6th HM Patel Memorial Lecture

Commercialisation of Medical Care and Changing Professional Values

by

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I feel truly privileged to have this honour of delivering the H M Patel Memorial lecture. I have the highest personal regard for Dr. Amrita Patel and was deeply touched by her invitation. For my generation of women she is a role model and an icon. We deeply admire her professional competence, her leadership qualities and vision for institution building.

The Late H M Patel is a distant figure for my generation. But even we know that, like many of his generation, he was a builder of modern India. He at once embodied the Gandhian values of social justice and equity and the Nehruvian vision of building a modern Indian state. This combination of a Gandhian vision for equity and social justice and a Nehruvian vision of growth and modernisation is what has now come to be known as "inclusive growth".

H M Patel's generation called it "growth with social justice". His vision for building a self reliant India was based on these notions of 'inclusive growth' and the desire to build social trust. His much-acclaimed role in the civil service and public life offered him opportunities to serve the country in many important capacities. His record of service as an officer remains a shining example for civil servants even today. His commitment to the concept of accountability in public life, to the values of probity and integrity earned him a place of distinction in Government.

The Charutar Arogya Mandal is an example of an institution that embodies values that were dear to HM Patel. In providing medical care that is guided by the spirit of service

rather than profit, it seeks to promote his vision. This is indeed a challenge in present times where crass, unregulated commercialisation of medical care and technology has fundamentally transformed the values and aspirations of the professional class.

In my lecture today, I propose to examine the transformation of commercial medicine as an important driver for changing the nature of medical practice and professional values in India in the public, for profit and non profit sectors over the last six decades.

I prefer to use the concept "commercialisation" to 'privatisation' because it goes beyond the activities of the private sector alone and brings into its ambit the increasingly 'commercial orientation' of publicly-owned and non profit institutions. Mackintosh and Koivusalo make an important conceptual difference between commercialisation and privatisation. As they observe:

> *"We employ the concept of 'commercialisation' to encompass, and to allow us to examine within a single framework, a number of related processes. By 'commercialised' health care we mean: the provision of health care services through market relationships to those able to pay; investment in, and production of those services, and of inputs to them, for cash income or profit, including private contracting and supply to publicly financed health care; and health care finance derived from individual payments and private insurance" (Mackintosh & Koivusalo: 2005; p.3)*

That is, even the public and non profit sector can become 'commercialised' without getting 'privatised'. This distinction

helps us to study trends going beyond the growth of the private sector, especially private corporate sector, and analyse how unregulated commercial interests change values in medical practice.

In studying commercialisation we must look at the history of markets in medical care; the changing relationship of market and state; the influence of markets in transforming behaviour of public and not for profit services. Today, I wish to highlight the influence of markets on professional values and the culture of medical practice.

History of Markets in Medical Care

At the time of independence commercial activity in health care was largely restricted to individual practitioners and the pharmaceutical industry. The Bhore committee report in 1946 took cognisance of the presence of individual private practitioners and chose to accommodate their interests. This was based on the assumption that a strong public sector would make the private sector redundant over time. However, under investment in the public sector enlarged the space for commercial activity within and outside public provisioning.

During the 1960s the Mudaliar Committee recommended employing private practitioners in government hospitals in order to overcome shortage of doctors. It opined that private practitioners should be *" given opportunities to serve in government hospitals on a part-time or honorary basis and the hospital authorities should encourage them to admit their patients needing in-patient care" (GOI:1961; p.136)*. This was the beginning of the accommodation and legitimisation of commercial interests in the public sector.

State and Market in Medical Care

The under investment in the public sector during the first few decades after Independence created a system ridden with anomalies and weaknesses. An example of this is the accommodation of commercial interests, mainly in provisioning and pharmaceuticals manufacturing that resulted in a mixed economy in medical care.

Much of the research on the 'for profit' sector has examined it independent of the public sector. This provides only a partial view of the characteristics of the mixed economy in medical care. Commercial interests were accommodated in the public sector in the form of private practice by government doctors. In some states private doctors were appointed as consultants in government hospitals.

By the 1970s, the nexus between government doctors and private nursing homes became more complex. Most nursing homes had senior government doctors as consultants on their panel. This resulted in the diversion of patients from government hospitals to the private sector who ended up paying for care in both sectors. The commercial nexus between the public and private sectors resulted in the blurring of boundaries.

A few studies have shown the pathways through which this happened. Consulting a doctor in a government hospital and getting referred to a private hospital for the procedure; making informal payments to a government doctor to get admission to a public hospital are few examples of these complex inter-relationships.

Characteristics of the 'for profit' and 'non profit' sector

The 'for profit' sector is characterised by plurality and heterogeneity in terms of providers and institutions. It is dominated by individual practitioners who are formally and informally trained. These are largely restricted to the primary level and distributed in rural and urban areas. The secondary level consists of small and medium nursing homes promoted by single owner and partners, mostly doctors. The spread of these institutions is marked by inter-state and rural-urban variations.

Studies have shown that in Punjab, Gujarat, Maharashtra, Andhra Pradesh, Karnataka, Tamilnadu and Kerala the 'for profit' sector has grown rapidly. The tertiary sector consists of multi speciality hospitals that are private limited or public limited concerns. These are mostly located in metropolitan centres.

Apart from the growth of private providers of medical care there has been a substantial growth of diagnostic centres and pathological laboratories across states. Several of these are promoted by single owners and a few by corporate entities.

Private capital has also made inroads into medical education since the late 1970s, a phenomenon that is more prominent in southern and western India. According to an estimate, over forty percent of the private medical institutions are concentrated in the states of south and west India.

These institutions are promoted by the intermediary castes and depend on large donations for admission. On an average

a student pays Rs 25 to 30lakhs for undergraduate admission and for a post graduate seat it is over a crore. Young graduates from these colleges seek employment in institutions that will recover the large investments that they have made in medical education (Ananthakrishnan:2010).

Whither non profit sector?

Within this scenario of rampant, unregulated growth of the 'for profit' sector, the space for the 'non profit' institutions started shrinking. Historically, the Christian Medical Association had the largest number of hospitals and medical colleges. Some of these institutions were forced to close down during the 1970s. A complex set of reasons seem to be responsible.

The economic recession, the reduced flow in funds from church donors; difficulty in paying salaries to doctors that matched public and 'for profit institutions; the rising cost of technology and debates regarding the appropriate deployment of technology (Baru:1999). These tendencies had an impact in terms of raising user charges for services.

A few hospitals that could not resist or adapt to these tendencies were forced to close down. Apart from the missionaries there were initiatives of trading communities who invested in non profit dispensaries and hospitals (Nundy:2005). Often small in size, these institutions provided general and few specialist services.

These institutions received public subsidies during the post independence period and several of these prided themselves in providing services to the poor and needy (Baru: 1996; Nundy:2005). With increased competition from the 'for profit' sector, these institutions were forced to either close

down or look for large investments to finance infrastructure and technology.

A study of this transformation of non profit hospitals in Delhi shows the emergence of partnerships between non profit hospitals and corporate entities. The institutional façade of a trust is used to secure tax exemptions while the corporate bodies invest, expand and manage these hospitals. Clearly, the principles on which these institutions function today are far removed from the values and ideals that they were founded on (Nundy: 2010).

Transformation of the 'for profit' medical care

Until the early 1970s the 'for profit' sector was largely restricted to individual practitioners. Subsequently, there have been several waves of transformation in the 'for profit' sector. The first wave of transformation was in the mid 1970s. It was marked by the growth of small and medium sized nursing homes that were promoted by doctor entrepreneurs. These nursing homes were located in regions that had seen agrarian prosperity. Gujarat, Maharashtra, coastal Andhra Pradesh, Tamilnadu and Karnataka saw a fairly rapid expansion of the 'for profit' sector during this period (Baru:1993).

The second wave of transformation was in the early 1980s when the state declared its inability to provide the required services and sought the co-operation of the 'for profit' and 'non profit' sectors. This paved the way for legitimising public subsidies to the growing 'for profit sector. The state started played a proactive role by offering subsidies and concessions to for profit medical institutions in terms of access to land, infrastructure and bank loans.

The third wave of transformation was during the late 1980s and early 1990s when government subsidies for import of high technology medical equipment were stepped up. This period saw the return of the Non Resident Indian doctor and the rise of corporate medicine.

Corporate medicine fundamentally transformed the organisation of 'for profit' medicine from a cottage industry to large scale production of medical care. During this period the rise of corporate medicine was restrict led to the tertiary level providing super specialist services which relied on the deployment of high technology medical equipment.

In my view the rise of corporate hospitals changed the culture of medical practice in several significant ways. Firstly, it raised the cost of medical care which was clearly related to the increase in the scale of production and operation. Secondly, it contributed to the growth of large scale production that required huge investments in infrastructure, human resources and medical equipment. Thirdly, in order to recover these large investments, the culture of medical practice also underwent changes.

The success of a doctor was judged by the number of patients he/she could treat. The volume of patient turnover and diagnostic testing were important for earning profits. As a result there was pressure on the doctor to treat more patients by prescribing diagnostic testing.

There was concern regarding the overuse and misuse of diagnostic testing in the corporate sector. The growing reliance on medical technology for diagnosis was influencing professionals, irrespective of whether they were in the for

profit sector or not. Questions regarding the appropriate use of technology were not really debated. There were several instances of unnecessary testing in the for profit sector but these were difficult to prove.

Unlike other commodities, medical care is characterised by an asymmetrical relationship between doctors and patients. Doctors possess the knowledge and skill that gives them the power to decide what is best for their patients (Deoganokar:2005). This influences the perceptions of patients who often equate technology with better care, a good example of provider induced behaviour. In the absence of medical auditing procedures in hospitals it is impossible to estimate the extent of overuse and misuse of diagnostic testing.

The nexus between the 'for profit' pharmaceutical, medical technology, medical education and provisioning was a powerful influence on the behaviour of doctors in public, for profit and non profit institutions. The doctor was an important actor in this process since clinical decisions largely rested with them. Sanjay Nagral highlights the role of commissions in influencing doctors. He observes that:

> *"It must be stated at the outset that the practice of giving commissions for referral of patients is not restricted to the GP-specialist interaction. It is now commonplace for commissions to be given by pathology laboratories, radiology establishments, equipment manufacturers and perhaps even institutions. In fact, even specialists practice a sophisticated form of commissions by referring patients to each other, often more as a 'return referral' than because there is a*

genuine need. Also, it is probably true that the idea of such commissions originated from aggressive specialists trying to increase their practice through commercial incentives." (Nagral:2002).

The pharmaceutical and technology industry uses diverse marketing strategies to promote the sale of their products. In the process they manage to influence the clinical decisions of doctors, overtly and subtly. Over the years the role of commissions in the form of cash incentive, sponsorship of conferences and research by the pharmaceutical industry are well known (Ghulati:2004). These are some of the pathways through which commercial interests of the medical industry influence institutions and individuals.

Influence of markets on the behaviour of public and non profit institutions

Rampant commercialisation has influenced the structure and culture of public and non profit institutions at the organisational and individual level (Baru:2005; Nundy: 2010). These processes are not adequately acknowledged in the ongoing debate on commercialisation. The culture of institutions and the values they embody is shaped by larger socio-economic forces. At a fundamental level, commercialisation has led to the commodification of medical care. Therefore monetary incentives have become the motivation for doctors. A retired doctor from a reputed national medical institute observed:

"I was not motivated by money. I think this was true for most doctors of my generation. Probably, this was an individual characteristic which was seen in most other doctors at the institute. I was motivated by the desire to gain name and

fame. Being the premiere institute of the country, the most of difficult cases, the most variety of cases came there, which you won't find anywhere else in any other hospital. So, you had the opportunity to continue to learn and to grow." (Baru: 2005; pp 106-107)

However, the growth and transformation of the 'for profit' sector has had far reaching impact on doctors in the public sector. It has managed to affect the culture of medical practice and redefine what constitutes good quality care. Some senior doctors from the public sector opined that the:

> *"growth of tertiary private sector produced stark differences in working conditions, patient load and salaries as compared to the public sector. The higher salaries in the private sector were attractive. For some, money was an issue because of changing lifestyles, and for others frustrations arising out of lack of promotional avenues and recognition provided the context for questioning and even undervaluing the public sector"* (Baru: 2005; p. 110).

These tendencies have led to the gradual erosion of values like equity, universality, patient centred care and concern for the poor. The socialisation of doctors and the embodiment of these values in their practice is an important determinant of organisational cultures. However the aspirations and values of doctors cannot be seen in isolation of their middle class moorings to which a majority belong. Therefore I would argue that the changing values of middle class India is an important determinant for shaping professional values.

Changing Values of Middle Class India and shaping of professional values

Several scholars who have studied the rise of the new middle class during the 1980s, have argued that this class is distinct from the old middle class in terms of its values (Mishra:1961; Fernandes: 2007). They rightly argue that the old middle class did not indulge in conspicuous consumption and encouraged austerity and simplicity as virtues.

However, economic liberalisation and the rise of private enterprise have encouraged and celebrated consumerism. This has led to changes in lifestyle and a redefinition of status, aspirations and values of the middle class. As a retired doctor observed:

> *"the coming in of globalisation and consumerism…. consumerism and the desire and the availability to people also added a materialistic approach. Society is wanting more than what they were. Doctors are not left behind. Their salary structure (in the public sector) had not improved with time…Life styles of people in the private sector appeared to be better. Lifestyle differences became glaring. The younger people found their counterparts in the business world, especially MBAs, making huge amounts of money. That's when they thought to themselves, why can't I afford and live their lifestyles…this produced dissatisfaction and frustration with the public sector" (Baru: 2005; pp. 111-12)*

The commercialisation of medical care has produced many conflicting tendencies within the medical profession. On the one hand, professionals are lured by the glamour of commercial

medicine and the monetary gains that can be made. There is excitement in using sophisticated high technology equipment for diagnosis and treatment. However I do believe that there are also professionals who are concerned about the uneven quality of medical care, rising costs and the marginalisation of those who are unable to pay for it.

Unfortunately professional associations do not provide a forum for such issues to be debated. Many of these issues are being raised in a variety of forums outside these professional associations. These include health and social movements, academia, civil rights groups and the non profit sector in health care. They highlight these dilemmas through the lens of human rights; ethics, values and morality. This provides an alliance for a collective moral conscience regarding the problems of crass commercialisation for patient centred care. I believe that some of these issues need to find a place in debates within the medical profession.

There are some who are cynical about the profession and feel that nothing can be done to reverse the negative tendencies of commercialisation and that there is no place for values in medical practice. I do not agree with this position because I do believe that a significant percentage of the medical profession is facing a great deal of ambiguity and dilemma in the choices that they have to make on a day to day basis.

If we subscribe to the earlier position, then we fall into the trap of labelling doctors as ethical and non ethical or as good and bad. This kind of a position does not take us very far and is divisive in the long run. It does not help to promote dialogue and debate within and outside the profession.

However, if we agree that these opposing tendencies exist among professionals in varying proportions then I believe that it is possible to initiate a dialogue. This would prevent putting doctors on the defensive and let them engage beyond their associations. This could lead to building alliances with peoples' health movements, social movements and others who are concerned about equity and social justice in access to health care.

In conclusion, I believe that there is an urgent need to recognise the pitfalls of commercialisation of medical care. This is essential for patient centred care and the future of medical practice that is ethical and rational. There are some who are cynical about the future of medical practice and argue that most doctors are dominated by the profit motive.

I do not subscribe to this view point because I think that not all doctors are lured by commercialisation or succumb to unethical practices. There are several well known personalities like Dr. N H Antia, Dr. P K Sethi, Dr. K S Sanjeevi, Dr. D Banerji and Dr. Binayak Sen among many others who have brought meaning and value to the practice of medicine.

While these are well known, there are many other doctors who work in difficult situations and have served people honestly and with integrity. It is extremely important for individuals and institutions that are swimming against the tide of commercialisation, both in the public and private sectors, to build alliances. This is important to get a sense of the larger picture and contribute to debates within government, civil society, public, for profit and non profit sectors regarding the value of practicing ethical medicine.

Institutions like the Charutar Arogya Mandal can provide leadership in facilitating such a dialogue. The growth of a people-centric health care system, be it for profit or non profit, would be the best tribute we can pay to the generation that the late H M Patel was such a proud part of.

References

Baru R Missionaries in health care. Economic and Political Weekly 1999. Available from URL: http://www.epw.org.in/showArticles.php?root=1999&leaf=02&filename=110&filetype=html.

Baru R Inter-regional variations in health services in Andhra Pradesh. Economic and Political Weekly, 1993;28:963-7.

Baru R Private and voluntary health services: An analysis of inter-regional variations. Report submitted to UNDP. 1996.

Baru R Private Health Care in India: Social Characteristics and Trends. New Delhi:Sage publications.1998.

Baru R 'Commercialisation and the public sector in India: Implications for values and aspirations' in Mackintosh M. and Koivusalo M.(Ed) Commercialization of health care: global and local dynamics and policy responses. Palgrave-Macmillan.2005.

Deoganokar M. Day-to-day decision making as a physician in India. Indian J Med Ethics.2005 Jul-Sep;2(3).

Fernandes L India's new middle class: democratic politics in an era of economic reform. New Delhi: Oxford University Press. 2007.

Ghulati C M Editorial: Marketing of medicines in India, BMJ, April 2004.

Mackintosh M and Koivusalo M.(Ed) Commercialization of health care: global and local dynamics and policy responses. Palgrave-Macmillan.2005.

Mishra B B The Indian middle classes: Their growth in modern times. New Delhi: Oxford University Press.1961.

Nagral S General Practice : some thoughts. Issues in Medical Ethics 2002. April-June 10(2).

Nundy M The not-for-profit sector in medical care in financing and delivery of health care services in India. National Commission on Macroeconomics and Health. Background Papers. Ministry of Health and Family Welfare. Government of India. New Delhi. 2005.

Nundy, M "The social transformation of 'not-for-profit' hospitals in Delhi", Unpublished PhD thesis, Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.2010.

Phadke A Drug supply and use: Towards a rational policy in India. Sage publications, New Delhi. 1998

Thomas G Practicing medicine in India: some ethical dilemmas. Indian J Med Ethics.2005 Jul-Sep;2(3)

Curriculum Vitae

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Publications

Books

Baru, Rama V. (1998) **Private Health Care In India- Social Characteristics and Trends**. Sage Publications, New Delhi.

Baru,Rama V. (Ed) (2008) **School Health Services in India: The Social and Economic Contexts, New Delhi, Sage Publications.**

Chapters in Edited Volumes

Baru, Rama V. Structural Adjustment and Health: The Changing Role of Non-Governmental Organisations in Sarkar,A (Ed) (2008) 'NGOs in Globalisation Era: Developmental and Organisational Facets, New Delhi, Rawat Publications.

Baru, Rama V. Ideology and Health Sector Reforms: A State Level Analysis in Girish Kumar (Ed) Health Sector Reforms in India: Issues, Trends and Prospects, New Delhi, Manohar Publications,2009

Baru, Rama V. and Dhaleta, S. Mahila Samakhya Approaches to Women's Health in Jandhyala,K. et al (Ed) Forthcoming, Zubaan Publishers

Baru, Rama V. And Nundy,M, 'Health Public Private Partnerships in India: Stepping Stones for Improving Women's Reproductive Health Care?' in Timmerman,M (Ed) UNU publication, 2009

Baru,R. 'Dynamics and Quality of Private Health Services in India' Paper presented at the International Workshop on 'Public-Private Mix : A Public Health Fix?-Strategies for Health Sector Reform in South and South-East Asia' Nareusan University, Phitsanulok, Thailand, 20-22nd June 2007.(Forthcoming as a research monograph).

Baru, Rama V. and Meena Gopal (2006) 'Decentralization and Disease Control Programmes: The Case of Filariasis' in Niraja Gopal Jayal, Amit Prakash and Pradeep K. Sharma (Eds) **Local Governance in India : Decentralization and Beyond,** New Delhi, Oxford University Press.

Baru, Rama V. (2006) 'Financing of Health Services: Alternatives to Private Insurance' in **Sujata Prasad and C. Sathyamala (Ed) Securing Health For All: Dimensions and Challenges,** New Delhi, Institute of Human Development.

Baru, Rama V. (2005) 'Commercialisation and the Public Sector in India: Implications for Values and Aspirations' in Maureen Mackintosh and Meri Koivusalo (Eds) **Commercialisation of Health Care: Global and Local Dynamics and Policy Responses,** London, Palgrave and UNRISD.

Baru, Rama V. (2005) **'**Gender and Social Characteristics of the Labour Force in Health Services' in **Exploring Gender Equations: Colonial and Post Colonial India** edited by Shakti Kak and Biswamoy Pati; New Delhi, Nehru Memorial Museum and Library.

Baru, Rama V. (2005) **Privatisation of Health Care in India: A Comparative Analysis of Orissa, Karnataka and Maharashtra** (Eds) Mehta, Aasha Kapur, P. Sharma, S. Singh, RK Tiwari & PR Panchamukhi, IIPA, CMDR & UNDP, New Delhi.

Baru, Rama V. (2005) "Private Sector in India: Raising Inequities" in Leena V. Gangolli, Ravi Duggal and Abhya Shukla (Eds) **Review of Health Care In India,** CEHAT, Mumbai.

Baru, Rama V. (200) Privatisation of Health Care: Conditions of Workers in Private Hospitals in Bhattacharya,M (Ed) Perspectives in Women's Studies: Globalisation, New Delhi, Tulika Publications

Baru,Rama V. (2002) 'Health Sector Reform: The Indian Experience' in Twaddle,A. (Ed) **Health Care Reform Around the World**, Auburn House, Connecticut.

Baru Rama V., Priya R, Qadeer I.(2001) **State and Private Sector in India: Some Policy Options.** in *Private Health Sector in India- Review and Annnotated Bibliography*, a joint effort of CEHAT, Mumbai; Foundation for Sustainable Development, Indian Institute of Technology, Madras; and Centre of Social Medicine and Community Health, JNU, New Delhi.

Acharya, A. Baru, Rama V. and Nambissan, G. (2001) 'The State and Human Development: Health and Education' in **Crossing A Bridge of Dreams: Fifty Years of India China,** Tulika, New Delhi.

Baru, Rama V. (2001) 'Health Sector Reforms and Structural Adjustment: A State Level Analysis' in I. Qadeer, K. Sen & KR Nayar (Eds) **Public Health and the Poverty of Reforms: The South Asian Predicament**, New Delhi, Sage

Baru, Rama V. (1990) Health Policy in Andhra Pradesh in Mukund K(Ed). *Andhra Pradesh Economy in Transition* (Booklinks Corporation, Hyderabad.

Journals

Baru, Rama V.(1989) **Medicine as Business**. Review Article of J. Higgin's The Business of Medicine: Private Health Care in Britain, Macmillan, London, 1988. *Economic and Political Weekly*. March 18.

Baru, Rama V. (1989) **Rehabilitation of the Disabled**. *Indian Journal of Social Work*. April.

Baru, Rama V. (1989) **Private Sector in Medical Care: A Brief Survey.** *Radical Journal of Health (Vol. 3, No. 4)*.

Baru, Rama V. (1993) Inter Regional Variations in Health Services: A Study of Selected Districts in Andhra Pradesh. *Economic and Political Weekly*. May 15, 1993.

Baru, Rama V. (1995) **Mixed Economy in Medical Care: Some Issues**. IASSI Quarterly. 14 (1&2):67-80.

Baru, Rama V. (1993) Reproductive Technologies and the Private Sector: Implications for Women's Health. **Health For The Millions**, Voluntary Health Association of India. New Delhi.

Baru, Rama V. and Jesani, A. (2000) The Role of World Bank in the Health Sector **Social Science and Medicine.**

Baru, Rama V. and G. Sadhana (2000) 'Resurgence of Communicable Diseases: Gastro-Enteritis Epidemics in Andhra Pradesh' **Economic and Political Weekly**, 30th September.

Baru, Rama V., I. Qadeer, Ritu Priya (2000) Medical Industry: Illusion of Quality at What Cost? **Economic and Political Weekly**, July 18th

Baru, Rama V. (2000) 'Privatisation and Corporatisation' in Unhealthy Trends, **Seminar** 489, May.

Baru, Rama V. (2003) 'Privatisation of Health Services: A South Asian Perspective' **Economic and Political Weekly**, October 18th.

Baru, Rama V. (2004) 'Abdicating Responsibility' in India Shining, **Seminar** 537

Baru, Rama V. (2005) 'Disease and Suffering: Towards an Explanation of Health Seeking Behaviour' **Indian Anthropologist**, 35:1 &2

Nundy,M and Baru, R (2006) 'Approaches to Health Financing: A Review of Country Experiences' **Journal of Health and Development,** Vol.2, No. 3 & 4. Pp. 37-57.

Baru, Rama and Nundy,M (2008) 'Blurring of Boundaries: Public-Private Partnerships in in Health Services in India' **Economic and Political Weekly.** January 26th.

Baru,R et al (2008) 'Full Meal or Packaged Deal?' – A Commentary, **Economic and Political Weekly,** June 14th, Pp. 20-22.

Deshpande,M., R. Dasgupta, R. Baru & A. Mohanty (2008) 'The Case for Cooked Meals: Concerns Regarding the Proposed Policy Shifts in the Midday Meal and ICDS Programmes' **Indian Pediatrics.** Pp. 445-449.

Mimeographs/ Proceedings/Unpublished papers

Baru, Rama V. KR Nayar and Malobika Bhattacharya, Proceedings of the Colloquiuim on '**Social Inequality and Health**' Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi, March 2nd-3rd 2006

Baru, Rama V. and Mithu Pathak (2005) **Issues of Compliance and Non Compliance in Disease Control Programmes: A Review,** Paper read at the Sixth Meeting of the Technical Advisory Group on Lymphatic Filariasis, September 20th - 23rd September, WHO, Geneva

Baru, Rama V. and Meena Gopal (2004) **Social Mobilisation of Lymphatic Filariasis: An Evaluation of the Sri Lankan Experience,** WHO, Geneva

Baru Rama V P. Nanda **(1993) Private Nursing Homes and their Utilization: Case Study of Delhi**.. Research Mimeo, Voluntary Health Association of India. New Delhi

Baru, Rama V. and P. Nanda (1993) **Trading of Organs: Need for Comprehensive Policy.** Voluntary Health Association of India. New Delhi.

Baru Rama V. and Unnikrishna P.V **(1992) Medical Negligence: Issues Before the Public**. Voluntary Health Association of India. New Delhi.

Baru, Rama V. and Sanjay Kumar (1992) **Food Adulteration: Issues Before the Consumer**. VHAI, New Delhi.

Unpublished Research Documents

Baru, Rama V. et al (2005) **National Evaluation of the Mahila Samakhya Programme –Andhra Pradesh –**Report submitted to the National Office of the Mahila Samakhya Programme, Ministry of Human Resource Development, New Delhi.

Baru, Rama V. Mitu Pathak and Surekha Dhaleta (2005) **Lessons Emerging from the State Human Development Reports-Health** (Mimeo) UNDP, New Delhi

Rama V. Baru and Meena Gopal (2004) **Social Mobilisation for Lymphatic Filariasis: An Evaluation of the Sri Lankan Experience**, WHO, Geneva

Baru, Rama V, Brijesh Purohit and David Daniel (1999) **Efficacy of Private Hospitals and the Central Government Health Scheme – A Study of Hyderabad and Chennai**. Report submitted to Ministry of Health and Family Welfare, Administrative Staff College of India, Hyderabad

Rama V. Baru (1999) **Community Health Financing: Proposal for a Pilot Project**, Consultancy Report submitted to the UNDP, New Delhi, Administrative Staff College of India, Hyderabad.

Baru,Rama V., Murthy, K and Rajashri, CKN (1999) **'Perceptions of Quality in Health Care: An Exploratory Study'** Monograph submitted to AP First Referral Health Systems Project, Hyderabad by Administrative Staff College of India, Hyderabad.

Baru, Rama V. (1996) **Regional Variations in Private and Voluntary Health Services: An Inter-State Analysis.** Project Report submitted to the UNDP. New Delhi.

Baru, Rama V**. (1996) Patterns of Bilateral and Multi-lateral Funding in Health: 1985-95**. Paper submitted to the VHAI as a part of the Independent Health Commission.

Raghunandan D. Baru, Rama V. et al (1988) **Health Seeking Behaviour and PHC System in India**.. Project Report submitted to the United Nations University, Tokyo.

Consultancies and Research Projects

Consultant, UNDP, **Lessons Emerging from the State Human Development Reports-Health,** New Delhi, 2005**.**

Consultant, UNDP, **Health Sector Situation Analysis.** *'India: The Road to Human Development'*. June 23-25 1997.

Resource Person, National Consultation for the Year of the Family, Ministry of Social Welfare, Tata Institute of Social Sciences, UNICEF. December 1993.

Resource Person, Workshop on `**Women's Health and Family Planning Services,** Madhya Pradesh Voluntary Health Association, Indore. November 1993.

Course Writer, `**Alternate Models in Delivery of Health Services: Cross Country Experiences**'. Indira Gandhi Open University for Diploma Course on Rural Development.

Text Writer, Course for health workers organised by the Parivar Seva Sanstha, New Delhi. Prepared a **curriculum and text relating to the prevention of STDs, AIDS, tobacco smoking, alcholism and drug addiction**. October 1992.

Consultant, Tropical Disease Research Programme, WHO and National Institute of Communicable Diseases, New Delhi. Multi-country study on '**Community Directed Treatment of Lymphatic Filariasis'**

Research Associate, U.N. University, Prepared report on `Health Seeking Behaviour and the Primary Health Centre System in India in a backward village in Nalgonda district, Andhra Pradesh'. 1986-1987

Social Worker, Spastics Society of Northern India, New Delhi. 1985.

Consultant, UNICEF, New Delhi. 1985. Prepared a text of syllabus-cum-curriculum to train urban basic service functionaries of the UBS programme in India.

Membership of Technical Advisory Groups and Editorial Boards

Member, Board of Governors, Institute of Rural Management Anand, Gujarat

Co-Chairperson and member of Task Force group on Public Private Partnerships in the National Rural Health Mission, Ministry of Health

Member, Research Overview Committee Public Report on Health funded by IDRC.

Member, Academic Advisory Council, Public Health Foundation of India, New Delhi

Chairperson, Focus Group and Syllabus Committee on 'Health and Physical Education' National Curriculum Framework for Schools, National Council for Education Research and Training, New Delhi

Member, National Resource Group for the Mahila Samakhya Programme, Min. of Human Resource Development

South Asia Editor for the Journal - Global Social Policy published by Sage

Member of the Standing Committee for the Programme for Discrimination and Social Exclusion, Jawaharlal Nehru University

Member, Task Force on Research, Indian Council of Medical Research, New Delhi

Member of Technical Advisory Group for Lymphatic Filariasis, WHO, Geneva

Member of Health Advisory Group for the Rajiv Gandhi Foundation, New Delhi

Member, Special Committee of the Centre for Law and Governance, JNU, New Delhi

Member, Committee to set up the Gender Sensitisation and Committee against Sexual Harassment, Jawaharlal Nehru University.

Seminars /Workshops Organised

Colloquium on 'Social Inequalities and Health' Centre of Social Medicine and Community Health, March 2nd-3rd 2006

Workshop on 'Affirmative Action in Higher Education-Engineering and Medical Colleges' Programme for Study in Discrimination and Exclusion, JNU, April 2006

Consultation on 'The Importance of Midday Meal Programme for Children' University School Resource Network, JNU, 22nd January 2008.

Chairman Address

Dr. Amrita Patel
Chairman, Charutar Arogya Mandal

Our Chief Guest, Dr. Rama Baru, our President Shri Hasmukhbhai, our Secretary Jagrutbhai, invited guests, faculty and students....

It gives me great pleasure to welcome you to the sixth HM Patel Memorial Lecture, being held today to pay tribute to the Founder Chairman of the Charutar Arogya Mandal on his death anniversary.

The Memorial Lecture series, as you know, is intended to provide a platform to bring together views and thoughts of eminent experts in the field of public health, so that not only do we benefit here within the institution from these diverse thought processes and experiences, but that we can in some small way contribute to influencing the minds of those who make health policies. Such is the process that I know the Founder Chairman would have followed and would have wished us to follow.

It is indeed our good fortune to have with us Dr. Rama Baru to deliver the Lecture this year. Dr. Baru is professor and Chairperson of the Centre of Social Medicine and Community Health, JNU. She has spent many years researching healthcare extensively, more particularly healthcare in the private sector. The subjects of her thesis, both during her PhD and M.Phil., were related to this area and she has contributed

significant literature, in the form of two books and a number of articles, papers, mimeographs and chapters. She is also a recipient of the Faculty Enrichment Fellowship by the Indo-Shastri Canadian Institute in 2004 and more recently in 2008, the Balzan Fellowship by the University College of London. With this background, it is no surprise that Dr Baru has chosen to speak on the topic of commercialisation of medical care and changing professional values. I find the subject not only extremely relevant, but perhaps one of the most worrying issues that the profession of Medicine is currently seized with. While I am sure she would elaborate on the various aspects of commercialisation that is slowly eroding the very spirit of the profession, I thought I would share with you our own experiences for a moment and how we are trying to deal with these.

That there is commercialisation taking place, I am sure no one would dispute. The fact that today any new healthcare facility that is set up is largely in the for-profit sector and their goal is maximisation of profits and returns to investors as opposed to service to humanity, is evidence enough that the healthcare sector is being commercialised. The dispute, if there is one, is whether such commercialisation is warranted and whether it is contributing in any way to improving patient care, patient safety or treatment outcomes; for these are the reasons put forward to justify the influx of private funds that lead to commercialisation.

But before I come to what we are faced with and our response, let me speak briefly on some of the justification put forth.

The argument that patient care improves is based on the presumption that with the acquisition of ever-advancing technology and administration of newer medicines, such improvement is inevitable. There is no doubt that technology has been of great support to clinicians in both diagnosing and treating patients better. However, to generalise this over the entire spectrum of equipment and facilities that are now being offered by the medical equipment firms is, I believe, too far-fetched. Take for example, the CT-scan machines. I believe that now hospitals are boasting of having acquired a 320-slice machine and are using it to promote their technological edge to the world. Or, the MRI-in-Operation Theatres that one hears are being installed in some hospitals. Or, the robotic equipment that are supposed to perform more accurate, safer laparoscopic procedures. While these technologies seem very state-of-the-art and impressive, I am not sure that their effectiveness and value addition over the traditional methods has been proven. Regretfully I am afraid neither the equipment manufacturing firms that sell these gizmos, who obviously would like to make as much money as they can in the bargain, nor the hospitals that employ them, who more often than not only use these equipment to further their claims of being ultra-modern, are even interested in determining whether the patient indeed benefits. Nor I believe have their claims been proven.

Similar, or probably worse, is the case with newer medicines. Enough has been written over the massive and undue influence the pharmaceutical industry bears on the profession of Medicine. When over a third of the cost of treatment

is the medicines that the patient is required to purchase, it is inevitable that there is a strong incentive for those engaged in manufacturing them to find ways to create such an influence. As with technology, research and availability of newer medicines have indeed helped. However, the manner in which these medicines are prescribed, with each prescription fetching an economic incentive to those who prescribe, the need for all the medicines and consequently, their effect on patient care, continue to remain in question.

The claim that investments are required for patient safety also undermines the role of simple precautions and greater attention to detail in making treatment safer. Indeed, international public safety experts such as Dr. Atul Gawande have emphasised the effect a simple tool such as a checklist could have in making the complex processes in practice of medicine safer. His recent book, the Checklist Manifesto, highlights the most ground-breaking developments in patient safety in two of the most unsafe, yet critical environments in a hospital in recent years; the pioneering work of Dr. Peter Pronovost of the John Hopkins Hospital in developing checklists for ICUs and the WHO's efforts in bringing about greater patient safety in OTs through a Safe Surgery Checklist.

Finally, the question is have treatment outcomes improved with higher spending on treatment? The jury is out on this as well. In fact, if I may quote Dr. Gawande from another of his articles, appropriately called The Cost Conundrum. He says and I quote:

"Two economists working at Dartmouth, Katherine Baicker and Amitabh Chandra, found that the more money Medicare spent per person in a given state the lower that state's quality ranking tended to be. In fact, the four states with the highest levels of spending—Louisiana, Texas, California, and Florida—were near the bottom of the national rankings on the quality of patient care.

In a 2003 study, another Dartmouth team, led by the internist Elliott Fisher, examined the treatment received by a million elderly Americans diagnosed with colon or rectal cancer, a hip fracture, or a heart attack. They found that patients in higher-spending regions received sixty per cent more care than elsewhere. They got more frequent tests and procedures, more visits with specialists, and more frequent admission to hospitals. Yet they did no better than other patients, whether this was measured in terms of survival, their ability to function, or satisfaction with the care they received. If anything, they seemed to do worse." Unquote

These are the dimensions of the issue that Dr. Baru would hopefully expand on later.

But let me, as I mentioned earlier, focus on what are our experiences and responses have been. Our commitment to the profession of medicine is in both providing care and preparing professionals who would provide such care. And in both these areas, we come across such flagrant violation of ethics that it would make the entire debate on the effects of commercialisation redundant. So, though on the one hand, our hospital is now recognised as one of the most advanced

and effective treatment facilities in the area, not just by the local community, but even by patients from abroad, we still have difficulty in persuading doctors from nearby areas to refer patients, they are not able to treat, to us. There is also reluctance or shall I say no value seen in using our nationally accredited diagnostic facilities by those practising medicine around us.

The situation so far as medical education is concerned is no different. With the increasing emphasis on private sector involvement in producing manpower for India's healthcare needs, the balance has necessarily shifted to fee-based education. Unfortunately, the private sector involvement has also brought with it its primordial instinct; greed. Today, seats in medical colleges, I believe, are "auctioned", with the highest bidder securing the seat. We hear that post-graduate seats are fetching upwards of Rs.1 crore. And, in some corner of the country, an entrepreneur has even thought of an integrated medical course that takes a candidate all the way from MBBS to a super-speciality qualification.

The casualty of this wanton greed is, of course, merit. There is scarcely any thought being given to the quality of medical professionals that our medical colleges are graduating. With all the advancement in technology and medicines taking place, we need to ask ourselves what future is there for healthcare, if those graduating lack the understanding or knowledge of how to use these.

In this situation, bleak and full of despair, it is indeed a matter of pride and great hope that we are one among those

few institutions where the doctors and supporting staff have chosen to come together to stand up to this malaise. In a move that I am certain will over time have a far-reaching impact, not just for this institution, but for the profession of medicine in general. Our doctors and medical employees at all levels have chosen to pursue a vision for themselves that seeks to restore the values for which their profession has been known for centuries; nobility, providing solace to the suffering and continually upgrading skills and knowledge to serve humanity better. And to bring the vision to reality, they have made the cornerstone of their strategy; giving patients an unmatchable humane experience – treating them with compassion. So that the faith of the community around us in the profession that is badly undermined is restored. So that there is at least one institution in this area that is held out as a beacon of hope. So that those who have faith in the nobility of the profession find themselves vindicated.

The vision, I should say, applies both to patient care and education. The educational institutions, through their innovation and sheer persistence, in introducing more effective ways of teaching – for example, system based integrated learning and problem based and case based learning, have emerged as premier institutions not just in Gujarat, but in India. We hope to inculcate in the young minds who come to us the values that we seek to make the basis of our approach to patient care. And we would hope that when they go out and practice, they would bring the same values to bear in their work as we do. In doing so, they would become our most effective allies and ambassadors.

As I close, however, I have to with all humility say that I recognise that a few institutions like ours alone cannot carry the burden of proving to the world that it is possible to restore the profession of medicine to what it should be. On much reflection, I have come to the conclusion that it is imperative that as an institution we do what we have to do – we do so not to prove anything to the world, but to prove it to ourselves. But, there is a great deal that the community and the Governments – which represent the people can do. The community needs to demand quality healthcare. It must hold those who provide health care accountable to their work. And the Governments must, through regulations, interventions and supervision, ensure that the provision of healthcare to our citizens, which is one of their fundamental rights, is made in an equitable, affordable manner, and that this remains the focus of all medical professionals.

May I, once again, thank Dr. Baru for having agreed to come here and all of you for your patient hearing. May I now request Dr. Baru to deliver the Memorial Lecture.

Thank you.