When corruption becomes the norm and ethical conduct an exception

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Introduction

India's health sector is facing a credibility crisis contributing to the growing trust deficit in the competence and integrity of our caregivers. This shift from trust to distrust within the span of two decades needs to be understood within the broader context of a rapidly changing macroeconomic environment and the shifts in values and perceptions governing social relations.

Neoliberalism, an economic term associated with Ronald Reagan and Margaret Thatcher, is used to signify the reduction in state spending and the creation of a *laissez faire* environment for promoting privatisation. Such an ideological shift that saw its beginnings in the mid-1980s became more pronounced in the health sector during the 1990s with India reducing its public spending on health (1) and extending financial and non-financial incentives to promote the privatisation of medical practice without putting in place a regulatory framework to contain and control the scope of perverse market behaviour.

Prior to the 1990s, India's health sector had a vastly spread out private sector. However, this was fragmented and consisted of small-sized hospitals and nursing homes where most doctors took fee for service but valued patient care and never really envisioned medical care as a means of multiplying money power. The launching of the Apollo hospital in 1983 in Chennai (2) in the mid-1980s introduced the corporatisation and financialisation of the medical sector that separated investment from the rendering of services. Part of the reason for this development was the advancements in medical technology that required institutionalisation of treatment and care, besides large investments. While corporate hospitals raised substantial resources from capital markets, brought in modern technology, better diagnostic capabilities, and improved quality of care saving many lives in the process, they also made healthcare into an industrial enterprise entailing changes in the way medical care is organised. While the autonomy of the doctor got reduced, that of the investor became centre stage. The focus too shifted towards declaring dividends to shareholders and from patient care to generating profits. But unlike other sectors, technology and the investment for supporting infrastructure resulted in increasing the price of medical services, while competition entailed a "race to the bottom" with the "kickback" culture taking roots. The rampant spread of this practice by doctors of kickbacks and cut-practice from pharmacy shops, diagnostic centres and hospitals in return for unnecessary referrals was recently elaborated in an article by Dr David Berger (3), attracting much media attention. The increasing trend towards prescribing a battery of tests, irrational medication, or unnecessary procedures and surgeries that have been well documented in the literature, are all facets of this process of commodification of healthcare.

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The case of medical education

In this changing scenario, the commercialisation of medical education was only a matter of time. Widening disparities between supply and demand for doctors created conditions of scarcity making education a profitable enterprise. With government withdrawing investment, control shifted into the hands of the private sector, as can be seen from the fact that 85% of the 106 medical colleges established during the period 1995–2005 were privately owned. As of today, of the 333 medical colleges, over 65% are private (4).

Given the weak regulatory environment, medical education is today a lucrative investment opportunity where risk is negligible and the return on capital very high. What is, however, significant, is the institutionalisation of the process of politicising this sector, with the 1993 amendment (5) to the MCI Act of 1956, under which section 10 (A) was introduced that made opening of any medical colleges, introduction of new courses, or expansion in the intake of students incumbent upon the explicit approval of the central government. This amendment centralised policy-making in the hands of the political executive using discretionary power. Often, colleges were sanctioned and established on grounds of political expediency. Accordingly today, several medical colleges function without the requisite faculty, or have hospitals without patients, or are fake to a large extent, yet are allowed to continue. The recent revelations in the media of the Vyapam scam where entrance examinations were written by others or undeserving candidates got admission on fake degrees signifies the extent of the rot (6). If running fake colleges is one aspect, the official policy of allowing half the medical seats to be auctioned to the highest bidder is yet another aspect of legalising fraud, in the process effectively undermining the system and making the health system unsustainable (7).That the system of governance does not necessarily comprehend these developments and policies as contradictory to ethics; or is unaware of the larger consequences it may have for the health system, signifies the large-scale failure of the system.

With resorting to courts of law as the only option (available for a few) and the absence of any institutional mechanisms that positively encourage complaints or feedback on adherence to norms or any systems that would ensure quality such as, for example, an All India National Exit Examination for obtaining the licence to practice or go abroad, there is no incentive for colleges to provide education as per standards laid down.

The Medical Council of India

To check the abuse of patients for commercial considerations, a strong regulatory environment was seen as a prerequisite to containing the impact of market failures. For the purpose of regulating physician practice along ethical norms and ensuring the quality of medical education, the Medical Council of India (MCI) was constituted in 1933 by an Act that was amended in 1956, as a self-governed elected entity functioning as a watchdog body against unethical practices and safeguarding the social trust and professional interests through peer pressure.

With the politicisation of professional education, the stature of the MCI gradually degenerated into being perceived as a corrupt and unreliable entity with serious conflicts of interest. With an estimated requirement of Rs 300 crore for establishing a medical college, only persons with financial muscle could establish them. With no prequalifying criteria laid down by the government regarding investors or management, moneyed persons have invested in medical education as a business proposition, not necessarily for creating doctors to treat the sick.

It was a matter of time before the nexus between politicians, investors and the MCI developed. MCI is the only regulator, as compared to other sectors such as the telecom, banking and financial sectors or power, to have been suspended twice in the course of less than a decade – the first time by the Supreme Court, and the second in 2010 by the government by way of an ordinance, and to have faced the ignominy of having its president jailed (8) for corrupt practices. Between the political system and business interests there is today a vicious cycle of corruption that is difficult to untangle, even while anecdotal evidence, as reported in the media from time to time, estimates that the illegal market could be in the order of Rs 25,000 crore per year.

Impact on the health sector

The impact of commercialising a service sector like health had an adverse impact on increasing corruption and unethical practices. In 2013, Transparency International declared that according to a survey in 17 countries (9), the health sector was perceived by 70% of the households interviewed to be the most corrupt. It was estimated that of the $7 trillion global health spending, corruption in government procurement accounted for about 10% to 25%; and about 3.29% to 10%, with an average of 5.6%, was lost to fraud. Nearer home, in early 2000, in the erstwhile Andhra Pradesh, an internal survey was undertaken by the government (unpublished) that showed that after police and revenue, the most corrupt was the health department. It is undoubtedly a profitable sector registering a cumulative annual growth rate (CAGR) of 10.3% during 2007–2010 when the global economy was reportedly facing a recession; and set to have a CAGR of 15% during 2012–2017 (10).

Corruption in the health sector takes the form of bribes in cash or kind - to physicians by pharmaceutical companies to prescribe banned or expensive drugs; in the public sector for manipulating the tender system so as to buy cheap drugs from the lowest bidder, and not check the quality or expiry dates, for allowing counterfeit and falsified drug markets to flourish; or in the realm of human resource management for appointments, promotions, transfers and siphoning off money as seen in Uttar Pradesh, where the scam in the National Rural Health Mission resulted in an inquiry by the Central Bureau of Investigation(CBI), the murders of five persons, and the imprisonment of the health secretary, the resignation of the health minister, etc (11).

Market failures in the health sector

Unlike other sectors, the health sector has inherent market failures and scope for conflicts of interest. First, there are barriers to entry as only those with certain qualifications can practise and administer medicine. Such authority is self-certified – bestowed by a body of doctors, chosen by themselves, that then create a situation where self-interest determines supply – what to teach, who to teach and for how long. The banning of the perfectly relevant Licentiates of Medical Practice on the recommendation of the Bhore Committee, or the refusal to allow nurse practitioners, or delegating some functions to other co-workers and disciplines are essentially motivated by such considerations resulting in keeping the numbers of entrants small, and prequalifying criteria opaque and mystifying in the name of science and patient safety.

The second is the psychological behaviour that surrounds this sector. No matter how educated and knowledgeable, when sick, the person becomes acutely vulnerable, willingly surrenders his judgement, and implicitly trusts the treating physician. The power play between these two individuals – the patient and the doctor – is assymetrical and it is in such a moment of trust that the doctor is faced with the ethical dilemma. He is undoubtedly in a better position to judge the real situation of the patient who, at times may need some counselling and encouragement, at times some simple diagnostic tests, and at other times a thorough examination. It is then that the temptation overtakes discretion —ordering unnecessary tests that may not necessarily harm the patient, or resorting to irrational drug prescriptions —a patented or a branded drug when a generic would do as well—or admitting the patient for inpatient treatment when an outpatient consultation would have been adequate. An even more worrying trend is the increasing loss of doctors' autonomy to take decisions on matters related to patient care, which

is being taken over by insurance companies and hospital managers. Further, though not documented, it is reliably learnt that doctors working in private (particularly corporate) hospitals are required to order a targeted number of tests or surgeries, irrespective of need, with their employment often dependent upon the achievement of targets.

Role of the state

With the imprisonment of the president of the MCI, the Ministry of Health, Government of India, in 2010 initiated three strategies[1]: (i) It took the unprecedented step of setting aside the elected body of the MCI with a nominated body of governors by way of an ordinance. (ii) It submitted a draft law to curtail the powers of the elected body of MCI only to registration of doctors and regulating physician practice.(iii)It introduced the requirement of a nation-wide entrance exam (NEET) for students desirous of pursuing a career in medicine.

The fact that the government was unsuccessful in implementing any of these measures is a reflection of how deep are the conflicts of interest. The ordinance was issued and a Board of Governors consisting of six experts was established. This board took several initiatives to bring in transparency and probity in the process of approval of colleges, seats or courses; sought to radically redraft the curricula for MBBS and MD, under which a student would need to study the social sciences and gain a broader understanding of the importance of values in medical practice and social dynamics that influence patient behaviour and bring in ethical standards in practice; developed the proposal for the national entrance examination, etc. Unfortunately, since the flexing of muscles by this body as a regulator was politically inconvenient, the Board of Governors was changed twice over the next two years with some members having controversial reputations or conflicts of interest and subsequently going back to the status quo with an elected body in 2013(12).

Likewise, the government failed to process the proposal to establish a National Commission for Human Resources for Health (NCHRH). The NCHRH was envisioned as an overarching body with nominated members to look after physician practice, accreditation, and academic matters related to curricula of medical doctors, nurses and paramedical personnel. The idea was to ensure complementarity, modernisation and adherence to standards. In October 2012, the Parliamentary Standing Committee returned the draft NCHRH bill to the Ministry of Health to reexamine three major concerns: (i) the states' autonomy and potential violation of federal principles (13); (ii) excessive bureaucratisation and centralisation; and (iii) faulty selection procedure of regulators, providing scope for abuse. Rather than seizing the opportunity to come up with a better draft, the ministry, for the third time, reconstituted the Board of Governors with a retired Director General of Health Sciences as chair and kept the main proposal in cold storage (14).

The NEET examination was an equally sad story. As students are subjected to multiple examinations for an admission into a medical college entailing stress and expense, and also because it was found that the standards of basic education were of varied quality, it was felt that one national entrance examination for qualifying for admission into a medical college would be in the interests of the meritorious and deserving. The proposal provided for a merit list out of which the students were to be selected based on merit and in adherence to the various quotas.

The NEET was to be followed by another national examination at the end of training to qualify for being registered by the MCI. By these two measures, it was envisioned to standardise the quality of the Indian doctor – ie certify to the people that the doctor licensed by the MCI had basic capabilities, skills and competencies needed for a doctor, irrespective of which college he or she was trained in. This was an attempt to smoothen the huge disparities in educational standards in different medical colleges of the country and give the Indian doctor a brand value.

The MCI orders on conducting NEET were challenged by 90 medical colleges in the Supreme Court. A three-judge bench, with one judge dissenting(15), declared by a strange logic that the MCI had no authority to impose this test and more so in the case of minority colleges, as it amounted to interfering with the rights accorded by the Constitution. Even though this proposal benefited students, promoted standards and ensured better patient care and enhanced social benefit, yet it could not be implemented as in effect it would curtail the freedom of private managements to cherry pick their students based on their ability to pay.

Crass commercialisation of medical education apart, what is of equal concern is unethical practice. This is related to the process of becoming a doctor. After paying Rs one crore for a seat, the graduating doctor has to earn it back not by ethical practice but by resorting to dubious means of kickbacks and cut-practice, made easier due to lax oversight over such deviant behaviour.

An overall decline in values has also affected the public health system. The policy of permitting government doctors the right to private practice is one that has vitiated and undermined the delivery system in the public sector. The logic of this policy is that since the government is unable to provide market determined salaries, doctors should be allowed to practise privately during their off hours to increase their earnings. It should be noted that no other government employee or professional enjoys such consideration. Yet, the doctors have abused this trust: absenteeism is high, with facilities having no doctors when needed, treatment in the public facilities is abrupt and unkind so as to push the patient to avail of good treatment to their private clinics; equipment and drugs to be supplied to the poor free of cost are diverted to their clinics, while in hospitals, expensive equipment is deliberately spoilt so as to force the patients to go to their preferred diagnostic centres for tests and so on; making the creeping privatisation of the public system inevitable. In order to permit such deviant behaviour, bribes are paid to the supervising officers and

an array of politicians, making transfers, appointments and promotions that are routine administrative matters, the most political action due to the huge possibilities for rent-seeking. So no matter what the government does, provides and aspires for, the public health system continues to be in a crisis, with the poor who rely on it continuing to incur huge expenses in seeking private care.

What next?

Policy-making is politics and an arena of huge conflicts of interest. For example, Members of Parliament or their associates running medical and nursing colleges or private nursing homes create a conflict of interest in discussing reform of the professional education in health or any policy measures that could hurt the commercial interests of their constituency, such as supporting the creation of a community doctor. And when there is rent-seeking behaviour by the ruling powers then it is ensured that no laws are either enacted or enforced. In several government committees, eg those on food safety or regulation of medical devices, under the guise of partnership with stakeholders, lobbyists and those to be regulated are made members, leading to the charge of regulatory capture. Such people then do not allow laws to be stringent.

What is needed today is to bring ethical values back to centre-stage by raising peoples' awareness and encouraging greater transparency and public disclosure. What is required is a public policy that strongly incentivises ethical behaviour and reward those several doctors, nurses and officials who have not allowed themselves to be lured by money and find satisfaction in rendering service. What is needed is for the government to enact a strong public health law and regulations that would bring in greater accountability and curtail malpractice.

Of equal importance is the need to reform and revamp the MCI on the lines of the British General Medical Council (GMC), which not only ensures academic standards but also enforces physician behaviour along ethical norms. Most urgently, the elected body must be replaced with a nominated one. The Board of Governors of the BMC are selected by a public authority, like the Union Public Service Commission, from out of applications received. The Body is also much more diverse containing representatives of the lay public, patient groups, medical college student representatives, doctors, etc. The BMC also enjoys functional autonomy while all its proceedings are placed in the public domain. Unlike India, college inspections are not a one-time event but held throughout the year to ensure that the quality of education being provided is consistently maintained. Government control is confined to the appointment of the Board and intimating the Council the number of doctors and specialists, discipline-wise, that are required to be produced.

Conclusion

There is an urgent need to reform the health sector; yet, the system is unable to undertake the process. While the struggle for probity and high ethical standards has to be led by the medical profession, there is an equal need for the political system to respond to the issues mentioned above and so eloquently described by MacAskill et al in their article (7) that talks of rampant fraud in medical schools. For the future sustainability of the health system in India, there is an urgent need to initiate the process of reform and restructuring in such a manner that distortions are minimised and health outcomes realised.

Note *[1] This was during the author's tenure as Union Health Secretary*.

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