

FactSheet

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

This FactSheet produced under the COHED project highlights findings of the research and investigation undertaken in three towns in the state of Chhattisgarh (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, 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 & 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 gross domestic product (GDP).

The other extremely important point touches on 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, Government of India, 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.

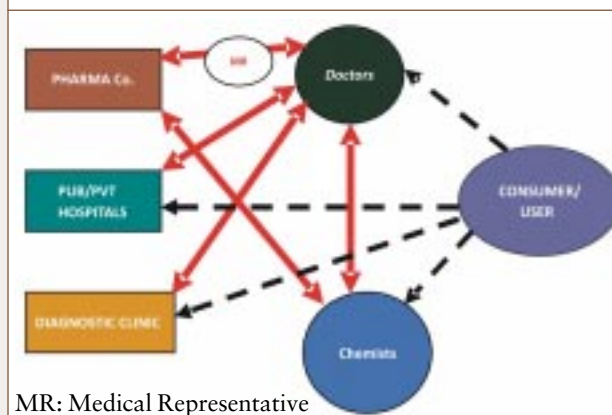
Despite policy recommendations for greater coordination between the Department of Pharmaceuticals (Ministry of Chemical and Fertilisers) and the MoHFW, there seems to be a lack of coherence in the process of policy formulation and adoption – which ultimately affects the efficacy of healthcare services. Lack of appropriate regulatory oversight on 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 coherency 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 provide 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

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



(reduced costs of healthcare services) but also in enabling greater access to quality healthcare services.

As a consumer organisation working to protect the interest of consumers', CUTS is interested to understand 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 the most important providers of healthcare services for consumers in India. Interactions of 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 (SUTRA Consulting was the partner in *Chhattisgarh*) 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 (COPRA) 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 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 (MRTP) 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 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 Chhattisgarh

The birth of this new state in the year 2000 saw a reinforced enthusiasm in improving the social sector policies (including healthcare) to benefit the people. The state government embarked upon consultations with various stakeholders including state officials, civil society, health activists and donor agencies to devise strategies and programmes in the health sector to deliver community based health services. A number of policies underlying affirmative action in healthcare sector have been undertaken by the state government as enumerated below:

Table 2: Healthcare Institutions in Chhattisgarh

Health Institutions	2007 (No.)	2008 (No.)	2009 (No.)	2010 (No.)
Medical College	3	3	3	3
District Hospital	14	14	17	17
Community Health Centre	113	137	143	148
Primary Health Centre	659	721	716	741
Sub-centre	4164	4758	4776	5076
Ayurvedic Hospital	6	6	6	6
Ayurvedic Dispensary	633	634	634	635
Unani Hospital	0	0	0	0
Unani Dispensary	6	6	6	6
Homeopathic Hospital	0	0	0	0
Homeopathic Dispensary	52	52	52	52

Source: RHS Bulletin, March 2007/2009, MoHFW, GoI

- **Revision of Essential Drug List:**

Chhattisgarh formulated an *Essential Drug List* in 2002, which was revised in 2007 to contain 350 drugs and consumables. This list is being further refined now.

- **The ‘Mitandin’ Programme:** The ‘Mitandin’ scheme of community based health services has become a huge success in the state and is also being considered for replication in other states. The programme involves ‘Mitandins’ (*Chhattigarhi* for ‘Friend’) or voluntary health activists who provide health services across hamlets/villages in the state. Currently, there are 60,000 ‘Mitandins’ in the state.

- **Improving Performance of the Hospitals:** The *Jeevan Deep Approach* – a pioneering hospital reform scheme (*Jeevan Deep Scheme*) that facilitates creation of ‘Hospital Management Committees’ (called *Rogi Kalyan Samiti* or *Jeevan Deep Samiti*) in all types of government health institutions. These committees have the power to recommend disciplinary actions as well.

- **Integrated Health and Population Policy 2007:** The Integrated Health and Population Policy (IHPP) recognises the contribution of socio-economic determinants of health and provides a comprehensive framework for strengthening the public health systems and healthcare delivery in the state.

- **Chhattisgarh State Integrated Health and Population Policy 2007:** It reiterates the commitment of the government to promote health and provide quality healthcare services. The state, however, has a number of challenges that still need to be tackled on a priority basis – like a high Infant Mortality Rate (IMR of 57 per 1,000 live births, which is above the country average of 53); immunisation (less than half of the children between 12-23 months are fully immunised) etc. With regard to health infrastructure, the number of health facilities in the state has steadily increased over time (Table 2).

Results and Discussion

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

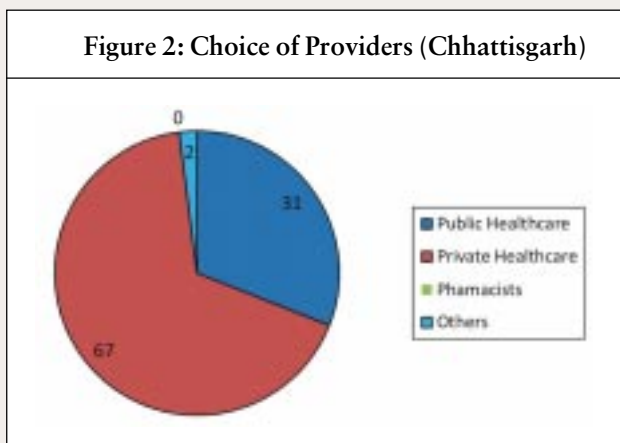
I. Survey of Consumers (visiting Public Healthcare Institutions)

In the first stage survey information was gathered from consumers on the basis of a questionnaire from three towns in each of the two states. In *Chhattisgarh* the information was gathered from 348 consumers from Raipur, Bilaspur and Durg. Some of the results are enumerated.

Income Classes	Average Monthly Health Expense (₹)	Percentage of Total Monthly Income (in percent)
Low	526	14.14
Middle	825	4.30
High	1674	3.34

- **Financial Burden of Healthcare:** It was clear that households belonging to the low-income class in the sample spent a larger share (14.14 percent) of their monthly income on healthcare as compared to people from the other economic classes. In monetary terms, it was ₹526 for the respondents from low income classes.
- **Choice of Provider:** Though only 41 percent of the respondents in Chhattisgarh believed that the consultation fee they were paying for treatment was ‘fair’, a majority of them (67 percent) still preferred private sources of treatment.

Source of Treatment	Respondents (in percent)
Public Healthcare	31
Private Healthcare	67
Pharmacists	-
Others	2



- **Choice of Healthcare Provider vs Income Classes:** When the above data is disaggregated across income-classes, then an interesting trend is observed. There was a high propensity among

Source of Healthcare	Percentage of Low-Income	Consumers across - Middle Income	Income Classes ⁸ High-Income
Public Healthcare	47	7	16
Private Healthcare	50	93	84
Pharmacists	0	0	0
Others	3	0	0

the low-income households to visit private sources of healthcare (50 percent). Public healthcare facilities were visited by a few high-income households as well (16 percent).

- **Factors Determining Choice of Healthcare:** Proximity to a healthcare facility seems to be the deciding factor for the surveyed households when it comes to choosing a particular healthcare provider (public hospital, private hospital/clinic, others, etc.).
- **Availability of Medicines in Public Hospitals:** Out of the patients visiting public hospitals for treatment, it was revealed that 72 percent obtained medicines from the public hospital itself in Chhattisgarh. Although, this indicates that a majority of patients visiting public hospitals got their medicines there, but it still meant that one in every three patients visiting a public hospital in Chhattisgarh obtained his/her medicines from outside the public hospital.
- **Referrals for Diagnostic Tests:** Frequency of ‘referrals’ for diagnostic tests was very high as it was encountered by 88 percent respondents. An interesting pattern emerged when the data was segregated according to the income class. The 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 (34 percent) bears testimony 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 the state of Chhattisgarh, over 60 percent of the providers indicated that they offered such commissions/cuts.

Some of the **key messages** 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 greater use of public healthcare services among consumers.
- There is a common belief that a simple correlation exists between cost of (private) healthcare and its quality, which needs to be questioned.
- There is a need for greater consumer/public awareness on healthcare to ensure that consumers get affordable and quality medical treatment across all income classes. A change in consumer attitude towards healthcare is also 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 quality is concerned and there is hardly any regulation to maintain a minimum standard of treatment.
- An extremely high frequency of referrals (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/annihilate 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.

- The existence of such arrangements/practices increases the cost of healthcare services and makes it unaffordable for the average consumers.

II. Prescribing Pattern and Analysis (in Public Healthcare Institutions)

A. Respondent’s Feedback on Public Healthcare System

The following patterns emerged from the analysis of the information gathered from the respondents who visited public healthcare institutions in the three towns in *Chhattisgarh*. The data was gathered by interviewing 259 respondents and by analysing their prescriptions and bills when they bought medicines from private sources. Information was gathered from respondents visiting the following public health institutions in Chhattisgarh:

- Dr. Ambedkar Hospital, Raipur
- District Hospital, Pandri
- District Hospital, Durg
- Chhattisgarh Institute of Medical Sciences (CIMS), Bilaspur

- *On an average, cost of drugs prescribed per prescription (prescription cost) in public hospitals were higher, where medicines were being mostly bought from outside (private) sources.* This is clearly evident from the data of Dr. Ambedkar Hospital (Raipur), District Hospital (Pandri) and District Hospital (Durg) – see Figure 3. Though medicines were mostly bought from private sources even in case of the CIMS (Bilaspur) hospital, the average cost of prescription was not as high as in case of Dr. Ambedkar Hospital (Raipur). A possible explanation was that much more *rational drugs*⁹ were prescribed in the CIMS (Bilaspur) as

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

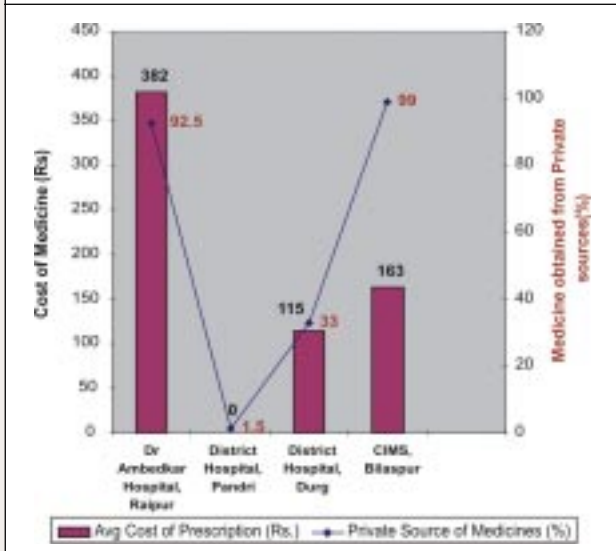
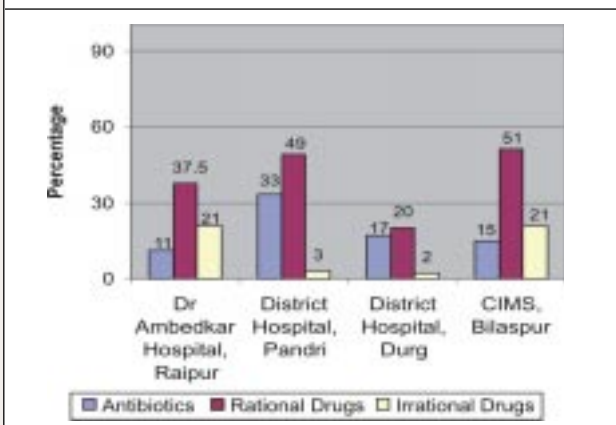


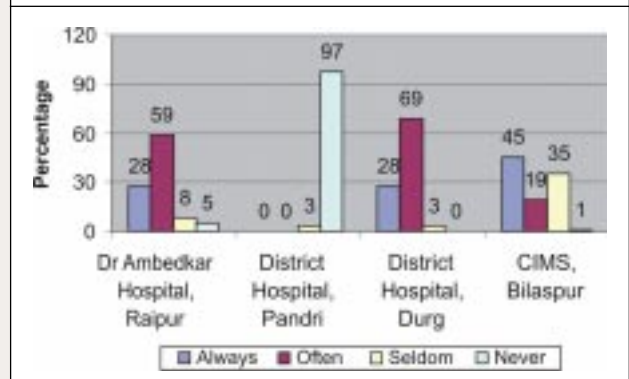
Figure 4: Prescribing Pattern in Public Hospitals (Chhattisgarh)



compared to Dr. Ambedkar Hospital (Figure 4). The District Hospital, Pandri emerges as a clear winner in terms of making medicines available to consumers – as it provided medicines for free to almost all consumers. Analysis of the pattern of medicines also indicated that a large volume of essential drugs (49 percent) were prescribed in the District Hospital, Pandri and very little irrational drug use was recorded.

- *Medicines prescribed in three hospitals (except the District Hospital, Pandri) were mostly procured from private sources.* Most of the respondents (97 percent) visiting the District Hospital, Durg bought medicines from outside (private) sources. This figure was just a little lower in Dr. Ambedkar Hospital, Raipur

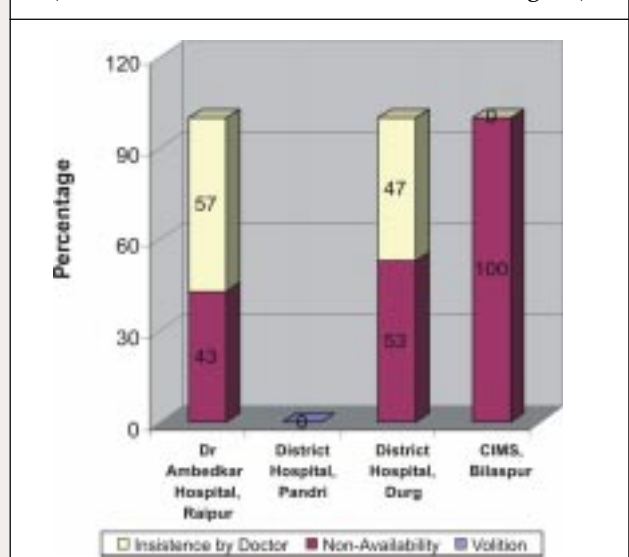
Figure 5: Procurement Pattern of Medicines (Public Healthcare Institutions in Chhattisgarh)



(87 percent) and significantly less in the CIMS, Bilaspur (55 percent). In the District Hospital, Pandri the respondents indicated that on most of the occasions (97 percent), they were provided the medicines from within the hospital.

- *Non-availability of drugs emerges as the main reason that respondents bought the medicines from private sources outside the hospital.* Provision of drugs through government health institutions is the responsibility of the state government and non-availability of medicines in public hospitals is an alarming situation (if this is found to be true on a larger scale as well). This can reduce the interest and intention of consumers further to seek healthcare services

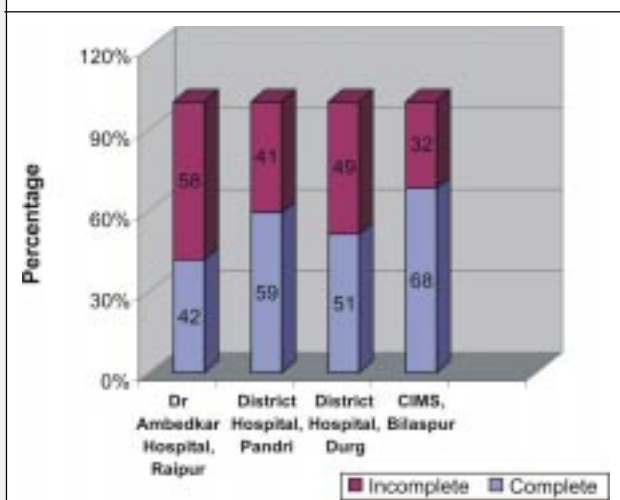
Figure 6: Reason for Buying Medicines from Private Sources (Public Healthcare Institutions in Chhattisgarh)



from public health institutions and increase the cost of healthcare even more for them.

Further, if the problem of non-availability lingers for a long time in a healthcare institution, then over time a tendency of ‘deflecting’ consumers to the private healthcare is created by the system. Again, the District Hospital, Pandri fared the best in this regard, as all medicines were available (for free) from this hospital. No drugs were available in CIMS, Bilaspur, while nearly half of the respondents in Dr. Ambedkar Hospital, Raipur (57 percent) and District Hospital, Durg (47 percent) complained of non-availability of medicines in both these hospitals.

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



- A close analysis of the prescribing pattern suggest problems with regard to ‘Completion of Diagnosis’ in most of prescriptions. The highest percentage of ‘incomplete diagnosis’ was noted in the Dr. Ambedkar Hospital, Raipur (58 percent), while it was least (32 percent) at CIMS, Bilaspur.

Some of the *key messages* that emerged from the results are:

- Although prescription of *rational medicines* was common in public hospitals, still a *large number of respondents bought medicines from private sources* while getting treated at public hospitals.

- *Non availability of drugs in public hospitals* was the main reason that respondents had to rely on private sources to obtain medicines. On an average 65 percent respondents indicated having encountered such non-availability of drugs in public hospitals in Chhattisgarh.
- *Insistence by doctors to obtain drugs from private sources* was quite significant (35 percent) in Chhattisgarh. This could either be due to their reliance on drugs that are only available in the private chemist shops, or simply because these doctors get a commission cut from these private chemists.
- A glaring fact was the *high percentage of incompleteness of diagnosis*, as revealed from the analysis of prescriptions. Nearly half (45 percent) of the prescriptions collected from Chhattisgarh did not bear any evidence of ‘signs and symptoms’ and/or ‘preliminary diagnosis’ in them.

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 occasion 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 consumers were being forcefully diverted to the private chemists to buy medicines in spite of the availability of medicines 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*

Figure 8: Publicly displayed Stock Register of District Hospital, Pandri

- *Of the medicines that were absent in the hospital stock list, some (14 percent) had substitutes that were available in the hospital stock but were not prescribed.*

- *A high percentage (43 percent) of medicines from the State List of Essential Medicines were absent in hospitals.*

CUTS urges the state government to immediately intervene and initiate investigation to clearly find out the reason that medicines that were present in the hospital stock list were not being offered to consumers seeking these medicines, forcing them to buy these medicines from the private sources.

Hospital Stock List from the other two hospitals (Ambedkar Hospital in Raipur and District Hospital in Durg) could not be obtained, and we suspect a similar pattern emerging. Further, the state government also needs to strengthen its drug procurement and distribution policy/strategy in public hospitals, as ‘stock-out’ has been encountered as well.

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.

why information about the stock of medicines in a public hospital should not be available the public domain?. This information is in public interest and therefore should be displayed publicly inside the hospital. During the survey, it was noted that the *District Hospital, Pandri* had publicly displayed the stock of medicines available. This is a good practice (see Figure 8) and should be made mandatory by state governments immediately, and properly monitored.

Stock list could only be obtained from CIMS, Chhattisgarh in order to undertake this assessment in Chhattisgarh, and Table 7 presents the analysis.

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

- *Over a third (36 percent) of drugs that were obtained by consumers from private sources (outside chemists) were available as per the record in the Hospital Stock List.*

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
CIMS, Bilaspur	190	68	36	122	14	43	52

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 also gathered from Raipur (Chhattisgarh) during the survey in order to identify some 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 ₹334. It was interesting to compare this figure with the average amount spent by people on medicines when visiting a public healthcare institution in Raipur (Dr. Ambedkar Hospital). The amount spent by respondents for medicines was ₹382 there.
- *Incompleteness of diagnosis* was observed in a third (34 percent) of prescriptions of private healthcare providers. This was much higher (58 percent) in the above public healthcare institution in Raipur.
- *Polypharmacy* (prescription of 4 or more drugs) was rampant and encountered over half (57 percent) of prescriptions collected from private providers. In Ambedkar Hospital (government hospital) in Raipur, polypharmacy was encountered in less cases (33 percent).
- *Irrational drug use* was being practiced on a large-scale, as it was observed in 41 percent of the prescriptions that were gathered from the private providers. Though irrational drug prescription was quite common (20 percent) in the above-mentioned public hospital in Raipur – yet it was much less than what was observed among the private providers.

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 strands – (i) issues for policy; and (ii) issues for consumer awareness and actions.

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 the public hospitals. For this, state level policies and ‘action programmes’ should be developed and implemented urgently.
- *Public disclosure of hospital stock of medicines* – A small step that can make a huge impact is that state governments should make it mandatory for public hospitals to publicly display their stock of medicines, and the figures (of current stock) should be renewed on a day to day basis and displayed in a prominent location in the hospital.
- *Periodic scrutiny of prescription patterns* – CUTS and the partner organisation (SUTRA Consulting) wanted to cover more prescriptions in its survey, but the lack of time prevented this. Though, CUTS has plans to repeat this exercise in these public healthcare institutions to see any improvements, but such an exercise should also be initiated by the state government and implemented in cooperation with local civil society organisations (CSOs). CUTS partner in the state (SUTRA Consulting) is well-equipped now to undertake this work.
- *Monitoring of chemists/pharmacies in close proximity of public hospitals* – State government authorities should undertake periodic (and ‘unannounced’) visits to private chemists and pharmacies outside public hospitals, and also get feedback from consumers visiting them.

- **Greater attention towards patients** – Doctors needed to spend more time on the consumer who is seeking healthcare service and document (in the prescription) ‘signs/symptoms’ and a ‘preliminary diagnosis’.
- **Identify ‘good practices’ within the state and replicate them** – The study reveals that there are ‘good practice’ hospitals that are existent in the state. 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 to emulate such ‘good practice cases’ in the other public healthcare institutions.
- **Adoption of the Clinical Establishment Act 2010** – All the states should adopt this at the earliest, to ensure a minimum standard of healthcare for consumers.
- **Prescription Audit** – The Central and state government need to cooperate in order to figure out the best way of implementing a prescription audit procedure for all drugs (currently, the antibiotic policy recently developed by the Central government covers only antibiotics for this audit).
- **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 consumer should demand for these from them. When they visit pharmacists with prescriptions with generic drugs written on them – they should ask 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 pharmacists. It is a practice to sell medicines at MRP only.

Issues for consumer awareness and actions 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.

CUTS encourages CSOs across the state of *Chhattisgarh* 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 For the purpose of this study, a classification of the respondents into income classes was done on the basis of the following measurement: (a) Low-income households were those with a total monthly household income less than ₹10,000; (b) Middle-income households were those with a total monthly household income between ₹10,000 to 40,000; and (c) High-income households were those with an average monthly household income above ₹40,000. The average household size was considered to be five individuals for this study.
- 9 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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