Collusion among Health Service Providers in India: Need for Effective Regulatory Enforcement

Executive Summary

By its very nature, the delivery of health services is marked by consumption decisions not made by consumers -- for instance, in most cases it is not the patients (consumers) who decide which medicines to consume but the physicians treating them. This property of health delivery encourages collusion by doctors, pharmacists and hospitals to profit at the expense of the consumer. —prescriptions, treatments and referrals tuned to maximisation of revenues rather than enhancement of consumer well being.

This briefing paper presents a project based solution, which would help identify such collusion through empirical research and induce needed policy and regulatory action through dissemination of research results and related advocacy.

Support for such research and advocacy as well as feedback to the proposed methodology from the Ministry of Health and Family Welfare, Government of India, the medical community, consumer groups, regulators and the media would greatly enhance the effectiveness of the project. To leverage such support and feedback a project inception meeting involving relevant stakeholders, where this briefing paper would be tabled and discussed, would be held. This paper would also be widely disseminated through other channels to get relevant feedback.

I. Introduction

The right to health is recognized in a number of international legal instruments. In India too, there are constitutional commitments to provide access to healthcare. However despite the existence of any number of paper pledges assuring the right to health, access to health remains a problem across the country. A survey conducted by the India office of the international non-governmental organisation, *Transparency International*, reveals that citizens perceive 'health services' as the most corrupt service sector in India on the basis of their experiences. Such corruption is associated with collusion among and within various classes of providers involved in providing healthcare services and affects both the quality and affordability of treatment of patients.

Collusive activities can range from cartelisation to vertical arrangements among service producers in the supply chain for medical services. Although there has been no systematically documented and compiled evidence of such activities in India, information garnered from various sources points to significant involvement in collusive behaviour of all major players in the health delivery system: doctors and hospitals; pharmaceutical firms and pharmacists; and diagnostic laboratories.

II. Collusion among health care providers: Incidence and effects

The health care industry is characterised by the consumption decision not being in the hands of the consumer – when a patient visits a doctor/hospital for treatment, the drugs he subsequently

consumes and the tests that he undergoes are stipulated almost entirely by the doctor. This unique characteristic of the health service industry is thus associated with an essential curbing of consumer freedom. Hospitals/doctors can use this characteristic to promote each other through referrals or certain brands of drugs or diagnostic laboratories in return for payments from the benefiting parties. The ultimate burden of such collusion falls on the consumer – inappropriate, excessive or costly medication; unnecessary and expensive diagnostic tests; prolonged and expensive hospitalisation etc.

Such collusion can be countered to a certain extent by consumer awareness. Thus, rural populations and the urban poor, who have been forced to turn to the private health service sector because of inadequate capacity of the public sector, are the worst sufferers of such exploitation as literacy/education and therefore awareness in regard to health and medical issues is low. Moreover, given their low levels of income, the direct, adverse economic impact of enhanced prices for healthcare services resulting from such collusion is more debilitating for these classes of the population. To illustrate, health care credit has a major share in total borrowing by marginal and small farmers. Further, the World Bank (2002) estimates that one-quarter of all Indians fall into poverty as a direct result of medical expenses in the event of hospitalisation.

2.1 *Collusion between doctors and hospitals*

Collusion between doctors and hospitals is indicated by an exponential increase in the number of Caesarean deliveries in the last two decades. The average Caesarean rate should not exceed 10-15 per cent, but in certain urban hospitals it is as high as 80 per cent. Such excesses are profitable both for the doctors performing such Caesarian operations and the hospitals where such operations are carried out, and their existence therefore points to collusion between the doctor and the patient.

2.2 *Collusion between doctors and pharmaceutical companies*

A very common practice indulged in by a typical pharmaceutical company is the provision of incentives to doctors so that they prescribe brands of medicine produced by that company even though these might be expensive or inappropriate. While the doctor should ideally be prescribing the cheapest and the most readily available drugs -- a practice that would ensure that consumers derive maximum possible benefits from competition among pharmaceutical firms – in reality, firms often try to capture the market through inappropriate market practices involving collusion with doctors. This in turn implies that consumers are often denied value for money spent on both the services of physicians as well as medicines.

Collusion with important agents in the health service sector has often been used by pharmaceutical companies to create a market for their product. For example, *Novarti*s, a company that has a large share in the market for pharmaceutical products in India, has recently been accused of fuelling the misdiagnosis of *Attention Deficit Disorder* (ADD) through its close association with psychiatric associations and its presentations at their meetings, and conspiring thereby to carve a niche in the market for *Ritalin*, their drug for ADD.[1]

The Medical Council of India (MCI), which till recently had functioned as the official regulator of health services, had taken a serious view on the incentives provided to doctors by pharmaceutical companies and amended its regulations in 2009 to prohibit doctors from accepting any gift or other pecuniary incentive from any pharmaceutical or allied health care firm. But these

[1] Novartis-Diagnosing for Profit, Writing May Be on Wall for Ritalin, InsightMag.com October 16, 2000)

continue under cover and even in the open. The Monthly Index of Medical Specialties (MIMS) has collected data on violations of the MCI code by drug companies. A few are cited in Box 1.

Box: Documented collusion between doctors and pharmaceutical firms

**Piramal Healthcare* in Mumbai took some 200 diabetologists in late January and then a batch of oncologists in mid-March to Turkey. Some of these travellers were investigated by MCI.

* *Dr. Reddy's Lab* in Hyderabad paid for about 200 doctors to visit Hyderabad in January.

* Navi Mumbai-based *Wanbury* dispatched some 100 doctors to Dubai in mid-February and put them up at the luxurious Dhow Palace Hotel. *Cox and Kings* handled the package tour at a cost of about Rs.40, 000 per person.

* *Lupin* of Mumbai held an all expense paid promotional event at Indore in late February and reserved rooms in three luxurious hotels (*Sayaji, Amar Vilas* and *Landmark Fortune*) for obliging doctors mainly from Madhya Pradesh. MCI was believed to be in possession of some names.

MIMS editor found that Ahmedabad-based *Troikka*, despite the MCI ban on doctors accepting gifts, had distributed some LCDs. He said that the case is already being investigated by the MCI and that the health ministry has already been approached to empower the Drugs Controller General, India, to take actions against companies that induce doctors to violate the law.

2.3 *Collusion between doctors and diagnostic laboratories and among doctors*
Investigation is yet another area where the interest of the patient is sacrificed to the greed of the care giver. For example, headache is a very common complaint, the cause for which can range from tension to a brain tumour. Doctors are often over eager in asking the patient to undergo an MRI of the brain on the basis of headache type symptoms, evidently because of the attractive commission that would be forthcoming from the referred diagnostic laboratories. .

Another example of collusion is associated with referrals -- a general physician referring his various patients to the same specialist for further treatment on the basis of an arrangement in which part of the fees thus earned by the specialist goes to the general physician. A similar arrangement might underlie referrals by doctors to pathological/diagnostic laboratories. Every referral that a doctor makes often means a 20 to 40 per cent commission on the amount charged to the patient by the laboratory/centre, variously called `interpretation charges' (IC), `referring charges' or plain `commission'. This has meant that in many a case the patient is unnecessarily sent to diagnostic centres. Reliable sources in the health care industry say that at least 60 per cent of all doctors take commissions. Most, if not all, hospitals pay commissions to doctors for asking patients to undergo tests such as CT scans and MRIs. They also insist that affiliated doctors and consultants refer patients only to in-house diagnostic establishments[2].

2.4 *Collusion between pharmaceutical companies and chemists*

[2] 'The diagnostic rip-off', Frontline, Volume 19- Issue 23, November 09-22 2002

Yet another example of an arrangement based on vertical collusion is that of pharmaceutical companies providing lucrative margins to chemists. The drug industry in India is characterized by exorbitant trade margins. The top selling brands are not the least expensive ones; rather these brands are pushed through collusion between the manufacturer and retailer. It is not that affordable medicines are not produced; they are often not stocked owing to collusive agreements. Incentives to pharmacists to induce them to buy large quantities of prescription drugs have become commonplace in India. The Drug Prices Control Order (DPCO) 1995, allows 16% margin to retailers and 8% margin to wholesalers for scheduled formulations; however, no such limit has been fixed in respect of non-scheduled formulations. This has encouraged companies to shift away from price-controlled categories i.e. those under DPCO's ambit. Hence, often there is a huge gap between the wholesale price and the retail price[3]

2.5 *Other forms of collusion*

In addition to these arrangements based on vertical collusion among players in the supply chain for medical services, horizontal arrangements among players of the same type are also observed: physicians might collude to charge a price higher than what should result from competition among them in the market; pharmaceutical firms might collude to boycott a particular firm/ firms until margins reach a certain high with the burden of such increased margins transferred to the patients in the form of higher prices etc

2.6. *Collusion, Wellbeing and Productivity*

The resulting losses in the well being of consumers/patients are not completely measurable as such collusion has both qualitative as well as quantitative effects. Collusion often results in health services becoming unaffordable for some consumers and for others it decreases the magnitude of other essential expenditures that can be incurred by the consumer, with adverse implications for his/her wellbeing. Collusion also affects the quality/appropriateness of health services, as the focus of such collusion is the augmentation of provider revenues. This has an adverse impact on the productivity of citizens and therefore on the productive capacity of the economy. To summarise, collusion among the important players in the health services sector affects the well being that consumers can derive from given incomes in the short run and adversely affects their productivity and therefore the growth of the economy in the longer run.

III. **The Way Forward**

The purpose of this briefing paper is to elaborate on and analyse the problem of collusion among and within important sets of players in the health sector and motivate a project based solution for the same through research and advocacy among relevant stakeholder groups. Such advocacy would not only stimulate awareness of this problem among the mentioned stakeholder groups but also help to hone the subsequent research and advocacy methodology to be implemented through the mentioned project. The project would thus facilitate regulatory changes that would lead to a reduction in the incidence of collusive practices.

The briefing paper would be tabled at an inception meeting attended by different groups of stakeholders such as the medical community, representatives of the *Ministry of Health and Family Welfare*, medical regulators, media and academia. It would not only highlight the problem

[3] Daniel Pearl and Steve Stecklow, Drug Firms' Incentives Fuel Abuse by Pharmacists in India, Wall Street Journal, 2001

of collusion in the health sector but also obtain feedback on the draft methodology for research and advocacy presented below.

IV. The Envisaged Project

4.1 *Rationale and Objective*

The rationale behind the project is the need for generation of recognition among the government, media and the regulators of health services about the crucial relationship between the incidence of collusion in the health sector and poor quality and affordability of healthcare. The objective is to stimulate remedial action in this regard. Support would be realised from relevant organisations to this effect. Research to clearly ascertain the incidence of collusive practices in the health sector will be followed by recommendations for better regulatory outcomes, especially through changes in the scope and effectiveness of the present regulatory system, Spreading awareness about these recommendations so as to lay the ground for their implementation would form an important part of post research advocacy.

4.2 *Benefits*

The above set of objectives would form the basis for formulation of robust criteria for identification of collusive practices in the healthcare sector. Such identification would feed into advocacy for changes in regulation to enhance access to quality and affordable healthcare. Advocacy would be used to increase awareness of the existing situation in regard to collusion in the health sector, disseminate research findings regarding its incidence, and involve the entire body of affected stakeholders in making recommendations for regulatory change which can then be suitably incorporated in the Draft National Health Bill.

4.3 *Proposed Research Methodology*

Apart from analysing information collected through secondary sources, primary information will also be collected through a field survey of diverse consumer and producer groups: patients, doctors, hospitals, pharmacists, pharmaceutical companies etc.

For collecting primary information, a survey of two priority states of Oxfam India – Chhattisgarh and Assam -- will be conducted to identify drawbacks, if any, in the healthcare system such as high prices, poor availability of healthcare facilities etc and the market imperfections causing these.

The survey would be carried out in two stages. In the first stage, there would be an extensive survey of consumers to elicit data on expenditures required for various kinds of medical treatment as well as household incomes. The juxtaposition of data on expenditure requirements on that on household income levels can be used to determine the ease of access to medical services. Such evaluation can be coupled with consumer perceptions about accessibility to health care etc.

In addition, other information can be collected from consumers, which would allow the evaluation of quality of health care – disease, or ailment treated for, medicines prescribed, length of treatment etc. Consultation with physicians of repute can then be used to benchmark the quality of medical services in each state.

Quantitative inferences about affordability and quality would then be used to identify states/regions with likely incidence of collusion among healthcare providers. States/regions with

relatively poor affordability as well as poor quality of health care would be suspects in this regard.

A second round of surveys needs to be carried out only in these 'suspect regions' to determine whether vertical collusive agreements exist between various sets of players in the supply chain of medical services – for instance those between doctors and pharmaceutical firms, doctors and diagnostic laboratories, doctors and hospitals etc – and whether there is collusion within important sets of players such as doctors and hospitals. Methods would include the collection of information from the consumer side on prescriptions made by randomly selected doctors and determining whether these reflect allegiance to pharmaceutical companies/pathological laboratories etc. Similarly, if within a small area, high and uniform charges for physician/hospital services not justified by costs co-exist with excess capacity and lack of affordability of such services for a large portion of the consumer segment, this constitutes strong evidence of cartelisation to maximise revenue (horizontal collusion). In other words, such evidence points to doctors/hospitals colluding to cater to a few at high prices rather than competing in terms of prices to provide services to many.

4.4 *Proposed Advocacy*

A robust identification of collusive practices would be followed by remedial recommendations in regard to regulation. A Draft Final Report, capturing the objective of the study, procedures used for data collection and analysis, and results and recommendations will be presented at a National Seminar of concerned stakeholders both on the demand and supply side, and also sent to two external reviewers for their comments. Upon the receipt of comments, the draft report would be finalised.

The final report would be released in a workshop for print media, radio and television in which the essence of the findings of the study would be highlighted so that these can be given wider publicity through articles in the press and appropriately designed radio and television campaigns. Workshops would also be held to share the findings of the report with state chapters of the Indian Medical Association (IMA) as well as officials of the relevant ministry, and initiate a liaising arrangement through which constant pressure can be maintained on IMA to discipline physicians indulging in market malpractices.

V. Conclusion

Collusion among doctors, pharmaceutical firms, diagnostic laboratories etc can have damaging implications for consumer wellbeing and productivity. This briefing paper presents a project based solution, which would help identify such collusion through empirical research and induce needed policy and regulatory action through dissemination of research results and related advocacy.

Support for such research and advocacy as well as feedback to the proposed methodology from the *Ministry of Health and Family Welfare*, Government of India, the medical community, consumer groups, regulators and the media would greatly enhance the effectiveness of the project. To leverage such support and feedback a project inception meeting involving relevant stakeholders, where this briefing paper would be tabled and discussed, would be held. This paper would also be widely disseminated through other channels to get relevant feedback.