Public Health Practice

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When doctors sell medications...

In many traditional communities physicians do not charge for a consultation. Instead they sell medications to the patient. The incentives built into this mode of payment are contrary to a rational use of drugs.

The way a physician is paid profoundly affects the way he or she practices medicine. This is obvious and well understood by government health agencies and health insurance firms. Third-party payers use a variety of payment systems, such as capitation or designating a fee for each service, to influence the number and type of medical procedures given and the amount and type of medication prescribed. Less obvious and less well understood are the informal modes of payment for physicians’ services, which differ from one community to another and influence medical practice.

In a town in south India, which I shall call Kerepuram, I observed a mode of payment common in rural India and in traditional communities throughout the world. The doctors did not charge for the consultation. Instead, they sold medications to their patients. The question addressed in this article is why the doctors used this mode of payment instead of charging a consultation fee and writing a prescription.

From traditional to modern health care

Until recently physicians and modern medicine were well beyond the means of most people in Kerepuram. Most people when ill went to the vaid (a man learned in Ayurveda, the ancient classical medicine) or to folk healers; only the elite went to the town’s three physicians. Economic growth in the 1970s brought higher incomes, and by the mid-1980s an additional 25 physicians had opened clinics and specialists were practising in the district hospital. Only one traditional vaid remained in town. His one or two patients a day were usually people with chronic illnesses referred to him by the doctors. Outside the town, in a rural ashram, a well known and highly respected religious vaid continued his flourishing practice of Ayurveda.

The doctors quickly became the preferred practitioners for most people in Kerepuram, but the lay health culture remained largely unchanged. Most people still held traditional beliefs about both the nature of illness and the proper relationship between practitioner and patient. They could not deny the effectiveness of doctors in relieving pain and
curing illness but, at the same time, they could not understand much of what the doctors said and did. Their advice on nutrition, for example, often ran counter to the people’s common sense, and their manner with patients often seemed impersonal, improper, and puzzling.

Virtually no one in Kerepuram, not even the doctors, would express a disbelief in Ayurveda. This did not mean that people knew much about it; they simply believed that Ayurveda was intrinsically superior, that it cured the basic underlying causes of illness, and that they were forced to resort to modern medicine because Ayurveda was so very slow-acting.

The attraction to modern medicine in this still traditional community lay in the seemingly magical qualities of the medications, not in an understanding of the physician’s professional role. In Kerepuram District, and throughout India, a large majority of the vaids, hakims (practitioners of Islamic classical medicine), and homoeopaths use modern medications along with, or even instead of, their traditional remedies.

Paying for the consultation

In many traditional systems of medicine, illness is conceptualized as being at least partly caused by wrongdoing. The vaid and his deity, to effect a cure, assume responsibility for the patient’s actions and guide him or her in identifying and rectifying the wrong for which the illness is punishment. This sharing of obligations between vaid and patient is analogous to the relationship between tenant and landlord or human beings and the gods. The traditional vaid is a religious leader and man of learning as well as a health practitioner. The mode of payment for his services reflects his social standing.

The traditional vaid does not request payment. The upper and lower limits of an acceptable price are customary and generally known but the exact amount and the time or occasion of payment are decided by the recipient, not the giver, of the service.

Payment for the consultation is a personal, not a commercial, transaction. The social status of the giver and the recipient and the social relationship between them is relevant to the price. If the giver of the service is prestigious, such as a Brahmin, he is paid more than a humbler person, such as the dai (traditional birth attendant). If the recipient is wealthy, he or she pays more than a poor person. It is a point of honour, and something to boast about, to pay highly for a service.

The outcome of the service is a consideration in the price. If the patient returns to good health a high price may be paid, but if the illness continues or death occurs the healer may receive nothing. The dai is “rewarded” more at a first birth or when a boy is born.

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Payment should be in the metaphor of the gift. The health practitioner rendering a service in a traditional setting is expected to do just that—serve, not sell. Courtesy requires reciprocation and a certain ritual should separate the counter-gift from the gift of service. In the rural ashram, for example,
a grateful father returned to thank the *vaid* for curing his daughter of "asthma". He also, quite incidently, gave the *vaid* 201 rupees, the odd number indicating that this was a gift and not a crass commercial payment. Before the monetization of the economy an ordinary family would have given produce from the household and the wealthy family would have given silver or gold coins or bestowed assets.

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In a preindustrial cultural environment an exchange of goods or services ordinarily constitutes both an economic and a moral transaction. A gift symbolizes the social bond between healer and patient. Outright payment for the consultation would be seen as invalidating the personal nature of the relationship.

**Selling medications**

Unlike the vendor who sells remedies in the marketplace, the religious *vaid* places the consultation at the centre of his practice. He expects reciprocation. However, the traditional *vaid* also makes or purchases Ayurvedic remedies. He sells these remedies to the patient to be used in therapy and includes in the price a charge for the consultation.

Nichter has written of the traditional *vaid* who practices in the villages: "*Vaid*s must include their consultation cost within the reasonable limits established by lay cost reckoning if they are to retain a poor patient. This influences the number of days of medicine a *vaid* gives to a patient per consultation as well as the types of medicines they directly administer and prescribe... Costly medicines, such as those containing minerals (e.g., gold, mercuric oxide) or musk (*kasturi*) are prescribed and not directly administered to the patient as it would be difficult to tag a consultation fee on to a medicine that is already costly. When such expensive medicines are required, the patient is asked to purchase them elsewhere and the *vaid* initially collects his fees through charges for a set of purification medicines required as a preliminary to the treatment" (1).

**The patient's perspective**

Modern medicine clearly increases the patient's prospects of gaining relief from suffering but it also considerably diminishes the patient's negotiating power in his relationship with the practitioner. Compared with his traditional role, the patient is, *vis-à-vis* the doctor, passive and reactive.

In the traditional system of medicine, the patient's lay concepts of illness and therapy are congruent with the *vaid*'s more specialized knowledge. A dialogue is easier with the *vaid* than with the doctor because the traditional healer explains illness in a vocabulary familiar to the patient. In modern medicine, the doctor diagnoses disease using esoteric biomedical concepts. The patient is expected to comply with a course of treatment that often makes little sense in the lay health culture.

The traditional *vaid* interests himself deeply in the patient's total life and problems. For the doctor in the modern professional role, responsibility for the patient does not
ordinarily extend beyond the clinic or hospital setting.

In a traditional health culture, the patient determines the ostensible price of the consultation, expressed as a gift, and the vendor sells his remedies at a price the patient can or will pay. When the doctor charges a consultation fee, it appears that he or she alone determines the cost to the patient and profits from the illness regardless of its outcome and regardless of the patient’s circumstances. When the doctor prescribes medications that are sold at a fixed price by the pharmacist, the patient has, again, lost autonomy and power in negotiating the terms and the cost of illness.

The people in a traditional community persist in using the mode of payment appropriate for the vendor because it is customary and seems natural. Being openly charged money for a personal service is considered unnatural and improper. Furthermore, by not recognizing the consultation fee, the patient can retain at least one aspect of his more powerful traditional role.

The doctor who is setting up practice in a traditional community, to attract and hold patients, abandons the consultation fee and juggles the conflicting roles of professional and tradesman.

The rational use of drugs

When doctors sell medications their incomes depend on the amount and the type they dispense. Injections are especially profitable and are preferred by many patients in developing countries. Kleinman noted in China (Province of Taiwan) that the practitioner made a higher profit on injections than on tablets and observed that “almost all medicinal agents that can be given by injection are so administered. That includes vitamins, mild sedatives, antipyretics, anti-inflammatory agents, and medicines used in the long-term management of chronic illnesses like hypertension, etc., for which there is no good reason to administer parenterally and good reason not to administer in this way, since it may increase the incidence of dangerous side-effects and can add complications of injection, like iatrogenic infection” (2).

The incentives are for both overmedication and undermedication. If the patient cannot afford a needed medication, the doctor may sell the patient something inexpensive, such as an analgesic, and give the patient a prescription. At the pharmacy, when the patient presents the prescription, the clerk opens a packet and sells the number of capsules or tablets the customer can afford.

Selling medications is not compatible with the doctor’s role as a professional and a fiduciary. It turns him into a vendor and sets incentives contrary to the rational use of drugs as recommended by the World Health Organization (3), which has pointed out that sometimes the appropriate therapy does not include drugs.

When I asked the doctors in Kerepuram why they sold medications, their reply was that they could not practise in the town as they would in a large city with a middle class clientele; rural people do not pay a
consultation fee. The doctors said they did not like being denied the right to a fee for their professional knowledge and time. However, they accepted the role of tradesman because only by so doing could they earn what they considered an adequate income.

Other aspects of patient behaviour also disturbed the young doctors. Townspeople did not show respect, nor would they defer to the doctor’s authority. They acted more like customers than patients. They shifted doctors if not satisfied, which was often. They watched the dosage to see that the doctor did not cheat them by giving them less than they paid for, and they compared doctors on this point. Doctors spoke of the gifts they received from grateful patients, but they also despaired of the not infrequent patient who bargained in the clinic over the price of medications.

**Consumer education may be the answer**

When doctors earn their livelihood as vendors rather than as professionals the incentives are contrary to the rational practice of medicine. However, one-stop shopping for medical care proves convenient for the patients and profitable for the doctors. Once established, this mode of payment becomes difficult to change, even when it contributes significantly to the widespread misuse of medications.

What action can be taken? The first step is to recognize that many doctors are selling medications and that the consequences are not necessarily beneficial to the public’s health. It should be recognized that the nature of medical practice is shaped quite as much by patients’ expectations and the lay health culture as by physicians and the profession. Most people, even in highly traditional communities, know about and want modern medications but often they are not aware of how complex these substances are and that when misused they can cause illness instead of curing it. Nor are people always aware that only a physician is qualified to prescribe medications and only a licensed pharmacist is qualified to sell them.

A possible way to proceed could be through programmes of consumer education that help the public to better understand the modern health care system. Health care consumer groups are already active in a number of developing countries. They can be encouraged to include the problems of medication utilization in their concerns and to reach out into the rural areas. Messages can be disseminated through schools and the media. Consumer education is an essential part of bringing modern health care to a nation. It needs to be given higher priority by the authorities.

**References**

