Cut Practice in Private Healthcare

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The Government of Maharashtra had set up a committee to draft the Prevention of Cut Practice in Healthcare Services Act, 2017 to stop cut practice in the medical profession. In the last two decades, there has been rapid commercialisation of medical services which has led to cut-throat competition among doctors to attract patients for higher revenue generation. This article presents the views of doctors about different aspects of cut practice, such as its prevalence, trends and the ways to stop it.

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"Honest Opinion. No Commission to Doctors," said the hoarding near Mumbai airport, for a well-known hospital (Pratap 2017). This advertisement led to an unprecedented uproar and triggered action by Maharashtra's medical education minister, Girish Mahajan. A committee was set up under the chairpersonship of former Maharashtra Director General of Police Pravin Dixit to look into the viability of the proposed law against "cut practice." After a round of deliberations, the proposed Prevention of Cut Practice in Healthcare Services Act, 2017 is now ready for being passed, which may happen in the upcoming winter session of the assembly.

The hoarding is not the sole declaration regarding the practice of taking commission. In the past, there have been discussions in the print media about this. For example, the case of H S Bawaskar, who had filed a case against a hospital in Pune for offering him commission for referring a patient (Iyer 2013), or the case where Kokilaben Dhirubhai Ambani Hospital in Mumbai had tendered an apology to the Maharashtra Medical Council for openly offering "cuts" to doctors for referring patients, have been discussed widely (Vora 2017).

Arun Gadre and Abhay Shukla (2016), in their book *Dissenting Diagnosis,* which delineates the perspectives of doctors about malpractices in medical practice, have also brought to the fore aspects of commission practice, like expensive tests being prescribed for higher commissions. There has been angst among doctors about the pervasive nature of unethical practices in the medical sector, especially private medical care (Gadre and Shukla 2016).

Despite such anecdotal experiences about commission practice in India, Indian Medical Association President Ravi Wankhedkar reacted:

> What is being claimed in the billboard is the basic work of a doctor. It's like banks saying we don't rob money. Moreover, it indirectly alleges that others are unethical.

Ramakanta Panda, the founder of the hospital that put up that billboard refuted Wankhedkar's claim and asserted that today, about 70% to 80% of doctors are indulging in cut practice (*Times of India* 2017).

A Study on Cut Practice

What is the truth? How common is cut practice? What could be done to address this malaise? Support for Advocacy and Training to Health Initiatives (SATHI), Pune, undertook a qualitative study in 2016 in Pune to explore the perspectives of medical practitioners about these issues. The study focused on the views of radiologists and pathologists regarding various dimensions of commission practice. Radiologists and pathologists were chosen as they are mostly dependent on the patients referred to them by other doctors and may need to give a commission in exchange.

The study explored the following aspects of commission practice: (i) perspectives about commission practice among the radiologists and pathologists in Pune city; and (ii) opinions about the extent and proportion of commissions, the factors that have led to the establishment and rise of commission practice, and the possible strategies for curbing commission practice in the private health sector.

A total of 20 in-depth interviews were conducted for this study in 2016. These were doctors from varied backgrounds, such as those having different years of experience of practice, and coming from different geographical locations. Nine doctors were doing individual practice. One pathologist was running a laboratory in partnership, which was situated inside a hospital. Three doctors were attached to a private hospital, out of which one was a corporate hospital and the two others were trust hospitals. One doctor was running her own laboratory and was also attached to a government hospital.

Overall the respondents were unanimous about the pervasive nature of

commission practice. In terms of the proportion of doctors they thought were giving commissions, some felt that only 10% of doctors may not be giving commissions, whereas a few others felt that only 1% to 2% doctors did not indulge in commission practice. So the results of this study seem to agree with Ramakanta Panda's assertion that 70% to 80% doctors indulge in cut practice.

And, how much commission is offered? What is the percentage? The opinion was that the proportion of the commission varied from 30% to 50% (that is, if the patient is charged ₹1,000 for a test or a scan, around ₹300 to ₹500 are sent back to the referring doctor as commission), and that the proportion of commission is as high as 60% in the laboratories run by laboratory technicians instead of pathologists.

From discussions with the respondents, it emerged that commission practice seems to have been formalised as a business norm and is now an inbuilt part of the accounting system of hospitals. It was reported that in some clinics, the rates of commission are fed into the software and the amount to be given as commission is automatically calculated at the end of the month, indicating the acceptance of commission practice and the openness in giving commissions.

The respondents were unanimously in agreement about the increasing trend in commission practice, especially in the last few years.

> When I passed out, it didn't matter much if you gave commission or not, but today my students say that they are put under terms and conditions for practice by a referring doctor. (Pathologist with 16 years of experience)

The respondents in the study opined that commission practice was not restricted only to radiology and pathology. In fact, the net amount given as commission to the referring doctors by radiologists and pathologists is much less as compared to commissions given by hospitals or specialists, like cardiologists, due to charges by hospitals or by cardiologists being much higher than the charges of radiologists or pathologists.

The study brings to light the shuddering reality that commission practice is presently so pervasive that one will not survive if they do not accept this practice. For example, several respondents insisted that it is almost difficult for a new practitioner to break even the expenses incurred in running a lab or imaging centre without indulging in commission practice.

> Not all doctors are from an economically strong background, they are also human beings, they also have other expenses, we think that doctors are God but it's not that, he also has to earn bread and butter, he has to send his children to a reputed school, doctor has to have money, not everybody can sustain if they lose patients for refusing to give commission. (Radiologist with six years of practice)

Further, it is not only the purse, but also the pride of the doctor who offers commissions that takes a beating in the process. As one respondent lamented,

> one of my friends was made to sit till 10 pm till the GP finished his OPD, they make you feel that you are dependent on them for patients. (Radiologist with five years of experience)

It is no wonder that some participants regretted having chosen the medical profession. Few sighed and complained that nobody told them about these malpractices when they chose medicine as a career; had they been warned, they might not have chosen it.

The pathologists and radiologists candidly tabled the fear in their minds:

> If you don't give commission, you will not die out of hunger! (Radiologist with 23 years of experience)
>
> Actually, it is also out of insecurity, otherwise nobody needs to do such things, there are enough patients for everyone. (Radiologist with 27 years of experience)

The participants expressed having a moral dilemma about why the noble profession has sunk so low. The most quoted reason behind the increasing trend in commission practice was the emergence of corporate laboratories. These corporate labs appoint public relations officers who meet doctors and offer commissions for referrals. There was a sense of helplessness and anger about corporate hospitals officially giving commissions as referral fees and still not being reined in by the Medical Council of India guidelines, which prohibit individual private doctors from giving commissions.

Another equally disturbing reason was the high cost of private medical education.

> In private medical colleges, one has to spend ₹1 to ₹2 crore for education; then to earn profits, they appoint PROs [public relations officers] and indulge in all malpractices! (Radiologist with 12 years of experience)

The human mind, by its need to survive, rationalises and justifies one's actions. There were many justifications offered: that commission practice was a reflection of what was happening in society, or that commissions were one of the important income sources for general practitioners, or that it was necessary for survival.

A Legal Solution?

What could be the way out? The doctors seemed to be convinced that it was very difficult to eradicate commission practice. As a possible solution, we asked them about the effectiveness of legal actions to stop the practice. Their responses have significance in the context of Maharashtra government's proposed act. The opinion was divided about the role of law in curbing commission practice. Some believed that such a stringent law may curb commission practice, whereas few others felt that, given the experience of other laws like the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994, the legal pathway may not be useful in restricting the malpractice.

Though, we asked them about the usefulness of the legal option to control commission practice at the time of the study, there was no such proposal by the government. However, within a year, the Maharashtra government set up a committee that has put forth the Prevention of Cut Practice in Healthcare Services Act, 2017.

Some of the important criticisms/observations of the proposed act that have implications for its effectiveness are as follows. The act covers corporate hospitals, and that is welcome. Further, the punishment has been brought down from up to five years to one year. This is a welcome step as even a one-year punishment is severe for any practising doctor, with this leading to loss of credibility in the eyes of the general public.

Apprehensions have been expressed by bodies of medical practitioners that

the Anti-Corruption Bureau (ACB), which will be handling these cases, might not understand intricacies like collection of a visiting doctor's money by a hospital and later handing it over to the consultant being assumed to be a cut. The doctors' apprehension over this is misconstrued. If any doctor visits a particular patient in the hospital and such charges are collected, probably no patient would assume it to be a cut. The suspicion of the patient would arise if the fee was disproportionate to the services given by a visiting doctor. Additionally, in a large segment of cut practice, there are no visits by referring doctors. For example, cuts are given by individual consultants, laboratories and other such set-ups.

It has been pointed out by a section of doctors that if a doctor or clinic ties up with a diagnostic lab to share profits, this can potentially be investigated on technical grounds under this act, even if no "cut" has been paid. Also, it has been highlighted that in medical tourism, an agent routes international medical patients to specific corporate hospitals for a commission. In the authors' opinion, both fall under the definition of a cut, and will be covered under the cut practice act.

According to the final draft, the complainant has to file an affidavit that they possess some evidence to lodge a complaint. According to Pravin Shingare, who heads the committee framing the rules, the idea of asking for supportive proof from a complainant is to discourage frivolous people from taking advantage of the law (Debroy 2017). Though, the idea to avoid frivolous complaints is laudable, we wonder why any complainant would give an affidavit under this act. Is it the job of the complainant to provide evidence or is it the job of ACB? Some of the members of the Alliance of Doctors for Ethical Healthcare recommend that any person who has reliable information along with valid source or valid document for such information should be able to file the complaint.

The drafting committee chairperson, Pravin Dixit, said in an interview to the *Indian Express* that "every bank transaction leaves a trail. We will check records of hospitals, clinics and doctors if such a complaint is made. If we prove a doctor has financially benefitted by such referrals, it is easy to pin them down" (Barnagarwala 2017). We fear that the act will push cut practice into the black economy. Those corporate hospitals that are paying cuts by check will now start paying in cash and/or kind.

Instead of this standalone act, the Maharashtra government should also think seriously about passing the Maharashtra Clinical Establishments (Registration and Regulation) [CERR] Act, the draft of which has been lying with the government for the past three years. Passing it will certainly be a desirable step in making the private healthcare sector accountable and regulated.

This study confirms that commission practice is embedded in private healthcare. It is ubiquitous, omnipresent, and virulent, and has hampered the quality of care as well as inflated the expenses of healthcare. This study as well as the gaps and inevitable possible paralysis of the proposed cut practice act point to the deep-seated disease that cannot be cured by cosmetic dressings.

Not Just Cosmetic Dressings

The government, the society, the civil society organisations, policymakers, politicians, and elected representatives need to wake up from their slumber and draw attention to the underlying septicaemia that is responsible for a symptom like commission practice. The main theme that has emerged from the study is that it would be futile to look at commission practice in isolation.

Nobel Prize winning economist Kenneth Arrow (1963) had speculated that if we treat healthcare as a commodity in the market, it will surely face market failure someday. If healthcare continues to be provided through the market, it is difficult to end commission practice, which is looked at as a tactic to increase business. Mechanisms like ethical guidelines or the CERR Act in isolation would be futile.

The only solution could be Universal Health Care (UHC), wherein there is no transaction of money at the time of service delivery; the medical service is bought and financed by an independent agency; standard treatment protocols, regulation of rates, gatekeeping mechanisms, and prescription and procedure audits could be enforced; and, hence, commission practice could be checked. Such a mechanism of UHC is well in place not just in developed countries like Canada, the United Kingdom, and in Europe, but also in Thailand. The Indian government had appointed a High Level Expert Group (HLEG) to prepare a report on UHC, with Srinath Reddy as the chairperson (Planning Commission 2011). The HLEG report assures us that UHC is possible in India, we have the resources for it, but what is lacking is political will.

With campaigns and mobilisation of mass opinion by advocacy with key policy shapers spreading awareness, we are sure that one day the symptom of commission practice will be eradicated with the systemic therapy that is UHC and not just with a symptomatic relief attempt like the cut practice act.

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