

Medical Pluralism and Health Care for the Poor

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The existence of medical pluralism has often been understood in terms of cultural differences in the understanding of health and disease, or as predominance of folk models of disease versus biomedical models in the functioning of health care for underserved populations. From the policy perspective, the presence of a large number of providers in rural and urban areas who are either trained in alternate systems of medicine or have no training except garnered through experience of working as paramedical staff or as informal apprenticeship but who have the status of Rural Medical Practitioners (RMPSs) is seen as a major impediment to rational health care delivery. Yet, the issues are much more complex and regrettably, there is little curiosity on how health care institutions actually function in both public and private sectors. My aim is to open up some of these issues for discussion by looking at the legal framework within which the right to practice is negotiated and the structure of markets, within which health care providers of different kind strive to sustain their medical practice. What implications do these institutional factors have for the character of health care for the urban and rural poor?

The Legal Landscape: Who is a Doctor?

A detailed analysis of the corpus of court cases pertaining to the issue of who has the right to practice allopathic medicine in the country is not possible in the short space of this paper. However, it is important to note that while the Indian Medical Council Act of 1956 (last amended in 2011) limits the right to be registered as an allopathic doctor to those with degrees in biomedicine awarded by an accredited medical college in India, individual States have the right to issue notifications under Clause (iii) of Rule 2(ee) of the Drugs and Cosmetics Act (last amended in 2015), through which exceptions are allowed to the above rule in order to meet specific needs of underserved populations. Several key judgments of the Supreme Court have noted that while the Indian Medical Council Act of 1956 discouraged the practice of cross-path (when a medical practitioner trained in one branch of medicine practices another branch of medicine), the need to serve people living in areas in which there were not enough allopathic doctors made it necessary for States to permit limited rights to prescribe allopathic medicines by those practicing other streams of medicine. Thus the judgments of the Supreme Court have generally deferred to the right of State Medical Registry to determine the qualifications of Indian medical practitioners holding degrees in integrated courses to practice modern systems

of medicine. For instance, as recently as in January of 2014, the Maharashtra State Cabinet decided to allow homeopaths to prescribe allopathic drugs provided they had taken a linked course in pharmacology. In February of 2014, the Maharashtra State cabinet decided to allow Ayurveda and Unani practitioners to perform minor surgeries, in addition to legally prescribing allopathic drugs.

In effect, these judgments reflect a struggle in which the associational politics of different kind of practitioners have played a crucial role to retain their market shares. However, the plethora of court judgments and State notifications create tremendous uncertainty at the ground level for providers trained in alternate systems of medicine as to what constitutes legitimate medical practice. During fieldwork in urban slums in Delhi, Mumbai, Patna and Allahabad, our team of researchers at the Institute of Socio-economic Research on Development and Democracy (ISERDD), documented a proliferation of degree granting institutions. This data was collected in different phase. Initially, through mapping exercises of providers in seven neighborhoods in Delhi in the years 1999-2002, our team identified the various kinds of providers by noting the degree or the training recorded on billboards (see Das 2015). This exercise was complementary to weekly morbidity surveys conducted on 1600 randomly chosen households in these neighborhoods for a four month period every year for a total of three years (see Chapter 2 in Das 2015 and also Das, Hammer, and Sánchez-Paramo. 2012, for a detailed discussion on methodology and results and particularly the latter for differences in recall in weekly versus monthly morbidity surveys.)

Recently there has been welcome scaling up of these exercises, based on a systematic survey of a random sample of households in one district in every state in India, authors of a recent study find that an average household in rural India can access 3.2 private and 2.3 public paramedical staff within their village (see MAQARI, cited in Das J: 2011). In Delhi there are 70 practitioners (most of whom are private practitioners) within a 15 minutes walk of every household. The extent of medical training varies in all these sites – in rural Madhya Pradesh 65% of practitioners accessed had no formal training while in Delhi only 10% to 15% had no formal training although what this formal training consisted of showed wide variation including, for instance degrees in ayurveda through correspondence courses. (see Das, Holla et al 2012).

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The ISERDD team also encountered a large number of providers who might have gained some knowledge of specific medical procedures through apprenticeship in hospitals or nursing homes as compounders, laboratory technicians, or, those who were integrated

in government schemes as health workers or Auxiliary nurse midwives, and who have subsequently drifted into the provider markets that serve the urban poor and the rural areas. From the perspective of providers trained in biomedicine, these practitioners fall in the category of “quacks”. There is a marked vigilantism in such organizations as the Quackery Eradication Wing of the Indian Medical Association (as well as at State level associations), which advocates the use of police force to stamp out this segment of the provider market in low-income areas of the cities. Such vigilantism leads to periods when there are raids in the markets in low-income areas to locate “quacks” and subject them to criminal proceedings that then give way to periods when it is business as usual. It is important, however, to realize that though landmark judgments of the Supreme Court such as *Verma v. Patel* (1996) that held a doctor with a homeopathic degree responsible for the death of a patient and stipulated that all States should take action to see that those not trained in biomedicine would have no right to practice it, there are other judgments in which litigation undertaken on behalf of the associations of doctors with different kinds of training led to considerable leeway in this matter through the recognition of the right of States to issue notifications to meet specific needs of the moment. (See for instance *Dr. Mukhtiar Chand & Ors vs The State of Punjab*, 1998; *Lceh Doctors’ Association vs State of Maharashtra* 2013)¹

Two questions that are rarely asked in this context are as follows— first, what are the *institutional mechanisms* through which these providers are able to sustain their practice? Second, what kinds of needs do these providers fulfill and what are the gaps in health delivery that lead to a demand for their services?

Markets and Networks

Regardless of the system of medicine they have been trained in, there are certain features that are common to all providers in low-income areas in urban areas as well as in rural areas in the way they diagnose and treat diseases. First, rigorous research on the basis of systematic observation has shown that on average a doctor in low-income areas spends about three minutes per patient regardless of the number of patients waiting in the clinic, and independent of the kind of training he has. Patients do not demand and doctors do not offer diagnosis – instead, patients are treated on the basis of symptoms. Most doctors practicing in low-income areas first give medicines for two to three days on the basis of symptoms – usually a mix of pills, capsules and a syrup consisting of a common antibiotic, analgesics, a vitamin and a steroid (see Das and Hammer 2004; Das, Hammer and Leonard 2008; Das, Holla, et al 2012; MAQARI Team 2011) Work in progress in Patna and Medicines by a joint team of researchers from McGill University, World Bank, and ISERDD, has found that medicines dispensed are usually unlabelled in low-income areas in Delhi and Mumbai, while in Patna and in Allahabad

district we found that the medicines are labeled and dispensed in their original packaging. Patients are given medicines for a maximum of two or three days in all these places and asked to return if they do not feel better. Very often a serious disease such as tuberculosis might be treated as a common flu initially and only over time when the patient returns with worsened symptoms are tests prescribed or the patient referred to a trained doctor. Thus the strategy the doctors employ is to use the medicines not only as therapeutic agents but also as diagnostic ones. Rigorous research using a combination of a vignette methodology that measures knowledge and a standardized simulated patients methodology that measures actual practice, has demonstrated that although providers trained in biomedicine (with degrees of MBBS) have more knowledge on diagnostic techniques and treatment, they do not apply their knowledge in the actual clinical setting (Das, Holla et al 2012, Das and Hammer 2014)). This know-do gap, as it has come to be known, accounts for the fact that regardless of the kind of training that a provider has received, the treatment given to patients in low-income urban areas and in rural areas, shows little variation. In fact, providers trained in biomedicine are likely to prescribe more unnecessary antibiotics than those trained in other streams, although they might ask more questions pertaining to the history of the disease. The point is that a degree in biomedicine is no guarantee that a patient will receive a proper diagnosis or correct treatment if he or she lives and uses the services of doctors in the neighborhood markets in these areas (see also Mohanan, Vera-Hernández and Das et al 2015). Researchers have also shown that despite expansion of PHCs and government dispensaries, in 2015, there were 11.9% vacancies in PHCs and a staggering 81/9% for specialists in Community Health Centers (Pulla 2015)). Add to that the rampant absenteeism – on a typical day, 40% of doctors might not be present in the PHC (Banerjee and Duflo 2006; Chaudhury 2006; Muralidharan and Chaudhury 2011) – and we can see why people will not bother to go to the PHC for treatment. Given these shortcomings, the typical illness trajectory in a poor family is that patients continue to visit local doctors for symptomatic relief unless the disease becomes critical when they might shift to a government or private hospital. Catastrophic health expenditures are often a result of the fact that a disease that could have been treated earlier goes undiagnosed and inappropriately treated till it becomes a crisis.

What kind of business models have providers in poor areas developed to sustain and grow their practice? Detailed interviews with medical representatives employed by pharmaceutical companies, medical stockists, warehouse owners, pharmacists and medical salesmen reveal a complex structure through which pharmaceuticals are marketed. In general, in the cities ISERDD researchers have studied, we find a classification of medicines, which tells us a great deal about the institutional structures of buying and selling, credit and debt, through which

providers in low-income areas sustain their practice. The three-fold classification of pharmaceutical products is that of “ethical medicines” – referring to medicines on which patents have not expired and which are, therefore expensive and are marketed through distributors and medical representatives to large hospitals and doctors practicing in more affluent areas. The second is “generic” which refers to off-patent drugs produced under license by small manufacturers and marketed to pharmacies in middle income and low-income areas. Finally there is the category of “dispensing medicines” which are usually unlabelled medicines that are sold in bulk to certain distributors who specialize in stocking these medicines in Mumbai. In Delhi and Allahabad we found that patented, generic, and unlabelled medicines can be found in the same wholesale shops but the unlabelled medicines are not displayed. In other places, (e.g. Patna and Mumbai) stockists distinguish themselves on the basis of the kinds of medicines they stock but to examine variations we need more systematic work. Unlabelled medicines are either sold through the agency of medical salesmen (and not MRs) who we might describe as freelancers or bought directly by providers in bulk. There are well worked out credit and debt networks through which supply chains are maintained and segmented markets are served. I do not have the space to describe the mechanisms through which generic medicines too move within specific networks such that some doctors will insist on patients taking only some brands while proscribing others, often leading to considerable price hike for the patient.

Finally, it is intriguing to see that different cities have evolved different patterns through which providers in alternate medicine and so-called informal providers (i.e. those who have learnt their craft through informal arrangements such as apprenticeship with a doctor) are linked with providers who are fully trained in biomedicine. We found that in Delhi, such informal providers and those with degrees in alternative medicine are not tied into any formal referral networks. If a disease worsens, they will ask the patient to go to either a government hospital or to a private facility. In only one area in Delhi, did we find that a local hospital provided incentives to providers in the local market to refer patients to that hospital by offering them a commission for every referral. These kinds of financial arrangement need more study.

A different kind of network between providers might be illustrated through a case study of an eight-bed nursing home from Korali, a relatively large and well-connected village near Allahabad. The owner of the eight-bed nursing home (I will call him Dr. Shailesh) had worked as a helper in the operation theatre of a private hospital in Allahabad in his youth, combining this with studying for a degree in pharmacology. After his B.Sc. degree, he set up a regular chemist shop in Korali with a small section of the shop separated by a curtain where he saw patients.

As a pharmacist, he supplied medicines to neighboring villages and small towns, including to the informal providers in these areas but he supplemented this income by treating patients from the village for minor ailments. As his business expanded, he also expanded his clinic so that today he has in-house facilities for basic laboratory investigations, an OPD where ordinary illnesses can be treated, and provision of admission and treatment of patients who require minor surgeries or need to be admitted for complications such as delayed labor, or for treatment of wounds and injuries. Dr. Shailesh recognizes that his own ability to treat complicated cases is limited and hence has contracted with three doctors from Allahabad with different specializations who run OPDs in his nursing home in Korali for one day each every week and treat inpatients from Korali and surrounding villages. If a patient needs more specialized attention these doctors have the connections to have patients admitted in larger hospitals in Allahabad. This is an interesting model, for Dr. Shailesh, as his name plate characterizes him now, has effectively redefined himself as a rural health worker despite the title of Doctor. He limits himself to performing triage functions and treating minor diseases. His income comes from sale of medicines, laboratory investigations, and fees for consultations. He does not get any rent or commission from the three visiting doctors as he claims that they are crucial contacts for his plans to expand further and build other such facilities in neighboring small towns.

We found similar strategies for medical establishments in small towns in the vicinity of Patna. Providers trained in biomedicine in Patna are linked to multiple locations, some of which are outside Patna. These networks have been facilitated in part because of the rules regarding private practice in Bihar whereby state employees are allowed to engage in private practice and partly by emerging entrepreneurship in small towns or large villages on the fringes of big cities like Patna. Some of the results have probably been positive as more qualified doctors become available in poorly served areas, but we have also witnessed so-called operation theatres where visiting surgeons who work in government hospitals perform such surgeries as appendicitis and hysterectomy as part of their practice but in conditions of very poor hygiene, no nursing staff, and no ambulance service for transferring patients who might develop complications. A future area of research is to investigate the conditions of possibility for different business models to evolve and their implications for quality of care. It is particularly important to inquire into the difference between fragmented markets in which the providers with different kinds of degrees move in separate circuits and remain isolated from networks of trained allopathic providers, laboratories and pharmacies; versus those located in more integrated markets in which either through ties of kinship or through different local business logics, informal providers become integrated into different kinds of referral networks redefining themselves as providing

first lines of contact with patients. The implications of these different models for quality of care, ability to diagnose, and access to expert knowledge provided by allopathic providers (with all the positive and negative implications), as well as the financial burden of treatment on patients, are likely to be quite staggering. While it has been very easy to blame “quacks” for all the ills of health care, it is salutary to keep in mind that providers trained in biomedicine participate fully in such practices as prescribing unnecessary antibiotics, performing surgeries in ill-equipped “operating theatres” with no provisions for after care and in some cases, not even the provision for clean bed sheets in what passes for a post-surgery ward. At ISERDD we have enough case materials to open up these questions but without a national level survey it is not possible to quantify these findings.

Experiments on Policy

I hope it is clear that the provider markets are not static and that quality of care is not easy to map on allopathic doctors versus doctors from different streams of medicine. On the basis of the present research, I suggest that policy debates need to take the existence of the large number of providers who use allopathic medicines but do not have access to information except through the mediation of medical salesmen – not as an impediment but as a resource that can be molded to stamp out harmful practices and provide better care to patients. One example of treating untrained providers as a resource is a training program run by the Liver Foundation located in Kolkata, which has been offering a training program for rural practitioners in Birbhum district in West Bengal in which trainees who are admitted to the program are given basic knowledge in subjects such as anatomy, physiology, and pharmacology. Unlike training that is oriented to diagnosis and treatment of single diseases, which is a pattern that has been often followed by government run institutions, these trainees are given more broad based information on how to do differential diagnosis for common diseases and above all to learn about harmful practices. On completing their training these providers have to agree to stop prescribing Schedule H and Schedule X drugs though they are allowed to dispense or prescribe first line antibiotics and to encourage patients to complete the full course of the medications prescribed. Most of all the idea is to teach such providers how to recognize serious illnesses and refer them to fully trained medical practitioners or to government hospitals (see Pulla 2015 for a very accessible discussion of the issues and the initiative taken by Liver Foundation for rigorous assessments and monitoring of their program. In some other States such as Telangana, the government has finalized schemes to train providers in a similar fashion. We saw earlier that already there are models evolving (as in larger villages and small towns in the vicinity of Allahabad and Patna) in which providers of different kinds are plugging themselves into referral

networks that can give their patients access to fully trained providers and to specialists. How might policy build on these initiatives in urban areas so as to mitigate any ill effects while increasing access? One important question relates to the kind of continuing education and access to facilities, which could be devised for such providers who are currently responsible for more than 60% of clinical interactions in rural areas and in low-income areas in cities so that they may be able to serve their clientele better. There are related issues on how to improve the functioning of PHCs and Community Health Centers but simple expression of pious intentions will not work. Instead one must ask which kind of health needs are better met in the public sector and if, instead, of a uniform territorial model that we have at present, it might not be better to devise a series of alternate models that can take more local factors into account. In short, we need to get out of ideological debates and ask, instead, what are the ways in which health policy can work in tandem with the innovations and experiments that are already happening on the ground. Instead of punitive models of regulation it is important to recognize the solutions people have evolved and give these support and direction so as to eliminate dangerous practices while also giving much needed access to underserved populations.

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