DEFENSIVE MEDICINE AND MEDICAL MALPRACTICES IN INDIA: AN ECONOMIC ANALYSIS

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ABSTRACT

Medical science claims to have developed several ways of controlling health risks, increasing safety standards and protocols related to medical practices and procedures but it cannot claim that it has eliminated all other kinds of risks associated with it. The recent spurt in the litigation against medical professionals for medical negligence and the claim for redressal or compensation has shaken the confidentiality and patient-doctor relationship to a new high level. The increasing cost of medical malpractice litigation has increased the practice of defensive medicine. It is a medical practice that can be said as an act of economic security against potential allegations of negligence. The present study on economic analysis of medical malpractices and practice of defensive medicine focuses on a pre-existing market relationship between medical negligence and the resultant defensive practices adversely affecting many aspects of human life. The present research is divided into five sections.

The first section deals with the nature of the existing market and the economic analysis of the relationship between medical negligence liability and its potential impact on the practice of defensive medicine. The aforesaid market relationship is much more pronounced in the western countries. It is based on the understanding of cost of litigation, the expectation of liability in excess to actual damages and the benefits accruing out of practicing defensive medicine in response to the above situation. However, in the context of India the relationship is not that simple. Particularly, when medical malpractice litigations are not very common practice by the victims and the so-called existing healthcare industry is already running at kickbacks for referring patients, inflating bills and thereby promoting defensive medical practices. In order to promote efficient transactions, exchanges and economic efficiency in the above market, role of legal means cannot be denied.

The second part of the study examines the role of the insurance industry in dealing with medical claims. In an inefficient insurance market, insured medical claims remain low and out-of-

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pocket medical expenditure remains very high. This unethical socio-economic malpractice is economically inefficient and thereby inducing loss of socio-economic welfare of the people.

The third section delves upon the unintended socio-economic impacts of the medical malpractices and defensive practice. Particularly in a welfare state like India, it neither results in an activity reinforcing excellence in the medical profession nor helps in achieving the constitutional mandate of 'Right to Health'. An individual's sense of wellbeing is incomplete in the absence of his physical as well as mental wellbeing and both of them are responsible for country's economic and social development.

The fourth part examines the relationship of law with defensive medicine. The role of law in regulating the market and thereby reducing healthcare costs is very important. Although it is very difficult to have correct estimates of medical liability costs and various components of it, the growing concerns related to increasing practice of defensive medicine has to be adequately addressed by law.

The fifth and the last section discusses the conclusions and recommendations. Today, when the entire world is going through a phase of health crisis, the concerted effort of citizens and government becomes indispensable. In a country like India accessibility and affordability of medical facilities and insurance has to be ensured. With the continuous increase in health care costs the very objective of fair distribution of available healthcare facilities has become a difficult and unachievable task. In order to deal with the above complex and perplexing problem we need greater involvement of economics, law and suitable public policies. India's fragmented health infrastructure may result in economic inefficiency, reduction in social and economic welfare, wastage of scarce medical resources and high-cost treatment.

1. INTRODUCTION

The government of India became the signatory of the Alma Ata Declaration at the World Health Assembly, in the year 1978, promising "Health for All" by 2000. The declaration was in response to existing widespread inequities in health and healthcare facilities across the world.[1]

[1] World Health Organization, *From Alma- Ata to the year 2000: Reflections at the Midpoint*. (Sep. 21, 2022, 11:24 PM) https://apps.who.int/iris/bitstream/handle/10665/39323/9241561246_eng.pdf?sequence=1&isAllowed=y

The signatory countries were expected to bring the radical changes in both content and design of the healthcare services and to fulfil the very fundamental objective of WHO- 'Health for All' by the Year 2000.[2] Pursuant to the above declaration, the government of India allowed the private sector to venture in healthcare infrastructure. However, back then there were not adequate laws to regulate private clinical establishments.[3] Central government through the implementation of the Clinical Establishments (Registration and Regulation) Act, 2010 attempts to regulate all clinical establishments in India. Although public health, hospitals and dispensaries are part of the State List under Seventh Schedule of the Constitution, unfortunately many states haven't ratified and implemented this law.[4]The abovementioned Act has to be accepted by the states under Article 252 of the Constitution but so far, only 11 states (Sikkim, Mizoram, Arunachal Pradesh, Himachal Pradesh, Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Uttarakhand, Assam and Haryana) and all union territories except Delhi have accepted it.[5]

As far as right to medical care is concerned, the 1948 Universal Declaration of Human Rights has already recognized the inherent dignity, and the 'equal and inalienable rights of all members of the human family.'[6] The rights of patients are also based on the very concept of fundamental dignity and equality of all human beings.[7]

2. ECONOMICS BEHIND DEFENSIVE MEDICINE AND MEDICAL NEGLIGENCE LITIGATION

Today, the doctor-patient relationship has undergone a major change and is no longer based on the proverb 'doctor knows the best'. Suspicion and distrust have overtaken this relationship and it is now purely based on a market relationship where individual consumers (patients) are availing services from the doctors and hospitals are working as service providers. What is more interesting is that in this market, demand can be easily influenced and encouraged by the service providers resulting in inefficient outcomes.[8] These inefficient outcomes are because of over treatment or under treatment when compared to economically optimum levels of spending done

[2] *Id.*
[3] Vidya Krishnan, *A Cure for Medical Malpractice*, The Hindu, May 26, 2018. (Oct. 11, 2022) https://www.thehindu.com/opinion/op-ed/a-cure-for-medical-malpractice/article23994053.ece
[4] *Id.*
[5] PTI, *11 states, all UTs except Delhi have adopted Clinical Establishment Act*, ETHealthworld.com (December 28, 2018) https://health.economictimes.indiatimes.com/news/policy/11-states-all-uts-except-delhi-have-adopted-clinical-establishment-act-government/67287028
[6] Tapas Kumar Koley, MEDICAL NEGLIGENCE AND THE LAW IN INDIA, 9 (Oxford University Press, New Delhi 2010).
[7] H.J.J. Leenen, Patients' Rights, 49 *World Health*, 5, 4 – 5 (1996). World Health Organization.
[8] Economic Survey of India 2020-21. (Oct. 15, 2022) https://www.indiabudget.gov.in/budget2021-22/economicsurvey/doc/vol1chapter/echap05_vol1.pdf

by the individuals.[9] This has resulted typically in patients filing negligence suits against doctors and the medical professionals practicing defensively. In the context of India, the market relationship is not that simple, particularly, when medical malpractice litigations are not very commonly undertaken by the victims and the so-called existing healthcare industry is already running at the kickbacks for referring patients, inflating bills and thereby promoting defensive medical practices. Defensive medicine is considered to be an act of commission or omission, permitted by medical science, intended to avoid negligence suits and compensation claims.[10] However, in common parlance it can be well understood as a practice of adopting a procedure which does not benefit patients, but acts as a protection against the possibility of negligence.[11] It is legally safe, economically expensive but medically of least or no value measure adopted by the medical professionals.

There are two concepts related to defensive medicine namely: (a) positive defensive medicine and (b) negative defensive medicine. While positive defensive medicine is more related to assurance behaviour, negative defensive medicine is an act of avoidance behaviour.[12] Positive defensive medicine results in wastage of financial and medical resources and also unnecessarily exposes patients to the risk of several kinds of medical interventions (unreasonable CT scans, X-rays, diagnostics procedures, frequent laboratory investigations, consultations etc.).[13] According to one of the studies, negative defensive medicines can best be perceived as an attempt to avoid the serious patients, the risky invasive procedures involved in treatment and most importantly evade any kind of legal risk or malpractice lawsuits.[14]

Whether it is medical negligence or defensive medicine, they always impose substantial economic costs on either doctor or patient. Theoretically, in a liability system it is noticed that medical practitioners always face trade-offs between socially-optimal amount of care and the inconvenience caused due to medical negligence.[15] Their choice of taking optimum amount of care largely depends upon certain economic observations.

[9] *Id.*
[10] Tapas Kumar Koley, *supra* note 6.
[11] *Id.* at 9.
[12] *Id.*at 9.
[13] D Studdert et al, *Defensive Medicine among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA (21) 2609, 2616 (2005).
[14] *Id.* at 2616.
[15] Daniel P. Kessler & Daniel L. Rubinfeld, *Empirical Study of the Civil Justice system* (National Bureau of Economic Research, Working Paper No. 10825, 2004), https://www.nber.org/system/files/working_papers/w10825/w10825.pdf

a) The economic cost of practicing medicine will include the cost of precaution plus cost of negligence;

b) High market price of negligence may create incentives for higher level of precaution resulting in defensive medicine;

c) Higher the transaction cost and information asymmetries regarding filing of medical negligence cases, lesser will be the incentive for taking appropriate precautions and care;

d) Information asymmetry exists in the healthcare insurance market which results in higher premium, restricted services on the premium resulting dissatisfaction amongst the buyer;

e) Inadequate government expenditure on public health care infrastructure forces majority of the individuals to seek expensive medical treatment in the private sector.

In a country like India where medical negligence cases are addressed mainly through the consumer courts under the Consumer Protection Act, 2019,[16] services provided by medical practitioners are subject to the same level of analysis and understanding as any other service provider. Therefore, at present when there is a spurt in defensive medicine practices, increase in medical negligence cases, rising insurance premiums and increasing cost of treatment, injustice and dissatisfaction will perpetuate among the patients.

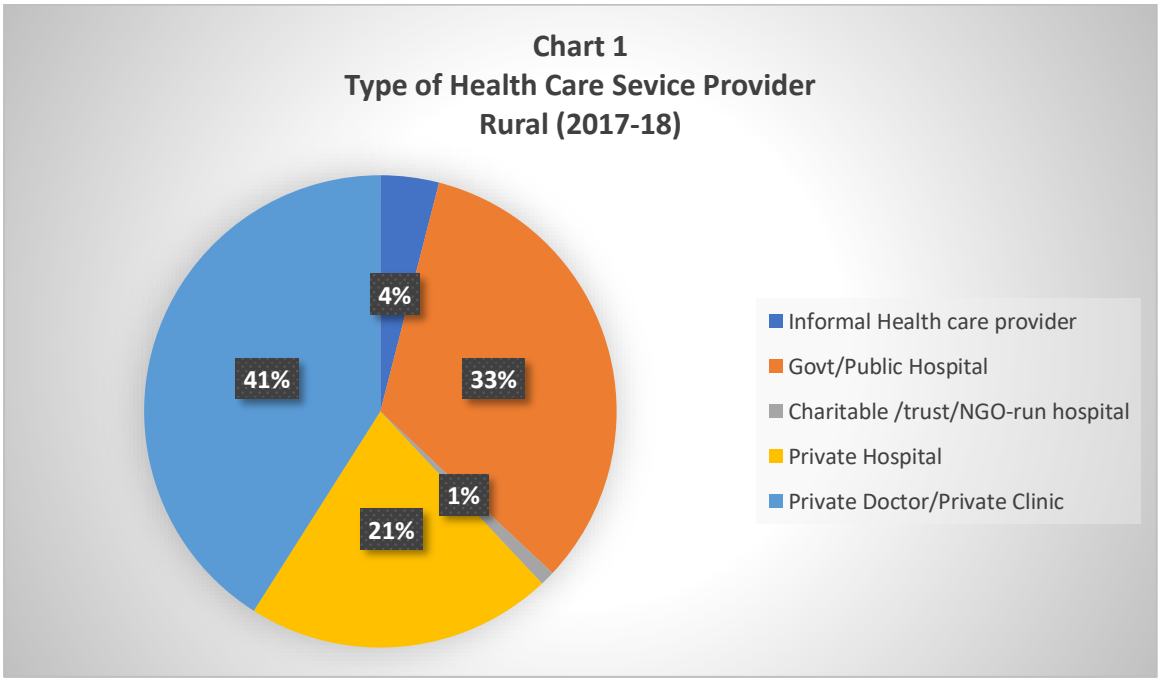
The economic consequences of such a paradoxical and complex situation get worse when there is inadequate investment in health infrastructure by the government. A survey conducted by the National Statistical Office, on household social consumption related to health and type of health care service providers in urban as well as rural areas, confirms that maximum share of ailments are treated by private doctors and private clinics.[17]

The charts below clearly manifest that in rural as well as in urban areas, private sector plays the leading role in providing health care services to the individuals. Approximately, 80% of India's healthcare requirement is met by the private sector which is slowly translating into

[16] S.V. Joga Rao, *Medical Negligence Liability under the Consumer Protection Act: A Review of Judicial Perspective*, 25 INDIAN J UROL. 361, 369 (2009). (Oct. 6, 2022, 12:04 PM)https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2779962/

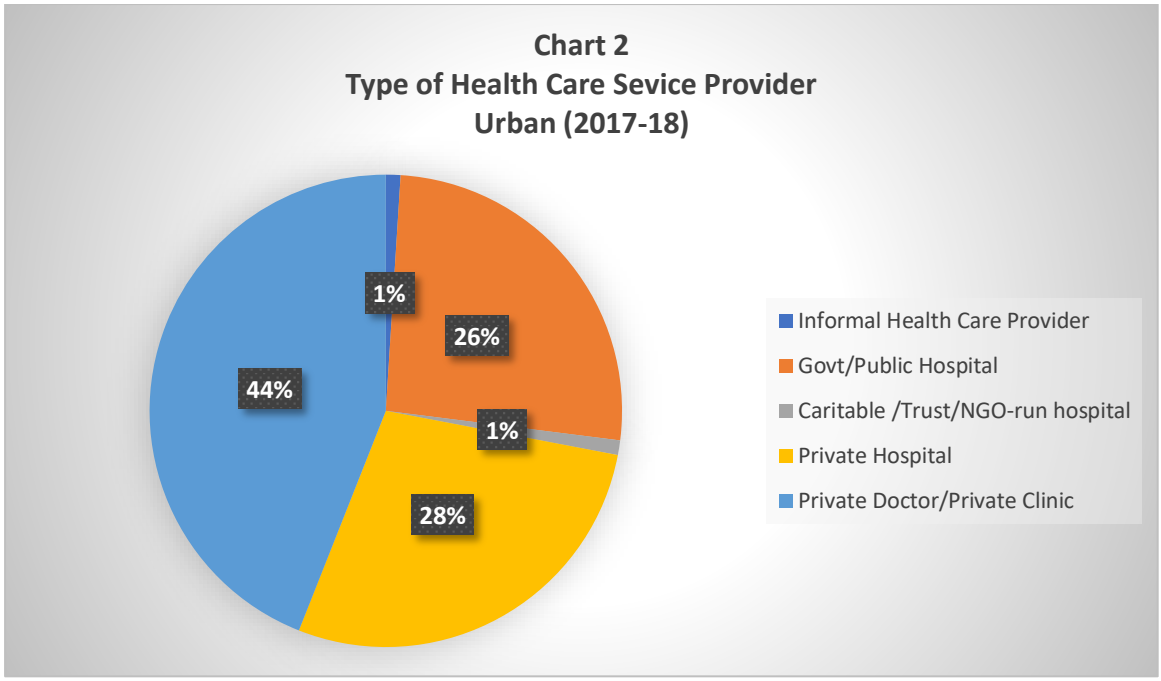
[17] Ministry of Health and Family welfare (Government of India), *Health and Family Welfare Statistics in India 2019-20,* pg 130https://main.mohfw.gov.in/sites/default/files/HealthandFamilyWelfarestatisticsinIndia201920.pdf (Dec. 19, 2022, 12:30 PM)

increasing cost of medical benefits and thus needs to be regulated strictly.[18] A quick look on the chart provided below can justify the statement.



Source: Health and Family Welfare Statistics in India 2019-20[19]

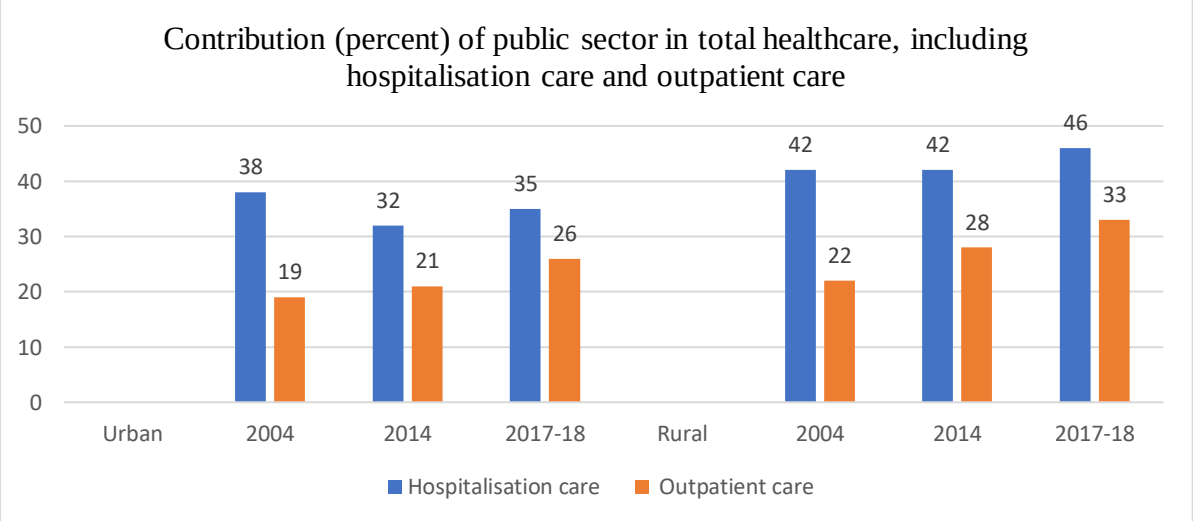
[18] Meghana S. Chandra & Suresh Bada Math, *Progress In Medicine: Compensation And Medical Negligence In India: Does The System Need A Quick Fix Or An Overhaul?* 19 ANN INDIAN ACAD. NEUROL., 21, 22 (2016).
[19]Health and Family Welfare Statistics in India 2019-20.
https://main.mohfw.gov.in/sites/default/files/HealthandFamilyWelfarestatisticsinIndia201920.pdf



Source: Health and Family Welfare Statistics in India 2019-20

The chart below shows contribution of the public sector in total health care services including hospitalization and outpatient care.

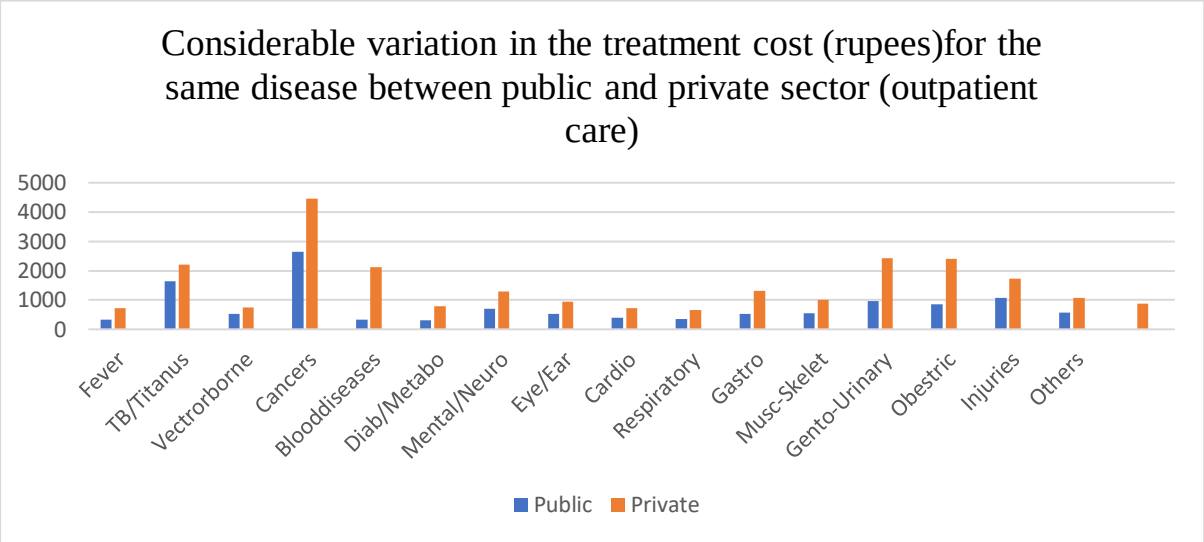
Figure 1



Source: NSSO, various rounds.

As per the Economic Survey of India, the existence of unregulated health care market coupled with asymmetric information has caused market failures causing sub-optimal output, as shown below with the help of the table given below:

Figure 2



Source: Economic Survey of India, 2021

Regulation of private medical care sector becomes more important when the government of India has to ensure universal access to healthcare.[20] With the existing gap between the urban and rural healthcare facilities, private and public healthcare services, the government needs to overhaul the healthcare system before it is too late. The existing asymmetric information in the healthcare structure results in 'high-cost treatment' in the private sector, although there may not be much difference in the 'quality of treatment' in the private sector in comparison with the public sector.[21]

Practically, it is impossible to have an accurate measurement of the extent of economic cost of defensive medicine in India. Also, it is very difficult to establish which aspect of the malpractice system in India has actually driven the majority of medical professionals to practice defensively. In a survey carried out by NLSIU, Bengaluru, it was found that the recent surge in the medical litigation in India is because of increased consumer awareness, flexible consumer forums, cost involved in medical services and increasing litigant mindset among the public.[22] In addition to this, it is also observed that with the rising cost of healthcare amenities,

[20] Paschim Bhanga Khet Mazdoor Samiti v. State of West Bengal AIR (1996).(Improper citation)

[21] The Economic Survey of India 2020-21, (Oct. 15, 2022, 10:15 PM) https://www.indiabudget.gov.in/budget2021-22/economicsurvey/doc/vol1chapter/echap05_vol1.pdf

[22] Health news, *Medical Litigation Cases go up by 400, Show Stats*, The Economic Times, (Dec 6, 2015). https://health.economictimes.indiatimes.com/news/industry/medical-litigation-cases-go-up-by-400-show-stats/50062328

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the general expectations from medical institutions are also increasing.[23] While, the possible positive outcome of the above situation has resulted in increasing accountability of medical practitioners and medical institutions, well documentation of care provided to the patients in order to avoid adverse outcomes, the likely negative effects are that the fear of huge liability or large compensation, increase in frivolous complaints and medical negligence cases, rising procedural costs has adversely affected the confidence of the medical fraternity.

What is more important today is how the present situation in India will unfold in the forthcoming years. If India replicates the western model in this regard, where medical negligence cases against medical practitioners cast substantial economic cost, then there is an urgent need of intervention by the government, because it will adversely affect majority of the poor population. Therefore, in the absence of proper monitoring there can be negative economic outcomes like:

a) Though medical profession will be more accountable but it will be highly discriminatory in treatment;

b) Doctors overprescribing and over treating patients through positive defensive medicines, thereby unnecessarily increasing the cost of treatment;

c) Due to negative defensive medicine, inelastic emergency demand of the patients will not be addressed;

d) Quality of services and products are uncertain and of lower level in an unregulated healthcare market;

e) There will be loss of consumer faith and negative externalities like higher costs and lesser efficient or economically optimal outcomes.

Therefore, before the present healthcare crisis transforms itself into a major economic and social crisis, the government must step in and intervene in the existing market to bring socially desirable and economically optimum outcomes. Particularly during the existing pandemic, the country is in dire need of higher healthcare investments and related health infrastructure to contain the problem.

[23] *Id.*

3. ROLE OF INSURANCE MARKET AND MEDICAL CLAIMS IN PROMOTING DEFENSIVE MEDICINE

Today, the healthcare sector in India has entered into the phase of transition because of increasing income, increase in living standard and mass awareness amongst the educated class. In fact, the role of the private sector in increasing healthcare facilities cannot be negated at this juncture. Unfortunately, in the field of insurance India has shown very little progress and development. Especially, in case of inelastic emergency healthcare demand, pooling of resources for the purpose of treatment becomes uncertain and highly irregular. In this regard, a well-planned and developed insurance market can play a vital role and can reduce healthcare risk at the macroeconomic level.[24] However, in a country like India, little inclination towards health insurance results in a hefty out-of-pocket spending by the majority of uninsured patients.[25] This has caused higher cost of treatment with no guarantee of quality.

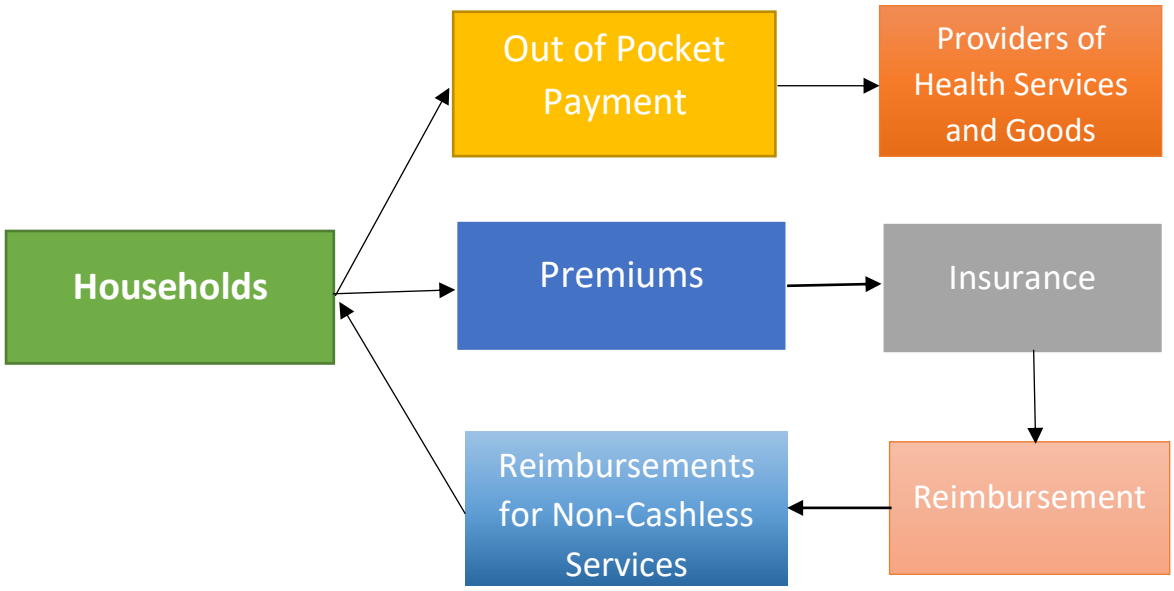


Figure 3: Flow of household health expenditure

[24] The Economic Survey of India 2020-21, *supra* note 21.
[25] *Id.*

The flow chart given above explains how fund is flowing directly and indirectly from households to service providers.[26] Generally Out of Pocket Expenditure ('OOPE') includes expenditure met on inpatient care, outpatient care, immunization, drugs, diagnostics and other medical therapeutic appliances etc. purchased from health care institutions.[27] In fact, OOPE which is an expenditure made by households while getting health services, indicates the extent of financial protection accessible to households towards healthcare payments.[28] A quick glance of the data in the table given below can easily enable us to compare household health and OOPE:

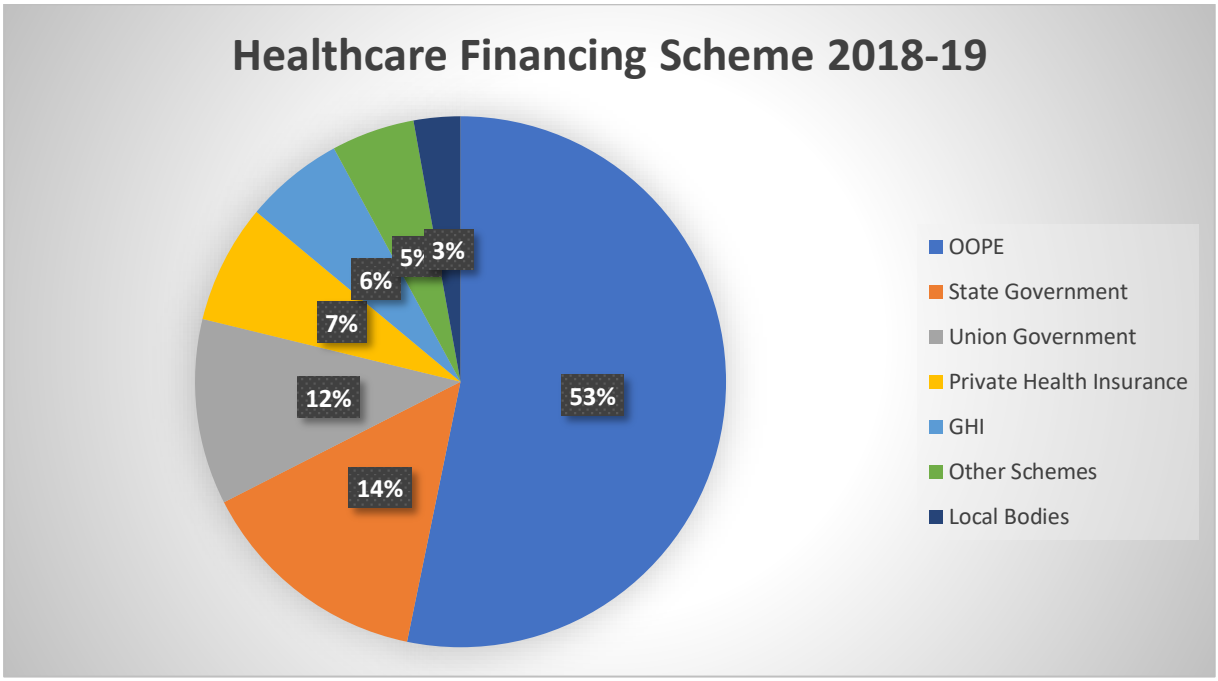
Table 1

Household Health and Out of Pocket Expenditure (OOPE)			
	Indicator	**NHA 2018-19**	**NHA 2017-18**
1.	Household Health Expenditure (incl. Insurance contributions) as % of Total Health Expenditure (THE)	54.4	54.3
2.	OOPE as % of THE	48.2	48.8
3.	OOPE as % of GDP	1.52	1.62
4.	Per capita OOPE (Rs.)	2,155	2,097

Source: National Health Accounts Estimates for India, 2018-19

Figure 4

[26] Providers of service includes sub centres (HSC)/ASHA (Accredited Social Health Activist)/ANM (Auxiliary Midwifery)/ Anganwadi Workers/Private Doctors/Primary Health Centre/Dispensary/Community Health Centre/Private Hospital/Public Hospitals/NGO's etc.
[27] National Health Accounts Technical Secretariat, Household Health Expenditure in India (2013-14), 2 (December 2016). https://main.mohfw.gov.in/sites/default/files/38300411751489562625.pdf
[28] National Health Accounts Technical Secretariat, National Health Accounts Estimates for India (2018-19), 6 (2022).



Source: National Health Accounts Estimates for India, 2018-19

NITI Aayog, recently in its report on *"Health Insurance for India's Middle Missing"* in 2021 has emphasized that it is primarily poor government expenditure on health that has constrained and adversely affected the healthcare services in the public sector and therefore has caused majority of the individuals to seek expensive medical treatment in the private sector.[29] In fact, the report concludes that approximately 40 crore people (30% of the population) called the 'missing middle' are devoid of any financial protection for health by the government.[30] Under such circumstances, it is easier to conclude, the 'missing middle' remains uninsured.

Even if insurance schemes are available, they are not designed for the above-mentioned class. In fact, whatever insurance schemes are available they are at least two to three times higher than the affordable rate for the 'missing middle' and are usually designed to suit high income groups.[31] It is pertinent to mention here that NITI Aayog's report highlights the significance of health insurance as a potential pathway in refining and improving the quality as well as efficiency of health care services in India.[32] Even after various health insurance schemes like government subsidized health insurance schemes predominantly targeting poor and informal

[29] Kumar Anurag, and Sarwal Rakesh. 2021 *Health Insurance for India's Missing Middle*, NITI Aayog (2021) https://www.niti.gov.in/sites/default/files/2021-10/HealthInsurance-forIndiasMissingMiddle_28-10-2021.pdf (Dec. 19, 2022, 12:45PM)
[30] *Id.*
[31] *Id* at 2.
[32] *Id* at 3.

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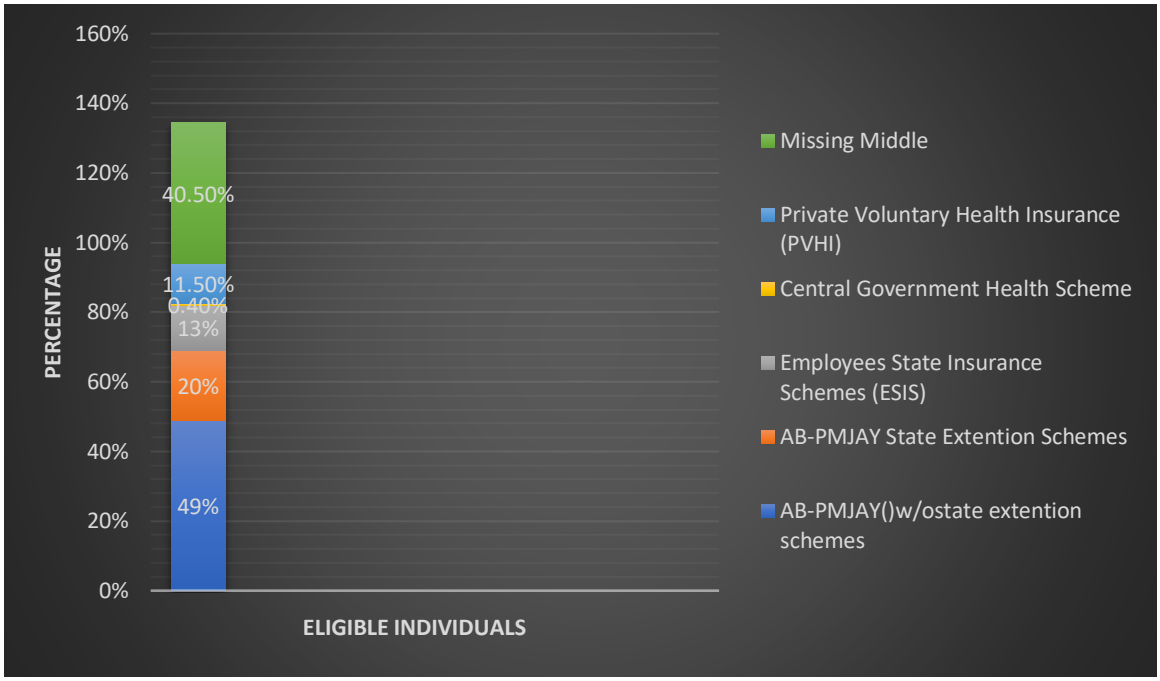
sector, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), other compulsory and contributory health insurance schemes for organized sector like Employees State Insurance Scheme (ESIS) run by state government, Central Government Health Scheme (CGHS) run by the union government for its employees, Private Voluntary Health Insurance scheme (PVHI) as a contributory voluntary scheme targeting private businesses, individuals and families, estimates suggest that nearly 50 % of the population still does not have health insurance.[33]

Interestingly, for the segment of population which can afford private health insurance scheme, product price plays very important role in the uptake of voluntary contributory health insurance. Furthermore, lack of consumer awareness of the health insurance benefits and the availability of related product can limit its uptake. Moreover, it is also observed that the existence of 'moral hazards' can induce an insured individual to take less effort in maintaining his health.

Figure 5

[33] Estimates based on NSSO's 75th round survey indicate this section may be larger than 30% of the population. Even after adjusting for PMJAY (since the survey was done prior to PMJAY), estimates based on the survey suggest that nearly 50% of the population does not have health insurance. https://www.niti.gov.in/sites/default/files/2021-10/HealthInsurance-forIndiasMissingMiddle_28-10-2021.pdf (Dec. 20, 2022, 1:30 PM)



Source: NITI Aayog, 2021

The practice of defensive medicine is much operated or controlled by the moral hazards of health insurance where neither the medical professionals nor the patients bear most of the costs of medical care because it is financed through health insurance.[34] Kenneth J. Arrow, an American neoclassical Nobel laureate economist in his research, found that the buyers in healthcare markets are hardly aware of the value of the information related to the product until and unless they purchase it. In most of the cases these buyers are not even in the position to evaluate them. The information asymmetry affects the prices of the insurance products.[35] Also, individuals always underestimate the potential health risks and therefore, the demand for health insurance gets adversely affected.

At present, the practice of defensive medicine is somehow resulting in a collusive oligopolistic market between insurance companies and corporate hospitals. The existing market of doctors, hospitals, nursing homes, diagnostic centers, and other medical services at different levels are trying to maximize their gains by creating mutually supportive and reinforcing links.[36] Such a collusive form of market may definitely make the entry of new firms very difficult. In fact,

[34] Daniel P. Kessler & Daniel L. Rubinfeld, *Empirical Study of the Civil Justice system* (National Bureau of Economic Research, Working Paper No. 10825, 2004), https://www.nber.org/system/files/working_papers/w10825/w10825.pdf.

[35] K Arrow, *Uncertainty and the welfare Economics of Medical Care*, 53 AMERICAN ECONOMIC REVIEW, 1963, 941-973.

[36] Niti Aayog, *Healthcare in India-vision 2020: Issues and Prospects*, (Oct. 11, 2022, 10:40 AM) https://niti.gov.in/planningcommission.gov.in/docs/reports/genrep/bkpap2020/26_bg2020.pdf.

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private health insurance sector constitutes less than 10% of the market size of the health insurance sector.[37] Recently, it was observed that a surge in claims arising due to COVID-19 pandemic has resulted in insurers colluding into strategic partnership with the established firms to offer COVID-19 insurance plans to the customers.[38] Niti Aayog, in its recent report has revealed that the opening of the general insurance sector to foreign companies will be beneficial for the healthcare sector in India majorly in the following ways:

a) Insurance business will widen and expand covering more health risks

b) Business will focus more on urban middle and upper class and employed people capable of buying good insurance products for their families.

c) Expansion in insurance market and their clientele, extensive use of hospital services and other medical healthcare products and services will be promoted

However, there will be some adverse and unintended economic consequences also:

a) In the absence of 'set norms' for the optimal use of more technologically intensive interventions, excess of diagnostic equipment uses and hospitalisations, the practice of defensive medicine will multiply manifold.

b) The degree of inequity in healthcare sector may intensify affecting majority of the underprivileged income groups

c) Health disparity will widen due to market distortions, and asymmetric information existing in the insurance market.

The equity in access to insurance services will depend much upon how the public sector and government is ensuring and promoting it. Government will have to lead and continue providing minimum services, while correcting the market failures existing in the insurance market. In

[37] NITI Aayog, Investment Opportunities in India's Healthcare Sector https://www.niti.gov.in/sites/default/files/2021-03/InvestmentOpportunities_HealthcareSector_0.pdf (Dec 20, 2022 1:21 PM).
[38] *Id.*

order to be socially relevant and desirable and also commercially viable, insurance products and services must aim to cover various income groups and the majority of social classes.[39]

4. UNINTENDED SOCIO-ECONOMIC CONSEQUENCES OF DEFENSIVE MEDICINE PRACTICES

The practice of defensive medicine is a kind of economic exploitation with no medical significance. There are serious unintended socio-economic consequences of such prevalent activities across the globe. Though, the awareness of patients' rights coupled with pro-patient legislation and judicial approach in addressing the issues or grievances may to certain extent increase medical negligence cases against medical practitioners but at the same time it has increased the practice of defensive medicine manifold. To have an accurate and correct estimate of how much defensive medicine costs in India is very difficult. However, from the estimates placed by the Centers for Medicare and Medicaid Services in the US shows that in the year 2009, annual defensive medicine costs were somewhere around $ 650-$850 billion.[40] It also estimated that the total healthcare spending was to the tune of $2.5 trillion, signifying thereby that almost $1 out of every $4 was spent on unnecessary tests and treatment asked by medical professionals.[41]

The economic costs of positive and negative defensive medicines are very obvious. Positive defensive medicine may cause unnecessary hospitalization, surgeries, over prescription of drugs, several laboratory tests resulting in not only high economic costs, but also unnecessary exposure to patients to several kinds of health hazards. The superfluous and expensive treatments are always economically favourable to the practitioners and are much widespread in case of surgery, obstetrics and gynecology.[42] Several studies have confirmed that there exists a negative relationship between malpractices done by the medical professionals and the healthcare access by lower socio-economic income groups.[43]The relatively low access to

[39] *Id.*

[40] Jackson Healthcare, *A costly defense: physicians sound off on the high price of defensive medicine in the US.*" Jackson Healthcare (2010). (Oct. 12, 2022, 11:12 AM). https://truecostofhealthcare.org/wp-content/uploads/2015/02/defensivemedicine_ebook_final.pdf.

[41] *Id.*

[42] L. Dubay, R. Kaesther., & T. waidmann, *The Impact of Malpractice Fears on Cesarean Section Rates*, 18(4) JOURNAL OF HEALTH ECONOMICS., 491-522 (1999).

[43] *Id.*

healthcare facilities by them may adversely affect economic welfare and social environment of the country.

This complex, misleading and unethical medical practice is heading towards professional corruption and is causing a serious health care crisis in the country. The economic interests behind defensive medicine are far above the benefits gained by the patients. Particularly in a welfare state like India, it neither results in an activity reinforcing excellence in the medical profession nor helps in achieving the constitutional mandate of 'Right to Health'. An individual's sense of wellbeing is incomplete in the absence of his physical as well as mental wellbeing. It is in this regard that a country's healthy population can determine economic and social development. However, the extent of socio-economic disparities widens if the access, quality and the costs of healthcare facilities differ among different income groups. In case of India, Niti Aayog's report on Healthcare India vision 2020, confirms that private OOPE dominates the cost of financing healthcare causing regressive effects.[44] 'Health care facilities' should therefore be recognised as a public good and the market should not be left to be synchronised and adjusted as per changing demand conditions.[45]

For a fair and just healthcare system, universal and adequate healthcare access without excessive financial burden is a must. It also requires that there should be fair distribution of burden and benefits in terms of financial cost for access and rationing of healthcare with special attention to weaker, vulnerable groups (women and children), especially disabled and old age people.[46] Due to the existence of large unregulated corporate hospitals and medical clinics, defensive practice and cases of medical negligence have increased manifold. Now, a million-dollar question arises whether we need doctors who can apply reasonable skills or doctors applying the highest degree of skills? There is a very narrow division between mistaken diagnosis and negligent behaviour.[47] Usually medical practitioners indulge into the practice of high-cost care and defensive medicine to cover their risk of malpractice suits.

5. Relation of Law and Defensive Medicine: A Searching Critique

Defensive medicine practice has come to be recognised as a universal problem. The practice of prescribing excessive diagnostic tests, medicines and providing unnecessary treatments with

[44] Niti Aayog, *supra* note 36.
[45] *Id.*
[46] *Id.*
[47] *Id.*

the sole objective of reducing the risk of liability for medical negligence prevails throughout the country.

Originally, for their culpable negligence the medical professionals were held liable on the basis of the general principles of liability under the law of torts or crime. The law of medical negligence had developed as a part of the law of tort as a result of the judicial pronouncement in several cases over a period of time. After the enactment of the Consumer Protection Act, the controversy arose about bringing the medical professional's liability for negligence under the purview of this newly enacted Act.

In *Indian Medical Association* v. *V.P. Shantha*,[48] It was argued on behalf of the medical profession that bringing the medical practitioners under the purview of the Consumer Protection Act, 1986 would result in huge surge in medical expenditure due to *inter alia* tremendous increase in defensive medicine. The Supreme Court held that it was not possible to entertain this apprehension. The Court observed that by holding the medical practitioners fall within the purview of the Act, no change is brought about in the substantive law governing claims for compensation on the ground of negligence.

In *Arun Kumar Manglik* v. *Chirayu Health and Medicare (P) Ltd*,[49] the Supreme Court held:

> "*...while adopting a course of treatment, the medical professional must ensure that it is not unreasonable. The threshold to prove unreasonableness is set with due regard to the risks associated with medical treatment and the conditions under which medical professionals function. This is to avoid a situation where doctors resort to "defensive medicine" to avoid claims of negligence, often to the detriment of the patient.* "

Even in the absence of any empirical studies, one can argue that there exists a causal relation between increasing litigations alleging medical negligence and practice of defensive medicine by the medical professionals. From the point of view of economic analysis, it is significant to decide whether the medical professionals have a right to exercise defensive medicine or whether the patients should be given this right not to be subjected to the exercise of defensive

[48] Indian Medical Association v. V.P. Shantha, (1995) 6 SCC 651.
[49] Arun Kumar Manglik v. Chirayu Health and Medicare (P) Ltd, (2019) 7 SCC 401.

medicine. If we decide this question in favour of the medical professionals, then the medical professionals get an entitlement and with an incentive to shun any liability arising out of a possible medical negligence litigation, the medical professionals will always be tempted to exercise this right. Moreover, due to the inelasticity of the emergency medical services, the patients who could afford the increased medical expenditures will undergo the prescribed course of diagnosis, tests, treatments and over prescription whether they actually need to undergo or not, and irrespective of their wish and desire. However, from the economic point of view, in a great majority of the cases it would be regarded as allocatively inefficient. In the whole transaction, in the great majority of the cases, neither the medical professionals are benefitted nor the patients would derive any good or benefit out of the whole exercise and the social wealth is simply wasted. On the Paretian model also it would not be regarded as an efficient allocation in all those cases where the position of the patients have not improved as they had not benefited from the defensive medicine practices.

Further, this would also adversely affect economically poor people, as due to the over prescription of the medical tests and medicines, the new equilibrium price for the specific health services, in the wake of a surge in demand due to the large-scale defensive medicine practices, would be pushed beyond the purchasing power of many poor. This would be worse, if the sector remains unregulated. The situation will be further aggravated due to lesser number of government hospitals and poor expenditure on health sector. The exorbitant and inconsistent billing for the ordinary and simple facilities during the Covid pandemic is a glaring example of unaffordability that may result into a given situation albeit at a lower scale. Vis-a-vis the Kaldor-Hicks criterion as well, the medical professionals would not benefit in any substantial way and would not be able to choose to compensate the patients.

The only perceived benefit is the psychological satisfaction that the medical professionals would derive on account of lesser possibility of him being held liable for any alleged negligence, since he had prescribed every course of diagnosis, tests, medical internment and prescription that was possible at that time. The liability rule that is applied in case of negligence simply required the medical professionals to take care that was due in the particular case.

A pertinent question to be considered in this regard is about the leading cause of medical malpractices claims. It is obvious that medical diagnostic errors are one of the principal causes of medical malpractice claims. But, if they are not the sole cause, and the resources put to use in defensive medicine practice is disproportionate to the risk of liability for medical negligence,

the whole transaction is allocatively inefficient. Viewed from the perspective of amedical professional, it is obvious that if the tests, procedures, surgeries and medicines prescribed were completely unnecessary. They would not reduce the chance of adverse clinical events. In such a case, the eventual medical errors would expose the particular doctor or professional to the same or higher risk of liability for medical negligence to which he would have been liable even if he had not indulged in the said defensive practice. Looked at from the perspective of the patients, it is obvious that his wealth has just been wasted on a completely unnecessary course of treatment resulting in no gain or benefit. The psychic benefit that a medical professional seems to derive may be fragile and temporary, as victim of the eventual medical error wields a firm motive to sue the doctor. The point is that greater use of resources in the defensive medical practice does not necessarily improve the clinical outcome. The clinical outcome can be improved only by skillful treatment and observance of standard due care.

6. CONCLUSIONS AND RECOMMENDATIONS

It is mostly observed that health system of a country is largely regulated by the political, social and economic setup of a country. Just like there cannot be a universal political, economic and social system, there cannot be a universal health system. It is much determined by the existing political, social and economic realities of the state. Today, when the entire world is going through a phase of health crisis, the concerted effort of citizens and government becomes indispensable. Increasing awareness amongst the public and their legal rights related to law can definitely bring positive changes in healthcare facilities and the medical profession.

In a country like India accessibility and affordability of medical facilities and insurance has to be ensured. With continuous increase in health care costs the very objective of fair distribution of available healthcare facilities has become a difficult and an unachievable task. It's high time, particularly during this pandemic, that the government and the legislators intervene timely in allocation of healthcare facilities.

Furthermore, such intervention should guarantee accessibility of healthcare facilities and services to each citizen across the nation. There is no denial that such measures require greater involvement of economics, law and suitable public policies. Today, we need minimum standards and accountability of private healthcare services consisting of self-regulation and government regulation with external accreditation agencies.

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It is always important to have laws guaranteeing patients' rights but it is more important to regulate the healthcare system of a country and seriously implement those laws. In order to restrict the scope of medical negligence, a clearly codified and quantified law is indispensable.[50] However, it cannot be guaranteed that cases of medical malpractice and, thereby induced defensive medicine practice can be stopped altogether. Technically speaking, it can be reduced to a substantial level or tolerable limit if there is a reduction in number of patients (India needs to work on improving sanitation, hygiene, adequate and food requirements at lower income level) and pressure on medical professionals to examine and investigate their disease without delay.

The mounting pressure and quick disposal of cases has also resulted in prescription of unnecessary tests and over medication causing medical negligence.[51] Contrary to this, we also need to understand that criminalising medical malpractices, punitive actions against erring medical professionals may not bring economically and socially efficient outcomes. Rather concerted efforts from government, patients, and medical professionals are required in order to have a safer and better healthcare system in India.

Last but not the least, we can say that in the world of complex economic and social setup, it is very difficult to decide what is just, right and good for the patients and doctors. To deal with such a perplexing and complex situation, the best way is to respect each other's rights while be equally aware of responsibilities. A healthy doctor-patient relationship can always result into economically efficient outcomes and may even help in preventing frivolous lawsuits, reducing various kinds of economic wastage. As rightly cited in the Economic Survey of India 2021,

> *"… most well-functioning health systems are structured as oligopolies purchasing from oligopsonies instead of individual consumers purchasing from individual providers."*[52]

The above market structure, if not regulated, may cast long term negative implications on the progress of the health care system in the economy. At this juncture one has to understand that the fragmented health infrastructure may result in economic inefficiency, reduction in social

[50] Preetam Kaushik, *Medical Profession Losing Its Aura of Sanctity with the Rising Cases of Malpractice and Negligence*, Business Insider India, (March 25, 2015). https://www.businessinsider.in/medical-profession-losing-its-aura-of-sanctity-with-the-rising-cases-of-malpractice-and-negligence/articleshow/46688610.cms
[51] Sandro Vento, Francesca Cainelli and Alfredo Vallone, *Defensive Medicine: It Is Time To Finally Slow Down An Epidemic*, 6(11) WORLD J CLIN CASES, 406-409 (2018). (Oct 13, 2022, 11:40 AM) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6163143/.
[52] The Economic Survey of India 2020-21, *supra* note 21.

and economic welfare, wastage of scarce medical resources and high-cost treatment. The need of the hour is that the government should realise these harsh realities and accept reformation and amendments to the existing laws. The rationale behind such steps should essentially result in greater availability of medical care at much affordable and lower cost to the majority of the underprivileged people. Increasing awareness amongst the public and proper enforcement of their legal rights can definitely bring positive changes in healthcare facilities and the medical profession.

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