continues to be bad. Preventable deaths continue, whether it be infants, children or adults, in their millions. India is worst among the various regions in the world (except for sub-Saharan Africa) if we consider the disease burden per 1000 population. The health systems have a number of problems : **misallocation of funds, inequity and inefficiency**.

Among the present and emerging problems are

- the widening gap in health care between the 'haves and the have-nots';
- the increasing costs of health care services;
- the greater dependence on costly, sophisticated and unnecessary tests;
- the weakening of the doctor – patient relationships;
- commercialisation of health care services; and
- non-adherence to the principles of medical ethics in the practice of medicine.

2. THE MIX IN THE HEALTH SECTOR

We have a mix of Public (Government), Voluntary (not-for-profit) and Private (for-profit) sectors in Health Care. The Public Sector has been the most dominant, though it is not the largest. The Voluntary Sector, though smaller, is significant. It has been a pacesetter in many areas. The Private Sector has always been very large in providing medical care. It has a very wide spectrum, starting from the individual general practitioner, the small nursing homes, to the large corporate

hospitals. In recent times, with the advent of the large corporate hospitals, the Private Sector has assumed greater visibility.

Privatization

The Governments, both at the centre and the states, are supportive of privatization. Such privatization is actively encouraged by the World Bank, International Monetory Fund and other similar powerful organizations. The Governments have encouraged privatization actively and passively by giving land (free or at a nominal price), allowing duty free import of equipment or handing over hospital buildings or other health care facilities to private agencies. The National Health Policy – 2002 welcomes the participation of the private sector. Private sector has also grown because of default by the public sector.

Number of hospital beds

Is there a need for more hospitals and hospital beds; or, is there an over supply of beds? If we consider the whole of India, we need many more hospital beds. India has the least proportion of hospital beds per 1000 population among all the regions in the world. But there is great variation between the states. The Bhore Committee (1946) had suggested a long term plan of more than 5 beds per 1000 population. Later committees suggested a reduced target, mainly because the country could not sustain such numbers. It is time that we had a realistic estimate of the need – numbers, location and types of hospitals and inpatient beds.

Type of care

We need comprehensive health care. The Public and Voluntary sectors have been providing, to a greater or lesser extent, wholistic care – promotive, preventive and curative care (very little of rehabilitative care). The emphasis of the private sector has always been on curative medical care, without providing promotive, preventive or rehabilitative care.

The Public sector is involved in primary, secondary and tertiary care. The stated policy has been to give emphasis to primary health care and public health. The Voluntary sector is mainly involved in primary and secondary care. The private sector is involved in primary care (general practitioners), secondary care (the nursing homes) and the private corporate hospitals mainly in tertiary care.

Cost of care

The Public sector is expected to provide free care, especially to those below the poverty line, meeting the expenses from the general taxes paid by the people. With the introduction of user fees and other charges, some payment is necessary. There are also hidden charges, unofficial payment demanded by health personnel to get things done. People (even the poor) are asked to buy medicines and other medical accessories. Even to see the newborn by the mother, money has to be paid (in some government maternity homes and hospitals).

The Voluntary sector works usually on the no-loss-no-gain basis, meeting all the operational expenses from the charges levied. This is achieved by having different levels of charges for the affluent, middle class and the poor. The poor are given free or concessional care, meeting the deficits by charging the rich higher than the standard rates. Some institutions have poor funds so as to enable them to give free care to the indigent. The private-for-profit sector is motivated by profit. Their charges are high so as to maximise profit. The services are mostly not accessible or affordable to the poor. Some institutions do look after a few poor patients and may give some concessions.

Some questions

A number of questions arise:

- How do the three sectors function together? Is it competition, collaboration or co-existence?

- Can the three sectors collaborate in ensuring comprehensive health care for all – available, accessible and affordable?
- Does the existence of the three sectors lead to additional resources in health care?
- Does one sector pull resources (especially human) from the other?
- Is there unhealthy competition (like providing costly, sophisticated equipment and advertising the same) increasing the cost of care?
- Does each sector learn from the other to improve quality of care and management of the institution?

3. ADVANCES IN MEDICAL TECHNOLOGY

The greatest change in health care services has been the increasing use of newer diagnostic and therapeutic technologies. Imaging systems like Ultrasound, CT scanning and Magnetic Resonance Imaging are being used routinely. Laporoscopes enable small hole surgeries. Cardiac surgeries – by-pass, angioplasty, correction of congenital defects and other open and closed heart operations – have become very common. Kidney transplantation is fairly common, mainly with kidneys obtained from unrelated, live 'donors', which is giving rise to many ethical problems. Other transplants include cornea, skin, liver, heart, lungs and others. In the case of unpaired organs like heart, it has necessarily to be from cadavers. Cadaveric transplantation in a big way is yet to take off.

Information Technology

The immediate advance will be in Health Information Technology. Medical informatics can be used to

- improve clinical practice;
- schedule resources (personnel, money, materials, time) more efficiently;
- improve patient records and quicker access to records.

Tele medicine can be an enabling technology to facilitate transfer of information. The idea is to bring service to the point of needs without moving anyone: patient to doctor; doctor to patient; doctor to doctor and doctor to society. E-medicine, faxes, and telephonic consultations link patients with health care providers. They promise to improve access to health care services in rural areas with shortages of doctors and health care institutions. Issues like cost, patient consent and licensing will have to be addressed before tele medicine becomes an accepted mode of delivery of services.

Genetics

Among the emerging technologies are genetics and genetic engineering. With the determination of the human genome and the identification of the genes responsible for the production of various proteins, genetic defects can be countered. With the research on stem cells, organs and tissues can be grown. These can be transplanted to replace defective or damaged organs and tissues or to enhance the functioning of existing organs and systems. Such developments can be misused for the discredited eugenics. Cloning technologies may be used and embryos obtained through in-vitro fertilisation. By embryo transfer, foetus may be grown for the sole purpose of using the cells for transplantation, destroying the foetus.

Experimental research is going on where organs and tissues of other species may be used to replace the damaged organ or to augment its function The pig seems to be a prime candidate for donating organ (eg., heart). There are many unresolved and unknown problems. Certain viruses may be released which may be pathogenic to the human and then spread rapidly among the people.

Newer technologies are coming all the time. Many of them are discarded soon after, because they are useless or even harmful. There is need for assessing health care technologies before they are used. Utilization reviews, quality assurance and medical audits are needed. Clinical, scientific and economic appraisals must be carried out of all new medical technologies, including the newer procedures.

4. INEQUITIES IN HEALTH

"Everyone should have access to basic health care independent of their ability to pay" – We hear this rhetoric from the politicians and policy makers all the time. Yet, the facts are different. There are major gaps between the 'haves' and the 'have-nots'. The poor die earlier; their life expectancy is less. They suffer more from disease and disability. We need greater equity in health.

Equity in health can be measured using different parameters:

- **Access to health care services**

  Access to basic health care is unequal. The poor have less access to simple, cost-effective services. There are economic, social and cultural barriers. They have often to travel more, because the health care facilities are situated further away and incur relatively more for travel expenses. The daily wage earners have to forego their wages.

- **Utilisation of services**

  Individuals, families and communities belonging to the lower socio-economic groups are less knowledgeable about the services available and hence, make less use of them. Individuals in the higher income groups make more visits to the health care providers than those in the lower income groups. The introduction of user fees has worsened the situation. The poor postpone or do away with the visits, even where necessary. When they do seek health care, the disease may be in an advanced stage.

  Health outcomes

  Health outcomes are the result of a combination of various inputs besides health services. These include education, food and nutrition, water supply and

sanitation, housing, exercise, life styles, occupation and income. The ideal measure of equity in health is health outcome, though it is difficult to measure the contribution of health services to health outcome.

Individuals fall ill differently based on their socio economic status and the level of development of the community. Individuals even with similar health problems fare differently depending on their social status and income. The poor are less likely to acknowledge that they are sick; when sickness is finally acknowledged (so sick that they cannot work), the poor are less likely to use the available services. Even if the services themselves are free, seeking care and getting it involve other costs, eg., transportation and time lost from work for self and persons accompanying. There are also hidden costs, such as gratifying the health professionals and workers.

There is inequitable distribution of public resources for health. The chief agents act to maximise individual utility rather than social welfare. Politicians seek to maximise capture of publicly financed services. They and the officials stand to gain from projects for large hospitals. These are highly visible and popular, often seen as evidence of government commitment to medical care.

Health professionals and their associations may be a major source of resistance to change, which is likely to benefit the poor. When smaller peripheral facilities are established, the doctors, nurses and others will be redeployed there and they often resent it. Specialists clamour for costly, sophisticated equipment and other facilities, which will not be available in the smaller health centres. They become frustrated and do not wish to work in such centres.

Equity requires a re-distribution of the allocations. It also requires information being made available to all people on the degree and distribution of the health facilities. If equality in health outcome, utilization of health facilities and access to them are to be ensured, we need higher public spending on the poor per person than on the rich.

Equity calls for greater public spending on healthcare. The poor depend on the public sector. The Alma Ata Declaration (1978) had called for increased government spending on health. India is a signatory to it. But under the influence of World Bank and International Monitory Fund (Structural Adjustment Programmes), India was forced to reduce allocations to the Public Sector (so as to repay the debt) and to privatize the services. Cost recovery schemes often placed the health services out of reach of the poor families. This tendency is likely to increase and we may find increases in child mortality and diseases like tuberculosis.

5. ESCALATING EXPENSES

The cost of medical / health care is increasing all the time. Health care services are being driven beyond the capacity of a large percentage of the population. The poor become poorer because of the medical bills.

The Cost of Drugs

The cost of drugs has been going up relentlessly. Price Control Orders are cutting down the number of drugs (bulk and formulations) under price control, giving free hand to the manufacturers to increase their profits.

The operation of the Drugs Prices Control Order by the National Pharmaceutical Pricing Authority is being sabotaged through a large number of litigations. The Government is considering the establishment of an Apellate Tribunal to hear all such cases. The proposed centralised, autonomous tribunal would arbitrate on all pricing – related issues. All cases on drug pricing in the various High Courts would be transferred to the tribunal. Appeals from the decision of the tribunal will be with the Supreme Court (The Economic Times, 21.7.2002).

The Patent Act

With India signing the GATT agreement and the World Trade Organisation pronouncing judgments in favour of the large multinationals, market economy has taken over. This affects the poor especially.

> "Market economy cannot solve the problem of poverty in the world"
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> - Butros Butros Gali, Secretary General, United Nations, 1995.

Market economy aggravates poverty and poverty affects health. Economic liberalization and free market economy have increased the prices of drugs and the equipments, affecting the cost of medical and health care.

Trade Related Intellectual Property Rights (TRIPS) brought product patents. This will be fully effective in India in less than three year's time. It allows product patent exclusive rights for 20 years from the date of filing the patent application. The Indian Patent Act, 1970 recognized only process patent. India could produce the essential drugs within 4 or 5 years of a product becoming available elsewhere, at a cost which was only a fraction of the cost in the affluent countries. Now it will take 20 years, by which time there will be newer and more effective drugs for the same disease and the cycle will be repeated. The cost of the patented drug will be kept enormously high as was seen in the case of anti-retroviral drugs against Human Immunodeficiency Virus causing AIDS. The patented drugs, produced by the transnational drug companies in USA, UK, etc., cost more than 10 times the cost of the same drugs produced by companies in India.

6. COMMERCIALISATION OF HEALTH CARE

Health care is changing from a humane service to a commercial enterprise. It affects all aspects of health care.

Health Professionals

Unnecessary procedures are being carried out increasingly, the motive being to make more money. An earlier example of such unnecessary procedures was 'transillectomy'. Later, 'appendicectomy' became popular. Still later, it became 'caesarian section'. While there are many genuine indications for caesarian section, far more caesarian sections are done than necessary. In some hospitals, the rate of caesarian section has become even 40% of all deliviries. The number of 'hysterectomies' has shown a quantum jump.

Far too many diagnostic tests (especially the costly, sophisticated ones) are being done, though not warranted by the need. These are sometimes 'justified' by saying that the Consumer Protection Act has made it necessary to avoid claims for damages. The doctors want to 'protect' themselves. They practice what is called 'defensive medicine'.

There is irrational prescribing of costly drugs because of kickbacks. Pharmaceutical firms give gifts and perks for prescribing them. These may include costly household goods or fully paid holidays in exotic regions.

Unnecessary referrals are made. When a patient is referred, the referring doctor may get a cut. The Medical Council of India is against such 'cut practices' but the practice goes on merrily.

Organ transplantation (the live, unrelated, kidney 'donation' and transplant) has become a big racket, with the spoils being shared between the doctor, the hospital and the agent; the poor 'donor' also gets a share. The World Medical Association, 2000, states : "Payment for organs and tissues for transplantation should be prohibited. A financial incentive compromises the voluntariness of the choice and the altruistic basis for organ and tissue donation …. Organs suspected to have been obtained through commercial transactions should not be accepted for transplantation". The doctors involved almost always know that the so-called 'donation' has been made for financial considerations, exploiting the poor but, prefer to close their eyes and shut their ears for financial gain. Another racket

which has been making headlines recently because of the Supreme Court decisions is 'sex determination and selective termination of pregnancy", if it is a female foetus. A lot of noise has been made but the effect is nil. "The dogs bark but the caravan moves on".

Pharmaceutical industries

There is unethical promotion of drugs, violating the WHO guidelines. Unwanted, unnecessary and 'me-too' drugs are produced and marketed using questionable procedures. Substandard drugs are marketed, whether the firms are the large multinationals or the small manufacturers. Brand drugs (high cost) are promoted when equally potent and much less costly generic drugs will do. Immunization procedures are promoted even when they are not necessary effective or affordable.

Equipments

Unnecessary and costly equipments of doubtful value are purchased (commissions?). Unnecessary tests are prescribed and carried out so as to recover the cost and make a profit. In the public sector, they often lie idle because there is no one to operate them or the needed repairs cannot (will not) be carried out.

Education of health professionals

Colleges for the education of health professionals (doctors, nurses, pharmacists, etc.) have sprung up in the private sector, exploiting the demand for 'qualified' persons. Recently, there was an advertisement in 'Deccan Herald, Bangalore', calling for the sale of a medical college. These colleges are substandard, without the necessary infrastructure. They do not have the required teaching staff, 'borrowing' the staff from neighboring colleges at the time of inspection by the councils. Substandard students get admitted paying enormous fees. Very often such students 'pass' the examinations, resorting to 'payments' to the examiners. Some examiners take advantage of the situation and demand 'payment' from all students : good students 'not to fail' and bad students 'to pass'. The demand for degrees, especially in nursing, is mainly for 'export'.

Hospitals

The Corporate Sector hospitals invest heavily in the 'health care industry'. These 'five star' hospitals invest in the latest (often unproved)high cost technology. They want quick returns and advertise the availability of these equipments. All methods are adopted to get enough 'clients'.

Diagnostic Centres

More and more high technology diagnostic centres are coming up in the cities and larger towns. To make profits on the investments, these centres need large loads of work. To attract more requests for the costly tests, 'incentives' are given to doctors who ask for them.

7. DETERIORATING DOCTOR–PATIENT RELATIONSHIPS

One of the cardinal requirements of health care is good patient-doctor relationship. The patient requests for help, placing trust in the doctor. The doctor has to respond both as a **healer** and as **professional**,

- being courteous, compassionate and committed to the patient; and
- using the medical knowledge, skills and attitude to the best of his/her ability and in the best interests of the patient.

***Sushruta Samhita* says:**

"The patient may doubt his relatives, his sons and even his parents, but he has full faith in the physician. He gives himself up in the doctor's hand and has no misgivings about him. Therefore, it is the physician's duty to look after him as his own son".

The relationship is one of trust.

There has been an erosion of trust and commitment. This is likely to continue and even increase. One of the requirements for good patient-doctor relationship is to inform as skillfully and accurately as possible about the patient's condition, the alternatives available, their benefits and risks and the best possible approach. The patient then gives the **informed consent** to the proposed procedure. The **autonomy** of the patient is respected.

With the advent of more and more sophisticated technology, there is the tendency to place greater reliance on the results of the tests and less on the perceptions of the patient. There is less communication between the doctor and the patient. There is deterioration in their relationships. The relationships become impersonal.

What should be the ideal doctor-patient relationship? There is the possibility of conflict between 'patient's autonomy' and doctor's view of what is 'best for the health of the patient'. There can be conflict between the 'values' held by the patient and those of the doctor. The doctor must appreciate the values of the patient, provide factual information, help the patient to make up his / her decision and implement the informed choice.

It is not enough to have good patient-doctor relationships. The doctor must cultivate good relationships with the members of the family of the patient and the community, while preserving confidentiality.

8. FORGETTING MEDICAL ETHICS

Doctors are bound to observe the principles of **medical ethics** in their practice. The cardinal principles of Medical Ethics are

- Beneficence (doing good);
- Non-maleficence (doing no harm)
- Justice (social / distributive);

- Autonomy (as opposed to paternalism).

Codes of Conduct

There have been many codes of conduct from ancient times. In India, these included *atreya anushasana, Charaka Samhita and Sushruta Samhita*. The Oath of Hippocrates (Greek) is followed by practitioners of Western Medicine. Doctors in India take this oath (in a modified form) at the time of graduation and admission to the medical profession. There is an International Code of Medical Ethics (1983).

The Medical Council of India had formulated a Code of Ethics to be followed by the practitioners of Medicine in India. This has now been revised and issued as the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. They deal with

- duties and responsibilities of the physician in general;
- duties of physicians to their patients;
- duties of physician in consultation;
- responsibilities of physicians to each other; and
- duties of physicians to the public and to the paramedical professions.

It gives also what are unethical acts, misconduct and punishment and disciplinary action.

Medical profession used to be considered a noble profession. But today, the profession is losing some of the respect and regards that it had enjoyed earlier. There are serious criticisms of the medical profession : its lack of accountability, its structure and organisation, its undue dependence on newer and unnecessary technology and its failure to address important issues in health. There are numerous litigations of malpractice, negligence and incompetence. Medicine in India is regarded as

- being overly protective of its rights, status and income;
- being guilty of ignoring the wider social problems; and
- failing to regulate itself effectively.

It is necessary to take immediate corrective action individually and collectively to stop the downward slide for the benefit of all.

The Future

The trend today is for more privatization and commercialization and for increase in the cost of health care. This trend will continue unabated unless active steps are taken to reverse it. There are positive signs that a change may take place. There are growing groups of people aware of the situation; they are protesting against commercialization locally, nationally and globally. There are national and international movements asking for low-cost medical care and generic medicine. There is some disenchantment with the costly, sophisticated investigation and demand for more humane medical care with better doctor-patient relationship. The Rajiv Gandhi University of Health Sciences, Karnataka has made the teaching and learning of **Medical Ethics** as an integral part of its curriculum for the medical students. Other Universities may follow suit. We can then expect Medical Practice to be more ethical, more people oriented and less commercial. There is rethinking about the role of the World Trade Organisation, which can change 'liberalisation' (meaning market economy favoring the rich nations). All these changes will need the **Political Will**. That political will come about if there is a movement of all concerned people.