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## ROUND TABLE

## Ethical issues in health care sector in India

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## KEYWORDS

Health care;  
Ethics;  
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**Abstract** The issue of ethics and economic efficiency in the provisioning and delivery of services becomes complex in the Indian context where health indicators are poor. In an attempt to explore this issue, this round table article first provides an overview of the field of ethics in health care, the health care sector in India and its facilities, the key institutional actors and finally, the key ethical issues concerning the different players in health care – the physician, the bio-pharmaceutical industry, and the chemist. In its second part, the article reports on a discussion of the issues with a panel of experts across geographic and organisational settings.

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## Academic perspective

Health care institutions across the world are facing challenges in the delivery and provisioning of services with financial solvency. Patient care now competes with the financial solvency of the health care institutions (Silverman, 2000), and the issue of ethics has become more relevant than at any other point in time. Health care services have a special moral quality. The purposes of health care services include saving lives, preventing or relieving suffering, preventing and curing disease and disability, and ameliorating the consequences of disease when it cannot be prevented or cured. Few people can be morally comfortable

with the idea that some people should be denied access to health care that might relieve their suffering or save their lives because they cannot pay for it (Enthoven, 1993). In the Indian context, where health indicators of the country are poor, the discourse on ethics assumes greater complexity and requires a more nuanced understanding and appreciation of the contextual elements. This note attempts to provide a brief overview of the field of ethics in health care, the status of the health care sector in India, the key institutional actors and finally, the key ethical issues arising out of the interactions across the various actors.

## Ethics and health care

The field of medical ethics has long existed, arising from the Hippocrates oath, and tenets of the early religious healing traditions of the West. Several Asian traditions have also had ethical tenets governing the physician–patient relationship (Tsai, 1999; Desai, 1988). In the field of contemporary medical ethics, the doctors in the USA were the first to develop a modern code of ethics. At the first meeting of the American Medical Association (AMA) in 1846,

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a committee was appointed to report on a code of ethics for the organisation. Modern medical codes of ethics are based on the works of Thomas Percival, a British Physician credited with giving much thought to the future of the profession. The International Code of the World Medical Association, an organisation representing physicians founded in 1947, ensures that physicians strive for the highest possible standards of ethical behaviour and care at all times (Backof & Martin, 1991).

In the 1970s, traditional medical ethics changed into an interdisciplinary field involving theologians, lawyers, philosophers, social scientists, and historians, as well as physicians and other health professionals (Veatch, 2006). The reason for this was the increasing impact of science and technology, the growth of specialisation in the field of medicine, public expectations from new medicines and surgical techniques, changes in the financing and delivery of health care, and the transformation of medical schools into large medical centres in the West. The field of medical ethics which focused on the moral responsibility of a physician to a patient was not adequate to address the ethical aspects emerging out of the changed context. With more stakeholders, such as medical devices companies, pharmaceutical companies, diagnostic clinics, insurance companies, clinical trial organisations, and other service providers entering the field, there was a need to expand the scope of the definition of ethics within the field of medicine. In recent years, the terms "bio-medical ethics", "bio-pharmaceutical ethics", and "health care ethics" are gaining importance. The term bio-medical ethics includes the issues related to reproductive biology, such as stem cell research and human cloning and the ethical dimensions arising out of these changes. The term bio-pharmaceutical ethics refers to the ethics associated with the discovery and development of the products. The term health care ethics is increasingly being used as an umbrella term to encompass ethical aspects previously included in medical-, bio medical-, bio-pharmaceutical- and also organisational- and business ethics of different stakeholders involved in the provisioning and delivery of health care services. It is this broad definition of health care ethics that is being used in this note and the round table discussion that follows the note.

## Indian health care sector

The health indicators of India have consistently lagged behind the economic development that has been witnessed over the last decade and the need for increased investment in health care has been acknowledged. The public expenditure on health in India remained at about 1.1% of GDP in 2010 (Ministry of Health and Family Welfare, GOI). Public health care delivery is done through a network of over 146,036 health sub-centres, 23,458 Primary Health Centres (PHCs) and 4276 Community Health Centres (CHCs). There is a 150-bed civil hospital at the district level to provide tertiary care. Only 23.5% of urban population and 30.6% of the rural people choose government facilities, thus reflecting the widespread lack of confidence in the public health care system (Central Bureau of Health Intelligence, 2010).

Studies have acknowledged that India ranks among the top 20 countries in the world in its private health care funding and that 82% of the total medical expense in India is

paid for through personal funds (Sengupta & Nandy, 2005). According to the Central Bureau of Health Intelligence, majority of Indians trust and visit private health care despite the fact that cost of treatment in private treatment is significantly higher than public facilities (Table 1).

Private sector health care is highly fragmented with over 90% of private health care being serviced by the unorganised sector. Eighty percent of the private hospitals are small clinics and nursing homes (less than 30 beds). Six to seven percent are 100–200 bed size hospitals and only 2–3% of hospitals are 200+ plus bed (Table 2). Most of the large hospitals are located in the urban areas.

The sector however has attracted considerable private investments and it appears that the participation of the private sector in this field is likely to continue in the near future. The conflict between the financial solvency of the private sector players to the need for affordable quality health care services in ways that enhance the health and well-being of citizens is an immediate and visible area of ethical conflict in the sector.

## Disease burden and adequacy of facilities

In the course of development, countries undergo an "epidemiologic transition". Initially the developing nations have high morbidity and mortality due to communicable diseases and maternal and child mortality. As economic development occurs, these morbidities decline significantly and there is an upsurge of diseases of the affluent class, that is, non-communicable diseases, injuries and geriatric problems. India, however, faces a dual burden of high incidence of infectious diseases (Tables 3 and 4) and a rising epidemic of non-communicable diseases. The trend of dual burden is consistent across urban and rural areas with a slightly higher proportion of non-communicable diseases in urban areas (Table 5). With the changing trends in the communicable diseases, changing demographics, increasing urbanisation, and increased lifespan, the burden of disease is likely to increase further, putting a burden on an already insufficient health care system.

Given the cost of treatment, disease burden, and the poor public health care facilities, the moral and ethical discussion on the "right to live" assumes a greater significance in India. In the next section, we introduce the typical experiences of an imaginary patient in the health care system in India.

## An imaginary patient

This section outlines the trajectory for an imaginary patient (Patient X) traversing through the value chain in Indian health care. Patient X might be a poor farmer, an entrepreneur, or

**Table 1** Average cost (in rupees) of a typical illness episode in public and private sector.

	Public facilities	Private facilities
Cost of an out-patient episode	242	310
Cost of an in-patient episode	859	9352

Source: Selvaraj & Karan, 2009

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