Letter from Chennai

HEALTHCARE CORRUPTION IN INDIA

Oxford University Press recently published a book entitled *Healers or predators? Healthcare corruption in India*, edited by Samiran Nundy, the founder editor of this *Journal*, Keshav Desiraju, former Health Secretary to the Government of India, and Sanjay Nagral, Chairman of the Forum for Medical Ethics Society. I have no doubt this book will be reviewed in the *Journal*, perhaps before you see this Letter, and will say no more about it.

On the occasion of the release of the book in Chennai, the Hindu Centre for Politics and Public Policy and the Oxford University Press organized a public discussion on 'Healthcare corruption in India'. The panellists were Dr Samiran Nundy, Mr Keshav Desiraju, Dr George Thomas, orthopaedic surgeon of Chennai and Chairman of the Institutional Ethics Committee of the Christian Medical College in Vellore, and I, and the moderator was Mr N. Ram, Chairman of the Hindu Publishing Group. After introductory comments from Mr Ram, each of us made a brief statement on the subject and answered a few questions from him. The topic was then opened to the public. The auditorium had a seating capacity of 230. All the seats were full and people were standing at the rear and the sides. It was a very interesting evening. I will summarize what each of the panellists said in their opening statements, and the discussion that followed.

Mr Ram opened the meeting with a brief outline of the book and introduced the participants. Dr Nundy spoke of his experience as a consultant at the All India Institute of Medical Sciences in Delhi. He found the work interesting, and the patients were very grateful for his ministrations. However, corruption was evident as many of the faculty visited politicians to get what they needed. David Berger, an Englishman who had done some voluntary work in India, found our healthcare system to be very corrupt, and wrote about it. This roused interest in the *British Medical Journal*, and Dr Nundy with two others wrote an editorial in the *British Medical Journal* on corruption in Indian healthcare. Many newspapers in India commented on it and brought it to the notice of our Health Minister who admitted the presence of corruption and criticized the Medical Council of India, which was subsequently superseded and replaced by a government-appointed committee. Oxford University Press invited Dr Nundy to edit a book on the subject, the present volume. He invited Mr Desiraju and Dr Nagral to join him as editors and many others to contribute chapters. He pointed out that the picture was not all bleak, as the system had also produced outstanding doctors such as Dr A.K. Basu of Kolkata, Dr N.H. Antia of Mumbai and Dr P.K. Sethi of Jaipur, and outstanding institutions such as the Banyan, the Christian Medical College, Vellore and the Mahatma Gandhi Institute of Medical Sciences, Wardha.

Mr Desiraju pointed out that it was not only doctors who were corrupt. Healthcare also involves policy-makers, regulators such as the medical and allied councils, the drugs controller, service providers including administrators, and the public, who had expectations and wanted something from the system. There are many instances of corruption in these components of the system too. While almost all aspects of corruption in healthcare have been brought out in the book, he felt we need to do something to address these issues. He was critical of Ayushman Bharat, which does not address the imbalance between the limited number of service providers and the vast needs of the populace. This imbalance is what leads to corruption in the system. He stressed that corruption exists in both the public and the private system, and both need to be cleansed.

Dr Thomas opened combatively by saying he represented R.K. Lakshman's common man, as he did both his undergraduate and postgraduate studies in state government hospitals unlike privileged doctors who came from the All India Institute of Medical Sciences, most of whom went overseas. He pointed out that the title of the book gave the impression that doctors were either healers or predators, but there is a large grey area between these two extremes. Corruption in the profession is not only financial, but also there is corruption for fame, for advancement in the profession. It is difficult for people who come from poor families to remain absolutely straight in the circumstances prevailing in the country today. He said in his early days in the profession he was a member of a group determined to practise ethical medicine. Most of the members emigrated because they could not make both ends meet in India if they stayed within the rules. Overseas, they could be ethical and survive. He insisted that as long as the public and the private sectors co-exist, the poor would always have inferior treatment because doctors working in public hospitals do not get the prestige and the wealth that go with treating the rich in private hospitals. He admitted that privileged doctors were not always a happy lot as their conscience would prick them. He wanted the public to make sure doctors in public hospitals were given conditions that would make them happy and appealed to members of the audience to look after them. He wanted there to be only one system of medicine akin to the National Health Service of the UK, where rich and poor are treated alike. He denied that the country lacked money. When a major problem such as famine had been eliminated from the country, there is no reason why we should not be able to tackle most diseases. It is only the lack of political will that prevents us from providing uniform healthcare for all.

In my introductory remarks, I stressed that many doctors in the country were honest and sincere. Corruption is not confined to the profession, but is also prevalent among the public, many of whom want false certificates, and who falsify the dates of their illness and take an insurance policy after they are diagnosed with some disease which is expensive to treat. I am pessimistic about all the attempts to reform our regulator, the Medical Council of India. I pointed out the frequent flouting of rules by most people. We are not a law-abiding people, and the best of reforms will just remain on the books. Our first priority should therefore be to protect the poor, for the rich and the upper middle class will manage somehow. The only way we will achieve this is to strengthen government hospitals. Insurance schemes are good vote-catching devices, but they result in government money going to private hospitals. The money spent on those schemes should just be used to make the government hospitals better. In days past, people went to private hospitals only to treat minor conditions in comfort. If they had a serious disease, they went to government hospitals. The only way we can recover that status today would be to insist that if anyone were treated with government funds, it should be only in a government hospital, and that applies particularly to senior government servants and ministers. I appealed for all in the audience to pressurize our rulers to see that they were never

reimbursed for care at private hospitals. Everyone has a right to go to the doctor and the hospital of his choice, but he should spend his own money for that privilege.

Points from the discussion

The title and content of the book. Mr Ram defended the title, and said there was much corruption in the profession, and publishers need a catchy title. Some in the audience agreed with Dr Thomas that it gave the idea that the whole profession was either white or black, while there were many shades of grey in between.

Why focus on corruption? Dr Nundy said corruption in society as a whole is not an excuse for corruption in the medical profession. He quoted Amartya Sen's introduction to the book, in which he said that when a man buys a toothbrush, he knows as much about the toothbrush as the seller, but when he goes to a doctor the difference in knowledge is huge and the patient necessarily has to trust the doctor and could thus easily become a prey. Costs would come down by 25% if kickbacks were eliminated. Doctors in Mumbai told him 90% of doctors gave or received kickbacks for referrals and investigations.

One of the audience said we should not have focused on corruption but on the honest members of the profession. Mr Ram said it was necessary to point out the defects where they exist and not to paint a rosy picture of the situation. A doctor in the audience felt that the book had taken a negative approach, and what should be done is to bring out the good work done by many in the government sector. He blamed the media for not highlighting this. Dr Nundy pointed out that 75% of Indians pay from their pockets and avoid government hospitals, thus voting with their feet. Mr Ram said there were plenty of stories in the media of sterling examples, but too much stress on that would miss the big picture and would not be honest.

Corruption in practice. I said the origin of large-scale corruption came with the introduction of expensive machines and high costs for investigations and treatments such as lithotripsy. Kickbacks existed even in the 1950s and 1960s, but the amounts involved were small as investigations cost just a few rupees. Capitation fee in medical colleges added to the problem, as people who spent colossal sums on admission to a college wanted a return and tried to make money in every possible way.

Mr Ram asked Dr Thomas to justify a statement he made in his chapter in the book: practising scientific medicine would automatically mean practising ethical medicine. Dr Thomas said a scientific doctor would not do an investigation if it were not necessary. He might or might not take a cut on an investigation, but he would ask for a test only if it was warranted.

A dental surgeon teaching in a private college spoke of the large-scale corruption in that sector. He said they were aware of a 'surprise' inspection a week ahead, and could bring microscopes from other colleges run by the same group, and even import patients to show a large attendance on the day of inspection. He blamed government for this corruption. However, Mr Desiraju, while agreeing that the system is corrupt, said everyone was complicit in it. It is up to senior members of the profession to put their foot down and say the limit had been reached.

Transplantation. I said corruption in transplantation is pervasive, beginning with the continuing performance of live unrelated donor transplants which are exploitative of the poor donor. The authorization committee of the government, which should prevent this, seems unable to realize that all the 'altruistic' donations they sanction go from donors from our slums to rich recipients from elsewhere. One of the members once told me that the donor (from a Chennai slum) said she loves the recipient (whom she could not have known more than a week earlier), and asked me, 'Who am I to say she does not?' He believes in love at first sight. Even in the deceased donor programme there are anomalies such as people moving rapidly up the recipients' list and overtaking many others. The number of foreigners who receive deceased donor grafts is suspiciously high. It is hard to conceive that so many organs should find no Indian recipients.

Dr Nundy was asked how he could justify liver transplants which were of use to only a few. How well were his patients rehabilitated after the huge amounts spent on them? Did they earn enough later to justify the money spent? He said 200 000 patients died of liver disease each year. He stressed that the results were very good, long-term survival was excellent, and 75% of the patients could go back to productive, useful lives for several years, almost a normal life span. The Indian expense of around ₹20 or 30 lakhs (2–3 million) was much more affordable than the ₹2 or 3 crores (20–30 million) they would spend overseas. Only 2% of Indian liver transplants are in the public sector, and obviously government cannot afford it.

Mr Ram objected to the earnings of the patient being used as a yardstick for rehabilitation. It should be enough if the patient were restored to good health for many years.

Dr Thomas maintained that it is not true that there are inadequate funds in India. He said the colossal sums spent on many unproductive schemes could well be used for medical care. On the other hand, if there was not enough money for Munuswamy from Gummidipundi (as he termed the common man) to have a liver transplant for want of funds, then the Prime Minister should not have it either.

A social activist mentioned an example of a patient on the waiting list for a transplant at a private hospital finding his position on the waiting list falling steadily while his health deteriorated and his expenses mounted. He felt brain dead donors from government hospitals were brought to private hospitals and recorded as dying there, and their organs went to the private sector. Dr Nundy called on Dr Amalorpavanathan, who was in the audience, to comment. He was for several years the Director of Transtan (the Transplant Authority of Tamil Nadu). Dr Amalorpavanathan pointed out that while he was in charge, the system was completely open, and anyone could find his position on the composite waiting list. The allocation of every organ was always done according to the rules and was noted on the website.

Government expenditure on health. Mr Desiraju admitted that we need to spend a lot more on health. There was a large increase in government outlay on public health with the introduction of the National Rural Health Mission in 2005, and many schemes have been added since. However, governments, and Members of Parliament using their local area development money, prefer to spend on hospital buildings and equipment, which are more visible and can yield more from corruption, rather than on services. What we need is more colleges in the public sector charging reasonable fees, to produce many more doctors, nurses and technicians so that the shortage of staff could be addressed. He complimented Tamil Nadu for having a government medical college in every district, whereas large tracts of northern India had primary health centres with no doctors at all, and some states had barely 6 or 7 colleges. Policy-making and planning was often faulty. Money spent on improving the nutrition of children would not yield results before the next election but only before the next generation. It is more important than curative treatment but does not appeal to politicians.

I gave the example of the Kidney Help Trust of Chennai that had been able to pick up diabetes and hypertension in a community with simple annual screening techniques, to treat all the patients so discovered with simple and effective drugs and to reduce the incidence of chronic renal failure from 28 per thousand to 11 per thousand, at a cost of ₹33 per capita per year, well within the government's spending capacity. Certainly, much more money should be spent on health, and this should be rationally distributed to try and prevent as much of disease as possible at a low cost. There were successful schemes that had eradicated smallpox, and greatly reduced poliomyelitis and leprosy. Tuberculosis had been controlled to some extent. All this is based on domiciliary programmes. If one expects a man on daily wages to travel 10 km to a primary health centre and stand in a queue for 4 hours to receive a week's supply of medicines, the programme would be doomed to failure. Much should be done at the patient's home with health workers, and the doctor could make occasional visits to supervise and direct the treatment as had been established by the Kidney Help Trust. Liver and kidney transplantation should certainly be done at some medical college hospitals to train youngsters so that when our finances improve or costs of transplantation fall, we would have people who could carry out the treatment, but we do not now have the money to provide transplants for all who need them.

Research in Indian institutions. Dr Nundy said 57% of Indian medical colleges had no publications in indexed journals, suggesting that their education was really of poor quality. He said the work of the Kidney Help Trust was an example of what should be done, producing simple solutions for Indian problems. Dr Thomas objected to his criticism of our colleges. He said the work was so heavy that everyone was tired out at the end of the day, and had no time or energy left for research. He is chairman of the Institutional Review Board of the Christian Medical College, and he said that college and the All India Institute of Medical Sciences are privileged places where staff have protected time for research. This model is not applicable to the majority of colleges in India.

Universal healthcare. Dr Nundy said this was not possible because there was not enough money. Mr Desiraju agreed with Dr Thomas in that government should not give up on its responsibilities just because some in the private sector tried to fill in for them. Only government could afford to cover the whole country, and it should not shirk its responsibility and leave it to non-governmental organizations. I believe that all treatment should be provided to people who have money and can afford it, but not at government expense.

Reform, should it be piecemeal or at one go? Dr Nundy felt it should be done in one movement, as was done by Flexner in the USA at the beginning of the 20th century. I was sceptical about whether any such reformer could influence a basically lawless society like ours, and Dr Thomas felt piecemeal would be the only Indian way.

Other systems of medicine. Another audience comment came that we stressed too much on allopathic medicine that came from the West, whereas a large number of people, especially in rural areas, went to practitioners of other systems of medicine. Dr Nundy said many studies showed that homeopathy was totally useless and should be removed from this country. Mr Desiraju said our government recognized AYUSH (Ayurveda, Yoga, Unani, Siddha, Homeopathy and Tibetan medicine), but he found there was more corruption in the agencies that regulated them than even in the Medical Council of India. Also, the temptation for those practitioners was always to dabble in allopathy, for which they were not trained, and it should be made clear that they should only practise the system they were qualified in. Dr Thomas pointed out that homeopathy is not Indian but German, having been introduced by Hahnemann.

Medical education. From the audience, Dr Manjula Datta, retired Professor of Epidemiology of the M.G.R. Medical University, pointed out that we lack information on the burden of disease in India. In our education, we are taught from western textbooks and not about our own illnesses and the methods we should use to treat them. We need to reform the education of our own doctors.

Equipment and pharmaceuticals. In response to a question, Mr Desiraju also said the pharmaceutical industry was very powerful and regulation was feeble because the regulatory agencies were underfunded and poorly staffed.

One of the audience objected to cartelization in the supply of equipment. He found he could buy a high-end hearing aid for half the cost on the internet, but the firm that had the agency refused to adjust it to his requirement.

Setting things right. The general impression was that we had highlighted corruption, but not suggested a solution. All of us spoke of the need for someone to pull up the profession and set things right, but nothing that seemed workable was offered.

M.K. MANI