"SUCCESS OF INDIAN NATIONAL HEALTH PROTECTION SCHEME NEEDS CREATIVE DESTRUCTION OF MINES OF HEALTHCARE CORRUPTION"

Vijay Sharma[1]*, Richa Sharma[2]

*[1] Senior Healthcare and Hospital administrator, Executive MBA Batch J17, University of Oxford, Säid Business School, Oxford, United Kingdom
[2] Asst. Professor, Department of Community Medicine, Jaipur National University, Jaipur, India

*Corresponding Author
E-mail: drrivhas@gmail.com

Abstract:-
We need Universal healthcare in India, Government has launched world's biggest health insurance programme covering half billion population with risk cover of INR 500,000 ($ 7500). Free healthcare will take away one major worry of poor masses. Things are going to change over the years with better healthcare, less sickness, less work loss, no medical expenditure related bankruptcy, better economic prospects & more food availability. This scheme will lead to enhanced business activities at all level, will create the job at many levels, there will the expansion of healthcare industry, but later it will lead to increased pollution and climate change leading to the new spectrum of diseases, increased health care use and increased insurance expenditure. Major problem is that corruption involves various layers of the healthcare system, including care providers, pharmacies, laboratories, corporate hospitals, mom and pop hospitals, clinics, pharmaceutical and instrument companies. Policymakers should use all technologies based measures including artificial intelligence, block chain technology, universal biometrics in healthcare, global positioning system, digital monitoring, mobile applications, point of care technologies, system reforms, big data collection, nudging, mobile health, telehealth, mass education, culture change and strong laws to prevent corruption as well as illness. Avoidance of inspector policy is best. For the success of the programme mines of healthcare, corruption must be destroyed.

Keywords: - *Healthcare corruption, Universal healthcare, Healthcare insurance, Indian Healthcare*

INTRODUCTION

Universal Health Coverage (UHC) is a major policy goal globally. Around 12% of the urban and 13% of the rural population is under health protection coverage. Despite the acceptance of UHC at the policy level in India, about three-quarters of healthcare expenditure is done by the public. One-fourth of the rural health expenditure is sourced from borrowings or selling of assets. Out of pocket expense pushes near 3-5% of population below the poverty line every year. Low access to quality public health care leads to either a barrier to accessing health services or catastrophic outcomes. The inefficient poor capacity public health system has resulted in mushrooming of private health care system, with a push towards various demand side financing mechanisms. In future aging population, rising income of middle class, and the development of primary care facilities are expected to shape healthcare industry in future. Medical devices sector is the smallest part of India's healthcare industry; it is one of fastest growing sectors as new regulatory challenges are promoting growth and development.

The government of India has launched world's biggest health insurance programme covering half billion population with risk cover of INR 500,000 ($ 7500). This amount is enough for five open heart surgeries in India. The government has very well done groundwork by price capping of medicines, stents, and knee implants; clean India campaign leading to better sanitation levels; strengthening of in healthcare laws; malpractice prevention acts; pharmaceutical industries regulation. Now with the proposed health scheme, poor households can choose cashless healthcare from impanelled private or public providers. Free healthcare will take away one major worry of poor masses. Things are going to change over the years with better healthcare, less sickness, less work loss, no medical expenditure related bankruptcy, better economic prospects & more food availability. People will have more money to spend now on recreation, addictions, likely will have the better lifestyle, money saved from healthcare will be used for vehicles, house, food; but now people will consume more resources, power, water, industrial output.

This scheme will lead to enhanced business activities at all level, will create the job at many levels, there will be an expansion of healthcare industry, but later it will lead to increased pollution and climate change leading to a new spectrum of diseases, increased health care use and increased insurance expenditure. It is likely there will be a reduction in mortality among those enrolled from conditions covered by the health insurance scheme. People will live longer, a larger number of population will develop old age-related problems, later they will over consume health care services. The number of patients will be much higher than the availability of services to treat them, creating high investment opportunities. The government has allowed 100% FDI in the healthcare industry, leading to many mergers and acquisitions, international hedge funds, investors, healthcare groups will be investing more and more money in Indian healthcare industry.

Issues for discussion

Problem is Indian healthcare industry has rampant corruption which has various forms such as graft, malpractice, kickbacks, bribes, inflated bills, wrong diagnosis, forged diagnosis, substandard therapy, placebo therapy. Corruption involves various layers of the healthcare system, including care providers, pharmacies, laboratories, corporate hospitals, mom and pop hospitals, clinics, pharmaceutical and instrument companies. Now millions of poor people many of whom are poorly educated, suppressed, likely to develop various diseases due to poor hygiene, climate change, addictions, exposure to chemical, harsh climatic conditions, poor nutrition, incomplete vaccination, high-risk behavior etc, will be entering private hospitals both big and small hospitals (earlier these people depended on most of the time on government sector and small private centres) due to cashless health insurance card, they will demand and expect best of care, they will not be concerned about the likely bill, medicine, investigations , procedures as long as they need not pay anything from their pockets. These people are easy targets to convince for the advanced investigations and procedures.

There are reports of uterus scam in India from northern states with government-sponsored healthcare schemes, people were deliberately directed to private hospitals with minor ailments like pain abdomen, many male patients underwent procedures like appendectomies, exploratory laparotomies, and cholecystectomies, while huge number of females underwent hysterectomies, appendectomies, exploratory laparotomies, and cholecystectomies. Sadly, the insurance scheme that will be started to protect the consumers will become the very instrument of their exploitation.

In future, there is a risk of misuse of organ donation, the patient can be advised kidney removal and it may be transplanted into a rich person. Masses will become guinea pigs for medical trials. Healthcare corruption has trapped millions of people in poverty, the government wants to save poor people from that, but the culture is not going to change. No public health programme will succeed in a setting in which scarce resources are siphoned off, due to overuse of insurance facilities in less needy patients, sick will be deprived and will not get essential health care. In the present scenario, quality care cannot be provided by healthcare delivery system in which kickbacks and bribery are a part of life, service providers are behind easy money.

Small versus Large Centers

Corporate hospitals are costly for the masses, they are growing in number, have better experts, provide quality care and work with protocols, and are highly competitive. Corporate hospitals are also providing services to patients with government-issued healthcare card (Medicare/Medicaid), but as the rates are equal for 10 to 50 bedded small centre managed by 5 to 10 people versus 300 bedded corporate hospital, value for money for patient will be the higher at tertiary care centre. With the same packages decided by the government multisystem, sustainable, high volume, high quality,

complete services are possible at big centres only. As there is a clear hierarchy, transparency, supply chain management, clinical protocols, ethics committee, mortality committee, pharmaceutical committee, academics, proper documentation at National accreditation board hospitals (NABH) accredited tertiary care or specialty care centers, overall care is better and reliable. There is a risk of rapid consumption of patient's insurance amount at critical care units of big hospitals, after finishing off INR 500,000, hospitals can ask the patient to deposit the fee now or can throw out the poor patient.

Small centers are providing lots of services but there is always possibility of bias, loss of control, lack of protocols, poor transparency, no monitoring, no security, no checklist, no reputation to lose, and no accountability. Whenever some wrongdoing is reported; regulators, Inspectors and media can take money from them and do not act against them, while big hospitals are always under the scanner of public, media, police, politicians and inspectors.

With the proposed National health protection scheme for 50 million population; there are various ways corruption mines are going to open at the many levels. As there is no clear monitoring system, volume of the patients, applications, documents are huge. It is difficult to monitor and verify every document for millions of cases with thousands of combinations of diseases and procedures. Less number of staff will create bottleneck so if they are strict thousands of cases will be waiting for approval. While on the other hand to clear the cases faster without demanding full reports, patient's testimony, biometrics, details of procedure done, recordings, evidence etc. will lead to lots of wastage.

With daily thousands of patients undergoing interventions, it is difficult to determine whether fake surgery is done, aggressive coronary angioplasty or unnecessary ureteric stone procedure done; hence bills will be approved in all unjustified cases also. Government machinery then will take credit for successful implementation of these mass schemes. Government hospital doctors can refer all patients with insurance card facility to the private center of their choice, now these patients will undergo fake surgery, unnecessary surgery for money, and kickback will go to the government doctor. Many government doctors run their hospital with the family member as owner, they can siphon off many patients every day to their own centers for unjustified procedures which may even be repeated after some time in the same patient with another indication. A false cancer diagnosis can be made from a benign tumour or lesion as maximum money is there in cancer, unnecessary surgery will be done, repeated chemotherapy will be done which is not required, as there is no block chain for chemotherapy, no guideline for pharmaceutical company name and dose, any center can give chemotherapy in any doses to any patients.

There are reports of thousands of counterfeit bills raised for cancer therapy or big surgeries for patients whose documents were taken by the hospital for minor ailments, this scandal was recently published in a reputed Indian newspaper, it happened at the state of Maharashtra. As the package for each chemotherapy cycle is INR 6000, low-quality medicine will be used for higher margin, intermittently no therapeutic dose will be given, even if sure system of medicine delivery to patients is followed chemotherapy can be given for meagre margin to those patients who do not need it, extra cycles can be given by unqualified persons at centres.

There are possibilities premature surgeries in those conditions where wait and watch policies can be followed, chances of doing scalp incision and closure in the name of craniotomy, chances of ureteric stone surgery for pain abdomen even in the absence of stone, later a stone gravel can be shown to relatives. Repeated safe cash-rich procedures like minor ear surgery, minor eye procedures, nasal procedures, dental procedures, gynaecological procedures, esophagos copy, bronchos copy are possible to name but the few. Again, and again, approval can be taken with no questions asked for these procedures and millions are flowing towards hospitals. For the procedures like esophagos copy INR 8000 is given while for Upper GI endoscopy INR 1300 is given, people are happy doing lots of these procedures. There are problems in rate listing for procedures, likely due to improper auditing, improper expert panel rate approval many minor procedures have high payment and many big procedures have the low payment. That can indulge doctors to do gaming, to document more of cash-rich procedures while avoiding important needed procedures. Patients with non-cardiac chest pain due to reflux or pneumonia undergoing coronary angiography and stenting is very common. It is easy to convince patients & relatives for cardiac procedures because people fear early death, cashless procedure, no government monitoring or audit system to prevent this.

Corruption vertically and Horizontally
Government is planning to strengthen peripheral services by the establishment of many health centers. There is scope for corruption in construction, recruitment, purchase etc. There will be mass corruption in procuring government contracts, leases or licences for the construction of thousands of healthcare facilities, supply of medicines, goods and services, contractors will try to ensure the terms of their contracts for profit, will prefix the bidding process; will manipulate records, will falsify records, and will modify evidence to give the impression of being compliant with the regulatory agencies; regulatory authorities will be more corrupt, bribe will be given to speed up permission to carry out legal activities, for institutional affiliation, for company registration, for construction permits; and also influence or change legal outcomes to avoid punishment for wrong doing. People have used hundreds of methods to settle black money after demonetization, billions of rupees returned to the banks through back door by the involvement of bank officers and employees, while millions of common people were standing in queues outside banks for returning their money. Now a new wave of corruption will start, which will deteriorate ethics in healthcare, cash transactions will increase for bribes and kickback, that money will collect in homes, will be used for unlawful activities, unfair transactions. God save the country.

If government hospitals are well equipped, there will be theft of instruments and medicines by individuals for sale in the grey market, for personal use in own center, for private clinics. Absenteeism is very common, doctors and staff do not work at their designated hospitals, they claim to salary, post, the power of government post but work at small private centers of their own or partners. It is always possible that head of the government hospital has her/his own center. In those Medical schools and institutions where private practice is allowed, faculty do not teach, they work very less in hospital, they do private practice most of the time, teachers move from one private hospital to another private hospital for surgeries and procedures, many professors even go to private laboratories for diagnostic procedures like endoscopy, ultrasound, echocardiography to name but the few; at the same laboratories they send their patients for investigations to get good commission. There are reports of professors keeping accessories, implants in their hospital Amirah, using it for the admitted patients, as poor patients fear senior doctors in government hospitals, they pay money for the implant used by the doctors. There was one report of two orthopaedics assistant professors fighting in operation theatre on the issue of claiming commission money for implant used in one patient. There are reports of government doctors keeping their touts or agents in Outpatient department; where these touts ask the poor patients to not wait in long queues, either the patients are diverted by agents to doctors home or cash bribe is collected by agent for early consultation and bypassing the queue. It is common practice in government medical institutions to divert patients out of hospital for private clinic visit, investigations, costly medicine, implants, surgery which brings commission to referring doctors, in fact, doctors compete to write referral slip to maximum possible patients, at some places students compete with teachers for commission. Professors take very few classes, they are arrogant due tax-free money coming from various sources and due to the power of the post, the capacity to decide students results. The student learns some science from but surely malpractice from their teachers, most of the patients are managed by postgraduate students as faculty is sitting at their clinic, and these poor patients have high morbidity and mortality. In future, these students will become consultants, they will have the same ethical principles followed by their teachers.

There is no system of medical school professor's performance review, quality of teaching, scoring by the students using the application or web service, there is no monitoring by government authorities as they are busy showing big data, implementation, and results of various government schemes. There are no unbiased private organization to monitor these services and give genuine reports. Government healthcare professionals can take informal payments from patients for better services, still, they will gamify the system for their benefit, patients from the public sector will be siphoned off for unnecessary surgeries and therapies. There will be wastage and underutilization of public health services, it will have an overall negative impact at all levels.

There is a high risk that private hospitals will create forged documents for paying procedures, will try overbilling in every insurance claims. Even appointment of healthcare professionals will be controlled by private hospitals or in reverse government doctor will control private hospital, he will feed the hospital with cases for quick money. Thousands of new centres will be started which will be run by government doctors, insurance company officers in partnership with another doctor, millions of patients will get needful treatment, millions of patients will undergo unnecessary treatment, many serious cases which cannot fetch easy money will not be treated, doctors will be busy in cash crops, while actual poor sick patients will be referred to another centre, that will lead to increased morbidity and mortality. There will be innumerable clandestine transactions of a highly corrupt nature among various stakeholders at many levels.

Drug trials and counterfeit medicines
Clinical researchers will be paid by clinical research organization for the recruitment of poor, illiterate, most vulnerable, human subjects for clinical trials. These patients have improper consent, unreported side effects, and they not even given compensation in case of death. There will be the creation of killing fields of Indian healthcare, at new government centers high cost, low-quality construction work will be done and those facilities which do not fulfil needs will be created which will result in inequity in access. To generate bigger bills high cost, substandard drugs, substandard equipment's, inappropriate drugs, goods, and equipment will be purchased.

There is a high risk that at private centers with no proper formulary and protocols circulation of counterfeit drugs will increase many folds. There is a high risk of poor universal precaution and hospital safety measures leading to spread of infectious and communicable diseases, drug resistance & side effects. Many needy cases can die from improper treatment or inadequate services. Poor people can be exploited as "guinea pigs" for unethical trials. There are reports of the death of trial participants without compensation, there are reports of fraud and misconduct in research and publication, as healthcare industry will grow, thousands of incompetent healthcare professionals will enter the market for money churning and exploitation of resources. Private medical colleges are expected to grow in number, can add more seats without government approval, will also provide services with health insurance, now for the training of students and young doctors, for money for keeping the doctors busy the patients at private medical college will undergo unnecessary extensive workup, procedures, surgeries etc.

Loss of faith and many angles to it
Over the time Indian masses especially educated classes have lost faith, developed cynicism and frustration with an unfair, corrupt healthcare system. There are thousands of ethically compromised professionals who are perpetuating the vicious cycle of unethical and corrupt practices, who do not mind intentionally damaging public assets and instruments in

government hospitals to make them unavailable to patients, with the aim of ordering the services from private nursing home, mom and pop hospitals in return for financial incentives or commission.

There is another angle too, how many times more people will move to healthcare facilities with the power of free insurance, asking hospitals to do whatever can be done, asking doctors for unnecessary advanced investigations, even surgeries. Low awareness level among the enrolled population, a pent-up demand because previously present barriers to access. However, this could explain the increase in hospitalization during early years of the implementation of health insurance schemes genuine reduction of financial barriers to access or a supplier-induced demand. increase in utilization and lack of significant improvement in financial risk protection

As health insurance schemes primarily cover the services requiring hospitalization, while nearly 70% of overall health expenditure is because outpatient care which is not covered, so there should be some contribution payment model for outpatient care. Ignorant patients can be asked to pay out of pocket for the procedures, accessories, specified services though they will be paid by insurance company too. Private high standard impanelled hospitals which exist in the urban areas remain elusive to most of the rural population which continues to face geographic barriers to accessing care, while benefits are mostly gained by the richer quintiles and urban population.

As an increase in utilization will be more concentrated in private sector hospitals, it is likely to impose fiscal constraints on the government for sustainability of insurance scheme as it is expected to divert a large amount of tax money towards the private sector. Government is already allocating significant supply-side resources through flagship health programs on strengthening public sector facilities for providing universal access to these conditions, this economics is inefficient as it leads to the double allocation for meeting the same demand.

As time passes and awareness levels improve, this could lead to further increase in utilization of health services, there are possibilities that many patients will be troubled in the name of incomplete documents, people with actual diseases whose treatment and surgeries gives less money to hospitals, will not be treated. There will be increased use of investigatory modalities, if insurers do not approve that, more procedures will be done with forged reports. There is another risk that at some centers public can develop a partnership with small hospital owners for fake procedure and treatment with forged documents, now half the money goes to the patient, half money goes to the hospital.

There are reports that bags of food grain, sugar, and oil boxes were given to poor family, their insurance cards were taken from them with documents signature, now all the money from the card was claimed to the government for fake procedures and therapy. There is possibility that all the tertiary care government hospitals which were giving free services, free stay to patients, now will start charging moderate payment for all services, bed charges, doctors visit, procedures etc., insurance card will be used in government hospitals also, whole new payment system will be deployed in government sector, possibly services will improve, budget deficit of healthcare spending will improve, likely many schemes of healthcare insurance will be merged in to one for convenience.

One possibility is that if there is no slot for the patient in a government hospital, she/he will be referred to private hospital for therapy/surgery and kickback will be received by government doctor referring the patient, Government doctors may not do their intended duties as surgeons, oncologist etc. as money is coming by referring, their seal of referral followed by advice by private expert are strong enough for any investigation, procedure, implant, surgery. In fact, they will be interested in referring more and more patients to private centers for a kickback. There are possibilities of getting disposable instruments from insured patients, costly medicines, which are not used for the patients and side-tracked to grey market, where healthcare providers will purchase those branded costly devices, disposable at half the cost. It was said in a joke that at the age of 40 years if your tonsil, appendix, and uterus are not removed surgically then you are either a doctor or belong to the family of a doctor. One report suggested that poor trauma patient without fracture was taken in operation theatre, his intact bone was broken, x ray of broken bone taken and then surgery was done for an insurance claim.

Needs of Hour
Patients are losing their patience, they are confused, fearful as this is not a humane world for them. There are many good possibilities like all the healthcare providers may be asked to do biometrics of the visiting and admitted patients, a massive amount of data of diseases, demography, reports, therapies will be now available to plan resources, services, and expansion by policymakers. Now with the use of technology, there can be documentation of every visit, treatment, side effects, complications, mortality, which will have great implications from clinical, scientific, research point of view apart from Healthcare economics, policy, and management angle. We need to learn from NHS how they are using common mobile application for doctor's hospital duty hours and tracing, performance, review, movement in hospital environment. There is a desperate need for convergence of government services delivery. As many departments work in isolation with a separate database, over the decades, systematic corruption and mismanagement have bred bad data, false information, and outright fraud. now with the use of biometrics large single interrelated traceable database can be prepared, followed & audited. To ensure genuine care lots of brainstorming for maximum use of technology, biometrics is needed, it will be better to avoid inspection system which will lead to more corruption at all the levels.

Creative destruction of mines of Healthcare corruption

"Creative destruction" was described by Schumpeter's ; In his vision of capitalism, innovative entry by entrepreneurs leads to disruptive forces that sustain economic growth, change in culture, change in ecosystem, change in values. These innovative changes destroy the value of established organizations that enjoy some degree of monopoly power derived from previous technological, organizational, regulatory, and economic paradigms.

We need forward and backward integration of healthcare services, there is need to link different activities in healthcare ecosystem with the use of technology, artificial intelligence, block chain and good governance. The system needs various value drivers for developing new management model and payment system with novelty, lock-in features, complementarities, interdependencies, and efficiency. There is a need for an automated big data system to monitor and analyse patient's database, demography, ailments, reports, referral, and double check for critical reports.

Matchmaking software can be created which will have complete information about the patient and services providers, now system will decide which patient goes to which centre, in which location, to which doctor, for what procedure, appointment booking for procedure, number of every day referral cases to each centre, types of surgeries, payment, symmetrical case distribution will be ensured through that. There will be no bias in referral by human intervention, while patients comfort, distance from home, appointment, transportation will be taken care off with automated messages, calls, booking managed by a nodal call center. There is a need for independent respected third-party auditing to find out the progress of the programme, irregularities, and inefficiencies. For specialized cases and procedures, the liaison will be developed with national nodal centers, for rarer diseases international collaboration with world-class centers will be developed to review the data and give the second opinion. Single national rate list for most procedures, surgeries, investigations, therapies can be created with tier system per hospital class. For complex rare surgeries with high-cost online bidding by hospitals with that specialized service can be done, the most efficient center should get more of those cases.

Healthcare services provider's database, biometrics will be matched with hospital database and with patient's database, on the day of procedures as per protocol video consent, verbal and written approval by the patient or family member (if patient not sane), description of status of patient, indication, type of surgery, other options available, and complications need to be discussed with patients, on the website all these data are to be filled in easy to fill one page form. Approximate GPS location of patients and doctors need to correlate on the day and time of surgery, both doctors and patient's biometrics also just before and after the procedure. Patients mobile will get regular update of funds available in insurance card, they will also get details of how much money spent, on what items and services should also be sent in local dialect as well as in Hindi.

Many policy reforms are needed, active, the honest role of the media, consumers, advocacy groups, patient complaint cells should increase. We need incorruptible technology, system, devices, applications, for monitoring and implementing the system. The government should make the provision of insurance amount to be INR 100,000 which can be maximum INR 500,000 in selected cases with special online approval. There is a need for a collective will, which should be backed with transparency in the system. Policymakers should address the issue of healthcare corruption, institutions should be reformed, there is need to establish and maintain high standards of medical education, and services.

It should be mandatory for doctors to write down complete prescriptions for the diagnosis and the medicines prescribed. All beneficiaries should be alerted about how much they are paying for treatment, they should check their card balance, otherwise, it will be consumed rapidly and then they should pay from the pocket. Beneficiaries should be trained to question if overcharged.

Capitation fees system for entry to the MBBS course should go away as it is the seed of lifetime corruption by doctors. Corruption in medical education is the main reason for a poor healthcare system. Only those who have high interest in healthcare services should get admission, public needs skilled doctors. Most of the unskilled doctors indulge in unethical practices to make quick money. National Eligibility-cum-Entrance Test as a qualifying requirement for all students is a great beginning. There is need to bring accountability and transparency, healthcare surveillance while avoiding digitized discrimination. We need good effective privacy, measures to avoid abuse of personal information should be placed.

As advancing technologies are converging, we have a new way forward. Aadhar (meaning Foundation) numbers can bring together various databases to make clean, authentic records. We have a billion mobile phones in the nation, which can serve as a gateway for India's masses into the digital financial system. Use of block chain for services can be great to follow medicine and instruments supply chain, to cover healthcare records, services, and long-term follow up, this record cannot be changed, medicine once issued from a factory can be followed till patient, counterfeit drug problem can be solved.

There is need to regularly audit the records, kickbacks are made illegal, western laws should be placed, we need faster legal action on corrupt healthcare professionals. There is a need for registration and regulation of all clinical establishments, ensuring the provision of minimum standard facilities in all medical establishments, but the problem is Inspector raj leading to more corruption and no actual improvement. There should be measures to introduce greater

transparency in the medical system. Like in China we need regulations for hospitals, physicians, and medical product manufacturers, the government should prohibit doctors from participating in product promotional activities or illegal disclosure of patient data. Strict laws to ban kickbacks, commission, and inducement from patients and families. The country needs prohibitive punishment for defaulters. Political interference should decrease in public sector, transparent electronic admission and bed vacancy system needed in all government system to avoid corrupt practices,

Something should be done to correct the imbalance of doctors as well as patient's knowledge, doctors should be stopped from taking advantage of ignorant people, doctors should behave like academicians and professionals, not as businessmen. Universal electronic medical records should be used, every visit, procedure, investigation should come on record, any deviation from the norm should be noted and action is taken, like recently in a private hospital 42 ear surgeries were done in one day, while it was not equipped for that, this incident was widely reported in newspapers and stakeholders circles, most likely all these cases were fake procedures for bill, all patients were referred from medical college OPD to private hospital, whether patient need or not procedures were performed.

NMC Bill
The national medical commission (NMC) has the provision of accreditation and exit examination. This accreditation will serve as a signal of the quality of education and research in medical institutions. Results from a common exit examination will provide information on the relative performance of students educated at different institutions, those doctors can be followed in future for their performance, hopefully, there will be no scandal in that exit examination. . .
Like in the USA, Indian doctors must renew their licenses every three years, evidence of continuing medical education, publication, an antiplagiarism law will be required which will replace inspections for medical institutions for infrastructure and number of personnel.

The government has proposed to offer bridge courses that would equip Ayurveda, yoga and naturopathy, Unani, Siddha and Homeopathy (AYUSH) doctor graduates to provide basic allopathic treatment to patients after completing the course. There are more than a million unqualified practitioners in both rural and urban areas, they need to be replaced by qualified doctors, as quacks promote corrupt practices, do abortion, procedures, misuse antibiotics and steroids and they refer patients to small private hospitals and take a commission.

Government is increasing the number of seats in private medical colleges, now an absolute number of seats falling under fee regulation will be large, new entrant colleges will create competition which would limit the ability of private colleges to raise their fees. Shortage of doctors should be corrected, that will decrease unfair practices, monopoly. Now more medical seats will generate greater access and reasonable fees in these areas. As mass insurance promoting demand-side health financing scheme will provide financial risk protection in the absence of a strong primary health infrastructure, it needs to be strengthened, equitably distributed and utilized. Over the time market forces will decide the ranking of medical college, grading of students and fees of medical colleges per NEET results and career growth of students. Many people are trying to stop NEET as it can change the Indian healthcare industry scenario towards good, NEET should be properly implemented with maximum use of technology, strictest sense, with best data privacy, ensuring sanctity and avoiding any mistake in conducting the examination.

There should be a growth of private sector in rural and disadvantaged areas along with strengthening public sector infrastructure. Inequitable nature of the enrolment and utilization should be corrected; efficient targeting is required for those who need the services most. Insurance companies under influence of local politicians may systematically attempt to enroll better offs rather than worse offs, who do not belong to community, caste, party. Insurance companies should be checked from cream skimming, backward villages and very poor will be unable to enroll in the scheme, there should be a special plan for them by increasing awareness and reach.

Policymakers should design schemes, create structure and implement safeguards so that the benefits of the risk pooling can be maximized. Strong primary health care services will be necessary while also serving as gatekeeping for specialist services. Doctors should not have the power to refer patients to private center from government system, they can refer on the online system, artificial intelligence(AI) will decide where to refer, which center, which area, for what procedure. AI auditing is must to study manual referral by doctors, the public sector needs to be strengthened and insurance payment should be there too for services. There is a need for the patient biometric check at every healthcare facility to see their movement pattern. It will generate revenue for the public health system, which will be used to strengthen services. Private practice should be banned in public sector, strict biometric attendance, random checks, GPS monitoring will be required during duty hours of healthcare professionals. It should be punishable by law if government doctor is caught operating a case in private hospital. Patients should get calls, message, mobile applications for scoring, reporting services and malpractice by doctors. High level of system investment required to monitor and evaluate the implementation of health insurance.

Various Stakeholders involvement
Physicians should address the issue in meetings, discuss it and take a stand against it, they can create opportunities for good governance and better health outcomes for the public. They can rebuild the trust of patients and the people. Policymakers should take appropriate measures to counter unnecessary investigations and overbilling, developing

mechanisms to handle allegations of misconduct, should censor members with questionable integrity, and should promote transparency and accountability in all areas of medicines.

Civil society organizations, voluntary health associations, patient rights groups, NGOs, media and the judiciary should be proactive against corruption in healthcare, they should promote enactment and implementation of legislation and regulations for good governance, transparency, and accountability in healthcare. Office of Ombudsman should be empowered with legal power, adequate resources, and infrastructure. Video and audio material with medical ethics content circulated to healthcare professional will create a favourable ethical climate. As in west good governance means no corruption will lead to a great health outcome. There can be a system of CGHS (Central government Health Scheme) rate list for all the diseases management, diagnostics and procedures can be implemented at national level for, which is to be updated, monitored, accessed by expert panel from different organizations, healthcare economist, policy makers. Possible economical misbehaviour at every level should be thought and corrected, all possible scenario should be thought, learned, and corrected beforehand.

There is a need for aggressive programmes to manage and prevent water pollution, air pollution. Governments pro-business policies should be sustainable, it should direct the companies to safe practices, green energy, & climate-friendly activities. Malnutrition must be corrected in poor population, sanitation should improve earliest, and every family should get safe water, safe food, clean air, education and proper housing; which will impact the overall success of the programme as well as the country.

Behavioral economics and Healthcare
Initially, there will be an increase in utilization of services due to pent-up demand because previously present barriers to access, genuine reduction of financial barriers to access, or likely supplier-induced demand. Purpose of insurance is to support for low-frequency, high cost events like heart attacks, not high-frequency, low-cost events like a vaccine, cold, reflux. But if low-cost events are undertreated, high-cost problems will emerge. Apart from good high tech governance of service part, policymakers should create programmes to prevent the illness, to create awareness, to prevent corruption and to increase healthy behavior among masses to prevent overuse of healthcare services. Traditional ways of doing video shock advertising commercials can be used to explain healthcare corruption, malpractice, strict laws, regular surveillance, responsibility, understanding their illness, saving themselves from unnecessary can be explained to people. But for prevention of illness campaigns do not work well, high-level strategy and use of behavioral economics principles will be required for that.

Whatever is immediately available is more valued, (Principle of temporal discounting), but people need to appreciate the benefits of behavior change with incremental long-term effects. Giving patients some feedback on how they are doing in relation to other people, can motivate them to improve behavior and compliance. Patients can be convinced to quit smoking by explaining their lung age compared to non-smokers. Cohesive patient groups can be motivated by changing their behavior to perform better than other members. Messages incorporating social norms, precise and targeted feedback about regular visits by others can reduce the number of missed appointments and maximize the effect.

There is a need for payment reform and alignment of incentives for stakeholders across the health system. Authorities should clarify quality and outcome metrics, financial and nonfinancial incentives to provider groups for a driving continuum of care, performance improvement, and cost savings. We need to preserve motivation, autonomy, broad focus of the staff while incorporating social comparison. People can be sensitized to self-image, goal gradient theory, gains, and losses. To motivate staff for the quality of care and meaningful peer comparison, we need clearly described incentives, targets, absolute performance indicators. Continuous performance improvement will happen with the encouragement of best practice sharing among workers.

Non-financial incentives [SEP] will appeal to self-image and professional identity of most individuals. While payment incentives will lead to tangible organizational and behavioral changes for efficient, higher quality, team-based care, better patient interaction, closer relationships across and within provider groups, deeper commitment in coordinating patient care and achieving favourable cost and quality outcomes.

The government can plan a financial incentives program for population, as a mobile coupon for payment of utility bill, if they quit an addiction confirmed by the urine test and doctor, can plan incentives to obese patients by registering them into lotteries or into deposit contracts for meeting weight loss goals. Due to status quo, bias people exhibit inertia, they do not deviate from the default option. For the care of terminally ill patients, family/ patient can be asked to sign comfort-oriented approach preselected in all; some people can cancel default (pre-ordered) option and chooses aggressive care option. Lots of healthcare cost can be decreased, quality improved by this option. Joint incentives can be given to doctors and patients both to meet diabetes care goals. To increase the probability of adhering to the healthy behavior they can be asked to sign a monetary bond at the beginning of de-addiction, which will be forfeited if they fail.

People need an example to fear their risky behavior (availability heuristic), video of known figure discussing disease suffering due to unhealthy behavior. We can prime the behavior, create responsiveness and increase awareness of personal risk among youth by providing relevant examples like news of celebrity death or accident due to drugs/ HIV. People

commonly have misperceptions of social norms, students think that drinking, smoking and unhealthy diet is very common, so they indulge more due to bandwagon or peer effects, those misperceptions should be cleared from minds of people by campaigns. Framing effect can be used by sending messages which discuss gains due to healthy behavior, while loss-framed messages discussing the benefit of early screening for certain diseases. Mass emailing to people for time and location of cancer screening can increase visits. People can be prompted to write down the day and time for planned vaccine shot, deaddiction clinic visit, sugar testing can change behavior. By using the concept of decision heuristics, by highlighting consensus people can be helped, chief doctors message that vaccine or medicine shot is safe, public acceptability can be increased.

Food serving stations can be asked to set defaults small portion sizes of unhealthy items, mandatory healthy food options which are placed closest to customers. As advertisements affect public perceptions of social norms, they should be regulated, kids show, movies should not have unhealthy kid item advertisement. Authorities should prevent advertisers promoting unhealthy diet, and unhealthy behavior. People should be trained not to do impulse shopping.

Policy making at many levels
Government should support home healthcare services, should make them tax free, should provide provision for faster approval, faster processing of requests, faster verification of individuals to ensure safety and security of both patients and service providers.

Newer laws and policies are required with changing healthcare scenario, changing technological scenario, changing people's perception. Now western society is progressing towards drone delivered medicines, telehealth, home health, community hospitals, internet of things in healthcare, wearable devices, we should also plan and implement the healthcare services accordingly.

Government should create common application, which must be installed in all people's phone when they enter hospital, in this application motivated patients will be submitting their reviews and score of doctors, students will be scoring their teachers in medical colleges, nurses will be scoring doctors and vice versa. Those people who are in database, and are not using the application, they will be sent a message and email with direct online link to private questionnaire for their scoring, this way maximum possible data will be collected. This application should have some feature like private message from one doctor to another, again they should not know each other's identity, now honest doctor can message corrupt one that we are noticing your wrong practices, by this message initial warning can be sent to corrupt doctors and staff that they will face action is do not improve, that will change culture as well as the ecosystem.

Medical students and nursing students should be empowered to report wrong doing, misbehaviour, corrupt practices, failure to do intended duties. Now big common data pool will be created, it will be encrypted, privacy of the review submitter will be ensured and collection of these reports will decide the promotion, pension and fate of senior doctors, tutors and nurses. There is need to recognize and reward genuinely good doctors, good nurses, it is possible only through a transparent platform which cannot be gamified by corrupt people.

There is a need for a point of care technologies like battery operated or sunlight charged laser biochemistry machine for mass screening, these devices should be connected to biometrics, internet, central data cloud space so that millions of patients can undergo screening test in peripheral and distant parts of the country, there diseases can be diagnosed early, managed well and if required complicated cases can be referral well in time. Common big data of this soft will give lots of information to policy makers for long term planning of resources, required interventions, healthcare workers, preventive care and life style management programmes. There are many devices or wearables; which can work with internet of things platforms, and we can collect massive common data for planning and implementing healthcare services, while individual patient's monitoring and specialized services will be provided by subscribed companies.

Conclusion
For the success of Indian National Health Insurance, we need creative destruction of mines of healthcare corruption apart for best preventive and primary care. Policymakers while making best of policies for the betterment of Indian healthcare system should also recommend to maximally use all technologies based solutions including artificial intelligence, block chain technology, universal biometrics, global positioning system, digital monitoring, mobile applications, a point of care technologies, system reforms, and big data collection. They have to work a lot for nudging, improvement of medical education, public health, culture change and strong laws to prevent corruption as well as illness.
"Great thanks to all my doctor friends, colleagues, patients and their relatives, social workers, writers and whistleblowers for giving insight into writing this paper"

Reference
[1].World Health Organization. The world health report: health systems financing: the path to universal coverage; 2010
[2].Norheim O, Ottersen T, Berhane F, Chitah B, Cookson R, Daniels N, et al. Making fair choices on the path to universal health coverage: Final report of the WHO consultative group on equity and universal health coverage: World Health Organization; 2014.

[3]. The government of India, Ministry of Health and Family Welfare. NCMH: Report of the National Commission on Macroeconomics and Health. 2005.

[4]. The government of India, Ministry of Statistics and Programme Implementation. NSSO 71st Round (January—June 2014): Key Indicators of Social Consumption in India Health. 2015.

[5]. Van Doorslaer E, O'Donnell O, Rannan-Eliya RP, Somanathan A, Adhikari SR, Garg CC, et al. Effect of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data. The Lancet. 2006; 368(9544): 1357–1364.

[6]. Garg CC, Karan AK. Reducing out-of-pocket expenditures to reduce poverty: a disaggregated analysis at rural-urban and state level in India. Health Policy and planning. 2009; 24(2): 116–128. doi: 10.1093/ heapol/czn046 PMID: 19095685

[7]. Berman P, Ahuja R, Bhandari L. The impoverishing effect of healthcare payments in India: New methodology and findings. Economic & Political Weekly. 2010; 45(16): 65–71. Government of India, Ministry of Health and Family Welfare. National Rural Health Mission (2005– 2012) Mission Document.

[8]. Bang a, Chatterjee M, Das gupta J, Garg A, Jain Y, Shiv Kumar AK, et al. High level expert group report on universal health coverage for India. New Delhi, Planning Commission of India. 2011.

[9]. "Healthcare: Reaching out to the masses" KPMG whitepaper

[10]. "Major Disease in India." India Health Progress (http://www.indiahealthprogress.in)

[11]. "Financing and Delivery of Health Care Services in India", Ministry of Health and Family Welfare Government of India.

[12]. Aarogyasri Health Insurance Scheme. [Internet]. [cited 2016 17 Feb]. Available from: http://www. aarogyasri.telangana.gov.in

[13]. Shankar Prinja et al; Impact of Publicly Financed Health Insurance Schemes on

[14]. Healthcare Utilization and Financial Risk Protection in India: A Systematic Review DOI:10.1371/journal.pone.0170996, February 2, 2017

[15]. Vian T. Review of corruption in the health sector: theory, methods and interventions. Health Policy Plan. 2008 Mar; 23(2):83–94. doi: 10.1093/ heapol/czm048. Epub 2008 Feb 14.

[16]. Schönhöfer PS. controlling corruption in order to improve global health. Int J Risk Saf Med. 2004; 16(3):195–205.

[17]. Transparency International. Global Corruption Report 2006. London: Pluto Press; 2006.

[18]. Editorial. Corruption in health care costs lives. Lancet. 2006 Feb 11; 367(9509):447.

[19]. United Nations Development Programme. Fighting corruption in the health sector – methods, tools and good practices [Internet]. New York: United Nations Development Programme; 2011Oct 31[cited 2013 Jul 4]. Available from:http://www.undp.org/content/undp/en/home/librarypage/democratic-governance/anticorruption/fighting_ corruptioninthehealthsector/

[20]. Chattopadhyay Subrata; Corruption in healthcare and medicine: Why should physicians and bioethicists care and what should they do?, Indian Journal of Medical Ethics Vol X No 3 July-September 2013

[21]. Dhruv Khullar Dana G. Safran Using behavioral economics in provider payment to motivate improved quality, outcomes & cost: The Alternative Quality Contract Healthcare 5 (2017) 6–8 http://dx.doi.org/10.1016/j.hjdsi.2016.04.010

[22]. Khullar D, et al. Behavioral economics and physician compensation–promise and challenges. N Engl J Med. 2015; 372(24):2281–2283.

[23]. Emanuel EJ, et al. Using behavioral economics to design physician incentives that deliver high-value care. Ann Intern Med. 2016; 164.2:114–119.

[24]. Cabinet Office and Behavioural Insights Team. Better Choices: Better Deals, Behavioural Insights Team Paper. Cabinet Office-Behavioural Insights Team website. http://38r8om2xjhhl25mw24492dir.wpengine.netdna-cdn.com/wpcontent/uploads/2015/07/better-choices-better-deals.pdf

[25]. B.C. Madrian Applying Insights from Behavioral Economics to Policy Design National Bureau of Economic Research; 2014, New York (2014), 10.3386/w20318

[26]. G.B. Chapman, M. Li, H. Colby, H. Yoon; Opting in vs opting out for Influenza vaccination JAMA, 304 (1) (2010), pp. 43- 44, 10.

[27]. S. van der Linden, C. Clarke, E. Maibach Highlighting consensus among medical scientists increases public support for vaccines: evidence from a randomized experiment BMC Public Health, 15 (1) (2015), p. 1207, 10.1186/s12889-015-2541-4

[28]. R.H. Thaler, C.R. Sunstein Nudge: Improving Decisions about Health, Wealth, and Happiness Yale University Press, New Haven, CT (2008)

[29]. Pandey Kundan, Down To Earth; 10/02/2018, 02(43 15 August 2014

[30]. How India's Corrupt Healthcare System Is A Failure Of Policy, Not Doctors, http://www.Youthkiawaaz.com 10/02/2018, 02(44)

[31]. www.economictimes.indiatimes.com/articleshow/62794948.cms?utm_source=content ofinterest& utm_medium=text&utm_campaign=cppst

[32]. http://guides.library.jhu.edu/c.php? g=202502&p=1335759), adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland

[33]. How Technology Can Limit India's Rampant Corruption, Forbes, JUL 9, 2012, 02(40) **33.** Rajasekhar D, Berg E, Ghatak M, Manjula R, Roy S. Implementing health insurance: the rollout of Rash- triya Swasthya Bima Yojana in Karnataka. Economic and Political Weekly. 2011; 46(20):56–63.

[34]. Devadasan N, Seshadri T, Trivedi M, Criel B. Promoting universal financial protection: evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India. Health Res Policy Syst. 2013; 11:29. doi: 10.1186/1478-4505-11-29 PMID: 23961956

[35]. Maeseneer J De, Moosa S, Pongsupap Y, Kaufman A. Primary health care in a changing world. Br J Gen Pract. 2008; 58(556):806–9. doi: 10.3399/bjgp08X342697 PMID: 19000405

[36]. Prinja S, Bahuguna P, Gupta R, Sharma A, Rana SK, Kumar R. Coverage and Financial Risk Protection for Institutional Delivery: How Universal Is Provision of Maternal Health Care in India? PloS one. 2015; 10(9):e0137315. doi: 10.1371/journal.pone.0137315 PMID: 26348921

[37]. Prinja S, Kanavos P, Kumar R. Health Care Inequities in North India: Role of Public Sector in Universal- izing Health Care.Indian J Med Research. 2012; 136: 145–55.

[38]. Sidak, J. Gregory; Teece, David J. (2009). "Dynamic Competition in Antitrust Law". Journal of Competition Law & Economics. 5 (4): 581–631 [p. 604]. Doi:10.1093/joclec/nhp024.

[39]. Nudge: Improving Decisions about Health, Wealth, and Happiness Book by Cass Sunstein and Richard Thaler