

FactSheet

Collusive Behaviour in Healthcare and Impact on Consumers *Evidence from Assam*

This FactSheet produced under the COHED project highlights findings of the research and investigation undertaken in three towns in the state of Assam (India), to gather evidence about collusive behaviour among healthcare providers. It was revealed from the analysis that certain practices existed in both public and private healthcare that reduced the availability of medicine and healthcare services for a large number of citizen consumers. Prevalence of such practices in public healthcare has huge implications especially for the poor. This document urges the state government and other relevant authorities to investigate the origin of such practices and take immediate remedial actions.

Background

The right to health is recognised in a number of international legal instruments and enshrined through constitutional commitments in India (Article 21, Indian Constitution). According to recent government estimates, India's overall performance in terms of life expectancy, child survival and maternal mortality has improved steadily over the recent years.¹ However, there are wide divergences in achievements across the country *vis-à-vis* health indicators. If, as a country, India is to achieve improvements *vis-à-vis* universal health coverage² and come close to achieving the 2015 healthcare-related targets of the Millennium Development Goals (MDGs), there is an urgent need to highlight policy areas that would require refinements and immediate (and effective) implementation.

Healthcare services in the country are characterised by a profound contrast in performance between the private and the public sectors. While the upsurge in private participation in this sector would continue to meet the demand of the increasing populace, the government needs to assess and adjust its role in this emerging environment. Through the initiation of the National Rural Health Mission (NRHM) in 2005, a number of states have made progress with provision of quality healthcare services to its citizens.

However, a number of challenges remain in the sector, especially since a large number of Indians still remain outside the reach of healthcare services (WHO, 2008).³ Over the process of implementing its 'Support for India's Health Sector Programme', the World Bank has observed, based on the National Sample Survey (60th round) in 2004, that 63 million individuals, or 12 million households, fell into poverty due to health expenditure. The majority of these households (79 percent) became impoverished due to spending on outpatient care, including drugs, and the remainder (21 percent) fell into poverty due to hospital care.

The *Annual Report to the People on Health*, Ministry of Health and Family Welfare (MoHFW September 2010) reveals that the health indicators of the country have lagged behind the impressive economic progress over the past two decades. It reiterates the need to adopt a national public health policy urgently, for reconfiguring the health system in the country – making it more efficient and equitable. One of the recommendations in this report is to raise public finance on healthcare to three percent of the gross domestic product (GDP).

The other extremely important point touches access to medicines. Private (out-of-pocket) expenditure in healthcare constitutes 80 percent of the total healthcare expenses in India. Expenses

made for buying medicines comprise 72 percent of the total out-of-pocket expenses on healthcare in India.⁴

The MoHFW issued an order nearly a year ago (Order SS-11025/45/10-MH-1, May 26, 2010) that government hospitals should prescribe only good quality generic medicines to the patients. However, it is evident that such practices have not been picked up by most state governments, yet.

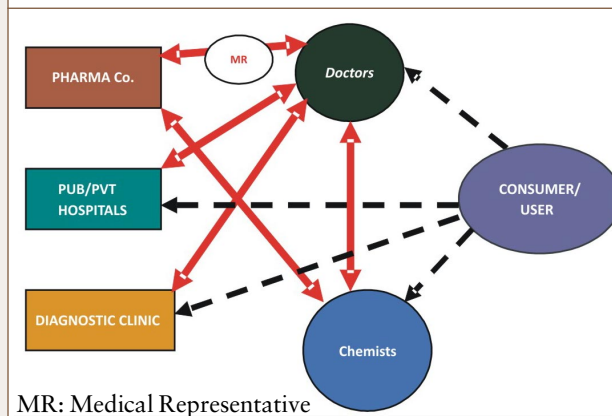
Despite policy recommendations for greater coordination between the Department of Pharmaceuticals (Ministry of Chemical and Fertilisers) and the MoHFW, there seems to be a lack of coherence in the process of policy formulation and adoption – which ultimately affects the efficacy of healthcare services. Lack of appropriate regulatory oversight of the healthcare sector remains a huge challenge, especially given the role that private providers play in the healthcare delivery in the country. Whether the concern is over cost, quality and availability of healthcare infrastructure/facilities/services or the nexus between various players in the healthcare value chain, consumers continue to remain at the mercy of providers and have little say or choice while seeking healthcare services in the country.

CUTS Project (COHED)

Various imperfections in the market for healthcare services remain due to the combination of a number of factors, including huge information asymmetry between consumers and providers, lack of coherence in policy formulation and implementation between the Centre and State, absence of proper regulatory oversight, etc. These imperfections have led to proliferation of market malpractices, which give huge commercial benefits to providers, to the detriment of the consumers.

It is, therefore, logical to assume that curbing such market malpractices would be beneficial for consumers, not only in terms of monetary benefits (reduced costs of healthcare services) but also in enabling greater access to quality healthcare services.

Figure 1: A Simple Representation of Providers in the Healthcare Services Sector



As a consumer organisation working for protecting the interest of consumers, CUTS is interested in understanding the nature and degree of such malpractices and explore measures (legal, policy, ground actions, etc.) that would help curb them. Market players in the healthcare sector are related to one another through a complex net, as presented in Figure 1. It is clear that the *doctor* represents one of most important providers of healthcare services for consumers in India. Interactions of the consumers with other players in the healthcare services sector (government hospitals, private hospitals, diagnostic clinics and chemists) are often facilitated by/through the doctor.

In June 2010, CUTS embarked on a project (*Collusive Behaviour in Health Delivery in India: Need for Effective Regulation*, referred to as the COHED Project, www.cuts-ccier.org/COHED) to study some of these inter-relations (arrangements) between providers in the healthcare value chain in two states of the country – Assam and Chhattisgarh. The project was implemented in cooperation with a local partner in each of the states (the ant or Action North East Trust was the partner in *Assam*) to meet the following objectives:

- perform advocacy among relevant organisations to garner support for research aimed at identification of medical malpractices in the health sector;
- identify possible market malpractices in the health sector;

- assess the scope and effectiveness of the present regulatory system, especially the competition law, to deal with the above concerns;
- make recommendations for better regulatory outcomes, given the above concerns; and
- spread awareness to prepare ground for implementing these recommendations.

A possible reason behind the proliferation of malpractices in the healthcare sector is their predominance at the micro-level and the gross absence of effective regulatory institutions to deal with them at that level. This is coupled with the lack of general awareness about existing legal and regulatory instruments that could be used to deal with such malpractices. Healthcare services were brought under the ambit of the Consumer Protection Act in 1995, when the landmark judgment was delivered by the Supreme Court in the *Indian Medical Association vs VP Shantha Nair* case.^{5, 6}

However, this has not reduced the occurrence of malpractices in the healthcare sector. Regulatory actions against malpractices can be more effective in an environment where citizen consumers are well-informed of regulatory powers and can inform regulatory authorities of such malpractices. Gross absence of such a trend in the healthcare sector motivated CUTS to embark on the COHED project.

In 2002, India adopted a new Competition Act, replacing the erstwhile Monopolies and Restrictive Trade Practices Act of 1969. The Competition Act 2002 (amended in 2007) of India prohibits ‘...enterprises or associations of enterprises (or persons or association of persons) from entering into any agreement in respect of production, supply, distribution, storage...which has an appreciable adverse effect on competition’. Agreements having such adverse effects on competition are those which result in determining purchase or sale prices; limiting or controlling production/supply/marketing/development/provision of services; geographical allocation of markets; and collusive bidding.⁷

The Competition Commission of India (CCI) has been operational since the last couple of years and has initiated investigations on various cases that are alleged to be violating the provisions of the Competition Act.

CUTS is of the view that evidence gathered from the field about collusive practices among healthcare providers in the country and its impact on the price and availability of healthcare goods (medicines) and services would enable the CCI to initiate investigations. Such evidence would also form the basis for consumer advocacy to build pressure over state governments/regulators to initiate actions.

Table 1: Select Health Indicators from Assam and Chhattisgarh

Health Indicators	Assam	Chhattisgarh	India
Total Fertility Rate, TFR	2.4	2.6	2.5
Infant Mortality Rate, IMR (per 1,000 live births)	64	57	53
Maternal Mortality Rate, MMR (per 100,000 live births)	480	335	450

Source: Data gathered from NFHS-3, World Bank, Office of the Registrar

The Indian Constitution has made healthcare services largely a responsibility of state governments and, thus, it primarily becomes the responsibility of the state to provide healthcare to all people in equal measure. Since health is influenced by a number of factors, such as adequate food, housing, basic sanitation, healthy lifestyles, protection against environmental hazards and communicable diseases, the term “healthcare” embraces a multitude of services provided to individuals or communities by agents of the health services or profession for the purpose of promoting, maintaining, monitoring or restoring health.

Health Sector in Assam

Poor literacy rate, low per capita income which is mainly due to the high density of population, wide urban-rural disparity, improper water and sanitation facilities, etc., are seen to have contributed towards the under developed health sector in the state.⁸ In order to address challenges facing the state *vis-à-vis* healthcare issues, certain reform measures have been adopted by the state as enumerated below:

- **Assam Public Health Act 2010:** Assam is a pioneer state in the country to enact Assam Public Health Act 2010, which seeks to guarantee people's right to appropriate and efficacious healthcare – especially towards effective measures for prevention, treatment and control of epidemic and endemic diseases.
- **Drug Procurement Policy:** Assam has drafted *Procurement Guideline*, in line with World Bank guideline, for procurement and logistic management of drugs and equipments. Under the guidelines, drugs are procured by their generic name.
- **Essential Drug List:** In 2007, the government (under the aegis of the NRHM) developed the *State List of Essential Medicines* and formulary based on common ailments.

The current status of the healthcare infrastructure in the state is summarised in Table 2:⁹

Table 2: Healthcare Institutions in Assam

Health Institutions	Number
Medical Colleges	4
State-level Hospitals	1
District Hospitals	21
Sub-divisional Hospitals	13
Community Health Centres	108
Public Health Centres	844
Sub-centres	4592
B.Sc. Nursing Colleges	1
GNM Training Centres	15
ANM Training Centres	18

Source: National Rural Health Mission, Department of Health and Family Welfare, Government of Assam, at www.nrhmassam.in

Results and Discussion

A multiple-stage survey and analysis methodology was developed by CUTS, along with its partner (the ant), and the same was employed for arriving at the following results.

I. Survey of Consumers (visiting Public healthcare Institutions)

In the first stage survey, the information was gathered from consumers on the basis of a questionnaire from three towns in each of the two states. In Assam, the information was gathered from 301 consumers from Guwahati, Bongaigaon and Nagaon. The results are enumerated below.

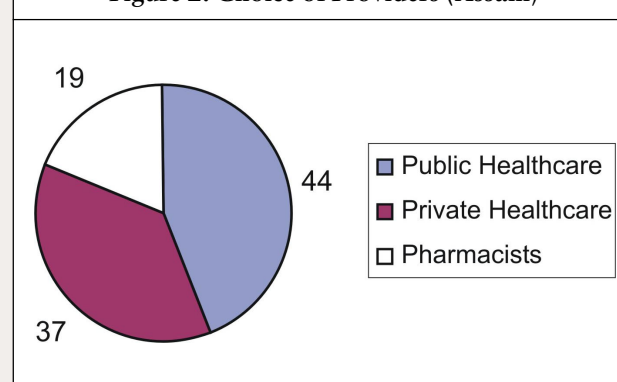
- **Financial Burden of Healthcare:** It was clear that households belonging to the low-income class in the sample spent a much larger share (20.56 percent) of their monthly income on healthcare, as compared to people from the other economic classes. In monetary terms, it was ₹902 for the respondents.

Table 3: Financial Burden of Healthcare for Different Consumer Classes (Assam)

Income Classes	Average Monthly Health Expense (₹)	Percentage of Total Monthly Income (in percent)
Low	902	2.56
Middle	1687	8.95
High	2055	4.43

- **Choice of Provider:** 44 percent of the respondents visited public hospitals for treatment, while 37 percent of them preferred private healthcare. Nearly a fifth (19 percent) of the surveyed population preferred visiting

Figure 2: Choice of Providers (Assam)



Source of Treatment	Respondents (in percent)
Public Healthcare	44
Private Healthcare	37
Pharmacists	19
Others	0

the pharmacist to get a drug for remedy (over the counter).

- **Choice of Healthcare Provider vs Income Classes:** When the above data is disaggregated across income-classes, then an interesting trend is observed. While mostly the low-income households covered by the survey visited public healthcare facilities, there were also a significant number of them who visited private providers.

Source of healthcare	Percentage of Low-Income	Consumers across - Middle Income	Income Classes ¹⁰ High-Income
Public healthcare	51	27	36
Private healthcare	30	53	64
Pharmacists	19	2	0
Others	0	0	0

- **Factors Determining Choice of Healthcare:** Proximity to a healthcare facility seems to be the deciding factors for the surveyed households, when it comes to choosing a particular healthcare provider (public hospital, private hospital/clinic, others. etc.).

Sl No	Factors (for choosing a healthcare provider)	Percentage (in percent)
1	Good/Known Doctor	4
2	Nearness/Proximity	68
3	Free Consultation	3
4	Cheap Treatment	25

- **Availability of Medicines in Public Hospitals:** Out of the patients visiting public hospitals for treatment that were interviewed, only 20 percent indicated having obtained medicines from the public hospital in Assam. This is a cause for great concern and needed a much closer look, especially to assess the reason behind most patients buying medicines prescribed by doctors in public hospitals from outside. This is especially critical, given that a large number of low and low-middle income patients visit public hospitals for treatment of critical/serious illnesses.

- **Referrals for Diagnostic Tests:** Frequency of 'referrals' for diagnostic tests was very high, as it was encountered by 90 percent respondents. High-income households were seen to be subjected to more referrals than the others. On more than half of these occasions, a particular diagnostic laboratory was suggested by doctors. The fact that only a third of these diagnostic tests ever revealed a serious illness (30 percent) bears testimony to the fact that, on most occasions, these tests might not have been necessary.

Interactions with providers (diagnostic clinics and pathological labs) revealed that there is a 'usual practice' of paying commissions/cuts to the referring doctors by these providers. In Assam, a third of the providers interviewed revealed paying such commissions/cuts.

Some of the key messages that emerge from the first stage (consumer) survey are enumerated below:

- A high tendency of choosing private healthcare facility (often to suit convenience and save time, etc.) existed among a majority of respondents. There is a need to motivate consumers to make greater use of public healthcare services.
- There is a need for greater consumer/public awareness of healthcare to ensure that consumers get affordable and quality medical treatment across all income classes. A change in consumer attitude towards healthcare is cardinal to ensure that available (public) healthcare services are utilised to their full potential.

- Private healthcare suffers from a high degree of variation (from hi-tech hospitals to the private practitioner in the neighbourhood) in as far as quality is concerned and there is hardly any regulation on maintaining a minimum standard of treatment.
- An extremely high frequency of referral (to diagnostic clinics), combined with the prevalence of ‘cuts’ for referring doctors, was noted. This is an extremely pernicious arrangement – and measures should be taken at the local/micro-levels to curb/eliminate such arrangements.
- In spite of having received medical treatment at a public hospital, consumers are buying medicines from private sources. This raises the cost of healthcare for consumers further. Whether this is due to sheer unavailability of drugs in the hospital (implies that public procurement of medicines is something that the states should consider very seriously) or due to collusive arrangements between providers in the public healthcare system and the private pharmacists (whose shops are mostly just outside the public hospitals) was an issue that required further investigation in the second stage of the survey.

II. Prescribing Pattern and Analysis (in Public healthcare institutions)

A. Respondent’s Feedback on Public Healthcare System

Information gathered from 210 respondents visiting public healthcare institutions in the second stage (prescription analysis) revealed the findings as mentioned in the following bullets. The following public healthcare institutions were covered:

- Guwahati Medical College and Hospital
- Civil Hospital, Nagaon
- Urban Health Centre, Nagaon
- Civil Hospital and Primary Health Centre, Bongaigaon

- *On an average, cost of drugs prescribed per prescription (prescription cost) in public hospitals was higher where a major chunk of the medicines had been bought from outside*

(private) sources by the respondents. This is evident from the data gathered from respondents visiting Guwahati Medical College and Hospital (Guwahati), Civil Hospital (Nagaon) and public health institutions in Bongaigaon (Figure 3). Medicines had been provided for free at the Urban Health Centre, Nagaon, for most of the respondents. On a deeper analysis of the general pattern of prescription (Figure 4), it emerges that, although a high proportion of *rational drugs*¹¹ were prescribed in case of Guwahati Medical College and Hospital, Civil Hospital (Nagaon) and public health institutions in Bongaigaon, yet there was also a significant percentage of ‘irrational drug’ prescription – which might have unnecessarily increased the cost of the prescribed medicines.

Figure 3: Cost to Consumers for Buying Medicines from Private Providers (Public Healthcare Institutions in Assam)

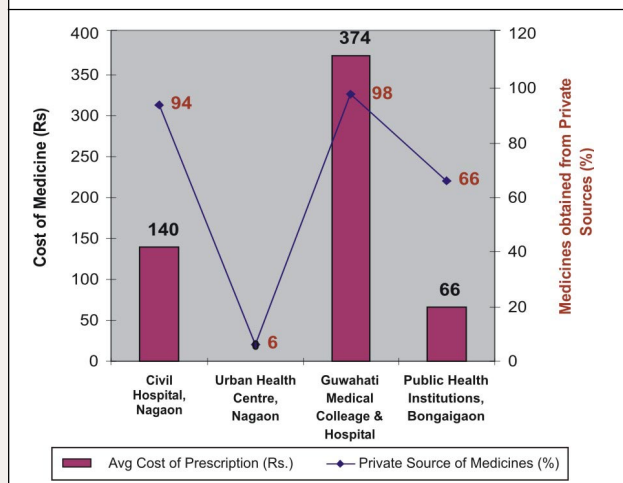


Figure 4: Prescribing Pattern in Hospitals

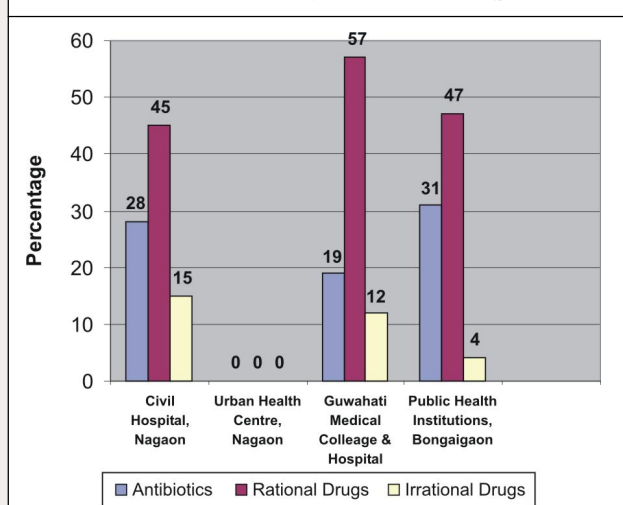
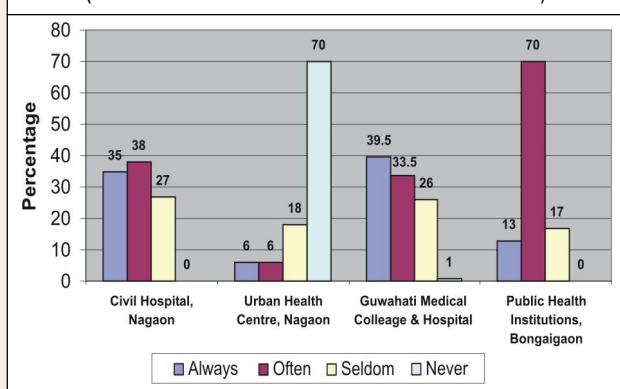
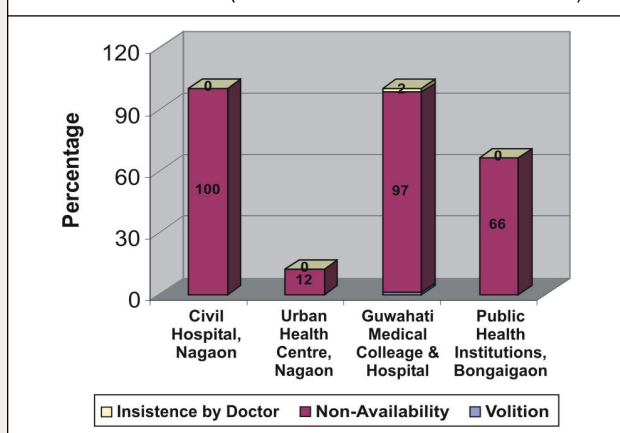


Figure 5: Procurement Pattern of Medicines (Public Healthcare Institutions in Assam)



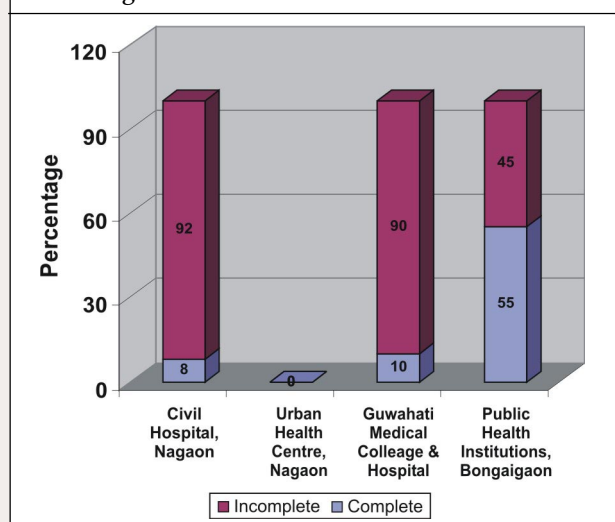
- Medicines were being obtained mostly from private (outside) sources in three of the four public health institutions surveyed. While this was the highest in the case of public health institutions in Bongaigaon (83 percent), such occurrences were a bit less (73 percent) in both Guwahati Medical College and Hospital and the Civil Hospital, Nagaon, while most of the respondents surveyed in the Urban Health Centre, Nagaon, had been provided drugs at the hospital itself.
- Respondents indicate non-availability of medicines in public healthcare institutions as the main reason for buying medicines from private sources while being treated at public healthcare institutions in Assam. If this is found to be true (as feedback) from a larger population of people visiting public hospitals in the state, then it is fairly alarming and the state government should take urgent steps in refining its procurement and distribution

Figure 6: Reason for Buying Medicines from Private Sources (Public Healthcare Institutions)



policies for medicines in the state. Only a small fraction of respondents who have been visiting the Urban Health Centre, Nagaon, indicated that they bought medicines from private sources. If distribution of medicine in a public health institution has been so efficiently

Figure 7: Completeness of Diagnosis of Patients Visiting Public Healthcare Institutions in Assam



handled in the case of the Urban Health Centre, Nagaon, then it should be emulated in other public health institutions as well.

- Incompleteness of diagnosis seems to be a frequently encountered phenomenon across the public health institutions surveyed. One of the reasons could be the influx of patients in some of these public hospitals, but that cannot be used as a defence by doctors in the public health institutions for not spending quality time on their patients. Greater supervision is imperative to ensure that comprehensive diagnosis is carried out and recorded in the prescriptions for future reference.

Some of the *issues of concern* that emerge from the results are enumerated below:

- Although prescription of *rational medicines* was common in the surveyed public hospitals, still a *large number of respondents bought medicines from private sources* while getting treated at public hospitals. On an average, 62 percent of the respondents bought the medicines from private sources while being treated at a public hospital.

- *Non-availability of drugs in public hospitals* was the main reason why respondents had to rely on private sources to obtain medicines. 69 percent respondents indicated having encountered such non-availability of drugs in public hospitals in Assam.
- A glaring fact was the *high percentage of incompleteness of diagnosis*, as revealed from the analysis of prescriptions in both the states. Over three-fourth (76 percent) of the prescriptions did not bear any evidence of ‘signs and symptoms’ and/or ‘preliminary diagnosis’ in them. Absence of such written record of ailment is a fundamental flaw in medical investigation and should be avoided at all costs.

B. Assessment of Nature and Types of Medicines Bought from Private Sources

It was clear from the above analysis, that many consumers who were visiting a public hospital expecting that s/he would have to shell out less money (and get good treatment) were actually having to pay a fair amount towards buying medicines, as, on many occasions, these medicines were not available within these public health institutions and had to be obtained from private sources.

CUTS decided to assess if such non-availability of drugs was due to genuine absence of medicines in the public hospital or was it because of the fact that the consumers were being forcefully diverted to the private chemists to buy medicines in spite of their availability in the stocks of these hospitals.

This exercise turned out to be a daunting challenge, as it involved obtaining *Hospital Stock Registers* from each hospital (for the period when the survey was undertaken) that had been covered in the survey.

Applications under the Right to Information (RTI) Act had to be filed to obtain these Stock Registers from the hospitals, as most of the hospital authorities refused providing them. *One wonders why information about the stock of medicines in a public hospital should not be available in the public domain?* This information is in public interest and, therefore, should be displayed publicly inside the hospital.

Our partner in Assam was able to get all the Stock Lists from each of the public health institutions that were surveyed, just in time for inclusion in this report, and the results of the analysis are quite revealing (see Table 7).

Three clear lines of analysis can be drawn from the above data and are presented below:

- *A significant percentage of drugs that were obtained by the consumers from private sources (outside chemists) were available as per the record in the Stock List.* This was the highest for public health institutions in Bongaigaon, but overall not too many drugs (only 24) were bought by consumers from private sources there. The findings are the most alarming in the case of the Guwahati Medical College and Hospital, where, of the 196 drugs that were bought by the surveyed consumers

Table 7: Reconciliation of drugs Bought from Private Sources with the Hospital Stock List

Public Hospitals	Total no of medicines from outside sources	No of these present in hospital stock	%	No of these absent in hospital stock	Percentage of those absent, with available substitutes (%)	%	No of medicines absent in hospital, but present in state list of essential medicines
Guwahati Medical College and Hospital	196	97	49	99	9	41	41
Civil Hospital, Nagaon	55	13	24	42	12	15	36
Public health institutions, Bongaigaon	24	13	54	11	27	7	64

from private sources, 49 percent were available in the hospital stock register.

- *Of the medicines that were absent in the hospital stock list, some had substitutes that were available in the hospital stock but were not prescribed.* These were nine percent and 12 percent, respectively, in Guwahati Medical College and Hospital and Civil Hospital, Nagaon. In public healthcare institutions in Bongaigaon this was 27 percent.
- *A consistently high percentage of medicines from the State List of Essential Medicines was absent in the hospitals.* This was highest in case of the Bongaigaon (64 percent), but also considerably high in Guwahati (41 percent) and Civil Hospital, Nagaon (36 percent).

CUTS urges the state government to initiate investigations in these healthcare institutions to clearly find out the reason why **medicines that were present in the hospital stock list were not being offered to a large number of consumers?**

As noted earlier, the Competition Act 2002 of India prohibits ‘...enterprises or associations of enterprises (or persons or association of persons) from entering into any agreement in respect of production, supply, distribution, storage...which has an appreciable adverse effect on competition’.

Agreements having such adverse effects on competition are those which result in determining purchase or sale prices; limiting or controlling production/supply/marketing/development/provision of services; geographical allocation of markets; and collusive bidding.

Given that the Competition Commission of India is sufficiently empowered, as above, it should investigate if supply and distribution of medicines in these public hospitals have been restricted due to agreements between the various players involved and necessary corrective measures should be taken.

III. Prescribing Pattern and Analysis (in Private Healthcare)

A random sample of private prescriptions was gathered from Bongaigaon (Assam) during the

survey in order to get a snapshot of the visible trends in private healthcare. From the analysis, the following results emerged:

- The average amount paid for medicines by the people covered under the survey each time they visited a private healthcare institution was ₹336.
- Incompleteness of diagnosis was rampant among the private practitioners (67 percent) in the prescriptions of private healthcare providers. This was also quite high (45 percent) in public healthcare institution covered in Bongaigaon.
- Polypharmacy (prescription of four or more drugs) was encountered in only half (52 percent) of the prescriptions collected from private providers. It was even higher among the public healthcare providers surveyed in Bongaigaon (63 percent).
- Irrational drug prescription was observed in 18 percent of the prescriptions gathered from the private providers, which was almost identical to its occurrence (17.5 percent) among the public healthcare institutions in Bongaigaon.

IV. Discussions with Medical Representatives

It proved quite a challenging task to gather information about the nature and extent of the allegiance between doctors and pharmaceutical companies in the two states. Only one such meeting/interview has been possible and a brief account of the same is presented here. *The name of the town/state from where this evidence was gathered has not been mentioned intentionally.*

While categorically denouncing such malpractices (allegiances between doctors and pharmaceutical companies) and asking for help in forcing the government to clean up the system, the medical representatives themselves flayed the unethical practices of doctors and listed out various systems in practices. These depended on various factors, including the pharmaceutical company, the product, bargaining capacity of the doctors, etc. These practices can broadly be classified under three heads: (i) reminders, (ii) inducements, and (iii) cash payments or bribes, as is elucidated below:

i. Reminders

- Small gifts like pens, paper pads, calendars
- Medicine samples

ii. Inducements

- Gifts in the form of medical equipment like stethoscope, torches, scopes, BP instrument, etc.
- Vacations for doctor and his family
- Paper reading at seminars in foreign countries for doctors identified as Key Opinion Leaders
- Sponsorship of Seminars and Continuing Medical Education Programmes for doctors

iii. Cash Payments and Bribes

- Gifts like cars, ACs, etc.
- Equated Monthly Instalments (EMI) for home appliances, cars, etc.
- Life insurance premiums
- School fees for their children
- Cash payments – doctors call companies and their managers promise X amount of their product sales and ask for commissions between 10 to 25 percent

There were also a number of ways in which the pharmaceutical companies kept track of the volume of products being sold through a particular doctor. Some of the popular tracking techniques to determine the amount payable to these doctors as *cash for sales* are presented below:

- Sales of products supplied by stockist to pharmacies where a doctor sits is attributed to the doctor; and
- Vials of costly injectables, etc., are manually verified on a day-to-day basis to ascertain the

Illustration: Injection Ceftriaxone that may be sold as low as for ₹50 per vial is also available at ₹200. The doctor would typically offer to sell this more expensive brand only on a daily cash basis, so that the medical representative would have to come every evening to make cash payments.

amount that is payable and cash payments are made on a daily basis.

- Some pharmaceutical companies provide special prescription pads to the doctors, which have carbonless self-copying chemicals that allow the doctor to maintain a copy of every prescription with him. The doctor would then produce each of these prescription copies for cash payments at already negotiated rates.

Some of the other issues that were revealed from these discussions were that:

- These practices are considered as usual and practiced by most of the doctors, barring a few.
- After the Medical Council of India announcement (2009) barring doctors from accepting gifts, etc., there was a temporary stoppage, but things soon returned to normal (even got worse).
- The situation in the hinterland is much worse, as compared to cities and towns.
- ‘Free samples’ of medicines are also sold.
- Doctors in both public and private healthcare institutions indulge in these practices.

Conclusion and the Way Forward

On the basis of the review and the field work undertaken, certain conclusions have been derived and recommendations made to ensure that a more consumer-friendly healthcare system is evolved. These are segregated into two specific categories: (i) issues for policy, and (ii) issues for consumer awareness and action.

Issues for policy that emerge from this study have been expanded in this section into the following sub-areas:

- **Procurement and distribution of drugs** – The state government should urgently ensure that medicines are available in public hospitals. For this, state level policies and ‘action programmes’ should be developed and implemented urgently.

- **Public display of hospital stock of medicines** – A small step that can make a huge impact is that the state government should make it mandatory for public hospitals to publicly display their stock of medicines and the figures (of current stock) should be updated on a day-to-day basis and displayed in a prominent location in the hospital.
- **Periodic scrutiny of prescription patterns** – A periodic exercise should be initiated by the state government and implemented in cooperation with local civil society organisations to scrutinise prescription patterns, especially in public hospitals.
- **Monitoring of chemist/pharmacist shops in close proximity of public hospitals** – The state government authorities should undertake periodic (and ‘unannounced’) visits to private chemists and pharmacist shops outside public hospitals and also get feedback from consumers visiting them.
- **Greater attention towards patients** – Doctors need to spend more time on the consumer who is seeking healthcare service and document (in the prescription) ‘signs/symptoms’ and a ‘preliminary diagnosis’, or face action.
- **Identify ‘good practices’ within the state and replicate them** – The study reveals that there are ‘good practice’ hospitals that are existent in each of the two states. It is necessary to develop a system of ‘performance evaluation’ of public healthcare institutions and recognise those which have been doing their job well. Efforts should also be made to explore the possibility of emulating such ‘good practice cases’ in the other public healthcare institutions.
- **Adoption of the Clinical Establishment Act 2010** – This Act should be adopted at the earliest and effectively implemented to ensure a minimum standard of healthcare for consumers.

Issues for consumer awareness and action are presented below:

- **Need to be more cautious in choosing healthcare providers** – Consumers seem to be very casual in choosing healthcare providers and often visit those providers who are located nearby. It is important that they choose providers who have an established good performance.
- **Approach Consumer Forum for redressal** – Consumers are unaware that they can complain against unfair and deceptive practices of doctors to the State Consumer Forum and get redressal.
- **Raise demand for generic drugs** – It is mandatory for doctors in public hospitals (run by the Central Government) to prescribe only generic drugs and the consumer should demand these from them. When they visit pharmacists with prescriptions with generic drugs written on them, they should ask the pharmacists to provide them 3-4 brands for each of these generics and then make a choice based on several criteria (company, price, advice of pharmacists, etc.).
- **Demand discounts from pharmacists** – Like any other consumer good/services, consumers should ask for discount on the price of medicines (MRP) from the pharmacists. It is a practice to sell medicines at MRP only.

CUTS encourages civil society organisations across the state of Assam also to take up these issues with the state government to ensure that healthcare services for consumers become cheaper and that they are not fleeced by commercially motivated providers in the healthcare value chain.

Endnotes

- 1 Annual Report to the People on Health, Ministry of Health and Family Welfare, Government of India, 2010, New Delhi.
- 2 *Universal Coverage* - Member States of the World Health Organisation (WHO) committed in 2005 to develop their health financing systems so that ‘all people have access to services and do not suffer financial hardship paying for them’. This goal was defined as universal coverage, sometimes called universal health coverage (World Health Report 2010, WHO).
- 3 According to a 2008 WHO estimate, 65 percent Indians do not have access to modern healthcare.
- 4 Shiva Kumar, A. K. et al., ‘India: Towards Universal Health Coverage’, LANCET Journal, January 2011 (www.thelancet.com).
- 5 Nihajwan, S. B., *National Commission and Supreme Court on Consumer Cases 1986-96, Part II*, International Law Book Company, 1996, New Delhi.
- 6 “...Services rendered to a patient by a medical practitioner would fall within the ambit of ‘services’ as defined under the Section 2(1)(o) of the Consumer Protection Act, 1986”.
- 7 Section 3 of The India Competition Act 2002 (amended in 2007).
- 8 Dutta, Indrani & Bawari, S. ‘Health and healthcare in Assam – A Status Report’, CEHAT, 2007, Mumbai.
- 9 http://www.nrhmassam.in/health_facilities.php
- 10 For the purpose of this study, a classification of the respondents into income classes was done on the basis of the following measurements: (a) Lowincome households were those with a total monthly household income of less than ₹10,000; (b) Middle-income households were those with a total monthly household income of between ₹10,000 to 40,000; and (c) Highincome households were those with an average monthly household income of above ₹40,000. The average household size was considered to be five individuals for this study.
- 11 Analysis of the rational use of drugs for this study was undertaken in line with its definition provided by the WHO, i.e., “*Rational use of drugs requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements for an adequate period of time, and the lowest cost to them and their community.*” (Report of the Conference of Experts on Rational Use of Drugs, WHO, Nairobi, 1985)

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