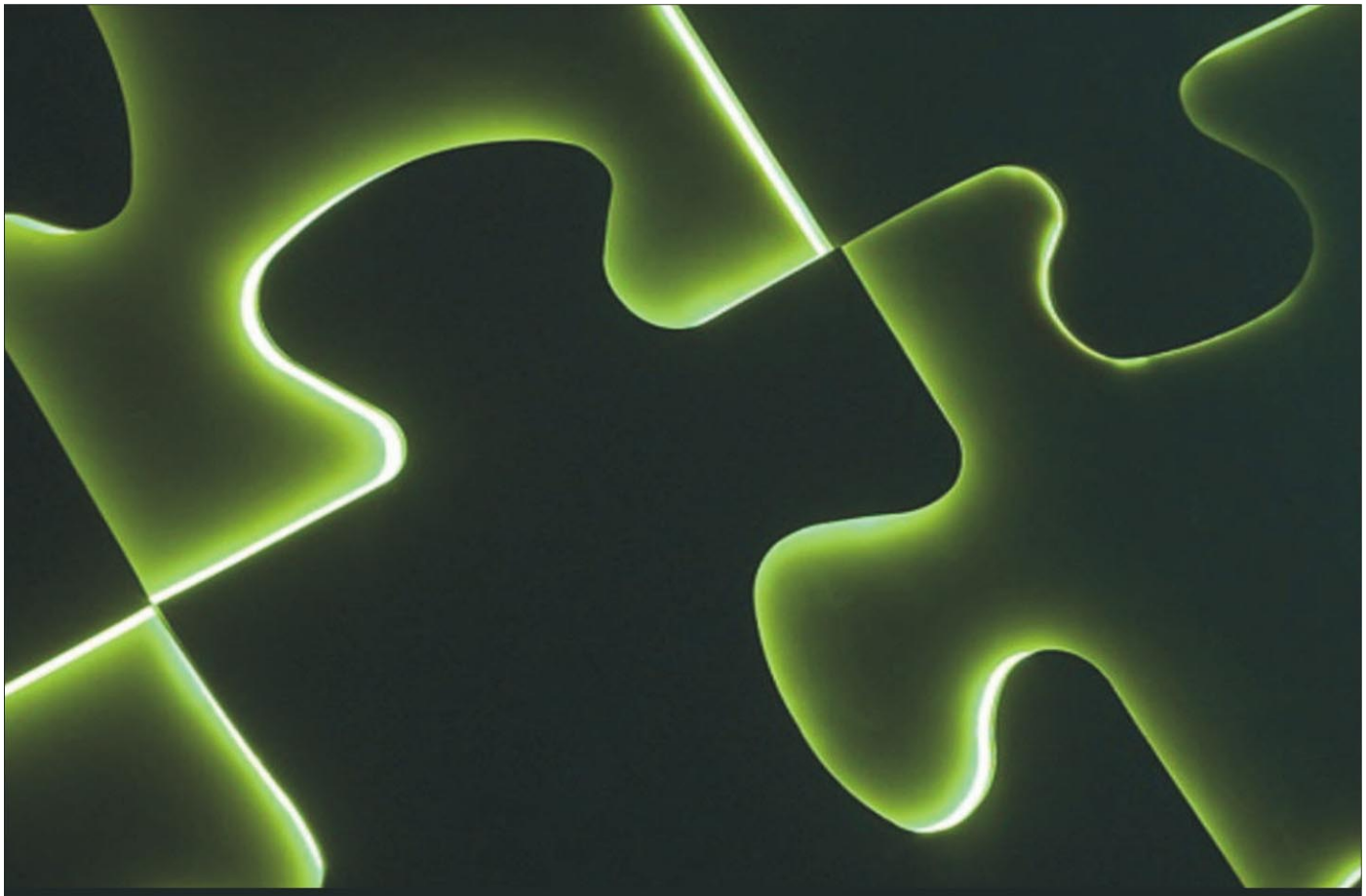

Unholy Alliances in Healthcare Services

Collusive Behaviour in Healthcare and Impact on Consumers:
Evidence from Assam and Chhattisgarh

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Foreword

The provision of adequate, reliable and accessible healthcare continues to remain a challenge to the Government. The provision of health care is a prime responsibility of the government, as enshrined in the Constitution of the Republic. One of the main challenges for the Government today is to be able to reach out to the vast population, which remains deprived of quality health services in the country. In its blueprint of the 12th Five Year Plan (2012-17), the government has identified healthcare as a priority. It has set itself a healthcare financing target of 2.5 percent of the GDP for the present plan period, which is critical for the country to come close to the Millennium Development Goals (MDG) targets by 2015.

Evidence on the healthcare sector and provision of services both by the public and private sector reveals a mixed picture of success and failure. While there is a tendency to be overcritical of the public health centres, even some private healthcare services are questionable. The questions that emerge are myriad given the complexity of the problem. Are hospitals (government) badly run or are they over-burdened; are doctors low on their responsibilities or they are overburdened; is there collusion between hospitals and chemists and between chemists and doctors or with diagnostic facilities. I would hesitate to make any generalisations. Nevertheless the scope for improvement and better provision of health care services is vast and the growing huge gap between demand and supply highlights the need for concentrated efforts on the part of both government and private providers including NGO's given a tendency to deride all government efforts.

CUTS has produced an interesting report based on its assessment of consumer access to healthcare services in two states of the country. This report is opportune, and raises a number of issues (based on evidence gathered from Assam and Chhattisgarh) for both the state and the central government to take cognisance and initiate appropriate actions. The study highlights predominance of various practices by healthcare providers at the micro-level. Owing to the huge gap that exists between supply and demand for healthcare services, a wide diversity of private providers (ranging from small clinics to big multi-speciality hospitals run by big corporates) have been providing healthcare services in India, alongside the government. While the cost of public healthcare services has been consistently maintained at low-levels, the efficacy of the sector has often been questioned.

CUTS in their study have identified three main issues.

- Lack of an appropriate regulator that spans all segments of the sector
- Possibility of collusion among the different players at different levels
- Consumer ignorance fed on by opacity of information or perhaps misinformation

Lack of effective regulation has been indentified as a major factor of concern. The existing framework to regulate the healthcare sector is ambiguous and hence often ineffective. Several institutions are empowered to intervene on matters having public interest implications, yet such actions are often few and far in between.

The possibility of collusion is yet another area that no doubt needs investigation. There are several levels and layers for collusions and calls for more carefully delineation of the specific areas and forms of collusion especially in the light of ambiguous regulation. Competition Commission of India is alert on this front. Private participation is likely to remain high in this sector to meet the ever burgeoning demand of the increasing populace, whereas the government has to introspect and might need to improvise its role if need be. From the evidence gathered in Assam and Chhattisgarh, CUTS and its partners point towards the possibility of collusive practices among various actors in healthcare that stifle the availability of such services for consumers.

The CUTS study also points to the major role played by advocacy. Consumer awareness of the available facilities and right to information in the public domain on drugs, diseases and their treatment, and the facilities that patients are entitled to is a major countervailing power for ensuring proper healthcare facilities. From the study the impression gained is that consumer ignorance and perhaps biases do tend to diminish the benefits of the gains from the 'generic capability' of India. Public information on the efficacy of simple drugs made known to consumers can go a long way to curb the noted tendency of preferring expensive drugs or even the cases cited of collusion between chemists and doctors. On a different level there is also the need for enabling detailed and universal classification of drugs and chemicals between branded generic and generic drugs.

Irrespective of actions initiated by regulators like the CCI, civil society organisations that have much better grip and presence on the ground will need to bring such issues to the attention of relevant government departments and authorities, thereby complementing the government's efforts to ensure better healthcare services for all citizens. CUTS and its partners have been able to highlight the situation in parts of Assam and Chattisgarh, and will definitely be a catalyst for further action oriented research.

Dr. Geeta Gouri
Member, Competition Commission of India
New Delhi, India

Preface

This report is an outcome of a research project that aims to identify collusive practices among the healthcare providers and its impact on consumers and provide feasible solutions and strategies for addressing concerns emanating from such deceptive and collusive practices

Various imperfections in the market for healthcare services remain due to the combination of a number of factors, including huge information asymmetries 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 provide greater commercial benefits to providers, to the detriment of consumers. It is, therefore, reasonable 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.

Healthcare services in the country are characterised by a profound contrast in performance between the private and public sectors. While the upsurge in private participation in this sector would continue to meet the demand of the increasing population, government needs to assess and adjust its role in this emerging environment.

The rising cost of delivering healthcare services by the state and other partners in the healthcare system is assuming critical importance. There is a vast vulnerable population which needs these services and despite the increasing healthcare network, still remains deprived of quality health services. One of the biggest concerns in the country is about people being taken advantage of by unscrupulous healthcare providers. The mechanisms to regulate the healthcare market are quite blurry, although there are several key institutions that, taken together, could play a valuable role. However, none of these can effectively address India's key regulatory concerns.

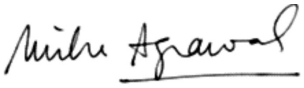
As a organisations working for protecting the interest of common people, CUTS and Oxfam India are interested in understanding the nature and degree of such malpractices and exploring measures (legal, policy, ground actions, etc.) that would help curb them. CUTS embarked on a project entitled, 'Collusive Behaviour in Healthcare Delivery in India: Need for Effective Regulation' referred to as COHED in partnership with Oxfam India to study some of these inter-relations (arrangements) between providers in the healthcare value chain in two states of the country – Assam and Chhattisgarh, as a starter.

As part of the project, CUTS along with local partners of Oxfam India gathered evidence from consumers and healthcare providers in select towns from these states about the existing collusive/deceptive practices encountered in healthcare delivery. In subsequent phases, an investigative research through the tool of prescription audit was conducted among few public hospitals in these towns to find out the prescribing practices of doctors and the availability of medicines in these hospitals.

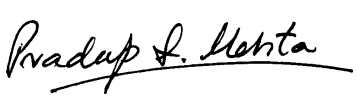
The review and analysis of information gathered from these two states indicated the possibility of collusive practices among various players in the public healthcare system aimed at restricting the availability of medicines for consumers. It is evident that there are challenges in public procurement of medicines in these two states, as it was revealed that a number of medicines were not available there. A steady supply of medicines and information to the consumers about their availability in the public health institutions would ensure that medicines are available (at no cost) to consumers who need them the most.

On the basis of review and the field work undertaken, certain conclusions have been derived and recommendations made to ensure that a more people-friendly healthcare system is evolved.

CUTS and Oxfam India are 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 greater scrutiny by civil society at the micro-level and also provide useful leads for the Competition Commission of India (CCI) to initiate investigations.



Nisha Agarwal
Chief Executive Officer, Oxfam India



Pradeep S Mehta
Secretary General, CUTS

Acknowledgements

The project entitled, 'Collusive Behaviour in Health Delivery in India: Need for Effective Regulation' popularly referred to as COHED, is an attempt in improving the affordability and quality of health care in India. It is an endeavour aimed at generating recognition among the government (centre and state), media and the civil society about the relationship between incidence of anticompetitive/deceptive practices in healthcare and quality of healthcare services, especially for ordinary consumer.

We express our gratitude to Oxfam India for their support in implementing this project. Successful implementation of this project would not have been possible without the assistance provided by the two project partners – Sutra Consulting in Chhattisgarh and Action North East Trust (the ant) in Assam. Contributions by Sunil Kaul, Shelley Dhar, Alok Acharya and Jagannath Kompella deserves special mention here. We are also thankful to stakeholders in the two states, various other scholars and practitioners.

This research report was prepared under the guidance of health sector experts who comprise the advisory committee of this project. Vikash Batham was responsible for the overall implementation and management of this endeavour. Bipul Chatterjee and Siddhartha Mitra provided their inputs during the design phase. Naseem Ahmed, Madhuri Vasnani and Mukesh Tyagi helped in various stages of the project.

We are thankful to Dr Geeta Gouri, Member, Competition Commission of India (CCI) for writing an encouraging 'Foreword', and the continuous support.

CUTS believes that the experience gained over the period of implementation of this project and the friends we were able to make during this period would continue to motivate and inspire us for developing such interventions, and deepening our work in the health sector in these two states and other parts of the country.

1
Executive Summary

As a consumer organisation committed to protecting rights of consumers in the country, CUTS (Consumer Unity & Trust Society) has undertaken various initiatives to raise important (and often overlooked) issues that are critical for promoting consumers' interests. Healthcare provision as a critical element of consumer welfare, and its importance in a country like ours cannot be over-emphasised. In India although provision of quality and affordable healthcare is a constitutional commitment, yet implementation of policies, laws, rules, etc. to translate this intent to actions has been rather laggard. A case in point is the foot-dragging that has happened with the National Health Bill drafted over two years ago (2009) by the Ministry of Health & Family Welfare, Government of India. There does not seem to be much forward movement in case of this legislation, which is a first major step towards legalising 'right to healthcare' in the country.

Unregulated private healthcare that has thrived on account of an inefficient public healthcare system in the country, coupled with information asymmetry (and even absence of information) has really left consumers at the mercy of healthcare providers. Even after they have invested huge sums of money on healthcare (which further impoverish them), consumers are not assured of quality treatment. Considerable out-of-pocket expenses towards healthcare highlight the lack of social protection in this area for the average Indian consumer. It is also startling that even when they visit public healthcare institutions, consumers have to dole out money for obtaining healthcare services. A large proportion of such expenses are towards medicines.

A number of state governments claim to be providing medicines for free to consumers getting treated in public healthcare institutions. So, why is it that they still have to buy drugs from private sources? CUTS has endeavoured to find answers to this in the project entitled, ***Collusive Behaviour in Health Delivery in India: Need for Effective Regulation*** *(referred to as* ***COHED project****, www.cuts-ccier.org/COHED)*. Analysis of information

gathered from the states of Assam and Chhattisgarh during the implementation of this project point towards the possibility of collusive practices between various actors in public hospitals/health system aimed at restricting the availability of medicines for consumers, as was revealed in most of the public hospitals covered under the study.

Private healthcare remains unregulated and prone to malpractices. One of the most common malpractices is the 'usual practice' of cuts or commissions available to doctors for referring patients to diagnostic/pathological tests. This often influences doctors to subject patients to unnecessary medical investigations increasing the financial burden on consumers, further. The lack of 'standard treatment protocol' and monitoring of prescriptions make it impossible to implicate the perpetrators of such malpractice. It was noticed in both the states that paying such cuts/commissions was a 'usual practice'. Existence of such malpractices by healthcare providers and the allegiance between doctors and pharmaceutical companies was confirmed by 'insiders' (medical representatives) who were interviewed during the course of this study.

Alleged collusive behaviour can be investigated by the Competition Commission of India (CCI), which is also empowered to take punitive actions in case existences of such practices are confirmed. In addition to taking such *ex-post* actions (through regulatory interventions) on malpractices in the healthcare sector, *ex-ante* treatment to reduce the 'motivation' behind such malpractices is also critical.

It is evident that there are challenges in public procurement of medicines in these two states, as it was revealed that a number of medicines were not available in them. A steady supply of medicines and (public) information to the consumers about their availability in the public health institutions would ensure that medicines are available (at no cost) to consumers who need them the most.

This report tries to identify feasible solutions and strategies for addressing concerns emanating from collusive practices in healthcare delivery in two states of Assam and Chhattisgarh – and would form the basis for advocacy and ground actions in them. The ultimate goal is to contribute to the process of evolving consumer-friendly healthcare systems in these two and other states of the country.

2
Introduction

2.1 Healthcare Sector in India

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. There are also inequities based on rural urban divides, gender imbalances and caste patterns. If as a country, India is to achieve improvements *vis-à-vis* universal health coverage[2] and come close to achieving the 2015 healthcare related targets of the Millennium Development Goals, there is an urgent need to highlight policy-areas that would require refinements and immediate (and effective) implementation. This is opportune, especially, considering that the government is in the process of developing the blueprint of the 12th Five Year Plan (2012-17) and has resolved for a greater thrust to the health sector not only in terms of curative care but also in terms of prevention[3] .

The Ministry of Health & Family Welfare (MoHFW), Government of India drafted the National Health Bill over two years ago in 2009 – and the government should adopt it without further delay, given the Bill endeavours to address certain systemic problems (refer Box 1) that have weakened the health sector in the country.

Box 1: Important Features of the National Health Bill, 2009

- **Right to Healthcare** – The Health Bill 2009 seeks to legalise 'right to healthcare', along with other rights.
- **Good Treatment** – It will strive to ensure that good treatment be made available to the vastly neglected groups such as those affected by HIV/AIDS.
- **Collaborations between the Centre and the State** – The bill demand a broad legal framework (that involves cooperation/collaborations between the Centre and the State) for providing essential public health services and to monitor its functions, such as responding to public health emergencies.
- **Emergency Care** – According to the National Health Bill 2009 'Patient's Right' includes emergency care. No individual should be denied emergency treatment because of his inability to pay fees or due to the requirement for police clearance.
- **Patient Complaints** – The new bill also seeks to make it mandatory for hospitals to address patient complaints, on a 24 x 7 basis.
- **Name of Doctor Involved in Treatment** – Every patient has the right to know name of doctor/nurse involved in his/her treatment.
- **Summary & Second Opinion** – Each patient has the right to avail of a summary of their condition and also to seek a second opinion.
- **Cost of Treatment** – A patient may protest against overbilling, transferring elsewhere without valid reasons and for denying medical records.
- **Rights of healthcare provider** – The rights of healthcare providers is also likely to get legal recognition.

For more details, please vist: THE NATIONAL HEALTH BILL - 2009 http://www.medindia.net/news/indiaspecial/THE-NATIONAL-HEALTH-BILL-2009-49956-1.htm#ixzz1MsGSPr6R

Source: www.medindia.net, April 14, 2009

The Indian health sector has registered appreciable growth in recent times and attracted considerable private investments. It is one of the fastest growing segments of the Indian economy, and expected to contribute eight percent to the gross domestic product (GDP) growth in 2012, as compared to 5.5 percent in 2009. The healthcare sector in India is expected to become a US$280bn industry in 2020.[4] 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),[5] and many who are somehow able to access these services are further impoverished.

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 expenditures. 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. In some states, such as Uttar Pradesh, Maharashtra and West Bengal, over eight percent of households were impoverished as a result of health expenditures.[6]

The *Annual Report to the People on Health* (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 urgent need for a comprehensive national health policy to help reconfigure the health system in the country – making it more efficient and equitable. It goes further in suggesting that such a policy must be evolved through wide-ranging consultations in which the voice of multiple segments of society are heard, unlike in the past where policies have been influenced mainly by recommendations of expert groups or international organisations.[7] One of the recommendations in this report is to raise public finance on healthcare to three percent of GDP to the current level (See Table 1).

Table 1: Public Expenditure on Health in India, 2005-10

Year	Public expenditure on health (percent of GDP)
2005-06	0.96
2006-07	0.98
2007-08	1.03
2008-09	1.10
2009-10	1.10

Source: *MoHFW, Government of India*

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.[8] These figures do not augur well for a country aiming to achieve universal coverage, so a greater commitment from the top policymakers is an imperative to ensure that at least the minimum healthcare needs of the population are met.

A recent phenomenon that has invited a lot of public attention and criticism by observers, especially from the perspective of availability of medicines, is the changing anatomy of the pharmaceutical sector in the country.[9] This sector has witnessed an unprecedented number of mergers and acquisitions involving big Indian pharmaceutical companies (those with a considerable generic 'product line') by large multinational corporations (MNCs), who specialise in patented drugs. This is likely to take the price of medicines further northwards, and restrict the volume of generic medicines supply in the market. The government has taken cognisance and recommended the use of tools like 'compulsory licensing' to maintain supply of drugs in the market in case there is a fall. It is a pity that these (above) mergers did not have to pass through the CCI's scanner (as provisions pertaining to merger review of the Competition Act 2002 of India, had not been notified then). In late 2010, the Supreme Court also directed the national government to bring all drugs under the *National List of Essential Medicines* (NLEM) under price control,[10] but the progress on this front has been very sluggish with a few piece-meal measures taken and proposed. Evidently, there is industry pressure against swift forward movement on this front, though the government is determined to revise the NLEM once every two years, now onwards.

The MoHFW issued an order nearly a year ago (Order SS-11025/45/10-MH-1, May 26, 2010), that government hospitals should prescribe generic medicines to the patients only. Subsequently, the state governments were also asked to ensure that doctors in public hospitals prescribed only generic drugs (as contained in the 45th Report of the *Parliamentary Standing Committee on Health and Family Welfare, August 2010*).[11] However, it is evident that such practices have not been adopted by the state governments in most states (expect a few like Haryana, Bihar and Tamil Nadu), and that the consumer continue to pay high prices for drugs. 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. An Inter-Ministerial Committee was also recommended by the

Parliamentary Standing Committee on Health and Family Welfare, but there is no visible movement forward in this regard. Many recommendations made by working groups/committees (under the 11th FYP or earlier) have still not seen the light of the day.[12] Further, while health related issues are under the purview of states (State List), the Central Government continues to make policies and relay them to states hoping for their effective implementation.

If the current healthcare situation in the country has to be improved, there is a need to evolve a 'balanced policy' on drug production and distribution in the country – one that would not dampen the spirit of innovation of the industry (drug producers) and yet make drugs easily available at low price to consumers. Lack of appropriate regulatory oversight in healthcare (as an integral part government's social protection measure) remains a huge challenge, especially given the role that private providers play in the healthcare delivery in the country. Whether it is concern over cost, quality, access and availability of healthcare facilities; or the nexus between various players in the healthcare value chain, consumers continue to remain at the mercy of the providers and have little say or choice while seeking healthcare services in the country.

Table 2: Healthcare Institutions in India (MoHFW, 2010)

Healthcare Institutions	**Number**
Health Sub-Centres	146,036
PHCs	23,458
CHCs	4,276
Public Hospitals	4,831
Private Hospitals	10,266

Source: Ministry of Health & Family Welfare, GoI

It is evident from the above discussion that certain key policy-areas need to be bolstered in healthcare delivery in the country, to ensure that quality healthcare can be easily accessed by a large number of citizen consumers at affordable costs. These policy-areas as enumerated below:

- Better coordination between Centre and states in evolving and implementing healthcare policies in the country
- Boosting healthcare financing to achieve universal health coverage as prescribed in the World Health Report 2010

- Efforts to ensure ready supply of generic medicines to the market and their easy availability for consumers
- Fast tracking development of a regulatory framework to supervise behaviour of providers and healthcare institutions in the country

2.2 Project Rationale

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 at different levels across India. Perpetrators of such malpractices are driven by the urge for greater commercial benefits at the detriment of consumers, especially given the gross absence of regulatory supervisions in this sector. 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. As a consumer organisation working to protect the interest of consumers', it is CUTS responsibility to understand the nature and degree of such malpractices and explore legal and policy measures that would help curb them. CUTS has been actively engaged in the area of healthcare (especially from a consumers' perspective) for a long period now – as is provided in Box 2.

Box 2: CUTS History of Working on Consumers related Health Sector Concerns

- One of the very first initiatives by CUTS in the arena of health and consumer safety was a Study of Drug Prescription Practices in India, undertaken in 1995. The study was conducted in six states, viz. West Bengal, Andhra Pradesh, Rajasthan, Maharashtra, Gujarat & Tamil Nadu and involved an all-India survey undertaken in association with the Voluntary Consumer Action Network (V-CAN). Data of nearly 2000 prescriptions were collected from these states and assessed for rationality by experts. The study revealed that there was a gross tendency to prescribe useless medicines and the dire need for prescription audit practices in healthcare systems.

- In 2004 CUTS, in association with Community Development Medicinal Unit (CDMU), Kolkata undertook a project entitled "An Assessment of Medicine Prices

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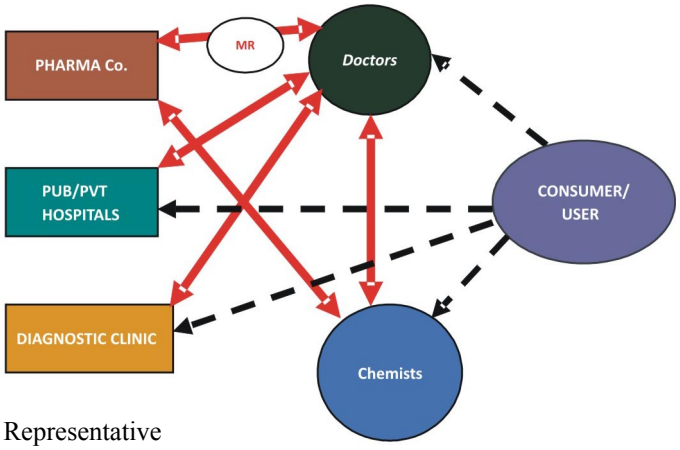
vis-à-vis Quality in Different Healthcare Sectors in West Bengal with Reference to Affordability & Availability of Essential Medicines" (report available at: *www.cuts-international.org/CRC/Consumer_Health/pdf/Report-Medicine_Prices_and_Affordability.pdf)*. Under this project, a survey was conducted to assess the affordability & availability of a pre-selected basket of medicines by collecting information on prices consumers are paying at different medical outlets and procurement prices at public facilities of those medicines. The initiative was supported by the World Health Organisation (WHO) and Health Action International (HAI).

- CUTS worked on Rational Use of Drugs with support from the WHO in 2005. It was aimed at promotion of rational use of drugs through patient information material and consumer awareness programmes. A Patient Information Manual (PIM) that CUTS had prepared provided a set of drug related do's and don'ts for consumers and inform them about what constitutes good practice related to drugs. The PIM (available at: *www.cuts-international.org/CRC/Consumer_Health/pdf/Report-Patient_Information_Material.pdf*) was tested through survey and group discussions in the four metros and five other state capitals in India. Based on the PIM, publicity material such as posters, leaflets and audio-visual aids were designed and a number of awareness programmes and workshops were conducted by CUTS.

- CUTS implemented a research assignment in 2006 with support from the WHO and MoHFW, Government of India looking at state of competition in the Pharmaceutical market and Healthcare delivery[13] in India. One of the issues highlighted was that the nature of the healthcare market in India is uncommon to any other – as consumers are mostly not involved in the decision making processes to buy goods (medicines) or services (healthcare services), and have to rely on the doctor's advice.[14] This is one of the prime contributors to market malpractices in the healthcare sector, at various levels. There is consensus and documentary evidence that such malpractices emanate from arrangements between/among various providers (see Box 3).

Market players in the healthcare sector are related to one another through a complex net. A simple representation of the same is presented in Figure 1. It is clear that *the doctor* represents the most important provider of healthcare services for consumers in India. Interactions of the consumers with other players in the healthcare services sector (government hospital, private hospital, diagnostic clinic and chemist, Figure 1) are often facilitated by/through the doctor.

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



MR: Medical Representative

Source: CUTS, 2011

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**. These two states were chosen specifically because these had been identified among 16 states by the government having weak public health indicators and infrastructure. Besides, Oxfam India who supported this study was keen to focus its healthcare work in seven states[15] of the country including Assam and Chhattisgarh. Specifically, the project was implemented 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 malpractice 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 about these recommendations so to lay the ground for their implementation.

As indicated above, one of the objectives was to understand if some of the (alleged) market malpractices infringed the provisions of the Competition Act 2002, which

prohibit entities from engaging with anti-competitive practices. In case the evidence suggests the above possibilities, then the CCI would be urged to initiate investigations.

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. Though healthcare services rendered to a patient by a medical practitioner would fall under the ambit of Consumer Protection Act, 1986, however, even this instrument remains grossly ineffective against medical negligence as the responsibility of proving negligence lies with the consumer.

Another regulatory body, the Medical Council of India (MCI) has a list of medical misconducts that can be brought before the council, yet it does not specify punishments. This makes the institution toothless, even against very serious grievances. Remedial actions against malpractices can be more effective in an environment where citizen consumers are well-informed and the regulatory authorities are proactive in taking actions to curb malpractices. Gross absence of such a trend in the healthcare sector motivated CUTS to embark on the COHED project.

2.3 What are 'Collusive Practices'?

According to the Organisation for Economic Cooperation and Development (OECD), "Collusion refers to combinations, conspiracies or agreements among sellers to raise or fix prices and to reduce output in order to increase profits (OECD, 2002)". In simple terms, collusive practices are 'arrangements' made among/between market players (in specific markets) to garner higher revenues than otherwise accrue to them under normal market situations, and which have adverse effect on other market players as well as consumers. Impacts on other players in the market (who remain outside the circuit of such arrangements) include barriers to entry, access to raw materials/supplies, impediments to distributions channels and lack of access to consumers. Increased costs, reduced supply and limited choice of goods and services are some of the adverse impacts of such collusive agreements on consumers.

In 2002, India adopted a new Competition Act replacing the erstwhile Monopolies and Restrictive Trade Practices Act of 1969. The Competition Act 2002 (amended 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.[16] The CCI has been operational since the last couple of years, and has initiated investigations on various cases that were alleged to contravene the Act (above-mentioned provisions) in specific markets.[17]

CCI has already (June 2010) initiated investigation to assess alleged anti-competitive practices of the All India Organisation of Chemists and Druggists (AIOCD) – association of drug traders controlling about 90 percent of ₹60,000 crore domestic drug trade in the country.[18] Complaint from a new (rival) drug traders association prompted the CCI to initiate these discussions to check allegations that restrictive (collusive) agreements imposed by the AIOCD on its members affect the supply and cost of medicines at the retail end (which ultimately affect consumers). It would be worthwhile to see what orders CCI comes out with (in case AIOCD is found to contravene the Competition Act 2002) – and inform the general public of the economic loss incurred by them as a result of

Box 3: Brazilian Competition Agency Fines Pharma Cos.

This case illustrates collusive conduct in the pharmaceutical industry and is significant, because most of the companies involved in this case have a foothold in the Indian industry as well. Twenty pharmaceutical laboratories were recently fined by competition authorities in Brazil, for participating in a cartel, which allegedly attempted to boycott the entry of new generic medicines.

The laboratories involved include large multinational groups such as Roche, Aventis, Bayer, GlaxoWellcome and AstraZeneca. The intention of the cartel was to establish joint action involving general practitioners, to develop an information campaign against generics, thereby spreading what was regarded as, "distorted information". This case reveals collusion between pharmaceutical companies and doctors on the matter of barring generics, an issue of grave concern since patients usually implicitly rely on the advice meted out by their physicians and in such a case may be deprived of quality products at less expensive prices.

Source: 20 Pharma Laboratories Fined for Cartelisation, Folha News, October 13, 2005.

such collusive agreements by AIOCD. Competition agencies in various other developing countries like South Africa, Brazil, Zimbabwe have taken stern actions against perpetrators of collusive behaviour in the health sector. Now that the CCI is functioning and has started to investigate alleged violations of the Competition Act 2002, it would be necessary for the CCI to keep a close watch on the healthcare sector in the country.

CUTS and Oxfam India are 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 greater scrutiny by civil society at the micro-level and also provide useful leads for the CCI to initiate investigations. Pursuing this objective CUTS had designed the COHED project methodology such that relevant evidence can be gathered from two states – Assam and Chhattisgarh.

Table 3: 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's 'India at a Glance', Office of the Registrar of India

3
Project

3.1 Genesis

CUTS has been at the forefront of 'research-based-advocacy' on competition policy and law issues in the country – especially from a consumers' perspective. Prevalence of market malpractices at various levels in the healthcare delivery system and continued exclusion of economically oppressed consumers motivated CUTS to understand the nature of arrangements between the market players – in order to assess the link between market malpractices and their economic impacts on consumers. If some of these malpractices manifest from arrangements between market players that is construed as (alleged) collusive arrangements, then the CCI can be urged to initiate investigations and take appropriate corrective actions. In any case, the prevalence of such malpractices through connivance and tacit arrangements that affect citizen consumers cannot be tolerated, and should be taken stern actions against, whether it is the CCI (if these fall within their jurisdication) or other government departments/regulatory agencies. Such actions would not only ensure that consumers affected by such malpractices get relieved, but would also act as a deterrent for others.

3.2 Project States

The Indian Constitution has made healthcare services largely a responsibility of the state governments and thus, it primarily becomes the responsibility of the state to provide healthcare to all the 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.

CHHATTISGARH

The birth of this new state in the year 2000 carved out of Madhya Pradesh saw a reinforced enthusiasm in improving the health system to work towards better health status of 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 health sector to deliver community based health services. This opened the doors for structural changes in the health sector. The Government of Chhattisgarh commits itself to achieving the highest attainable level of physical, mental, and social health of its citizens through processes that will empower local communities and citizens as well as lead to poverty reduction paving way for equitable and gender sensitive communities in the state. Universal access to comprehensive quality primary healthcare is a priority for the state.

A number of policies underlying affirmative action in healthcare sector have been undertaken by the state government, as are presented below:

- ***Revision of Essential Drug List:*** Rational use of drugs is a burning issue dogging the nation. To address the same, Chhattisgarh formulated an *Essential Drug List* in 2002. The same was revised in 2007 to contain 350 drugs and consumables. Currently, a revised version of *Essential Drug List* 2010 is being developed by the state government.
- ***The 'Mitanin' Programme***: The *'Mitanin'* scheme of community based health services that began as a small community-level project has become a huge success in the state and is also being considered for replication in other parts of the country. The programme/scheme involves *'Mitanins'* (*Chhattigarhi* for 'Friend) or voluntary health activists who provide voluntary health services across hamlets/villages in the state. Currently, there are about 60,000 such *'Mitanins'* in the state.
- ***Improving Performance of the Hospitals: The Jeevan Deep Approach*** – In order to improve the quality of management of the government run hospitals and to change the perceptions of general community about the poor quality of services in government hospitals, a pioneering hospital reform scheme called the *Jeevan Deep* Scheme has been put in place in the state. Under this novel scheme *hospital management committees* (called *Rogi Kalyan Samiti* OR *Jeevan Deep Samiti*) have been created for every level of government hospitals up to the Primary Health Centre (PHC). These committees will also have the power to recommend disciplinary action against non-performing officials. Under this scheme, every hospital in the state will be graded based on its service quality.

- ***Integrated Health and Population Policy 2007:-*** The formulation of the Integrated Health and Population Policy (IHPP) by the Government of Chhattisgarh is seen as yet another initiative to improve the health of the people of the state especially the disadvantaged. It acknowledges and recognises the pivotal contribution of socio-economic determinants of health, an important aspect in improving tribal health. The Policy document provides a comprehensive framework for strengthening the public health systems and healthcare delivery in the state.

- **The *Chhattisgarh State Integrated Health and Population Policy 2007*** reiterate the commitment of the state to promote health for all and to provide quality healthcare services. The Policy aims at sustainable human development by ensuring that every citizen has adequate access to the basic essentials of life, reducing socio-economic disparities, improving the quality of life, and stabilising the population. In spite of such a reformist attitude towards healthcare provision, the State has a number of challenges in the healthcare sector that still need to be tackled on a priority basis. One of them is a high Infant Mortality Rate (IMR of 57 per 1,000 live births, which is above the country average of 53). The other is with respect to immunisation – less than half of the children (between 12-23 months) are fully immunised (BCG, measles and 3 doses each of Polio/ DPT).

With regard to health infrastructure, the number of health facilities in the state has steadily increased over time, as has been illustrated in Table 4.

Table 4: 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 Hospitals	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				

ASSAM

Despite its rich natural resources and high concentration of business and economic activities among the Northeastern states, Assam has not been able to achieve the desired health outcomes. 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.[19] It has the country's highest rate of maternal mortality rate (MMR), as per the latest official data. According to experts, insurgency which affects access to healthcare services is one of the main reasons for this. According to the Sample Registration Services (SRS) 2004-2006, the MMR for Assam was 480 per 100,000 live births – the highest in the country.

In order to address these and some of the other challenges facing the state *vis-à-vis* healthcare issues, certain reform measures have been adopted by the state for the healthcare sector. Some that are relevant for this report are enumerated below:

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

The current status of healthcare infrastructure in the state is summarised in the Table 5:[20]

Table 5: 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
Primary 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

3.3 Project Partners

The two partners chosen for this study were the Action North-East Trust (the ant) from Assam and SUTRA Consulting from Chhattisgarh. Both these organisations have been working in the health sector in these states. CUTS had discussions with these partners including at the launch meeting of this project, when the research methodology was discussed and the tasks that each of these partners would be involved with was elucidated to them. The activities to be conducted by these partners included broadly three items – (i) Fieldwork and Survey, (ii) State-level dialogues, and (iii) State-level dissemination and advocacy.

3.4 First Stage of Survey – Survey of Consumers

The main purpose of this survey (primary survey) was to gather evidence (to the extent possible) of collusive arrangements in the states. Three towns each from **Assam (Guwahati, Bongaigaon and Nagaon)** and **Chhattisgarh (Raipur, Bilaspur, Durg)** were chosen for this survey. The nature and extent of such practices would assist CUTS to suggest remedial/corrective measures. This survey was conducted by administering a questionnaire to consumers (refer ***Annexure 1***), in order to elicit information about various aspects of healthcare delivery – for example household expenditure on healthcare, behaviour of heathcare providers, availability of healthcare services, prices of such services, etc. While undertaking this survey, the surveyors also gathered relevant qualitative information that corroborate (and/or supplement) the information collected by administering the questionnaire. Further, information was also gathered from diagnostic labs/pathological clinics in order to record the prevalence of 'cut' practices in the select towns in the two states (refer ***Annexure 2*** for the questionnaire that was used for this).

Size of sample – a sample of approximately 300 adults (18 years and above) surveyed in the first phase. [Another 300 respondents would be surveyed in the second phase, for which a methodology would be separately devised].

Selection of respondents – selection of respondents would be done (to the extent possible), such that they represent the following three income classes:[21]

a. High income group
b. Middle income group
c. Low income group

The surveyor(s) carried out these surveys by interviewing (willing) consumers/ users (of healthcare services), who come for treatment at public and private hospitals in the selected cities/town. The surveyor used visual enquiry skills to determine if the respondent belonged to the high, middle or low income groups. This was also cross-checked by the surveyor while filling-up the questionnaire.

Some salient features of the survey process are indicated below:

- Special attention was paid to ensure that distribution of the above three classes within the sample population is in the right proportion (to the extent possible) – so that a larger picture can emerge.
- Data was collected from consumers by visiting public and private hospitals in the selected city. 2-3 major hospitals were targeted in each of the selected cities/towns.
- Only consumers/users residing within the 'selected city' were interviewed.
- Patients were interviewed outside the OPDs - general and special wards of the hospitals.
- Before initiating the questionnaire, the interviewers introduced himself/herself and briefly mentioned the purpose of the survey to the respondent; and encourage the interviewee to participate 'whole-heartedly' in the interview.
- While name, address and phone numbers were necessary for follow-ups, but not compulsory. If the respondent felt intimidated, such details were avoided.
- An emphasis was laid on getting qualitative (relevant) information from the consumers to the extent possible. Such information would complement the data already collected from the consumer.
- The questionnaire refers primarily to healthcare received by the household that the respondent represents in the recent past.
- Specific/qualitative (and detailed) information about 'cases' in secondary/tertiary healthcare were also collected where possible.

Below are some key aspects/questions that the surveyor were asked to remember during the survey process:

- What is the level of confidence of the general public (consumers) on the public hospitals/health centres, especially in terms of access to and quality of treatment?
- How do doctors in public hospitals behave – especially while prescribing medicines and suggesting diagnostic tests?
  (Do they seem to force the consumer/patients to get tests done from outside the public hospital, or prescribe drugs that are not available in the public hospital?)
- What do consumers/users feel about the fees/charges of primary healthcare facilities (doctor's fees, common tests, etc.)?

- Is there any tacit arrangement that seem to emerge from the responses given by the consumer?
  i. Among private doctors
  ii. Between private doctors and diagnostic clinics
  iii. Between private doctors and pharmaceutical companies (through medical representatives)
  iv. Between public hospital administration or doctors and private heathcare providers (chemists, diagnostic clinics, etc.)

3.5 Second Stage Survey – Prescription Analysis

Findings of the first stage of the survey were used to devise the methodology for the second stage. This comprised the following components:

- Analysis of prescription pattern in public hospitals
- Analysis of prescription pattern by private doctors
- Discussions with a select group of Medical Representatives in each state

I. Sampling & Analysis of Prescription Pattern in Public Hospitals

HYPOTHESIS I: *Given the availability of low-cost and/or free medicines (substitute medicines) in public hospitals (and/or in chemist shops in the vicinity of public hospitals) there is a consistent and statistically significant pattern that doctors of public hospitals are prescribing relatively high cost medicines which are available in chemist shops in the vicinity of public hospitals.*

Data Collection: To collect information from a random sample of patients visiting a public hospital. Ask a few questions (refer ***Annex 3*** for the Questionnaire) and collect a copy of the **prescription** from about **200 patients** (in each state). Some of the key information to be collected include those pertaining to **where** (chemist inside public hospital OR private chemist outside in the vicinity) did s/he buy the prescribed medicines from; **why** and for **how** much. A photocopy of the prescription would also be collected (to the extent possible).

To do a preliminary analysis of the collected prescriptions[22] for assessing their types, manufacturers, costs, etc. some other characteristics on the basis of a set of criteria. Also, to establish for each public hospital, if the medicines that were bought from the private sources, were available in the hospital stock list and/or were part of the state List of Essential Medicines. Collect a copy of the Stock-

Register[23] (medicines available in the stock in the last 30 days) to cross-check this information.

HYPOTHESIS II: *In spite of facilities for diagnostic/pathological tests being available in public hospitals, there is a tendency among doctors in public hospitals to refer patients to private diagnostic/pathological laboratories for tests, purely driven by commercial motivations.*

II. Sampling & Analysis of Prescription Pattern of Private Doctors

HYPOTHESIS I*: *In spite of availability of low-cost substitutes, there is a tendency among many doctors in private practice (and private hospitals) often of prescribing relatively high cost medicines and not their cheaper alternatives.

HYPOTHESIS II: *Doctors refer their patients too often for diagnostic/pathological tests, which is driven by commercial motivations rather than by requirements for future medical interventions.*

Data Collection: 100 prescriptions from patients visiting private doctors in certain localities in any of the three towns were collected. Photocopy of the prescriptions were gathered. Analysis of the collected prescriptions was done to assess:

- If these doctors are prescribing non-branded costly drugs (which are sold in the vicinity of these private practitioners) instead of their cheaper alternatives (which are not available in the vicinity of these private doctors).
- If the doctors are prescribing diagnostic tests too frequently (and suggesting a specific diagnostic clinic for these tests to be undertaken).[24]

III. Discussions with Medical Representatives

The study team in each state spoke to a few Medical Representatives in order to gather information to address the following queries.

- If there are any discussions/agreements that happen between pharmaceutical companies about how their respective fleet of Medical Representatives interact with doctors in a particular geographical boundary (say, town, district, state)
- If there is/are a union(s) of Medical Representatives in a state and their role, etc.

4
Results and Discussion

4.1 Survey of Consumers (First Stage Survey)

As indicated earlier, in the first stage survey the partners gathered information 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, Nagaon and Bongaigaon***. In ***Chhattisgarh*** the information was gathered from ***348 consumers*** from ***Raipur, Bilaspur and Durg***. Some of the results are enumerated below.

i. **Financial Burden of Healthcare:** It was clear that *households belonging to the low-income class in the sample spent a larger share of their monthly income on healthcare* (14.14 percent in Chhattisgarh and 20.56 percent in Assam) as compared to people from the other economic classes. In terms of percentage share, this was considerably higher than the portion spent by the middle and

Figure 2: Monthly Financial Burden on Consumer Classes from Healthcare

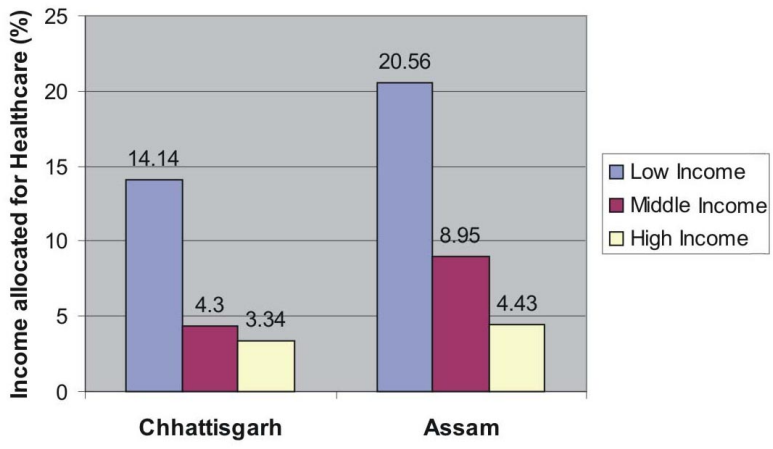


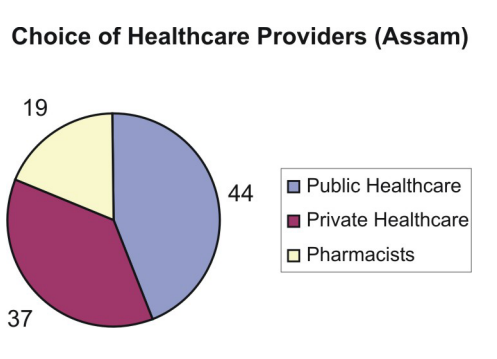
Table 6: Financial Burden of Healthcare for Different Consumer Classes				
Income Classes	**Average monthly health expense (₹)**		**Percentage of total monthly income (in percent)**	
	Chhattisgarh	Assam	Chhattisgarh	Assam
Low	***526***	***902***	***14.14***	***20.56***
Middle	825	1687	4.30	8.95
High	1674	2055	3.34	4.43

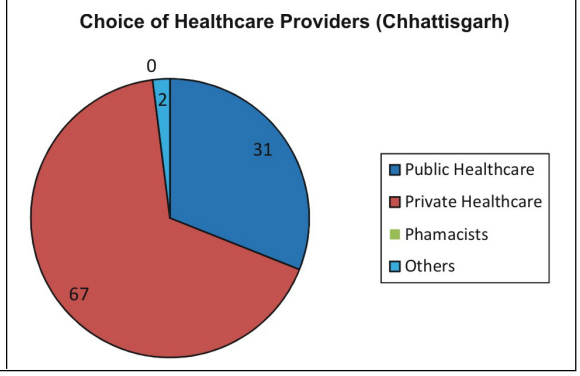
the higher income classes. In monetary terms, the amount that the low class people surveyed in the states paid every month for healthcare services in Chhattisgarh and Assam was ₹526 and ₹902 respectively (See Table 6).

ii. **Choice of Healthcare Provider:** (Table 7, Figure 3) 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. The situation was quite different in Assam, with a large portion of the respondents preferring public healthcare institutions more. 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 the pharmacist to get a drug for remedy (over the counter).

Table 7: Healthcare Providers Visited by Respondents		
Source of Treatment	**Chhattisgarh (Percent of Respondents)**	**Assam (Percent of Respondents)**
Public Healthcare	31	44
Private Healthcare	67	37
Pharmacists	-	19
Others	2	0

Figure 3: Choice of Providers for the Surveyed Consumers in Two States





iii. **Choice of Healthcare Provider vs Income Classes:** When the above data is disaggregated across income-classes, then an interesting trend is observed in both the states. It is noted that in both the states, there was a *high propensity among the low-income households to visit private sources of healthcare*. Public healthcare facilities were visited mostly by low-income household and to some extent by the high-income households. Middle income household surveyed seldom visited public healthcare facilities. (Table 8)

Table 8: Disaggregated Visits to Healthcare Facilities by Income Classes in Two States

Source of Healthcare	Percentage of Consumers across Income Classes					
	Low-Income		Middle-Income		High-Income	
	Chhattisgarh	*Assam*	*Chhattisgarh*	*Assam*	*Chhattisgarh*	*Assam*
Public Healthcare	47	51	7	27	16	36
Private Healthcare	50	30	93	53	84	64
Pharmacists	0	19	0	2	0	0
Others	3	0	0	0	0	0

iv. **Factors Determining Choice of Healthcare:** Proximity to a healthcare facility seems to be the deciding factors (refer Table 9) for the surveyed households when it comes to choosing a particular healthcare provider (public hospital,

Table 9: Factors for Choosing a Particular Provider			
Sl No	Factors (for choosing a healthcare provider)	(in percent)	
		Chhattisgarh	*Assam*
1	Good/Familiar doctor	1	4
2	Nearness/Proximity	88	68
3	Free Consultation	8	3
4	Cheap treatment	3	25

private hospital/clinic, others, etc.). The patterns were largely similar incase of both the states. In Assam the other determinant of a provider was availability of free treatment.

v. **Availability of Medicines in Public Hospitals:** Out of the patients visiting public hospitals for treatment that were interviewed, *only 20 percent obtained medicines from the public hospital itself 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. This figure was comparatively much higher (72 percent) for Chhattisgarh, but still indicated that *one in every three patients visiting a public hospital in Chhattisgarh obtained his/her medicines from outside the public hospital.*

vi. **Referrals for Diagnostic Tests:** Frequency of 'referrals' for diagnostic tests were very high in both the states (88 percent in Chhattisgarh and 90 percent in Assam). An interesting pattern emerged from when 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 in Chhattisgarh and 30 percent in Assam) bears testimony to the fact, that on most of the occasions, these tests might not have been necessary.

vii. Interactions with providers (diagnostic clinics and pathological labs) in the two states revealed that in both of them, there is a *'usual practice' of paying*

commissions/cuts to the referring doctors by these providers. In case of Assam a third of the providers surveyed, indicated that they had paid commissions/ cuts to the referring doctors. In the state of Chhattisgarh, over 60 percent of the providers indicated that they offered such commissions/cuts.

From the above analysis a few points emerged, which were considered while developing the outline of the second stage survey methodology and framework for analysis. 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 the 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 referral (to diagnostic clinics) combined with the prevalence of 'cuts' for referring doctors was noted. This is an extremely pernicious collusive 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 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 demands 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.

4.2 Prescribing Pattern and Analysis in Two States (Chhattisgarh and Assam)

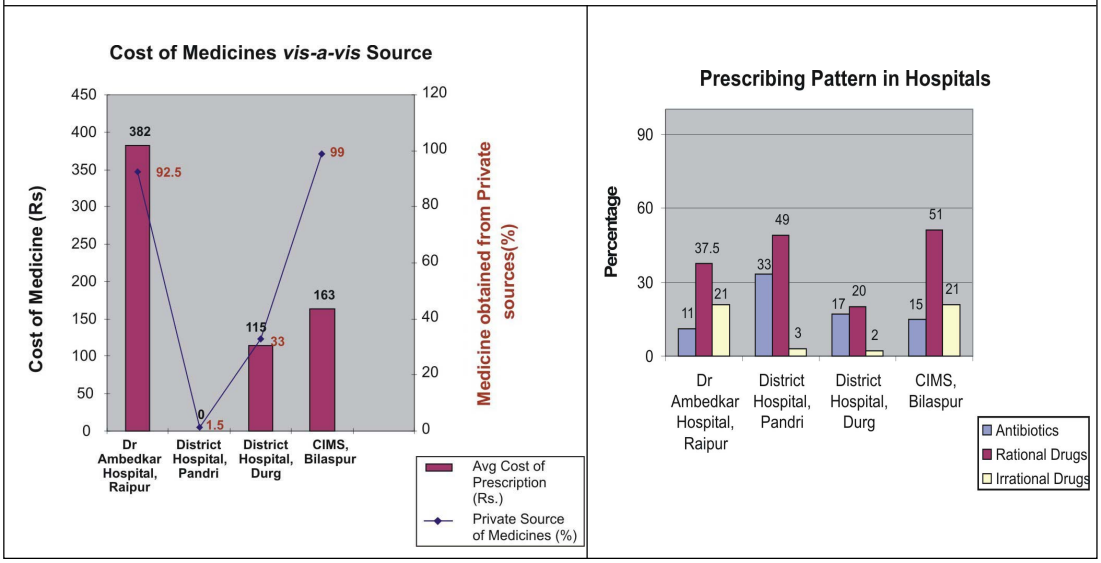
I. Respondent's Feedback on Public Healthcare System

The following patterns emerged from the analysis of the information gathered from the respondents who visited public healthcare institutions in the three towns across the two states. Below are the findings from ***Chhattisgarh*** gathered from **259 respondents** and by **analysing their prescriptions** and the bills when they bought the medicines from private sources (private pharmacists, who are always located right outside the public hospitals). Information was gathered from respondents visiting the following public hospitals 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 mostly being bought from outside (private) sources.*** This is clearly evident from the data of Dr. Ambedkar Hospital (Raipur), District Hospital (Pandri) and District Hospital (Durg) – Figure 4. Though medicines were mostly bought from private sources even in case of the

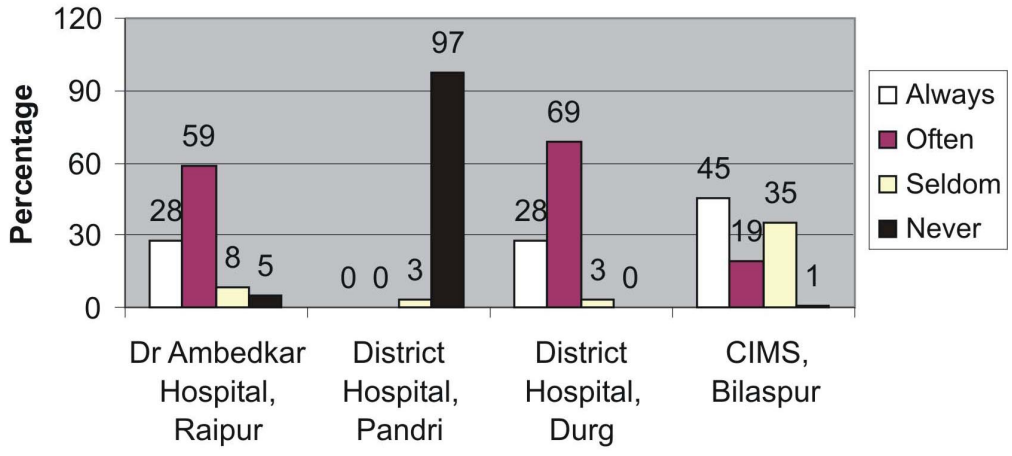
Figure 4: Cost to Consumers for Buying Medicines from Private Providers (Public Healthcare Institutions in Chhattisgarh)



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*[25] were prescribed in the CIMS (Bilaspur) as compared to Dr. Ambedkar Hospital (Figure 5). 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.

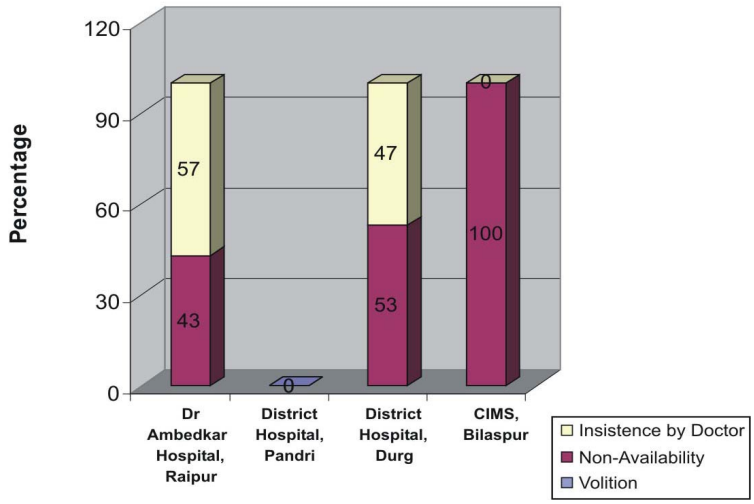
- ***Medicines prescribed in the three hospitals (except the District Hospital, Pandri) were mostly procured from private sources.*** Most of the respondents (97 percent) visiting the District Hospital, Durg bought medicines from outside (private) sources. This figure was just a little lower in Dr. Ambedkar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

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



- ***Non-availability of drugs emerge 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

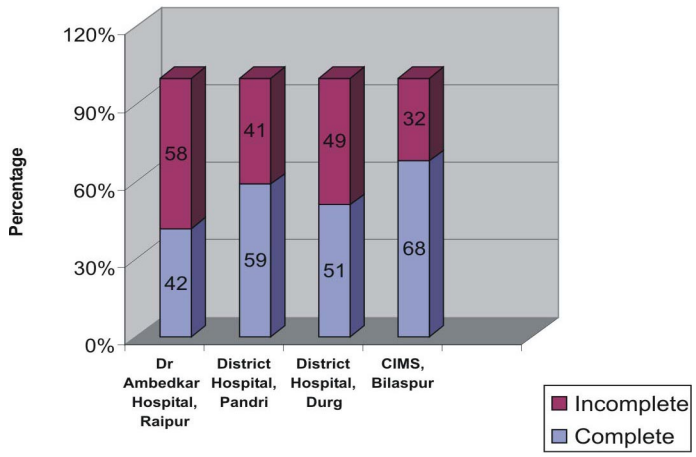
Figure 6: Reason for Buying Medicines from Private Sources (Public Healthcare Institutions in Chhattisgarh)



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 from the public health institution 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 within the system. Again, the District Hospital, Pandri faired 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, Drug (47 percent) complained of non-availability of medicines in both these hospitals.

- ***A close analysis of the prescribing pattern suggests problems with regard to 'Completion of Diagnosis' in most of the 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.

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



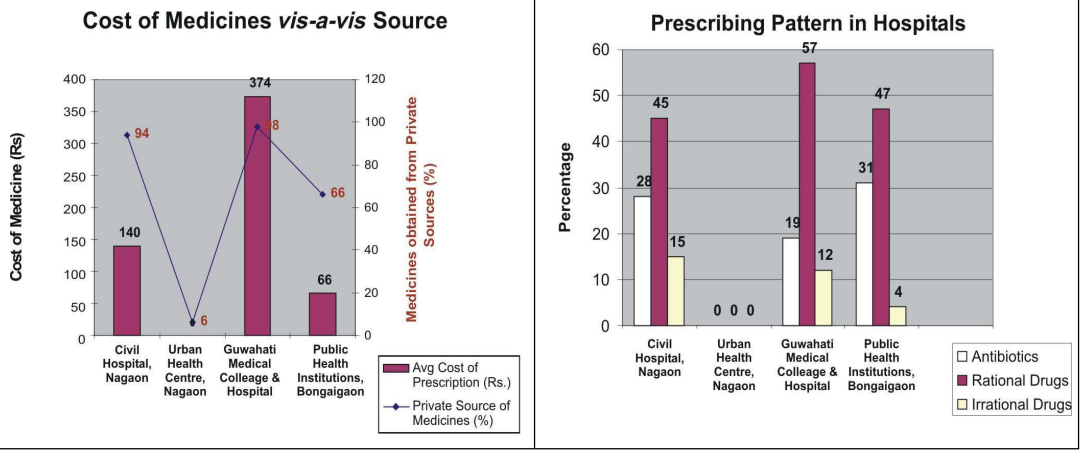
Analysis was also done for the information gathered from ***210 respondents*** from ***Assam***. Information was gathered from respondents visiting the following hospitals:

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

Below are the findings in the same line as that presented (above) for Chhattisgarh, to offer comparisons, etc.

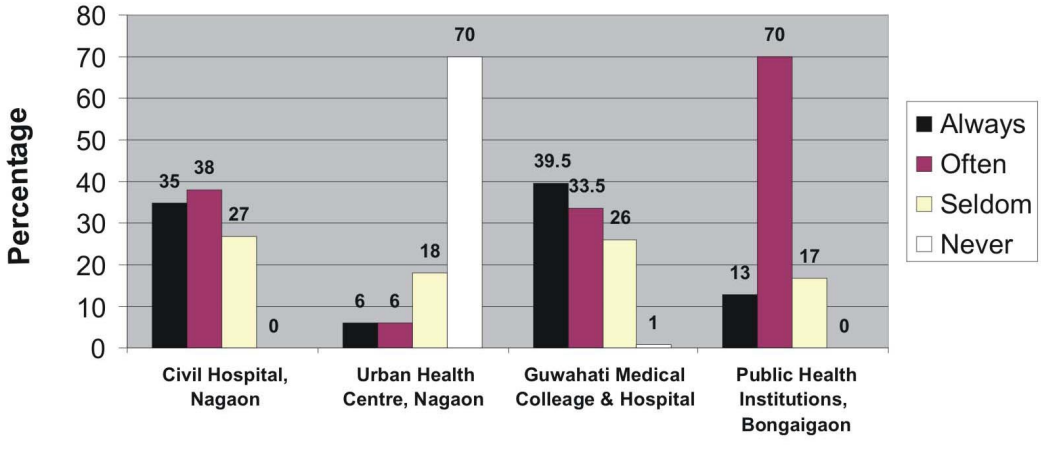
- ***On an average cost of drugs prescribed per prescription (prescription cost) in public hospitals were high, where a major chunk of medicines were mostly being bought from outside (private) sources by the respondents.*** This is evident from the data gathered from respondents visiting Guwahati Medical College & Hospital (Guwahati), Civil Hospital (Nagaon) and Public health institutions in Bongaigaon. 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, it emerges that although a high proportion of *rational drugs* were prescribed in case of Guwahati Medical College & Hospital, Civil Hospital (Nagaon) and Public health institutions in Bongaigaon, yet there was also a significant percentage of *irrational drug* prescription – which unnecessarily increased the cost of prescribed medicines.

Figure 8: Cost to Consumers for Buying Medicines from Private Providers (Public Healthcare Institutions in Assam)



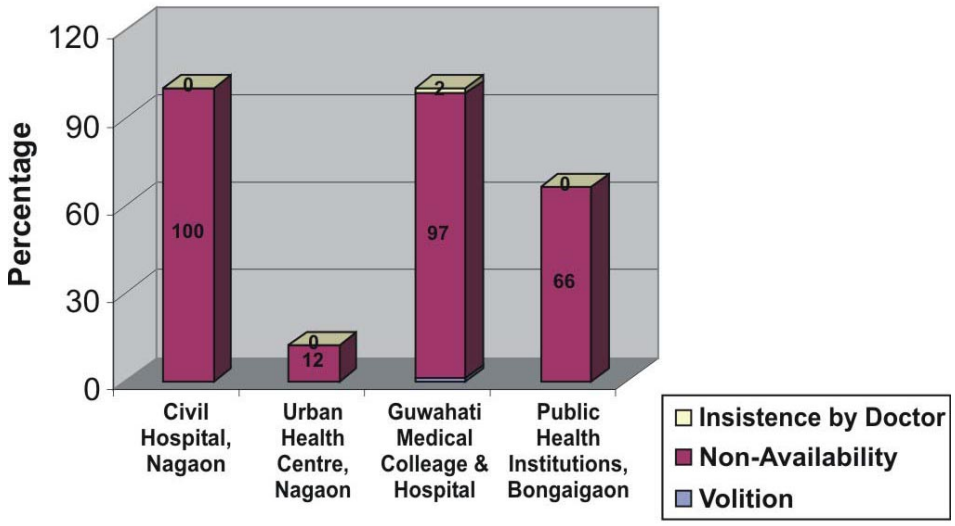
- ***Medicines were being obtained mostly from private (outside) sources in three of the four public health institutions surveyed.*** While this was the highest in case of public health institutions in Bongaigaon (83 percent), such occurrence was a bit less (73 percent) in both the Guwahati Medical College 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, still occasionally (12 percent) they had to buy medicines from outside sources as well.

Figure 9: Procurement Pattern of Medicines (Public Healthcare Institutions in Assam)



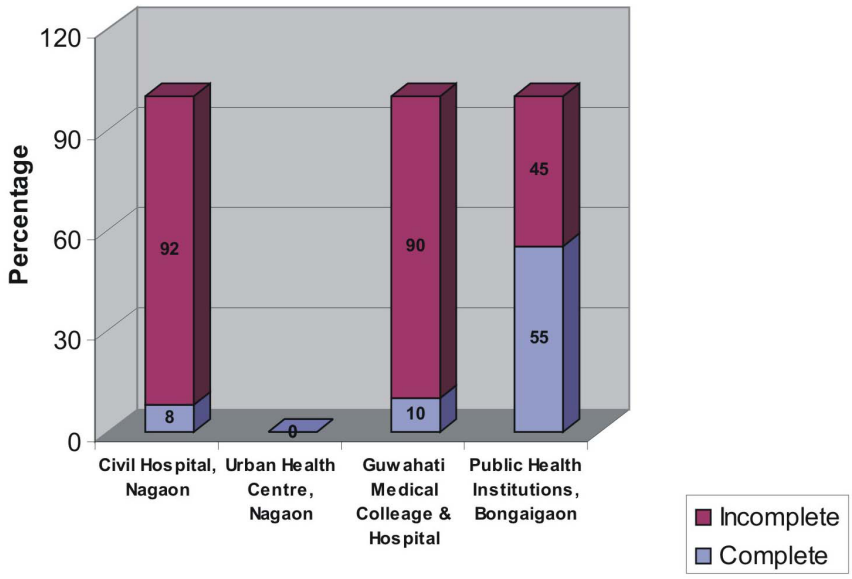
- ***Respondents indicate non-availability of medicines in public healthcare institutions as the main reason for buying medicines from private sources, while being treated at public healthcare institutions in Assam.*** If this is found to be true (as feedback) from a larger population of people visiting public hospitals in the state – then it is a fairly alarming 'state of affairs', and the state government should take urgent steps in refining its procurement and distribution policies for medicines in the state. Only a small fraction of respondents who have been visiting the Urban Health Centre, Nagaon indicated that they brought medicines from private sources. If distribution of medicine in a public health institution has been so efficiently handled in case of the Urban Health Centre, Nagaon – then it should be emulated for other public health institutions as well.

Figure 10: Reason for Buying Medicines from Private Sources (Public Healthcare Institutions in Assam)



- ***Incompleteness of diagnosis seems to be a frequently encountered phenomenon across the health institutions.*** One of the reasons could be the influx of patients in some of these public hospitals, but that cannot be used as a defense 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.

Figure 11: Completeness of Diagnosis of Patients Visiting Public Healthcare Institutions in Assam



Some of the ***common issues of concern*** emerge from the results gathered from the two States, and are enumerated below:

- Although prescription of *rational medicines* was common in public hospitals in both the states (39 percent in Chhattisgarh and 50 percent in Assam), still a *large number of respondents bought medicines from private sources* while getting treated at public hospitals. In Chhattisgarh, on an average 60 percent of the respondents bought medicines from private sources, while being treated at a public hospital, while in Assam it was 62 percent.
- *Non availability of drugs in public hospitals* was a 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, while 69 percent indicated this in the case of Assam.
- *Insistence by doctors to obtain drugs from private sources* was quite significant (35 percent) in Chhattisgarh.
- A glaring fact was the *high percentage of incompleteness of diagnosis*, as revealed from the analysis of prescriptions in both the states. 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. In Assam this was even more alarming and was found in over three-fourth (76 percent) of the

prescriptions. Absence of such written record of ailment is a fundamental flaw medical investigation, and should be avoided. Such an approach could also be responsible for patients being deflected out of the public healthcare system to private healthcare. Further, the absence of a written medical investigation in a prescription could also jeopardise future course of treatment in case the consumer switches over to another hospital.

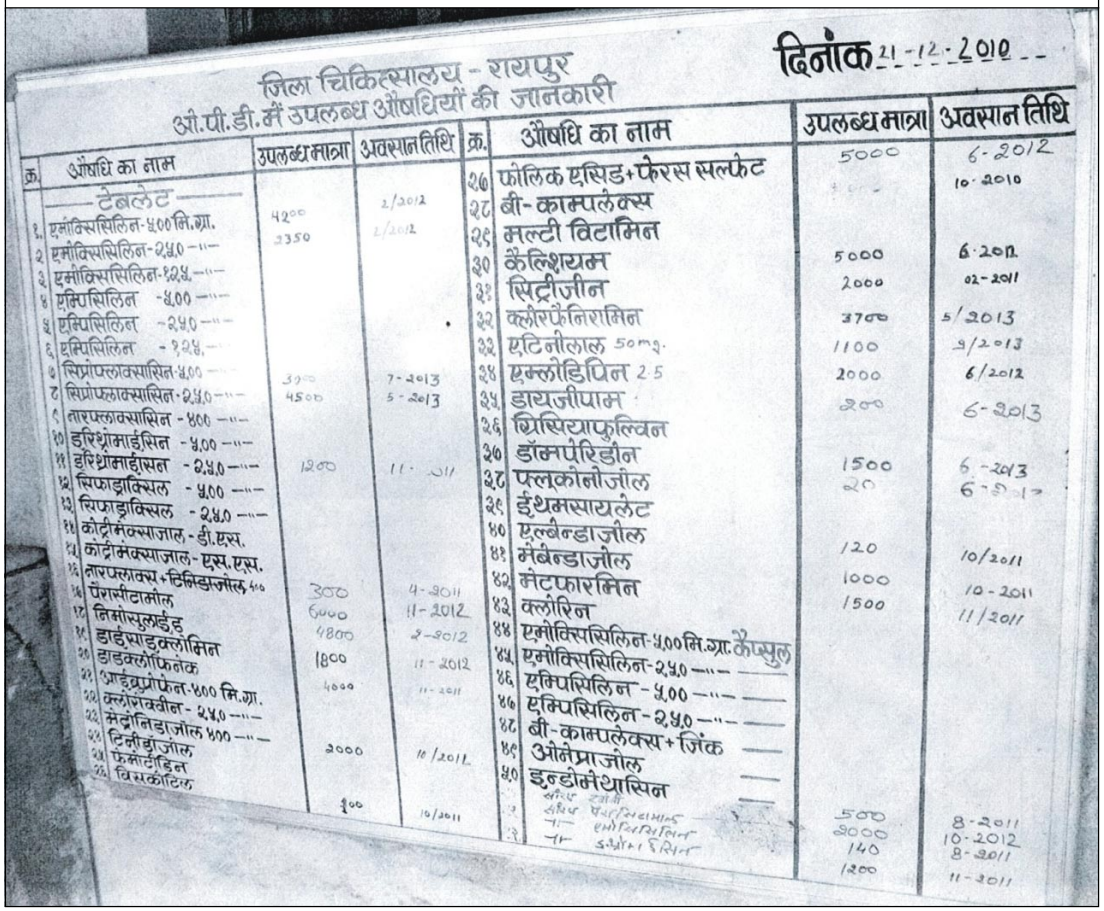
II. Assessment of Nature and Types of Medicines Bought from Private Sources

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 (chemist shops, often located just outside the government hospital premise). The account gathered from consumers implied that they had encountered such non-availability on many occasions, in both Assam and Chhattisgarh.

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 their availability in the stocks of these hospitals (in line with its Hypothesis-I, refer para 3.4.2). 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.

Our partners in both the states had to file ***applications under the RTI Act*** to obtain these Stock Registers from the hospitals, as most of the hospital authorities refused providing them to our partners, otherwise. ***One wonders why information about the stock of medicines in a public hospital should not be available the public domain?***. This is information that is in public interest and therefore should be **displayed publicly inside the hospital**. During the survey, our partners in Chhattisgarh encountered that the ***District Hospital, Pandri*** had publicly displayed the stock of medicines available. This is a good practice (see Figure 12) and **should be made mandatory by state governments immediately**.

Figure 12: Publicly Displayed Stock Register of District Hospital, Pandri



Our partner in Assam was able to get all the Stock Lists from each of the public health institutions that were surveyed, and the results of the analysis are quite revealing (see Table 10). Our partner organisation in Chhattisgarh was only able to obtain the stock list from Chhattisgarh Institute for Medical Science (CIMS), Hospital located in Bilaspur to undertake this assessment, and Table 11 presents the analysis.

Table 10: Reconciliation of Drugs Bought from Private Sources with the Hospital Stock List (Assam)							
Public Hospitals	**Total no of Medicines from Outside Sources**	**No of them Present in Hospital Stock**	**%**	**No of them Absent in Hospital Stock**	**Percentage of those Absent, with Available Substitutes (in percent)**	**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

Table 11: Reconciliation of Drugs Bought from Private Sources with the Hospital Stock List (Chhattisgarh)							
Public Hospitals	**Total no of Medicines from Outside Sources**	**No of them Present in Hospital Stock**	**%**	**No of them Absent in Hospital Stock**	**Percentage of those Absent, with Available Substitutes (in percent)**	**No of Medicines Absent in Hospital, but Present in State List of Essential Medicines**	**%**
CIMS, Bilaspur	190	68	36	122	14	52	43

Three clear lines of analysis can be drawn from the above date, and are presented as 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 on the overall not too many drugs (only 24) were bought by consumers from private sources there. The findings are the most alarming in case of the Guwahati Medical College and Hospital, where of the 196 drugs that were bought by the surveyed consumers from private sources, 49 percent were available in the hospital stock register. This figure was 36 percent in case of CIMS, Bilaspur.
- ***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.*** This was 9 and 12 percent respectively in Guwahati Medical College and Hospital and Civil Hospital, Nagaon. In public healthcare institutions in Bongaigaon this was 27 percent. In CIMS, Bilaspur this figure was 14 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, Nagain (36 percent). In case of CIMS, Bilaspur, 43 percent of drugs absent in the hospital was from the State List of Essential Medicines.

CUTS urges state governments in both Assam and Chhattisgarh to immediately intervene and initiate investigation in these healthcare institutions, to clearly find out the reason that medicines that were present in the hospital stock list were not being offered to a large number of consumers seeking these medicines, forcing them to buy these medicines from the private sources. ***May be, the state government should also limit the number of private chemists who can operate in the near vicinity of the public hospital, and monitor them closely.***

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 CCI is sufficiently empowered as above, they 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 Snapshot

A. Survey Results from Raipur, Chhattisgarh

A random sample of private prescriptions was 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 the prescriptions of private healthcare providers. This was much higher (**58** percent) in the above public healthcare institution in Raipur.
- **Polypharmacy** (prescription of four or more drugs) was rampant and encountered in a quarter (**57** percent) of the 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.

B. Survey Results from Bongaigaon, Assam

A random sample of private prescriptions was gathered from **Bongaigaon** (Assam) during the survey in order to identify 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) of 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. Till now, only one such meeting/interview has been possible, and a brief account of the same is presented below. **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:

i. Reminders

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

ii. Inducements

- Gifts in the form of medical equipment, such as 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, AC, etc.
- Equated Monthly Installments (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 product 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 doctors sits is attributed to the Doctor.
- Vials of costly injectables, etc. are manually verified on a day-to-day basis to ascertain the amount that is payable, and cash payments are made on a daily basis.

(***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).

- 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:

- These practices are considered as usual and practiced by most of the doctors, barring a few
- After the MCI announcement (2009) barring doctors from accepting gifts etc. there was a temporary stoppage, but things soon returned back 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

5
Conclusion and the Way Forward

5.1 On the basis of the review and the field work undertaken in the two states, certain conclusions have been derived and recommendations made to ensure that a more consumer-friendly healthcare system evolve in both these states. These are segregated into two specific strands – (i) issues for policy; and (ii) issues for consumer awareness and actions.

5.2 **Issues for policy** that emerge from this study have been are 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. Assam has developed a *Procurement Policy* for medicines, which is a step in the right direction and should be implemented.
- ***Public disclosure of hospital stock of medicines*** – A small step that can make a huge impact is that state governments in both the states 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 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. Our partners in both the states are well-equipped now to undertake this work.
- ***Monitoring of chemist/pharmacist shops in close proximity of public hospitals*** – State government should undertake close monitoring of these chemists and

pharmacists shops and also get feedback from consumers visiting them to find out why did they do so.

- ***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'. Development of clinical protocols, guidelines and a 'peer review' mechanism has become extremely urgent now.
- ***Identify 'good practices' within the state and replicate them*** – CUTS 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 (this can be done by having state level standards for healthcare institutions and accrediting all healthcare institutions, if they comply with the standards). Efforts should also be made to explore the possibility to emulate such 'good practice cases' in other public healthcare institutions. All these reforms should be initiated as part of strengthening 'social protection' measures especially for the poor citizens.
- ***Adoption of the Clinical Establishment Act 2010*** – All states should adopt this at the earliest, to ensure a minimum standard of healthcare for consumers.

5.3 **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.
- ***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 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.

5.4 CUTS would take up these issues and others with the Central and state governments in order 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 & 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 www.planningcommission.nic.in/plans/planrel/12appdrft/pc_present.pdf

4 www.ibef.org/industry/healthcare.aspx (March 2011)

5 According to a 2008 WHO estimate, 65 percent Indians do not have access to modern healthcare

6 www.worldbank.org.in/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/INDIAEXTN/0,,contentMDK:21461167~pagePK:141137~piPK:141127~theSitePK:295584,00.html

7 *Ibid*

8 Shiva Kumar, A. K. et al., 'India: Towards Universal Health Coverage', LANCET Journal, January 2011 (www.thelancet.com)

9 Mehta, Pradeep S, *Overseeing Pharma Mergers through the Competition lens*, The Financial Express, June 20, 2010

10 www.business-standard.com/india/news/revised-list-may-see-price-control50domestic-drugs/415990/

11 http://164.100.47.5/newcommittee/reports/EnglishCommittees/Committee%20on%20Health%20and%20Family%20Welfare/45th%20report.pdf

12 Ministry of Health & Family Welfare, 'Report of the National Commission on Macroeconomics and Health' 2005, New Delhi

13 Healthcare delivery for this study comprised the following providers – doctors, pharmacists and hospitals

14 *Options for Using Competition Law/Policy Tools in Dealing with Anti-competitive Practices in the Pharmaceutical Industry and Health Delivery System*, CUTS, 2006 (report prepared for WHO India & MoH&FW, Government of India)

15 Oxfam India Strategy Note 2010-2015

16 Section 3 of the India Competition Act 2002 (amended in 2007)

17 Decisions and orders taken by the CCI are available at: www.cci.gov.in/index.php?option=com_content&task=view&id=150

18 www.businessstandard.in/india/news/drug-trade-bodies-face-cci-probe/400396/

19 Dutta, Indrani & Bawari, S. 'Health and Healthcare in Assam – A Status Report', CEHAT, 2007, Mumbai

20 www.nrhmassam.in/health_facilities.php

21 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 5 individuals for this study.

22 Criteria for 'Prescription Analysis' would be developed with inputs derived from such analysis available in the literature

23 This can be done in two ways – (i) By requesting the stockist to provide this list; or (ii) by using the Right to Information (RTI) legislation to obtain this list

24 In competition terminology this is referred to as *third line forcing (a type of full line forcing)*

25 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).

Annexure 1

Questionnaire for Survey to be Administered to Consumers

प्राथमिक सर्वेक्षण के लिए उपभोक्ताओं को दी जाने वाली प्रश्नावली

Information from Consumers:
उपभोक्ताओं से जानकारी

1. Name & Address: _____
   नाम व पता: _____
   _____
   _____

2. Size of Household (no. of members): _____
   परिवार के सदस्यों की संख्या: _____

3. Please indicate the no. of each type of member
   कृपया बताए कि निम्न प्रकार के कितने लोग आपके परिवार में हैं:
   a. Male Adult – _____
      वयस्क पुरूष: _____
   b. Female Adult – _____
      वयस्क महिलाएं: _____
   c. Male Children – _____
      बालक: _____
   d. Female Children – _____
      बालिकाएं: _____

4. Medical history for the last six months
   पिछले छह महीनों की स्वास्थ्य संबंधी जानकारी

Name नाम	Age उम्र	Sex लिंग	Visit (1)				Visit (2)					Visit (3)		
			Date दिनांक	Purpose कारण	Referrals निर्देशित / उल्लेखित		Date दिनांक	Purpose कारण	Referrals निर्देशित / उल्लेखित		Date दिनांक	Purpose कारण	Referrals निर्देशित / उल्लेखित	
					Specialist विशेषज्ञ	Diagnostic Lab. प्रयोगशाला			Specialist विशेषज्ञ	Diagnostic Lab. प्रयोगशाला			Specialist विशेषज्ञ	Diagnostic Lab. प्रयोगशाला

Note: Collect information for 3 visits, including the present visit; & then 2 other visits before that
टिप्पणी: वर्तमान विजिट सहित पिछले 2 विजिट की जानकारी संग्रह करे

5. Total monthly household income in (₹) (i.e. total income of all earning members)
घर की मासिक आय (समस्त कामकाजी सदस्यों की आय)

a. Less then 5000
5,000 से कम

b. 5000 to 10,000
5000 से 10,000

c. 10,000 to 20, 000
10,000 से 20,000

d. 20, 000 to 40,000
20,000 से 40,000

e. Above 40,000
40,000 से अधिक

6. Average monthly household expenditure on healthcare in (₹)
औसत मासिक स्वास्थ्य सम्बन्धी खर्च

a 100 to 500
100 से 500

b 500 to 1000
500 से 1,000

c 1000 to 2500
1,000 से 2,500

d 2500 and above
2,500 और अधिक

7. How many times have members of your household visited doctors in the last six months?
पिछले छह महीनों में आपके घर के सदस्य कितनी बार डॉक्टर को दिखाने गये हैं?

a. 0 to 4
0 से 4

b. 5 to 9
5 से 9

c. 10 to 15 (why so often?)
10 से 15 (इतनी बार जाने का कारण:?)
_____

d. If about 15 times (why so often?)
15 और अधिक (इतनी बार जाने का कारण:?)
_____

8. What was the average consultation fee in (₹) in each of the following cases? (tick appropriate boxes for each of the three types):
औसत परामर्श शुल्क कितना था? (उचित बॉक्स में निशान लगाएं)

Type of physician किस प्रकार का चिकित्सक	Consultation fee in ₹ परामर्श शुल्क			
	50 to 100 50 से 100	100 to 300 100 से 300	300 to 500 300 से 500	Above 500 500 से अधिक
Primary care General Physician प्राथमिक देखभाल सामान्य चिकित्सक				
Secondary care Specialist माध्यमिक देखभाल विशेषज्ञ				
Tertiary care Super Specialist तृतीयक देखभाल वरिष्ठ विशेषज्ञ				

Explanatory note: *स्पष्टीकरण:*

a- Secondary specialist; surgeon, gynaecologist, chest specialist, diabetologist, child specialist, orthopaedist etc.
माध्यमिक चिकित्सा विशेषज्ञ: सर्जन, स्त्री रोग विशेषज्ञ, छाती विशेषज्ञ, मधुमेह चिकित्सक, बाल रोग विशेषज्ञ, हड्डी विशेषज्ञ इत्यादि

b- Tertiary specialist: oncologist, cardiologist, neurologist, etc.
तृतीयक देखभाल विशेषज्ञ: कैंसर विशेषज्ञ, हृदय विशेषज्ञ, न्यूरोलोजिस्ट इत्यादि

9. Do you think the above charges are fair?
आपके अनुसार क्या चिकित्सा सम्बन्धित शुल्क उचित है?
   a Yes
     हां
   b No
     नहीं

9.1 (what is the fair charge then?) _____
उचित शुल्क क्या होना चाहिए?: _____

10. Which sources of treatment do you prefer for common ailments? Please give reasons.
आम बीमारियों के लिए आप किस प्रकार का इलाज चुनते हैं? कृपया कारण बताएं।

Public hospital/ health centre सार्वजनिक स्वास्थ्य सेवा	Private hospitals निजी अस्पताल	Walk-in clinics निजी चिकित्सालय	Others अन्य	Reason to choose चुनाव का कारण

11. Distance from house to medical facility (in KM)
आपके घर से चिकित्सा सुविधा कितनी दूरी पर उपलब्ध हैं?

a 0 to 2 (0 से 2)
b. 2 to 5 (2 से 5)
c. 5 to 10 (5 से 10)
d. Above 10 (10 से अधिक)

12. For each type of treatment facility visited by you, please indicate where did you purchase the drugs from? (tick boxes that apply)
हर प्रकार की चिकित्सा सेवा का उपयोग करके आप दवा कहां से लेते हैं? (उचित बॉक्स में चिन्ह लगाएं।)

Treatment facility इलाज सुविधा	Source of Drugs दवा कहां से लेते हैं			
	Chemist at public hospital/ health centre सार्वजनिक अस्पताल का दवाखाना	Chemist at private hospital निजी अस्पताल का दवाखाना	Private independent chemist निजी दवाखाना	Others (specify) अन्य (वर्णित करें)
Public hospital/ health centre सार्वजनिक अस्पताल				
Private hospital निजी अस्पताल				
Walk in clinics चिकित्सालय				
Others अन्य				

13. What was the response of the hospital staff in the case of emergency, if encountered by you? Please provide details regarding the type (public/private) and location of hospital, and the ailment for which emergency treatment was sought.
आपातकालीन स्थिति में अस्पताल कर्मियों की प्रतिक्रिया कैसी थी? कृपया अस्पताल का प्रकार एवं जगह बताए। साथ ही किस प्रकार के रोग के लिए आपातकालीन उपचार दिया गया?

a Denial or refusal
अस्वीकृति या इंकार

b Seeking source or police enquiry
पुलिस जांच

c Seeking bribe
रिश्वत की मांग

d Late admission/treatment
इलाज में देरी

e Normal acceptance
सामान्य स्वीकृति

14. How many times have you (all household members) visited diagnostic centres in the last six months?
पिछले छह महीनों में आप (आपके परिवार के सदस्य) कितनी बार जांच केन्द्र गए हैं?

a 0 to 5
0 से 5

b 6 to 10
6 से 10

c 11 to 15
11 से 15

d Occasionally (Exact number of time_____)
कभी कभार

15. Was the diagnostic clinic suggested by your doctor?
क्या जांच केन्द्र का पता आपके डॉक्टर ने दिया था?

a Yes, every time
हां– हर बार

b Only sometimes
एक–आध बार

c No (own preference)
नहीं

16. How many times have diagnostic tests revealed serious illnesses for household members in the last six months? (Please specify the nature of illness in each
पिछले छह महीनों में आपके परिवार के सदस्यों द्वारा कराई गई जांच में कितनी गंभीर बीमारियों का पता चला? (कृपया प्रत्येक बीमारी का कारण निर्दिष्ट करें।)

a 0 to 1
0 से 1

b 2 to 3
2 से 3

c More then 3
3 से ज्यादा

17. In case of each of the above ailments
उपरोक्त लिखी बीमारी के संदर्भ में:

Ailment 1

रोग– 1

a Was the specialist doctor referred by a general physician (Yes / No)?
क्या सामान्य चिकित्सक ने विशेषज्ञ को दिखाने के लिए कहा था? (हां/नहीं)

b What was the nature of the ailment?
किस प्रकार का रोग था? _____

c How long did the household member undergo the treatment?
इलाज कितने दिन चला? _____

d How much have you spent on treatment (approx)?
इलाज में कितना पैसा खर्च हुआ? _____

e Are you satisfied with the treatment (Yes/No)?
क्या आप इलाज से संतुष्ट है? (हां/नहीं)

f Do you think that the doctor is cheating you (Yes/No)
क्या आपको लगता है कि डॉक्टर ने आपके साथ धोखाधड़ी की है? (हां/नहीं)

g If yes, how can you say?
अगर हां, तो आप यह कैसे कह सकते हैं?

_____

_____

Ailment 2

रोग– 2

a Was the specialist doctor referred by a general physician? (Yes / No)
क्या सामान्य चिकित्सक ने विशेषज्ञ को दिखाने के लिए कहा था? (हां/नहीं)

b What was the nature of the ailment?
किस प्रकार का रोग था? _____

c How long did the household member undergo the treatment?
इलाज कितने दिन चला? _____

d How much have you spent on treatment (approx)?
इलाज में कितना पैसा खर्च हुआ? _____

e Are you satisfied with the treatment (Yes/No)?
क्या आप इलाज से संतुष्ट है? (हां/नहीं)

f Do you think that the doctor is cheating you? (Yes/No)
क्या आपको लगता है कि डॉक्टर ने आपके साथ धोखाधड़ी की है? (हां/नहीं)

g If yes, how can you say?
अगर हां, तो आप यह कैसे कह सकते हैं?
_____

Ailment 3

रोग– 3

a Was the specialist doctor referred by a general physician (Yes / No)?
क्या सामान्य चिकित्सक ने विशेषज्ञ को दिखाने के लिए कहा था? (हां/नहीं)

b What was the nature of the ailment?
किस प्रकार का रोग था? _____

c How long did the household member undergo the treatment?
इलाज कितने दिन चला? _____

d How much have you spent on treatment (approx)?
इलाज में कितना पैसा खर्च हुआ? _____

e Are you satisfied with the treatment (Yes/No)?
क्या आप इलाज से संतुष्ट है? (हां/नहीं)

f Do you think that the doctor is cheating you? (Yes/No)
क्या आपको लगता है कि डॉक्टर ने आपके साथ धोखाधड़ी की है? (हां/नहीं)

g If yes, how can you say?
अगर हां, तो आप यह कैसे कह सकते हैं?
_____

Note: टिप्पणीः

1.

2.

3.

4.

5.

6.

7.

8. _____

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

16. _____

17. _____

Annexure 2

Questionnaire for Survey to be Administered to Providers

प्रदाता को प्रशासित करने के लिए प्रायोगिक सर्वेक्षण के लिए प्रश्नावली

Questionnaire 2: Information from Diagnostic clinics

प्रश्नावली 2: निदान क्लिनिक से सूचना

1. Cost of pathological test
   रोग परीक्षण की लागत

Test Type टेस्ट	**Cost (₹) लागत (₹)**					
	100 to 500	**500 to 1000**	**1000 to 1500**	**1500 to 2000**	**2000 and above**	**Name of centre केन्द्र का नाम**
Haematological test रक्त परीक्षण						
Urine test मूत्र परीक्षण						
X-ray एक्सरे						
CT scan सी.टी. स्केन						
Sonography सोनोग्राफी						
ECG ई.सी.जी.						

2. Who decides the charges for various tests?
   विभिन्न परीक्षणों के लिए कौन शुल्क तय करता है?
   a- Self decided/स्व–निर्णित ☐
   b- Association (which association)/संघ (कौनसा संघ) ☐
   c- Other body/अन्य निकाय ☐

3. Do you provide discount to poor patients?
   क्या आप गरीब मरीजों को छूट प्रदान करते हैं?
   a- Yes/हां ☐
   b- No/नहीं ☐
   c- Sometime/कभी–कभी ☐

4. What is your policy about providing cuts/commission for the references made by doctors?
   डॉक्टरों द्वारा अनुशंसित संदर्भ को कमीशन एवं कटौती उपलब्ध करवाने के बारे में आपकी क्या नीति है?

   _____
   _____
   _____
   _____

Annexure 3

Questionnaire for Pilot Survey to be Administered to Hospitals

प्रदाता को प्रशासित करने के लिए प्रायोगिक सर्वेक्षण के लिए प्रश्नावली

Questionnaire 3: Information from Hospitals
प्रश्नावली 3: अस्पताल से सूचना

For private hospitals only:
केवल निजी अस्पतालों के लिए:

1. When was the hospital registered? .....
   अस्पताल कब पंजीकृत हुआ था? .....

2. Number of visiting doctors: .....
   कार्यरत चिकित्सकों की संख्या कितनी है? .....

3. Number of in-house doctors: .....
   घरेलू चिकित्सकों की संख्या कितनी है? .....

4. Number of bed available: .....
   कितनी संख्या में बेड उपलब्ध हैं? .....

5. Availability of in-house chemist (Yes / No)
   घरेलू दवाई विक्रेता की उपलब्धता हां □ नहीं □

6. Cost of room per night in ₹ .....
   प्रति रात कमरे का मूल्य .....

7. Who set the rates (Self/Association)?
   दर कौन तय करता है? स्वयं □ संघ □

8. Emergency service available (Yes / No)
   आपातकालीन सेवा की उपलब्धता हां □ नहीं □

Annexure 4

Questionnaire for Consumers Treated in Public Hospitals, While Collecting Prescriptions
(Second Round Survey)

Note: *Some questions are multiple choice* ***(e.g., Qs 4, 5, 6, 7, 8, 9)*** *for which the applicable choice has to be ticked (☐); and for others the exact information has to be filled-up by the surveyor*

1. What is the name of the doctor prescribing the medicine, date and time of prescription? Name of the public hospital?

   NAME OF PUBLIC HOSPITAL: _____
   NAME OF DOCTOR: **Dr.**_____
   DATE OF PRESCRIPTION: _____
   TIME OF PRESCRIPTION: _____**(A.M./P.M.)**

2. What is the cost of medicines prescribed in the prescription?

   A ₹. _____ for _____days
   B _____ (number of medicines out of a total of _____ in the prescription bought from outside

3. How much have you spent each month on the following medical expenses while treated at the public hospital (based on information of at least the last 1 or 2 months)?
   - ☐ Hospitalisation _____(₹)
   - ☐ Medicines _____(₹)
   - ☐ Doctor consultation fee _____(₹)
   - ☐ Diagnostic test _____(₹)

4. What is your total monthly household income?
   - ☐ Less than ₹ 5,000

- ₹5,000 to ₹8,000
- ₹8,000 to ₹12,000
- Above ₹12,000

5. Where did you buy medicines prescribed from as by the doctor in the public hospital?
   - Public hospital itself
   - Chemist outside (in the vicinity of the public hospital)
   - Other

6. What is the reason of buying medicines from outside sources, if that is the case?
   - Non-availability of medicines in public hospital
   - Insistence by doctors
   - Other reason(s) _____(Please specify)

7. How often have you bought medicines from outside sources, while getting treatment at the public hospital?
   - Always
   - Often
   - Seldom
   - Never

8. Where did you get your tests done while being treated at the public hospital and why?

   Tests done at: _____

   Reason (the applicable choice)
   - Insistence by doctors
   - Facilities not in good condition in public hospital
   - Better quality of results
   - Other(s) _____(Please specify)

9. How much on an average did you have to pay for such tests?

   Tests done at: _____

   Cost of tests (apprx.): ₹_____

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