Regulating the Health Profession in India

NIPFP-INET Law Economics Policy Conference, New Delhi
28 November, 2018

National Institute of Public Finance and Policy

What does the past tell us?

What does the past tell us?

- The MCI was established in 1933
  - *Self-regulation:* Control entry of new doctors

What does the past tell us?

- The MCI was established in 1933
  - *Self-regulation:* Control entry of new doctors
- Expansion in role, same framework
  - *Self-regulation:* Protect patient interest (1964)

What does the past tell us?

- The MCI was established in 1933
  - *Self-regulation:* Control entry of new doctors
- Expansion in role, same framework
  - *Self-regulation:* Protect patient interest (1964)
- Over the years, it simply could not function
  - MCI remained suspended for 13 out of 18 years (2000-18)

What does the past tell us?

- The MCI was established in 1933
  - *Self-regulation:* Control entry of new doctors
- Expansion in role, same framework
  - *Self-regulation:* Protect patient interest (1964)
- Over the years, it simply could not function
  - MCI remained suspended for 13 out of 18 years (2000-18)
- Five external bodies appointed, not worked
  - MCI officials don't follow instructions

There has been no political consensus on a solution

Proposal	Key provisions	Status
Indian Medical Council (Amendment) Bill 2005	Reduce elected members and increase accountability to the government	Withdrawn
National Commission for Human Resources for Health Bill 2011	Separate regulation of medical education from the profession	Pending
Indian Medical Council (Amendment) Bill 2013	Reduce term and provide conditions for removal of president and vice-president	Pending
National Medical Commission Bill 2017	Reduce size of regulator and provide patient interest representation	Pending

Table 1: Bills in the Parliament proposing some changes to the MCI

But, some piecemeal measures for reform

- **Medical education**
  - National Eligibility and Entrance Test (NEET), 2016
  - Online Faculty Attendance Management System, 2017
  - Publicly-available inspection reports, 2018
  - Videographed inspection, 2018
  - Competency-based undergraduate curriculum, 2018
- **Professional conduct**
  - *Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations*, 2002
  - Ban on freebies from pharmaceutical companies, 2015
  - Mandatory prescription of generic drugs, 2016

An intellectual framework for regulation is missing

- Broad framework given, some incremental reforms

An intellectual framework for regulation is missing

- Broad framework given, some incremental reforms
- *SARFESI Act* 2002 vs *IBC* 2016

An intellectual framework for regulation is missing

- Broad framework given, some incremental reforms
- *SARFESI Act* 2002 vs *IBC* 2016
- New bills, but old regulatory approach

Some beliefs require re-examination...

Myth I: ‘Centre proposes, state disposes’ is the go-to approach

Myth I: ‘Centre proposes, state disposes’ is the go-to approach

Present arrangement

- Power to regulate *professions* is in the concurrent list
- Medical profession is governed by *parallel regulatory systems*
  - MCI under the *Indian Medical Council Act* 1956
  - SMCs under respective *State Medical Acts*
- The parallel systems have *overlapping functions*
  - Maintain register and regulate professional conduct

Issues

- MCI has no power to monitor or coordinate with SMCs
- Transfer of information between MCI and SMCs is broken
- Multiple authorities to deal with complaints

Which register is reliable?

WHICH NUMBERS DO WE BELIEVE?

State	Doctors on IMR according to MCI	Docs registered with state council
Maharashtra	1,58,998	86,567
Karnataka	1,04,794	1,23,436
Kerala	56,999	66,866
Odisha	21,681	23,169
Delhi	16,833	64,377

Figure 1: In August 2018, several SMCs expressed shock at the MCI submitting outdated data on doctors to the Parliament. While the MCI blamed the SMCs for not sharing information, the SMCs refuted the allegation.(*Source: Times of India*)

Where to appeal?

- **SMC to State Government**[1]
  An appeal shall lie to the State Government against every decision of the Council under section 13 or section 16.

- **SMC to Central Government**
  Where the name of any person has been removed from a State Medical Register on the ground of professional misconduct...he may appeal in the prescribed manner and subject to such conditions including conditions as to the payment of a fee as may be laid down in rules made by the Central Government in this behalf to the Central Government...

- **SMC to MCI**
  Any person aggrieved by the decision of the State Medical Council on any complaint against a delinquent physician, shall have the right to file an appeal to the MCI within a period of 60 days from the date of receipt of the order passed by the said Medical Council

[1] Like, Punjab, Rajasthan, Madhya Pradesh, West Bengal and Tamil Nadu.

Possible models of regulation

- *Centralisation model:* One regulator, may have state units
- *Decentralisation model:* Each state has its own regulator

Move towards centralisation

Move towards centralisation

Australia

- AHPRA develops and administers procedures for ensuring
  - efficient and effective operation of National Boards,
  - registration of students and health professionals,
  - keep up-to-date and publicly available registers, and
  - resolution of complaints

Move towards centralisation

Australia

- AHPRA develops and administers procedures for ensuring
  - efficient and effective operation of National Boards,
  - registration of students and health professionals,
  - keep up-to-date and publicly available registers, and
  - resolution of complaints

United Kingdom

- PSA monitors all health profession regulators, including GMC

Move towards centralisation

Australia

- AHPRA develops and administers procedures for ensuring
  - efficient and effective operation of National Boards,
  - registration of students and health professionals,
  - keep up-to-date and publicly available registers, and
  - resolution of complaints

United Kingdom

- PSA monitors all health profession regulators, including GMC

India

- ICAI, IBBI

Myth II: MCI should be democratic and representative

Myth II: MCI should be democratic and representative

- **Present arrangement**
  - The MCI board (and SMCs) comprises of more than 100 members
  - Majority of the members (barring 37 members) are elected by the profession
  - Majority of the members (barring 8 members) must be from the profession
  - In practice, all members are from the profession
- **Issues**
  - Repeated suspension of the MCI board
  - Delegation of all functions of the board to a sub-committee
  - Reluctance to punish doctors

Poor enforcement record

1963-2009: 109 licenses revoked in India[2]

2001-2010: Action taken in 45 out of 515 complaints in India[3]

[2] See Para 9.20, Department-Related Parliamentary Standing Committee on Health and Family Welfare 2016.

[3] Based on an RTI inquiry filed by the *People for Better Treatment*. See Nagarajan 2013.

Possible models of regulation

- *Elected board:* With some representation of patient interest
- *Appointed board:* With substantial representation of patient interest

Substantial public representation

Substantial public representation

Jurisdiction	Regulator	Doctor	Public	Govt	Total
India	MCI	104	–	–	104
	NMC	**20**	**3**	**2**	**25**
UK	GMC	6	6	–	12
Australia	AHPRA	8	4	–	12
California (USA)	MBC	8	7	–	15

Table 2: Composition of medical boards in different jurisdictions

Myth III: More medical colleges, more doctors

Country	Medical colleges per million[4]	Physician density[5]
India	**2.93**	**0.76** (2016)
Brazil	1.16	1.85 (2013)
China	1.14	1.81 (2015)
USA	0.56	2.56 (2014)
UK	0.85	2.82 (2016)

Table 3: Comparison between the number of medical colleges per million and physician density in different jurisdictions

[4] Total number of medical colleges per million population, as of 2017. See, World Federation for Medical Education 2018.

[5] Total number of physicians per thousand population, as per latest available year. See, Gobal Health Observatory Data (WHO) 2018.

Is there capacity to monitor so many medical colleges?

Is there capacity to monitor so many medical colleges?

- Large number of approved medical seats are cancelled subsequently
  - *Uttar Pradesh:* 2100 out of 5000
  - *Maharashtra:* 350 out of 1500 (Private)
  - *Karnataka:* 1210 out of 8000
  - *Bihar:* 250 out of 1122

Is there capacity to monitor so many medical colleges?

- Large number of approved medical seats are cancelled subsequently
  - *Uttar Pradesh:* 2100 out of 5000
  - *Maharashtra:* 350 out of 1500 (Private)
  - *Karnataka:* 1210 out of 8000
  - *Bihar:* 250 out of 1122
- Quality of inspections
  - Serial inspectors
  - Focus on infrastructure, faculty and clinical workload deficiencies
  - Reports not shared with medical colleges (seeking recognition)

Is there capacity to monitor so many medical colleges?

- Large number of approved medical seats are cancelled subsequently
  - *Uttar Pradesh:* 2100 out of 5000
  - *Maharashtra:* 350 out of 1500 (Private)
  - *Karnataka:* 1210 out of 8000
  - *Bihar:* 250 out of 1122
- Quality of inspections
  - Serial inspectors
  - Focus on infrastructure, faculty and clinical workload deficiencies
  - Reports not shared with medical colleges (seeking recognition)
- Multiple disputes in court

Is there capacity to monitor so many medical colleges?

- Large number of approved medical seats are cancelled subsequently
  - *Uttar Pradesh:* 2100 out of 5000
  - *Maharashtra:* 350 out of 1500 (Private)
  - *Karnataka:* 1210 out of 8000
  - *Bihar:* 250 out of 1122
- Quality of inspections
  - Serial inspectors
  - Focus on infrastructure, faculty and clinical workload deficiencies
  - Reports not shared with medical colleges (seeking recognition)
- Multiple disputes in court
- Burden on other medical colleges

Light touch regulation has not worked

Light touch regulation has not worked

Recognition framework: Introduced in 1993

Light touch regulation has not worked

Recognition framework: Introduced in 1993

> *Where, within a period of one year from the date of submission of the scheme to the Central Government under sub-section (2) no order passed by the Central Government has been communicated to the person or college submitting the scheme, such scheme shall be deemed to have been approved by the Central Government in the form in which it had been submitted, and, accordingly, the permission of the Central Government required under sub-section (1) shall also be deemed to have been granted.*

Light touch regulation has not worked

Recognition framework: Introduced in 1993

> *Where, within a period of one year from the date of submission of the scheme to the Central Government under sub-section (2) no order passed by the Central Government has been communicated to the person or college submitting the scheme, such scheme shall be deemed to have been approved by the Central Government in the form in which it had been submitted, and, accordingly, the permission of the Central Government required under sub-section (1) shall also be deemed to have been granted.*

Monitoring framework: Call for information, inspections and visits

Fixed inspections

HOW INSPECTIONS ARE FIXED

2001 » Case against Dr Ketan Desai alleged that he was **involved in inspections norms being bypassed** in the case of Santosh Medical College, Ghaziabad, and the D Y Medical College for Women, Pune, **to allow admission to NRI quota beyond what was allowed**

2010 » CBI case against management of Melmaruvathur Adiparasakthi Institute of Medical Sciences, Tamil Nadu, where one of several doctors deposed before the MCI ethics committee **that he received ₹3. 25 lakh in cash** for being visiting faculty for inspection

2010 » CBI case against management of Sri Balaji Educational & Charitable Public Trust, Chennai, involved 26 doctors who were not working as full time faculty

2010 » CBI case alleged that Dr Desai, then MCI president, tipped off management of Gyan Sagar Medical College, Patiala, about an **inspection** through a tout, J P Singh, for which the college allegedly gave **₹2 crore** as **part payment**

2010 » CBI chargesheet alleged that inspections of Ram Murti Smarak Institute of Medical Sciences, Bareilly was fixed by Dr Desai by instructing MCI inspector Dr Suresh Shah to **overlook huge shortage of faculty** and residents to get **college recognized.** The college allegedly forged IT returns, ration cards and residential certificates of several so-called faculty and resident doctors

Note: Most of these cases are pending in courts

Figure 2: Instances of corruption cases in relation to inspections of medical colleges in India, including bypassing inspection norms, ghost faculties and tipping off management of college. *(Source: Times of India)*

Ghost faculty

ANATOMY OF A SCAM

College	Established in	Annual student intake	Faculty in place	Ghost faculty*
Adesh Institute of Medical Sciences & Research, Bathinda	2006	150	160	48
Gian Sagar Medical College, Patiala	2007	100	97	64
Maharishi Markandeshwar Medical College and Hospital, Ambala	2008	150	145	240
Maharishi Markandeshwar Medical College, Solan	2013	150	155	74

**Figures pertain to ghost faculty shown on rolls since inception*

Figure 3: In 2014, the Punjab Medical Council found 426 fake doctors enrolled as full-time faculty in four medical colleges across Punjab, Haryana and Himachal Pradesh, since their inception. *(Source: Times of India)*

Ghost Patients

> *The Assessors after a physical inspection, found that a number of patients were not genuine. The Assessors were of the opinion that patients with minor ailments were admitted in the hospital. There were others who were shown as patients with no serious health condition deserving an admission in the hospital. This was done by the Petitioner with a view to get renewal for admission of students by showing that it was complying with the minimum standards.*

In 2018, the Supreme Court fined Mahavir Institute of Medical Sciences, Telangana, INR 20 million, for projecting healthy persons as sick for the purpose of showing compliance of minimum standards. (See Para 7, *Mahavir Institute of Medical Sciences vs Medical Council of India* 2018)

Need for intensive regulation

- *Strict entry barriers* for aspiring medical colleges

- *Comprehensive monitoring* with checks and balances

Need for intensive regulation

- *Strict entry barriers* for aspiring medical colleges
  - Feasible *financially sound*
  - Compliant *adheres to standards*
  - Sustainable *execution of the plan*
- *Comprehensive monitoring* with checks and balances

Need for intensive regulation

- *Strict entry barriers* for aspiring medical colleges
  - Feasible *financially sound*
  - Compliant *adheres to standards*
  - Sustainable *execution of the plan*
- *Comprehensive monitoring* with checks and balances
  - Ongoing *periodic reporting*
  - Evidence based *focus on areas of concern*
  - Feedback loop *report card*
  - Due process *adjudicating withdrawal of recognition*
  - Transparent *accessible to public*

Increase entry barriers

Increase entry barriers

United Kingdom:

- Three year assessment process for recognition
- Ongoing monitoring through reporting, risk-based visits, feedback and enhanced monitoring

Increase entry barriers

United Kingdom:

- Three year assessment process for recognition
- Ongoing monitoring through reporting, risk-based visits, feedback and enhanced monitoring

Australia:

- Accreditation and approval
- Two year assessment process for accreditation
- Ongoing monitoring through periodic reporting, comprehensive reporting, visits and re-accreditation

Policy options

- Centralised *or* decentralised model
- Elected *or* appointed medical board
- Strict entry barriers *and* comprehensive monitoring of medical education

Thank you