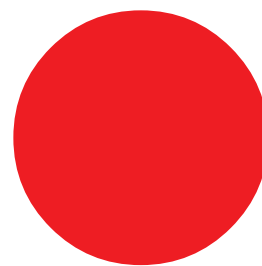


375-376

medico
friend
circle bulletin



March 2017 – July 2017

Pediatric Perspectives

Vandana Prasad

Pediatrics was always meant to be about keeping children safe, healthy, growing and happy, rather than simply curing them when they fall ill. It is no mistake, therefore, that the struggle for the Convention on the Rights of the Child (CRC) was significantly led in part by pediatricians, and that so many pediatricians work in the domain of social pediatrics, and form the bulk of clinicians that enter the domain of public health. That is to say, concern for the prevention of ill-health, promotion, and a focus on overall well-being of every child is seminal to the practice of Pediatrics, even as the clinician grapples with sickness and disease where her skill and expertise can and often does, make the difference between life and death.

It is therefore intriguing at best, and of concern in general that, in a context where so many of the world's children suffer from continuing hunger and an unacceptable lack of access to good quality food, the 'technical community' should be so fixated on solutions that offer only some transient and temporary respite with massive opportunity costs, and remain so silent on the underlying situation of child hunger.

This is best demonstrated in the Indian subcontinent where we know that the majority of children suffering from malnutrition exist. What is less well understood, is that these children suffer from a specific kind of malnutrition that symbolizes both a chronic lack of decent food, as well as acute distress generally due to illnesses; an acute on chronic kind of malnutrition. A characteristic of this kind of malnutrition, where stunting is widespread and underlies wasting, is the relatively lower incidence of mortality. The situation created by long and short-term stressors, also demands solutions that offer both long and short-term alleviation. It is critical to stem the problem at its roots rather than solve it transiently for a mere few weeks or months.

However, experts across the world have favoured short term 'quick fix' solutions using the distribution of

preprocessed nutraceuticals rather than community-based solutions, with a few voicing concerns about their relative costs, long-term implications upon child health as well as relatively low unsustainability for long term gains. The evidence suggests some small additional efficacy from such nutraceuticals, but at the cost of sustainability, with no prevention. While this is done in the name of urgently 'saving lives', significantly, evidence suggests that mortalities are not high and do not seem to be affected by choosing community-based solutions using local foods and resources.

Despite repeated data and reports related to the lack of food quantity and dietary diversity amongst over 80% of children, the commonest refrain of the technical community is to bemoan only micronutrient insufficiency and not food insecurity in general - again to be countered, not from better quality, more diverse food, but from pills, syrups and fortification. Meanwhile, the community is conveniently blamed for poor feeding behavior, even as their age-old traditions of eating wholesome foods are eroded by the development paradigm of the day.

Why is it that there is such a resistance to commonsensical approaches to managing malnutrition - of taking care of children, feeding them often and well and taking care of health care needs - that even high-quality data cannot break?

Is it the medical practitioner's need to retain power and control inherent in technical expertise that would be lost if communities were considered able to manage malnutrition with a little help? Or is it the influence of the production companies that have created major conflicts of interest in technical discussions and guidelines, whether they be within the multinationals of UNICEF and WHO, or within national or state technical advisory committees?

(contd next page)

Health Workforce in India: Discussion Note MFC Mid Annual Meet July 2017

Organizing Committee

The definition

Health workers play a central role in ensuring the appropriate management of all aspects of the health system. A society's health and its development are strongly linked and health workers have an indirect but crucial role in the achievement of sustainable human and economic development.

WHO defines health workers as "all people engaged in actions whose primary intent is to enhance health". Health workers play a central role in ensuring the appropriate management of all aspects of the health system: From logistics and facility management to finances and healthcare interventions

Health personnel in India - pattern of distribution

India's health workforce is a combination of both registered, formal healthcare providers and informal medical practitioners, the latter being the first point of contact for a large proportion of the population. Human resource shortages hinder scale - up of health services and limit the capacity to absorb additional financial resources. However, in India, the existing database on health workers has always been inadequate. Information on those employed in public sector health facilities are available but there is a lack of information on the large numbers in private practice; data from professional registries are available, but these are scattered and inaccurate as they do not reflect retirement, death or migration.

The 2001 Census reveals that at the national level the density of doctors of all types (allopathic, ayurvedic, unani and homeopathic) in 2001 was 80 doctors per 100,000 of the population and the density of nurses and midwives was 61 per 100,000. It is ironic that despite an increasing shortage of health professionals locally, India has emerged as the most important source country in the global health workforce market (Anand Sudhir and Fan Victoria, 2016).

Not only is there a scarcity of health professionals,

but there is also a skewed distribution of these professionals with the density being four times higher in urban areas than rural areas. Of all health workers, 59.2% were in urban areas, where 27.8% of the population resides, and 40.8% were in rural areas, where 72.2% of the population resides (Census 2001 as cited in Anand Sudhir and Fan Victoria, 2016). Further, there is enormous variation in density across states. The density of doctors in Chandigarh (a city which is a Union Territory) was ten times that in the worst state, Meghalaya. The doctor density in Punjab, one of the upper income states, was 2.6 times higher than in Bihar, which is one of the poorest states. Better-off states afford more doctors and nurses per capita. The lowest 30 districts ranked by density of allopathic doctors and nurses with a medical qualification are found mainly in the states of Uttar Pradesh, Bihar and Madhya Pradesh. Among the highest 30 districts ranked by density of allopathic doctors, 18 are in state capitals with 7 being in the national capital. What is an issue for concern is that as many as 73 districts had no nurses with a medical qualification, while on the other extreme the state of Kerala had 38.4% of the country's medically qualified nurses but only 3.1% of the population (ibid).

Further, there are a large number of quacks or informal providers who claim to be 'doctors' but do not have the requisite professional qualifications. Almost one third of those calling themselves doctors in India were educated only up to secondary school. Among the self-proclaimed 'doctors', as many as 31.4% were educated only up to secondary school level and 57.3% did not have a medical qualification. The lack of medical qualifications was particularly high in rural areas; whereas 58% of the doctors in urban areas had a medical degree, only 19% of those in rural areas had such a qualification (ibid).

Gender intersectionality in the work force

(contd next page)

(contd from previous page)

Either way, it is our children, supposedly the primary concern of every pediatrician, who struggle to survive each day on meagre, carbohydrate-predominant, low cost meals, as we continue to fight over the kind of food-packets we would like to deliver to them, pretending to be oblivious to the social injustice we propagate by not putting food sufficiency and quality first. Even if we could ignore the data, in our hearts, we know our own children eat much better, and we know the costs of the food we bring to that table.

Have we succumbed so completely as a community to the notion that the poor will never have access to decent food, so we may as well do our bit by

prescribing them what the given situation allows; which is nutraceuticals that alleviate but maintain the status quo. When, exactly, did we, the pioneers and proponents of the CRC, give up so completely on child rights, child equality and social determinants?

When we recommend strategies for malnutrition as pediatricians, let us revisit the fundamental precepts of pediatrics and also see if we have done them, and the children we stand for, justice.

Vandana Prasad is a community pediatrician and public health professional who has been engaged with the social sector for 25 years.

Email: chaukhat@yahoo.com

A larger number of doctors were males - 53.4% of all male health workers were doctors while only 17.1% of all female health workers were doctors. On the other hand, there were more female than male nurses and midwives, with females accounting for 83.4% of the nurse category (Census 2001, as cited in Anand Sudhir and Fan Victoria, 2016).

The percentage of female doctors who had medical degrees was much higher than male doctors. In every health worker category except "ancillary health professionals", a higher proportion of female than male health workers were educated to more than secondary school level. In every health worker category, a higher proportion of females had a medical qualification than males. Among allopathic doctors, 67.2% of females had a medical qualification compared to 37.7% of males. Among nurses and midwives (hereafter referred to as "nurses"), 11.3% of females had a medical qualification compared to 2.9% of males.

Despite females being more educated and medically qualified than males in almost every health worker category, females turn out to be less qualified than males in aggregate. The lower education level and medical qualification of females compared to males in aggregate is explained by the different composition of females and males in the different health worker categories. In aggregating health worker categories for males and females, the weight of doctors (high medical qualification) among males is large and the weight of nurses (low medical qualification) is small; among females, in contrast, the weight of doctors is small and the weight of nurses is large. Further a larger percentage of marginal workers were female: 53.2% of marginal workers were female compared to 37.4% of main workers.

Health Workforce: Production and training

Review of the available data on training of health workers highlights three important developments. First is the recent rapid expansion in the training capacity of health workers. Between 1991 and 2013, the number of admissions to medical colleges increased by 121%, while within the same period admissions to dental institutions expanded 668% (Medical Council of India). Similarly there has been a three-fold increase in nursing and midwifery institutes. However, there exist inequalities in the distribution of these training institutions among states. Although the EAG¹ states account for almost half of the country's population, they house only approximately one-fifth of the medical colleges and a quarter of the dental and nursing institutes (Hazarika 2013).

Second, there has been a notable increase in the private sector's involvement in medical education. Prior to 1991, 70% of the medical colleges were government but by 2013, there has been a disproportionate increase in the number of non-government colleges with 67% of the new institutions being private (recognized or approved). Similarly, before 1991, 47% of the dental colleges were government owned and by 2013, 93% of the new dental institutions (recognized or approved) were in the private sector.

Third, despite the consistent increase in health-worker production, posts in public-health facilities remained unfilled, for instance although between 2007 and 2009 the number of health workers, i.e. doctors, dentists,

nurses and midwives increased the total number of vacant posts in for medical officers at primary health centres and specialists at community health centres also increased by 43.6% and 17.5%, respectively, during 2005-2010, with EAG states contributing to two-fifths of these vacancies (Rural Health Statistics in India, 2006, as cited in Hazarika, 2013).

This trend has persisted with Rural Health Statistics (RHS) 2016 report, once again pointing out the crisis in the primary health care in India in the form of poor infrastructure, staff vacancies, shortage of doctors and specialists and inadequate facilities in government health centers. The CHCs in rural India are suffering from 'missing doctors syndrome'. Nearly 81% of the posts of specialists in the CHCs are vacant. The CHCs are required to have 4 specialists- surgeon, physician, gynaecologist and paediatrician. According to RHS 2016, the CHCs in rural India are facing a shortage of 84% surgeons, 77% gynaecologists & obstetricians, 83% physicians and 80% paediatricians. This shortage is being used to justify indiscriminate specialization, thus, further belittling the graduate-level education.

Growing Informalization of health workforce

The privatization agenda started during the 8th (1992-1997) and 9th (1997-2002) Five Year Plans with the neoliberal turn in India. Shortcomings of the public sector were used as a pretext to increase and encourage the participation of the private sector, especially through public-private partnerships. It was argued that around 70% of the health care budget goes into the salaries of public health workers and professionals, who do not perform commensurately. This was used as the basis to promote the informalization of labour in the public health system. The assumption was that by creating a pressured work environment where performance would form the basis of renewal of contracts, the quality of services would improve. But not only did this not happen, the basis for any kind of public health system strengthening got further eroded. Informalization of the public sector has been driven by the intent to make space for the private sector in healthcare, which has in turn fuelled the fragmentation of the health workforce. Within the 'formal' medical sector, there is a growing informalization which dates back to the 1970s with the employment of Class IV contract workers in hospital. Human resource appointments in hospitals were more or less fixed and vacant posts were not being filled as per the requirement even for medical officers at primary health centres and specialists at community health centres. This has led to under-staffing and overload of work for existing staff, in turn affecting the quality of healthcare.

With the coming in of the National Rural Health Mission (NRHM) in 2005, financial support was provided to States/UTs to strengthen their health systems including support for engagement of health workers, but on contractual basis. Under the NRHM, in 2014, a total of little over 1.78 crore human resources employed were contractual across the country; these were employed to fill the posts of Medical officers, specialists, staff nurses, ANMs, paramedics, Ayush doctors and paramedics, District Programme Managers, block managers and accounts managers (Ministry of Health and Family Welfare,

2014). The largest number of contractual staff category was the Auxiliary Nurse Midwife (ANM) who comprised of nearly 41% of the posts.

In addition, the NRHM ushered in a cadre of 'Accredited Social Health Activists' (ASHA), a kind of community health volunteer who is also known by other names in various states (Sahiya in Jharkhand, Mitani in Chhattisgarh etc). Currently there are close to 10 lakh ASHAs across the country² who are provided training by the health department, supervised by the local PHCs and ANMs and meant to provide health promotion services in the community. They are paid small incentives for various tasks while some states like West Bengal and Tripura also pay a fixed honorarium, and they continue to struggle to become formally recognized workers within the health system in India (Dasgupta et al 2017).

The introduction of contractual workers, instead of permanent workers, resulted in these workers neither having job security nor social security (except in Jharkhand where, the workers engaged on contract basis under NRHM are granted casual leave, maternity leave, paternity leave and compensatory leave). As a result they were not only less dedicated to their work but were also not able to unionize to fight for better working conditions. High dissatisfaction among these workers has adversely affected the quality of service provisioning. Thus, informalization of work needs to be looked at in the broader context of neoliberal health policies. At the same time, the role of informalization in further weakening public health institutions and compromising the quality of health services has to be recognised and highlighted.

Growth of Corporate Healthcare

Even in the pre-independence era, India had a very large private medical sector especially for non-hospital care. India has seen the rapid and unregulated expansion of the private sector in health. While the colonial state developed the hospital sector at a slow pace, individual private sector expanded without any state intervention (Duggal Ravi 1997). Investments in the private hospital sector was very small until the 1970s, after which it spread rapidly. The reasons for this were the slowing down of state investments in hospital sector and the promotion of private sector by giving them subsidies, soft loans, duty and tax exemptions. Further, a market for modern medicines in the peripheral regions sprung up after the government established PHCs and cottage hospitals in rural areas (ibid).

In recent years, new medical technology has added another dimension to the private sector expansion by the participation of corporate sector in healthcare provisioning. Several specialty corporate hospitals are being built in collaboration between Indian and foreign companies (Chanda Rupa 2002). These specialty corporate hospitals 'export' health services through consumption abroad. Patients come to these hospitals from industrialized and developing countries for surgery and specialized services attracted their pool of highly qualified healthcare professionals and by their ability to provide good quality, affordable treatment (ibid). This has further implications on the availability of specialists in the public health sector. The Indian government's next salvo was to promote

insurance from private sector by pooling resources and risks. Insurance has allowed the discourse to shift from provision of care to merely assuring coverage, thus reducing the need to hire more health professionals in the public health sector. The National Health (Assurance) Mission is precisely this. According to global estimates, most developing countries spend around 7-8% of their Gross Domestic Product (GDP) on health, whereas India spends around 4% of its GDP, of which only about 1.2% is spent by the government. Because of the meagre contribution of government, people are major contributors to healthcare spending, paying close to 71% of total health expenditure 'out-of-pocket'.

With this backgrounder, we need to get papers on the following

- I. Generation of databases about healthcare users, a mapping of the growing informalization of health workforce, influences of the current development paradigm on human resources - the impact of structural adjustment and neo-liberalism - drain into the private sector, shortages in the public sector
- II. Plural health landscapes (suggested by Rebecca) - interaction and opposition of Ayurveda/Unani/Folk traditions with 'modern medicine' interaction with popular culture
- III. Gender and caste intersectionality in the work force
- IV. Medical education (including role of private colleges), selection procedure to re-designing curriculum, faculty development, pedagogy, evaluation and efforts towards social/community orientation
- V. The role of Role of Professional Associations including IMA, IPHA, IAPSM, regulation, exploitation
- VI. Quality of HR (Clinical/Public-health skills and attitudes) - Issue of task shifting (Specialist vs. generalists; Doctors vs. Nurses; ANMs vs. ASHAs), In-service training, Progress made w.r.t. National Medical Commission, Issue of Multi-tasking (Administration, Financial and General Management, Digitization)
- VII. Health budgets in relation to health human resources
- VIII. Health Workforce and their problems -
 - a) Living and working conditions of all workers (and not just the contractual ones)
 - b) Posting, transfer, promotions, career pathways, pay parity, basis of payment (as a part of recruitment and retention strategies)
 - c) Health Workforce in Rural and remote parts of India (focusing on their Recruitment and Retention strategies if any)
 - d) Health workforce Trade Unions, their Struggle (Lab Technician Trade Unions/Nurse/Group D/ASHAs etc),
- IX. Growth of corporate healthcare market and Healthcare Workforce in the Private Sector
- X. Use of IT impact on health workforce,
- XI. Community Health Workers: Roles and Responsibilities and their Employment Conditions including Community Physiotherapists

(contd next page)

Air pollution: health sector action needed for well-being and equity

Adithya Pradyumna .

Abstract

Air pollution is now well recognised as a key health risk factor, contributing significantly to mortality in India. Both outdoor and indoor air pollution are of equal concern, and are linked to the issues of energy access and social justice. Some health sector actions towards reducing attributable air pollution are worthy of note, including efforts towards improving energy efficiency. Several local level initiatives are also springing up towards increasing the awareness and accountability of air pollution control. Health sector can contribute immensely in increasing the focus on prevention and management of air pollution and its impacts.

Air pollution has been prominently in the news, and the reason for this is two-fold: the evidence that air pollution is highly lethal (and now also classified by the World Health Organization as a carcinogen, and established as the fourth leading cause of death worldwide), and the ever-increasing levels of air pollution in major cities. Unfortunately, what has stirred policy circles is the high ranks being awarded to Indian cities for pollution levels, rather than the pollution itself. The levels of pollution not only transgress the air quality standards, but are several-fold higher. Let us not forget that the air quality standards in India are more lenient than those prescribed by the WHO (the standard for 24-hour mean for particulate matter PM_{2.5} is 60 ppb in India against 25 ppb by WHO) (1)

Based on a recent report, ambient (outdoor) air pollution may be contributing to 11.2% of all deaths in India making it a greater threat than several traditionally revered and feared health risks (2).

The type of long term health impacts caused by air pollution are respiratory diseases (such as asthma, chronic obstructive pulmonary disease, and lung

cancer), cardiovascular diseases (atherosclerosis, ischemic heart disease, and cerebrovascular accidents), and others such as urinary tract cancer. In addition, episodes of high air pollution leads to higher hospitalisation and mortality in the exposed population in the short term. Contrary to what might be expected, deaths are primarily due to cardiovascular (accounting for 72% deaths) rather than respiratory (28%) pathologies (based on current literature, though this is being contested) (3).

For various physiological reasons (including high lung-to-body surface area ratio, and lower immunity), children are more vulnerable to the impacts of air pollution. In a first, holidays were declared for schools in New Delhi on 4th and 7th November 2016 due to poor air quality. Due to reasons of continued negligence in taking decisive action on air pollution, public interest litigations (PILs) have been filed with the Supreme Court of India, some with children as lead petitioners! Some schools have advertised about air conditioning and air filtering systems to keep children safe, but what about schools that are not able to afford those systems?

From the perspectives of source and population at risk, air pollution is generally classified as ambient (outdoor) and indoor (IAP). It is important to note that from the perspective of health impact, IAP is still of greater concern (though outdoor air pollution is breathing down its neck), especially child mortality due to pneumonia. IAP itself contributes to an estimated 1.3 million deaths in a year (4) - approximately 13.5% of all deaths annually in India! Air pollution, whether indoor or outdoor, should indeed be a top health concern.

(contd next page)

(contd from previous page)

This backgrounder has been prepared by the organizing committee of the MFC Annual 2018.

Email: convenor2016mfc@gmail.com

Notes

1. Empowered Action Group, including the states that had poor health indicators like UP, Bihar-Jharkhand, MP and Chhattisgarh, Rajasthan, Odisha and Assam
2. <http://nhm.gov.in/communitisation/asha/asha-support-mechanism/supporting-mechanism.html> seen on 1 July 2017.

References

1. Anand Sudhir and Fan Victoria (2016), The Health Work Force in India: Human Resources for Health Observer, Series No. 16, WHO

2. Chanda R (2002), Trade in Health Services, Bulletin of the World Health Organization, Vol.80 No.2
3. Dasgupta J, Velankar J, Borah P, Hazarika Nath G. The safety of women health workers at the frontlines. Indian J Med Ethics. Published online on February 21, 2017.
4. Duggal Ravi (1997), Health Care Budgets in a Changing Political Economy, Economic and Political Weekly, Vol. 32, No. 20/21 (May 17-30, 1997), pp. 1197-1200
5. Hazarika Indrajit (2013), Health workforce in India: assessment of availability, production and distribution, WHO South-East Asia Journal of Public Health 2013 | April-June | 2(2)
6. Ministry of Health and Family Welfare (2014): Contract Workers Employed in NRHM
7. Rural Health Statistics (2016), Ministry of Health and Family Welfare, Government of India

Air pollution is intrinsically linked with the issue of "energy". Most of the air pollution worldwide occurs because people burn fuels (and potential fuels and resources such as agricultural residues and municipal solid wastes) for various reasons. The electricity and transportation sector is very much dependent on fossil fuels - coal and natural gas in the former, and petrol and diesel in the latter. Indoor air pollution is driven by firewood and other biomass such as dung cakes, but is compounded by inadequate ventilation inside kitchens of poor households, among other things. So it would not be right to look for solutions to the problem of air pollution without discussing the issue of energy.

Energy poverty is the lack of access to modern forms of energy (electricity and LPG). Many households (80.7 million households, based on 2011 census) do not have access to electricity, and 72% households depend on biomass fuels for cooking. The unfair thing is that communities located near thermal plants themselves don't have adequate access to electricity - a situation of gross social injustice. In areas where coal mining occurs, local communities use coal in cooking, causing even higher levels of indoor pollution. This is besides the several challenges faced because of displacement, contamination of water bodies, and loss of livelihoods. Why should one community enjoy the benefits of electricity and another suffer the impacts of environmental degradation caused by the production of that electricity?

As a nation, we should aspire for all families to have access to modern energy while also addressing the issue of air pollution. Various individuals and institutions working on energy are focusing on leapfrogging polluting technologies by using renewable energy technologies in a decentralised manner in areas that do not have access to electricity. Indoor air pollution could be addressed by fuel substitution (to LPG), or by using smokeless chulas. The KEM Research Centre at Vadu, near Pune, are testing several types of chulas and engaging with the community to understand their needs from a chula. SELCO Foundation has designed a chimney that can be used with a traditional chula to reduce pollution indoors.

A large number of primary health centres (PHCs) and remote mission hospitals also suffer from poor power supply. A reliable power supply is essential for delivery of quality services, including lights, refrigerator, fans, autoclave and water heater. More importantly, water supply itself depends on access to power - for pumping water into the overhead tanks. There are situations in remote rural PHCs where PHC doctors have to spend time and energy collecting water from a local source each day for personal use. Efforts are being made by SELCO Foundation and the Council for Energy, Environment and Water (CEEW) towards installation of solar panels are installed in PHCs (especially in remote areas) to ensure reliable electricity supply. The Tribal Health Initiative in Sittilingi, Tamil Nadu now runs its operation theatre fully on solar power!

Most interventions that reduce air pollution also have other health benefits. For instance, switching from cars to riding bicycles leads to not just lesser air pollution but also improves cardiovascular and mental health. In his enjoyable book "The Energy Glut", Prof Ian Roberts discusses how the fossil fuels is the root cause of obesity, road traffic accidents, and climate change. At the global level, mitigation of air pollution directly correlates with mitigation of climate change, the greatest global health challenge of the 21st Century. While there is an important role for individuals to contribute towards reducing air pollution, there is an urgent need for the government to reform energy policies to ensure lesser air pollution, mitigation of climate change, and improved access to modern energy for all. Steps are being taken, such as improving fuel quality (BS IV standard currently), revision of thermal power emission standards, the "odd-even" experiment, the LPG cross-subsidy etc, but these are nowhere adequate towards significantly reducing mortality and disease due to air pollution.

What is heartening is that efforts, although nascent, are being made within health systems which will reduce the air pollution attributable to it. For these interventions, reducing air pollution itself may not be the primary goal, but such "win-win" situations should be exploited. For instance, the All India Institute of Medical Sciences (AIIMS), New Delhi, the apex medical institute in India, has initiated action towards reducing electricity consumption by 50% per patient. Such actions set very worthy trends to imitate by other large medical establishments in India. SOCHARA has participated as a resource group with the Healthy Energy Initiative India in raising awareness about health impacts of fossil fuel based energy among medical and public health professionals and students all over India. Three round-tables have been conducted in Chennai, Kolkata and New Delhi during 2014-15, but the mobilisation is far from adequate. Some interesting local projects in Bangalore, such as Sensing Local and Sensors Without Borders, are putting in place several low-cost air pollution monitors by engaging local people from high pollution areas in their efforts to understand the actual exposure at ground level. This has also helped to increase access of this data to local people towards action. Internationally, due to recognition of climate change as a great health challenge, public health schools and medical institutions have divested from fossil fuel companies as a statement of concern and solidarity.

People need a reliable source of energy and reliable services to be able to do their work. It is not the primary concern of people of whether the lights are powered by coal-based energy or by solar energy. Similarly, light is needed, not light specifically from incandescent bulb light, LED light or sun light. The challenge in India is four-fold - bringing modern technology in renewable energy to those who have not access to electricity, support the shift from polluting sources to renewable sources, support the use of energy efficient devices and building designs, and encourage the reduction in energy use in total in areas of high consumption. People's wellbeing is dependent on good air quality, and green spaces, and physical activity - all of which can be achieved by reducing dependence

(contd next page)

A state specific, civil society led UHC framework: Maharashtra report

Compiled by Abhay Shukla for Maharashtra UHC group¹

Abstract

MFC had initiated developing a discourse on Universal Health Care/Access to Health Care in India, during the period of 2010-2012. This process followed the conceptual milestones laid down by the High Level Expert Group in 2011. The Maharashtra UHC group has published a Report outlining the state specific framework for UHC, which includes detailed innovative approaches for developing a movement toward UHC. This article outlines the key features of the framework, which have emerged in the Report, which includes: sources, its distinctiveness from the term "Universal Health Coverage", its socialized 'health care system' approach by integration of public health care providers in rural and urban areas in Maharashtra and a socialized regulation and insourcing selective private health providers, health care pluralism, institutional and legislative changes, role of public health system in addressing social determinants of health and finally, financial resources including selective state supported health care insurance schemes. This article can contribute to build up the "political will" for UHC in Maharashtra.

Medico Friend Circle has played a pioneering role in developing the discourse on Universal Health Care / Universal Access to Health Care in the Indian context, through three successive annual meetings on this theme (2010, 2011 and 2012), accompanied by a large number of related articles in this bulletin. The High Level Expert Group (HLEG) of the Planning commission developed a detailed framework for Universal Health Coverage in India, elaborated through a widely publicized report released in 2011, along with a series of background papers. These conceptual milestones laid the foundations for the discourse on UHC in India. However, moving forward from broad policy to concrete models, it became clear that actual implementation of UHC in India must be

operationalized in diverse, state specific contexts. Given the diversity among Indian states of levels of socio-economic development, functionality of public health services, size and nature of the private medical sector, existing health insurance schemes, and complex socio-political dynamics, there is no way that UHC could be implemented in India through a one-size-fits-all approach. Given this backdrop, the Maharashtra Universal Health Care (UHC) Group was founded in 2013, to take the next step of developing a state-specific framework for UHC, in context of one large Indian state.

The Maharashtra UHC Group² consists of around a dozen social activists, health professionals working in civil society organisations, and progressive public health scholars drawn from various parts of Maharashtra, with its facilitation by SATHI, Pune., This group developed the outline contours of a UHC system in Maharashtra Based on chapters written by the members, additional expert authors etc. It has been elaborated in a draft policy document. While developing this state-specific detailed framework, the group realized that various innovative approaches needed to be adopted to address the health sector challenges as well as socio-political realities, for enabling movement towards UHC in realistic manner. Many of these innovations may be relevant for other states also, though the particular configuration of UHC would naturally vary from state to state. This article is based on the major collective exercise by the MUHC group and contributing authors, which has been put together over last three years. Here if a summary of the detailed proposed framework for UHC in Maharashtra, is desired then please refer to the Policy brief . However here, we will briefly outline some key features related to the UHC framework that have emerged.

Some key features of the proposed approach in Maharashtra UHC report

The Maharashtra UHC report draws upon the basic

(contd next page)

(contd from previous page)

on fossil fuels, and health professionals have a very important role to play towards this shift.

Acknowledgement

An older version of this article by the author was published in "Health Action Vol 30 No 5".

Adithya Pradyumna is co-convenor, Society for Community Health Awareness, Research and Action (SOCHARA), Bangalore

Email: adithya.pradyumna@gmail.com

References

1. WHO. WHO Air quality guidelines for particulate matter, ozone, nitrogen - Global update: 2005 Summary of risk assessment [Internet]. Geneva: World Health Organization; 2006 [cited 2017 Jul 3]. Available

from: http://apps.who.int/iris/bitstream/10665/69477/1/WHO_SDE_PHE_OEH_06.02_eng.pdf

2. IHME, HEI. State of Global Air 2017: A special report on global exposure to air pollution and its disease burden [Internet]. Institute for Health Metrics and Evaluation; 2017 [cited 2017 Jun 21]. Available from: https://www.stateofglobalair.org/sites/default/files/SoGA2017_report.pdf
3. WHO. WHO | Ambient (outdoor) air quality and health [Internet]. World Health Organization. 2016 [cited 2017 Jul 3]. Available from: <http://www.who.int/mediacentre/factsheets/fs313/en/>
4. WHO. Burning Opportunity: Clean household energy for health, sustainable development, and wellbeing of women and children [Internet]. Geneva: World Health Organization; 2016 [cited 2017 Jun 21]. Available from: http://apps.who.int/iris/bitstream/10665/204717/1/9789241565233_eng.pdf?ua=1

discourse generated by MFC during 2010-12. Further, it has several distinctive features, and seeks to move forward, elaborate or add value to existing articulations of UHC. Some of these features are:

A. Firstly, not being a government initiative, this report is strongly informed by experiences and insights of the health movement. It is an attempt to give shape and voice to the aspirations of common people regarding the health system. Its recommendations flow from close engagement with grass-roots reality, related to the public and private health sectors, with how programmes made by the government get implemented, and ground level challenges. In this sense, this report is a continuation of the stream of thinking initiated by MFC on Universal Access to Health Care.

B. The approach to UHC adopted by this report is distinct from dominant articulations and international discourse on Universal Health 'Coverage'. The latter generally has narrow scope and objective of 'extending coverage' of the existing health care system to the entire population, focusing on financial measures such as insurance, rather than entire range of measures required for transformations in the health-care system. The group has used the term Universal Health Care (UHC), to engage with the emerging UHC discourse, and to shape it on alternative approaches inspired by the vision laid out by the Alma Ata Declaration. It is not merely a question of increasing the coverage of the existing health care system through insurance and other financial mechanisms. What is being proposed is a new kind of health care system, a system of Universal Health Care which would build upon existing resources. It also takes the entire system to a higher level of functionality. In this vision, a system for UHC can be built only by rejuvenating the debilitated public health system and transforming currently unregulated, often irrational, exploitative private healthcare - in tune with the logic, goal and practice of public health. This would ensure comprehensive health care to all residents as part of movement towards 'Health for All' as enshrined in the Alma Ata declaration.

C. The MUHC group adopts a health systems approach to tackle the mixed health system in India comprised of both public and private healthcare providers, interacting with each other in complex manner. Since the private medical sector currently dominates the entire health system, the direction of Universal Health Care in Maharashtra must be towards overall socialization of health care, with major strengthening of public provisioning, while harnessing large sections of the currently unregulated, profit-oriented private healthcare sector through public action.

D. Expansion and strengthening of public provisioning would involve recruitment of additional staff as well as in-sourcing of some human resources such as specialist doctors. There is need for integration of existing public providers at various levels which are currently compartmentalized - State health department facilities, State medical colleges, Municipal corporation hospitals, ESI hospitals, Railways and PSU hospitals etc. into the UHC system.

Some measures recommended for rural areas include - an upgraded and improved ASHA programme, with one ASHA per 500 population. ASHA would be substantially upgraded in terms of skills, linkage with health facilities, along with provision of regular honorarium. Sub-centres would be upgraded to function as first contact care units, with availability of a basic integrated doctor / nurse practitioner, to ensure symptomatic/curative care for all covered rural habitations. PHCs would be empowered to perform the full range of essential public health functions to the population covered by it, involving Public Health Officers (PHOs) responsible for implementing essential public health functions beyond curative care. Specific chapters are devoted to rural health services, health related humanpower, and essential medicines which outline with state specific figures and concrete proposed mechanisms how these components would be developed in integrated manner as part of the UHC system in Maharashtra. These draw upon many existing innovative recommendations for these sectors, hence are not repeated here.

E. Given the large urban population in Maharashtra, the report devotes a chapter on creation of a coordinated urban health care system in the state. It calls for preparing a 'Maharashtra Urban Health Plan' to set up a common urban public health system structure across the state. Yet differentiated strategies would need to be adopted to address the specific healthcare needs of three distinct categories of urban Maharashtra: the metropolis of Mumbai, Municipal Corporation cities, and smaller Council Towns. An effective state level coordinating mechanism such as Urban Health Directorate involving State health department and various Corporations/ Councils is proposed, along with ensuring an organised system of urban health care, with a three-tier structure: Urban PHCs, peripheral hospitals to provide secondary health care with insourcing of trust hospitals and small / medium sized private hospitals, and District hospitals which may be upgraded to public Medical Colleges having responsibility to provide tertiary care to both urban and rural populations in the district.

F. To tackle the currently predominant private healthcare providers, a process of social regulation and progressive socialization of private healthcare sector is proposed. Large number of individual, small, medium and not-for-profit private providers would be brought into the ambit of the publicly organised health system by in-sourcing, to make up for certain existing deficiencies, while these providers are made to work within the goals and boundaries of the public system. The state should exercise and re-assert its authority over this sector, since the private sector has grown over time with major state support and subsidies; hence it has an obligation to serve the people rather than only work for profit.

However, this in-sourcing should be in a manner that would complement and strengthen public systems rather than replacing them, while minimizing cost inflation, moral hazards and siphoning of funds. Over time such providers would conform more and more

to 'public logic' instead of the now dominant 'profit logic', and such ongoing insourcing would lead to their progressive 'socialization'. Charitable trust hospitals have received significant public aid, and are supposed to provide 20% of beds for free/subsidized treatment beds - all these beds would be brought under public management for UHC.

This direction would be based on a differential approach to private providers, for example corporate hospitals would be treated quite differently compared to individual providers, small hospitals and genuinely not-for-profit providers. The proposed approach of social regulation is distinct from traditional bureaucratic regulation, and envisages systematic social accountability of the regulatory system, linked with multi-stakeholder oversight bodies and a developed system of patients' rights. This would prevent 'regulatory capture' by officials or powerful private actors, which distorts and defeats the regulatory process, and is common in the Indian context.

G. The report also takes a somewhat distinctive approach to the issue of AYUSH systems and providers. The model to begin with would be healthcare pluralism, where AYUSH systems will be available to people as a choice at various levels, and practitioners would be enabled to practice their system with adequate resources and space. AYUSH practitioners would be offered a choice of either exclusively practicing their own system, or working as 'basic integrated doctors' at primary level, based on additional training, to provide primary health care with core bio-medicine skills based on standard guidelines. The goal would be of moving towards an integrative system, drawing upon and synergizing the best features of bio-medicine as well as AYUSH systems of medicine, based on appropriate evidence.

H. A range of institutional and legal changes are recommended to support the UHC system in Maharashtra. This would include reform of existing administrative systems, such as merging the Medical Education Ministry into Public Health Ministry to ensure their close coordination for integration of tertiary care required for UHC; expansion and democratization of Maharashtra Medical Council (MMC) and other State Councils with civil society participation; starting new courses like Bachelor in Community Health, and Public Health Officer (to deal with social determinants and inter-sectoral coordination), and diploma courses for skill upgradation of MBBS doctors in major specialties.

Further, given the high level of commercialization of Medical and para-medical education in Maharashtra, this needs major overhaul and effective regulation. All private medical colleges would be strictly monitored to function within the fee structure defined for state medical colleges, without charging any donations, otherwise these would be taken over by the state government. No new private medical colleges would be allowed in the state.

New comprehensive legislations would be required such as Maharashtra Right to Healthcare Act to provide entitlements and redressal mechanisms regarding right to healthcare for patients; Maharashtra Public Health

Act to deal with health determinants and public health functions while ensuring effective inter-departmental coordination; and Maharashtra Clinical Establishments Act to standardize quality of care, costs and human resources in all clinical establishments, whether involved or outside of UHC. A State Health Regulatory and Development Authority to co-ordinate and integrate all providers into the UHC system and a State Health System Evaluation Unit to ensure standards, appropriate costs and rationality of care, would also be required.

I. The report devotes an entire chapter to the principles and range of measures necessary to ensure inclusiveness of the UHC system, which is essential to make the system genuinely universal. Discrimination or differential quality of care on the basis of gender, caste, ethnicity and other forms of vulnerability in health care settings must be proactively overcome while developing UHC. There is need to recognize and overcome various forms of marginalization based on stage in life cycle (children, pregnant and lactating women, elderly persons etc.); social position (women, dalits, adivasis, muslims etc.); health status or bodily capacities (persons with mental health problems, people living with HIV-AIDS, differently abled persons etc.); occupation (sex workers, sanitation workers, waste pickers etc.); sexual orientation (transgender people and persons with diverse kinds of sexual orientation); and socio-economic context (situations of displacement, migration, conflict etc.). These forms of exclusion are often overlapping, and the same group is likely to face multiple barriers to access quality care.

Some measures proposed to address exclusion and ensure inclusion include - placement of Health care delivery units in areas where the most marginalised sections reside; appointing service providers from socially excluded groups; regularly sensitizing all healthcare providers regarding gender, sexuality, violence and discrimination; ensuring confidentiality and adequate physical and emotional space in health care settings; and democratization of health systems through involvement of organisations and groups of marginalised people in planning and monitoring, so that denial, violation or neglect of rights is eliminated.

J. With respect to Social Determinants of Health (SDH), moving beyond voicing general principles, the report proposes that the public health system (PHS) should have a definite and concretely defined role in addressing social determinants of health. The PHS should not just be a 'Public health services system'; it must function as a proactive advocate and catalyst to ensure action by other concerned departments on diverse determinants, and would require additional staff and powers to fulfill these functions. At the same time there is need to actively encourage community inputs which would help to ensure 'convergence from below'. This report suggests mechanisms by which the public health system can achieve this, through a combination of 'top-down' advocacy and support to 'bottom-up' community based action. The Public health system must promote people-centred convergence,

where popular initiative and demand for health rights would help to break down existing compartmentalization. It could ensure integrated provision of nutrition, clean water supply, sanitation and other determinants of health at the ground level.

K. This report is clearly against using the insurance model for publicly supported healthcare provisioning, and in the chapter on health insurance schemes, gives a detailed rationale for the primarily tax based approach to funding required for achieving a genuine system for UHC. However, grappling with the existing reality of large scale state-supported health insurance schemes in Maharashtra (as in many other Indian states), the report outlines how a transition can be made from these existing insurance schemes to a qualitatively different, public centred UHC system. It involves elimination of the role of commercial insurance companies, while not diluting existing health care entitlements in the process. The report also outlines how the Employees State Insurance (ESI) scheme can be reclaimed by workers, and ESI healthcare facilities can be brought into the broader UHC framework. While maintaining all social security benefits for workers, as far as the health care component is concerned the ESIC hospitals could be integrated with the UHC system, with care also being provided to unorganised sector workers, beyond existing enrolled workers.

This report takes a step forward by developing norms for requirement of health services at various levels based on morbidity and other health care needs, which informs the projected provisioning system for rural and urban areas. This forms the basis for outlining an evidence based estimate of the finances required for Maharashtra to achieve a UHC system in next five years. While noting that Maharashtra has the highest GSDP in the country (around 15% of national GDP), it is calculated that about Rs. 2450 per capita at current prices, or 2% of GSDP will be sufficient for setting up a reasonable UHC system in the state. The pathways for raising health care expenditure to this level are also suggested. They include primarily raised general tax revenues by the Central and State Governments, linked with eliminating existing tax exemptions to the corporate sector and business class, possible Financial Transaction Tax, and tax on inherited property, each of which would generate substantial revenues.

Further measures may include a state health tax on lines of professional tax (This part of the Report needs to be relooked into on the basis of provisions under the new GST Act, 2017. -Ed.) For instance, health cess may be charged from owners of personal four-wheelers, and on sale of health degrading products like alcohol, tobacco etc. Complete insourcing of around 10,000 Hospital beds under charitable trust ownership, which are supposed to be provided to poor patients free or at subsidized rates, would bring in about Rs. 1000 crores annually, to boost the UHC system in Maharashtra.

Termination of existing commercial insurance-based health schemes would make available several hundred crores annually.

L. Finally, the report proposes that along with strengthening the public health system, there is

simultaneous need for major changes in governance to systematically democratize the entire health system, while making it much more responsive and accountable to ordinary people. The report proposes ways to democratize public health services, such as generalization of ongoing Community based monitoring and planning (CBMP) in Maharashtra, moving to a system wide process. Ensuring regular forums for direct democracy including Jan Sunwais at PHC, block and district levels and Arogya Gram Sabhas, along with creation of highly participatory health and social services councils at Block, District and State levels. These would expand and activate existing Panchayat and Legislature based bodies, to ensure genuine, broad based people's participation in health decision making at all levels.

The report emphasizes that Maharashtra possesses three major prerequisites for moving towards a UHC system namely- economic resources, healthcare resources, and vibrant social movements. Maharashtra has the highest GSDP among Indian states, it has second highest numbers of medical colleges and AYUSH colleges in the country, and one-fourth of the total medicines in the country are manufactured here. The state has a legacy of progressive social movements and civil society initiatives, including pioneering work in community health. If properly mobilized and reoriented, all these can be the basis for developing a UHC system in Maharashtra, within next five to ten years. However, the crucial factor for developing UHC anywhere is political will. It is hoped that this report could provide one critical input towards informing and inspiring a broad based social movement for UHC, which would help to generate such political will for ensuring a system of Universal Health Care for all residents of Maharashtra. In addition, the analyses and innovations contained in this report may be of use for similar state-specific efforts for moving towards UHC in context of various Indian states, and towards building a national discourse around UHC.

Maharashtra UHC group is a collective of social activists, civil society health professionals and public health scholars from various parts of Maharashtra, which has developed a framework for UHC in the state.

Email: sathicehat@gmail.com

Notes

1. This article is an abridged version of the Introduction to the Maharashtra UHC report, and the Policy brief on a system for UHC in Maharashtra. It has been compiled and adapted in form of an article for MFC bulletin by Abhay Shukla.

2. Members of Maharashtra UHC group are Abhay Shukla, Anant Phadke, Brian Lobo, Jaya Sagade, Kamakshi Bhate, Mathew George, Poornima Chikarmane, Ravi Duggal, Sanjay Nagral, Satish Gogulwar and Shailesh Deshpande. Authors, editors and contributors beside MUHC group members include - Abhijeet More, Amita Pitre, Ashwini Devane, Indira Chakravarthi, Leni Choudhuri, Manisha Gupte, Nandita Kapadia, Nilangi Sardeshpande, Padma Deosthali, Rudraneel Chattopadhyay, Shweta Marathe and Soumitra Ghosh.

The secretariat of Maharashtra UHC group is managed by SATHI, Pune.

<http://sathicehat.org/images/uhc-policy-brief-english.pdf>

Mental Healthcare Act 2017: A critical appraisal

Nilesh Mohite

Abstract

Recently president of India has signed Mental Healthcare bill. It was published on 7th April 2017 in official Gazette of India. Soon it will be implemented as mental healthcare act 2017 replacing previous Mental Health act 1987. It is very important step in history of Indian mental health legislation. Though act is very progressive and patient centric it has its own limitations. Current essay will briefly discuss about background, need of law, its positive and negative aspects in context to present condition of mental health in India.

History

Mental illness is strongly associated with many socio-cultural factors and have very strong impact on various aspects of society like safety, crimes, human rights. Since last 3 centuries British made various laws for commonwealth nations. They made various mental asylums for safety of society from mentally ill people. As asylums were made only to isolate mentally ill from rest of society care, treatment, rehabilitation, rights of patients etc. was totally missing from this asylum. India has gone through various asylum laws like Indian Lunatic Asylum Act 1858, Military Lunatic Act 1877, Indian Lunacy Act 1912. After independence, Indian Psychiatric Society (IPS) insisted government to have new law for mental hospitals. After many years of hard work from various stakeholders, Mental Health act 1987 came into existence. Though act was formed in 1987 it has taken 6 years for government to implement it. After implementation of law various limitations and shortfalls of law came forward. Law was mainly criticized for having complicated and biased procedures, no emphasis on rehabilitation, lack of adequate infrastructure and manpower for implementation, lack of planning for future directions of mental health in India. This act was formed mainly to simplify admission and discharge procedures. Individual patient and family concerns were sidelined in law. Many organisations including Indian psychiatric society demanded to have new law which will give solution to problems faced with previous law. The Government of India ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2007. The Convention required the laws of the country to align with the Convention. After consulting various stakeholders, different organisations and law experts, Mental Healthcare bill was prepared in 2013. With many corrections, it was passed in Rajya Sabha in Aug 2016. On 28th March, it was passed by Lok Sabha and signed by president of India on 7th April 2017.

Key features

Act have 16 chapters and 126 sections. First chapter is dedicated to definitions. As previous act was largely criticized for it ambiguous terms and incomplete

definitions law makers have tried to define many terms in best possible way. In new definition of mental illness substance use disorders has given importance. Mental illness is defined as a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by subnormality of intelligence.[2]

Advance directive is a very progressive concept which allows people to make decisions of their future treatment before they get any mental illness. After discussing with psychiatrist anyone who wishes to have Advance directive can apply to mental health establishment. Except in emergency it is compulsory for mental health professionals to follow advance directives while giving treatment. If a mental health professional/ relative/care-giver does not wish to follow the directive while treating the person, he can make an application to the Mental Health Board to review/alter/cancel the advance directive.[2]

As mentioned earlier this new act is "Patient centric" one whole chapter is dedicated to Rights of mentally ill people. There is a mention of the right to access Mental health care and treatment at affordable cost, good quality which is acceptable to person with mental illness, their family members, and caregivers. The onus will be on appropriate Government to make such provisions for range of services including outpatient and inpatient services, half-way homes, sheltered accommodation, supported accommodation, hospital- and community-based rehabilitation, free cost of medicines, specialized services of child and adolescent, and old age mental health. The appropriate Government will ensure necessary budgetary provisions for effective implementation along with integration of mental health services into general health care at all levels of health. Every person with mental health illness will have right to protection from cruel, inhuman, and degrading treatment.[3] Rights to have information about concerned laws, proposed treatment, confidentiality, refusing visitors, to complain against authority will help to empower patients.

The key feature in this new act is the provision for medical insurance for treatment of mental illness at par with physical illness by all insurers. Mental health insurance has remained a neglected area for long. This new feature will have huge and significant impact for the persons with mental illness, family, and caregivers.[4]

The new act clearly describes the "Duties of appropriate Government." This is a unique feature as the appropriate

Government will have responsibility to plan, design, and implement programs for mental health such activities related to promotion, prevention, reduction of suicide, stigma. The important aspect will also to address the human resource needs which include training of medical officers and other persons.[3]

Decriminalization of suicide is very important feature of act. Previously suicide attempt was considered as crime against self under section 309 of Indian penal code. According to new law person who attempts suicide shall be presumed to be under severe stress will not be punished under the Indian Penal Code. The government shall have a duty to provide care, treatment and rehabilitation to a person, having severe stress and who attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide.[2]

According to new law person with mental illness shall not be subjected to electro-convulsive therapy without the use of muscle relaxants and anaesthesia. Also, electro-convulsive therapy will not be performed for minors. Sterilization will not be performed on such persons. They shall not be chained in any manner or form whatsoever under any circumstances. A person with mental illness shall not be subjected to seclusion or solitary confinement. Physical restraint may only be used, if necessary.[5]

The empowers the government to set-up Central Mental Health Authority at national-level and State Mental Health Authority in every State. Every mental health institute and mental health practitioners including clinical psychologists, mental health nurses and psychiatric social workers will have to be registered with this Authority.[5]

Under the Mental Healthcare act, the punishment for flouting of provisions will attract up to six months in prison or Rs 10,000 fine or both. Repeat offenders can face up to two years in jail or a fine of Rs 50,000 to Rs 5 lakh or both.

Limitations

Though act is progressive and patient centric it has its own limitations. Many mental health professionals have criticized it on various implementation issues.

1. The biggest impediment to the proper and widespread implementation of the provisions provided by the act is the percentage share of the budget allocated to the health sector. With a meagre one to two percent of the Union budget dedicated to the entire health sector, India cannot reasonably hope to make a visible change in eradicating the mental health crisis. This is abysmal, compared to developed countries who dedicate 10 to 12 percent of their budget towards providing healthcare. According to WHO report 2011 India spends 0.06 percent of its health budget on mental healthcare, which is significantly less than what Bangladesh spends (0.44 percent). Most developed nations spend above four percent of their budgets on mental health research, infrastructure, frameworks and talent pool. According to a 2016 study conducted by National Institute of Mental Health and Neurosciences (NIMHANS), a

premier medical institute of India, it is estimated that India has just about 40 mental institutions (out of which only 9 are equipped to provide treatment for children) and fewer than 26,000 beds.[6]. Another WHO report reveals that for every million people in India, there are just three psychiatrists, and even fewer psychologists, 18 times fewer than the commonwealth norm of 5.6 psychiatrists per 100,000 people. The guidelines and rules for implementation, which have not yet been provided, will determine the effectiveness of the bill in the future. It will be up to the Centre to ensure that the provisions of the bill are implemented and that they do not just stay on the paper as a formality.

2. The new act tries to be over inclusive in its approach stretching beyond its legislative limit, and despite noble intentions behind it, it would be a challenge for the stakeholders whether the contents of the act are legislation, program, policy, or even a treatment guideline.[3].

3. This act premises on a hypothesis that the MHC providers and family members are the main violators of the rights of the persons with mental illness, which is unfortunate. On the other hand, the Bill does not take into account family members' significant contribution, caregivers' burden, isolation, frustration, and violence they undergo because of persons with mental illness.[7]

4. National Mental Health Programme (NMHP) (National policy) advocates integration of mental health into general and primary health care. However, the act mandates all the establishments to take license for treating patients; this may come in the way of integrating mental health into general health and, thus, the implementation of the policy. Many private hospitals and nursing homes may refuse to treat patients with mental illness reporting that they do not have license to do so. Hence, the proposed Bill should be in line with the NMHP (Mental health policy). To encourage treatment in general hospitals, they need to keep those establishments out of the purview of licensing.[8]

5. Person with mental illness may revoke, amend, or cancel advance directives many times in a day, and family members will be finding difficult to handle such situations. Only the mental health board has powers to amend or overrule the advance directive. This needs to be done in a very short time to enable the treatment (24-48 h). If patient has written costly treatment or private/corporate hospital (which family cannot afford) in advance directives, then who will bear the cost of treatment. Considering the available human resources (Medical and Judicial), economic constraint, and our collective community efforts in treating patients with mental illness, our Indian population is not ready for such advance directives. Above all these, research studies data do not support the use of advance directives in person with mental illness (Cochrane review). It would be prudent to do more research in this area in our population before to introduce this advance directive.[9]

6. The act also gives power to nominated representative to unlimited access to the records of the persons with mental illness. Mental health professionals have expressed reservations over sharing of information, describing it as "breach of confidentiality," as per the Medical Council Ethics, 2002. However, according to the Bill, information regarding MHC needs to be shared with the nominated representative. This issue impinges on the fundamental rights - "right to privacy." Hence, there is a need to introduce a clause that information shared will be only with family members and will be in verbal form only. Written documents or medical records will be shared only with patients/legal authorities on obtaining a written request.[3]

7. The Bill mandates State Mental Health Authority to grant permission for research. Too many regulations (DCGI, ICMR, and Ethic Committee) can kill or undermine research in persons with mental illness. There is a need to delete this clause "State Authority to grant permission for research" and to replace with "as per the ICMR guidelines." [3]

8. Electroconvulsive therapy (ECT) is a form of treatment recognized for depressive patients with high degree of suicidal ideas/attempt and acutely agitated and disruptive patients. In emergency treatment, ECT is a form of treatment and in children has been banned in the Bill. If this clause is not removed, effective treatment will be lost to the patient whose life can otherwise be saved.[10] Further, ECT is usually given in acutely ill patients. Waiting for the Board's approval for ECT in minors or emergency is withholding the much-needed treatment.

9. Act has given so many rights to mentally ill person during custody but it hasn't given much emphasis on rights while staying in community. With existing low manpower, it is difficult to implement all human right clause with mentally ill in custody.

10. Many psychiatrists are of opinion that medical professionals has given less importance over other stakeholders during establishment of medical boards.

11. Present act borrows heavily from western concepts and mental health Acts of western countries, especially of the UK. There are several Acts, both in England and Scotland, which refer to detention of patients, capacity of patients to decide for or against a particular treatment intervention, and patient rights in general. Indian act appears to combine all of these into one single power-packed document. In doing so, it has become quite 'exotic' (of foreign origin), but perhaps also 'quixotic' (with fantastic but unrealistic plans). [5]

12. Mental healthcare act is being implemented with the presumption that it will be applicable across the country irrespective of geographical, cultural and resource variations. It does relax some of the deadlines for the northeastern states, but this does not seem to be enough. Disparities exist in rural and urban areas, in different states and in different terrains and also need to be addressed.

13. The Mental Health Act, 1987 was not implemented

across the country because of severe shortage of resources. However, a new act has been introduced without addressing the issues which haunted the Mental Health Act, 1987.[11]

Future Directions

1. Dialogue must be initiated with policy-makers of the relevant ministries regarding the process of development of a Code of Practice (a guidance to all who will be using the new Mental Healthcare Act on how they should proceed when undertaking duties under the new Act), akin to the Code of Practice developed for the Mental Health Act, United Kingdom, 2008. [5]

2. Along with increasing number of mental health professionals it is necessary to redistribute existing services and manpower to rural and tribal areas of country.

3. Government must increase budget and give proper guidelines for distribution of budget for implication of act.

4. Before implementing law government should do appropriate planning, training and arrangements to reduce problems of implementation and future disappointment.

Mental healthcare act with many progressive concepts will be important milestones in history mental health legislation in India. We hope all efforts taken by various stakeholders and government will help us to create healthy minds and healthy society.

Nilesh Mohite is a practicing neuropsychiatrist who works in Lgb regional institute of mental health Teazpur Assam as psychiatrist.

Email: nmohite9@gmail.com

References

1. S Nambi. Forensic Psychiatry (Psychiatry and law) Indian Perspective. Jaypee brothers Medical publishers limited.
2. Mental healthcare act 2017.
3. Rao GP, Math SB, Raju MS, Saha G, Jagiwal M, Sagar R, Rao TS. Mental health care bill, 2016: A boon or bane?. Indian journal of psychiatry. 2016 Jul;58(3):244.
4. Pattanayak RD, Sagar R. Health insurance for mental health in India: A welcome step toward parity and universal coverage. J Ment Health Hum Behav. 2016;21:1-3.
5. Gupta N, Basu D. The Mental Healthcare Bill 2016: Exotic in nature, quixotic in scope... but let's take the plunge, shall we?. The National Medical Journal of India. 2016 Nov 1;29(6):317.
6. Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, Misra R. National Mental Health Survey of India, 2015-16: Summary. Bengaluru: National Institute of Mental Health and Neuro Sciences, NIMHANS Publication. 2016(128).
7. Avasthi A. Preserve and strengthen family to promote mental health. Indian J Psychiatry. 2010;52:113-26. [PMC free article] [PubMed]
8. Narayan CL, Shikha D, Narayan M. The Mental Health Care Bill 2013: A step leading to exclusion of psychiatry from the mainstream medicine? Indian J Psychiatry. 2014;56:321-4. [PMC free article] [PubMed]
9. Sarin A, Murthy P, Chatterjee S. Psychiatric advance directives: Potential challenges in India. Indian J Med Ethics. 2012;9:104-7. [PubMed]
10. Kala A. Time to face new realities; Mental Health Care Bill-2013. Indian J Psychiatry. 2013;55:216-9. [PMC free article] [PubMed]
11. Antony JT. A decade with the mental health act, 1987. Indian J Psychiatry. 2000;42:347-55. [PMC free article] [PubMed]

Mental Health Care Act 2017: Comment on appraisal by Nilesh Mohite

KS Jacob

Dr. Mohite has reviewed the salient features of the Mental Health Care Act 2017, its historical context, limitations of past legislations, changes made, etc. He has compiled the standard issues and arguments marshaled by Indian psychiatrists and the Indian Psychiatric Society. However, it is necessary to fill in some troubling details and provide depth to the article by articulating some points as below:

1. There are many complexities and nuances of the issues facing people with mental illness, their families and communities and the roles and responsibilities of civilized societies in caring for them are in the process of change (Jacob, 2016a).
2. The biomedical model of mental illness locates all pathology for mental distress and illness within the body even though it is well recognized that social determinants of health and mental health play a significant role and are recognized as causal for many conditions (WHO-CGF, 2014).
3. To understand the significance and shortcomings of the MHA fully, it is necessary to have a perspective on the changing social trends and its impact on the doctor-patient interaction i.e. changes from a paternalistic mindset of the psychiatrist and the ensuing relationship with the patient, to a contractual partnership (Jacob & Rose, 2015).
4. There is also the problem of the contradictory paradigms of the biomedical approach and that of the legal point of view. Medicine focuses on the "Right to health and treatment" while legal perspectives favor the individual's autonomy, choice and right to refuse treatment. Thus, while the author mentions that the Act is in line with United Nations Convention on the Rights of People with Disability (UNCRPD), it is important to appreciate the UNCRPD's central tenets, how it changes the perspective on mental illness and its shift from a medical model (disease) to a social paradigm (disability) (UNCRPD, 2006).
5. It is important to understand that the UNCRPD argues that people with disability have rights equal to others, viz. rights to legal capacity, liberty, physical and mental integrity and the right to informed consent. While the broad structure of the UNCRPD does not explicitly ban use of force in treatment of the mentally ill, its logic clearly suggests prohibition of compulsion to treatment without consent.

The author highlights many reforms included in the new Act and criticizes it based on the biomedical model

of mental illness. In the interests of more informed psychiatric decision making which is of service to the changing conditions faced by people with mental disorders, it is also important to see opposing points of view (E.g. of mental health activist perspective, antipsychiatry movement, etc. See for instance, Szasz, 1960; Davar, 2012; Jacob 2016b).

In my opinion, psychiatrists in India are most often quick to believe the biological explanations and pharmaceutical solutions from the West for all mental health, distress and illness. However, they are much slower to change their paternalistic culture and accept rights of people with mental illness. They are also unwilling to allow oversight of their clinical practice.

Another major problem is that all mental health legislations discriminate against people with mental illness. Their underlying assumptions increase stigma (Jacob, 2016a).

However, as Dr Mohite suggests, and in even more ways, the new Act will remain a work in progress. However, the extent of its implementation, both in letter and spirit, will determine its success in reducing burden, increasing provision of care and in supporting human rights of people with mental illness. The practice-theory and law-justice gaps demand periodic review. Laws, which fail to deliver justice, need to be reinterpreted and rewritten.

KS Jacob is Professor of Psychiatry, Christian Medical College, Vellore 632002

Email: ksjacob@cmcvellore.ac.in

Notes

Davar BV (2012) Legal Frameworks for and against People with Psychosocial Disabilities. *Economic and Political Weekly*, 47 (52), 29 Dec, 2012.

Jacob KS (2016a) Mental Health Legislation: Contradictory paradigms, uneasy compromise. *Economic and Political Weekly* 2016; LI 50, 22-24.

Jacob KS (2016b) Robert Spitzer and psychiatric classification: technical challenges and ethical dilemmas. *Indian Journal of Medical Ethics*, 1 (2): 95-100.

Rose A, Jacob KS (2015) Teaching bioethics in India. *National Medical Journal of India*, 28, 61-63.

Szasz T. (1960) The myth of mental illness. *American Psychologist*, 15, 113-18.

United Nations (2006) Convention on the Rights of People with Disability People (UNCRPD) <http://www.un.org/disabilities/convention/conventionfull.shtml> (accessed on 24.8.2016)

World Health Organization & Calouste Gulbenkian Foundation (2014) Social determinants of mental health. Geneva, World Health Organization.

The origins of public interest litigations in India and its changing contours

E. Premdas Pinto

Abstract

The Public Interest Litigations (PIL) jurisprudence, initiated in mid-70's in India, has been hailed in the legal literature as a judicial revolution, while different civil society actors including activist lawyers have seen in it an instrumental value for achieving at least an incremental societal change, and to that end, a tool for social justice.

PILs in India took shape in the social churning and movements which called for radical changes for the realization of social justice for the marginalized communities in India. Such churning challenged the status-quo forces across the political class including the judiciary. In the initial years, citizens and some progressive advocates, used this flexibility as a foothold to bring various issues of marginalized communities (such as violence against women, child and bonded labour, violations of civil liberties of under-trials, issues of health care or the issues prioritised by middle class social activists on pollution and environment) before the High Courts and the Supreme Court. Some citizens have also used it to challenge regressive norms and policies of the State or to build public discourses around issues such as death penalty, issues of abortion, health care, gender-stereotypes and discrimination and the like.

Over four decades, this tool of easier access to the courts and higher judiciary has been undermined by the steady decline of social justice overall. Except for the fact of crossing the threshold of admission of the case with relative ease, the PILS continue to be treated on par with other litigations leading to extended bureaucratic court procedures and indefinite outcomes. Such stagnation of PIL jurisprudence as a tool for social change is worsened by resistance of the judiciary who carry an elitist image with their class-caste and gender biased social status.

Introduction

In early 80s, a prisoner lodged in a jail in Bihar as an undertrial, sent a letter to the chief justice of India on the inhuman treatment and conditions in prisons. The letter itself was converted into a writ petition which famously came to be known as 'epistolary jurisdiction' of the courts. This was part of a serious legal reform and a commitment to civil rights that some of the judges espoused then. In contrast, in 2015, a formal writ petition was filed in Bombay High Court by a woman president of slum dwellers in Mumbai who prayed for a stay on a road which was to pass through their slum displacing the entire community. The Bombay High Court (HC), which is otherwise deemed to be a progressive court, not only dismissed the petition, but also imposed a fine of one lakh rupees for filing 'frivolous' petition and wasting precious time of the court.

These two cases symbolize a quiet but steady shift in the approach of courts to PILs over a span of four decades, especially in matters that are central to the life and dignity of the marginalized. This article revisits the Public Interest Litigation (PIL) Jurisprudence in India, its historical driving spirit, characteristics, and the underlying shifts that have been taking place with its implications to the lives of the poor and vulnerable.

Judiciary, politics of courts and PIL

Judiciary or the institution of courts is an organ of the State. An independent judiciary armed with the power of judicial review is considered an essential ingredient of the modern democratic State. Paradoxically, it is an integral part of the same State architecture, where it is supposed to be playing the role of balancing power vis-a-vis the legislature and the executive and is dependent on the other branches of the State for its survival.

The Indian legal system was designed to further the goals and policies of colonial rule. (Cassels 1989). The judicial and legal reforms (or the lack of them) are an important issue which has been untouched hitherto, both by the political class and the judiciary. In post-independent India, at least till early 70s, the judiciary and legal institutions continued to retain their impeccable class and caste character, continued to be elitist, aristocratic and engaged in defending the rights of the upper and propertied classes.¹ Politically they aligned with their political masters and continued to be the guardians of status quo, both within and beyond the precincts of legal institutions, through the legal and social power vested in their profession. As an institution, it unquestioningly continued the Anglo-Saxon juridico-legal traditions in the manner of its functioning, bureaucratic architecture and procedural rules, thus systemically keeping these institutions beyond the reach of the vulnerable populations. In such alignments, the leaning of the judiciary with the 'classes' as against the 'masses' was very apparent. (Kothari, 2002)

In this context, in post-independent India, the PILs which originated in 70s, have been hailed as a major breakthrough in the Indian Jurisprudence, and have been attributed primarily to 'judicial activism'. Jain (2003:2) The criticism, on the other hand, has referred to PILs as judicial adventurism and over reach. (Cassels, 1989) Literature on PILs has largely originated from the legal fraternity and judges who described them as judicial innovations and as judicial revolutions for social justice. In the United States of America PIL was energized by the drive for 'civic participation in governmental decision making' and represented 'interests without groups' such as consumerism and environmentalism. Hence, the terms 'public interest' came to be attached to this process.

However, such a process in India is said to be directed against 'State repression and governmental lawlessness'. (Deva, 2009) They are more aptly described as social action litigations rather than public interest litigations, as they address the oppression and injustices meted out to the most vulnerable. (Baxi, 1988)

Socio-political contexts and the driving spirit

The origins and evolution of PILs in India have been attributed to a range of factors: at one end, they were attributed to a judiciary on a mission to salvage its image as one ridden with excessively legalistic and bureaucratic procedures that stifled access and justice to citizens from lower classes; at the other end, they were attributed to the militant social movements prompted by the ideals of social justice that challenged the political class including the judiciary. In this broad spectrum, two key elements, distinct but inter-related, can be identified. A drive for legal reforms (including image makeover of the judiciary) largely engineered by the sensitive judiciary, and in response to the socio-political movements in 70's. The State, including the judiciary, had very little option but to respond to such social churning.

The legal aid movement that began from within the judiciary as a response to the social ferment of 70's provides the immediate context of access to justice process through the PILs. The three decades since independence left both masses and civil rights thinkers disillusioned. The former revolted and the latter denounced prison atrocities on the poor and the apathy of the judiciary to such human rights violations. The State responded to the revolt and dissent of the subaltern communities through police and judiciary, with illegal custody, detentions, encounters and torture. While bail is the rule and jail an exception in criminal jurisprudence, lakhs of undertrials suffered in the jails without having access to judicial hearing.

Access to justice was enhanced through legal aid committees and courts' initiatives to make legal aid a fundamental right (FR). At first, the preamble of the Constitution which embeds socio-political and economic justice and the spirit of socialism articulated as socio-economic equality provided a legitimizing lever. In 1976, Article 39A was inserted in the Constitution which stated, 'the State shall... provide free legal aid, by suitable legislation or schemes or in any other way to ensure that opportunities for securing justice are not denied to any citizen by reason of economic and other disabilities'.

During emergency too the judiciary, seen as being appointed under the political patronage, were accused of aligning themselves with the ruling dispensation and thus for being classist and insensitive. (Gadbois 2011). A finer reading of the literature indicates that there was a desire by the higher judiciary to make good the lost image. There were also a handful of Supreme Court (SC) judges (such as Justice P. N. Bhagwati and V. R. K. Iyer) espousing themselves to the socialist ideals of the Constitution. Both these provided the impetus for the proactiveness of judiciary to address

issues of gross human rights of violations of the deprived sections. Cases of those tortured in police custody and undertrials detainees in prisons provided immediate context for such intervention.

Characteristics of PILs

From the perspectives of litigation and jurisprudence, four key features characterise PILs. (Cassels 1989)

a) Liberalization of the rules of standing²: The word 'public interest' refers to doing away with the rules of standing when the matters refer to large number of people, and not necessarily the one aggrieved individual. The pioneers of PILs who espoused the cause of access to justice emphasised doing away with these rules. In one of the earliest judgments Justice P. N. Bhagwati ruled: Where a legal wrong or a legal injury is caused to a person or to a determinate class of persons ... and such a person or determinate class of persons is by reason of poverty, helplessness or disability or socially or economically disadvantaged position, unable to approach the court for relief, any member of the public can maintain an application for appropriate direction'.³

b) Procedural flexibility: Indian courts inherited from Anglo-Saxon jurisprudence, excessive legalism and bureaucratic procedures. The courts were battlegrounds for private conflicts and private interests, and only those who suffered legal injury could bring a plaint through lawyers. Criminal offences are being defined as the offence against the State, and hence the State machinery which includes investigation, prosecution and adjudication took responsibility for the criminal cases. However, the defining of crimes and the rules of adjudication itself, were largely not in favour of the poor. The rules of judicial manoeuvring favoured the elite; even admission of a petition in the court was a lengthy process. Among the many procedural reforms seen in PIL jurisprudence, the judiciary, instead of responding to formal complaints, also took suo-moto cognizance of the violations reported in newspapers and converted them into petitions.

c) A creative adjudication and the elaboration of rights: Although the Constitution of India inherited the substance of a human rights framework, its structure handicapped any attempt to bring issues of the poor to courts. In the Constitution, the liberal-private and individual rights are categorised in Chapter III (Fundamental Rights) and are considered justiciable. The social-economic and cultural rights, placed in Chapter IV (Directive Principles of State Policy) are categorised as non-justiciable, beyond judicial review. In the legal reform process being discussed, the judiciary interpreted Article 21, the fulcrum of all fundamental rights, to bring many socio-economic rights under the ambit of fundamental right to life. This has been hailed as a jurisprudential revolution in India. (See below)

d) Remedial flexibility, ongoing judicial participation and supervision: The doctrine of separation of powers limits the power of the courts

to adjudication, while legislating and administration is delineated to the legislature and the executive. Capitalising on the power vested in the institution and power of its judgments which enjoy the status of case law under the common law tradition, SC developed mechanisms for the administration of justice too. Such measures were in the form of court constituted commissions and administrative supervision for monitoring compliance of its own orders.

The disadvantaged communities and social justice aspirations

In tandem with the legal aid and access to justice, PILs augmented the social justice delivered to deprived communities through two processes: viz., expansive definition of right to life and social rights as part of fundamental rights (referred to as 'personhood' or fundamental rights jurisprudence) and legal articulations or formal guarantees of socio-economic rights within the larger definition of FRs.

a) Expansive definition of the fundamental right to life: As stated above, one of the key gains of PIL is fundamental rights or 'right to life' (personhood) jurisprudence. Article 21 remained as the fulcrum of all the fundamental rights articulated in articles 12-35 in the Constitution of India. However, Article 21 itself was limited by its definition of procedures. Article 21 declares that 'No person shall be deprived of his life or personal liberty except according to procedure established by law'. Article 21 was also subject to change by the State till SC declared that Art 21 is part of the basic structure of the Constitution which cannot be altered. Significantly, within the liberal concept of right (to personal liberty), the fundamental rights were construed as negative rights where the State had to restrain from interfering with the individual. However, in a landmark case, SC breathed life into Article 21 by re-defining right to life and personal liberty as 'right to life with dignity'.⁴ This expanded and included many other positive dimensions of human life such as livelihood, food and nutrition, health and health care, clean air and water and the like into the definition of right to life.

b) Social rights as part of the fundamental rights: The social-economic and cultural rights (referred to as Social rights) including right to health, determinants of health, livelihood etc are classified in Chapter IV in the Directive Principles of State Policy. These positive rights which require positive intervention by the State in terms of governance and allocation of resources, however, are classified as non-justiciable. Through the PILs, courts have ventured into converting formal guarantees into positive human rights. These reinterpretations of Article 21, are at the heart of public interest litigation, and have been instrumental in bridging the gap between the negative and positive rights. These expanded nuances of the fundamental rights made procedures and bureaucratic limitations subservient to letter and spirit of Article 21, i.e. right to life.

The major policy gains which have touched the lives of the poor through PILs include the following:⁵

- *Prison justice:* The reliefs to prison inmates, most of whom were undertrials languishing in the jails without bail due to the want of sureties and bond, came in the form of releasing prisoners unconditionally,⁶ addressing custodial brutalities,⁷ releasing prisoners who had become mentally ill,⁸ Other issues that were addressed were right to speedy trial, right to free legal aid, right against solitary confinement and issues of amenities to prisoners including minimum wages.

- *Equality:* Several petitions raised the issue of discrimination in wages, employment, discrimination based on sex. The SCI in varied realms of societal life including recruitment, wages, remuneration, equal pay for equal rank of work, admission to education to educational institutions.

- *Addressing issues of women:* Prominent petitions enforced dowry demand as a crime, made the dying declaration of woman suffering cruelty as the unquestionable evidence, recognized custodial rapes, and awarded compensation in rape cases.

- *Children:* Among the issues of children seriously considered by SCI several petitions challenged bonded labour of children,⁷ children in conflict with law (Juvenile offenders), state of observation homes, child trafficking and child labour.

Notably, environmental rights have been recognized as significant jurisprudence that SC and HCs have established through PILs. The outcomes included shifting factories from the Yamuna river belt, enforcing CNGs to address pollution and weeding out polluting vehicles, addressing some of the health care issues such as mental health care and maternal health.

The decline and eclipse of 'public' and 'social' from the PIL jurisprudence

The strongest resistance to PILs has come from the within the ranks of higher judiciary. Except for a handful of judges, the majority did not share such aspiration even during the heyday of PIL (Gadbois 2011). Post 1980s, landmark judgements in favour of the poor has been rare. Various political and pragmatic perspectives coupled with class bias of the judiciary itself has denuded this tool of social action of its moving spirit of social justice.

It is also perceived that PIL has become a facade to fulfil private interests, settle political scores or gain easy publicity. Judiciary in a democracy should also not use PIL as a device to run the country on a day-to-day basis or enter the legitimate domain of the executive and legislature. The challenge for states, therefore, is to strike a balance in allowing legitimate PIL cases and discouraging frivolous ones. (Deva 2009)

India's judiciary is described to be one of the strongest in the world. Post 70s, along with the image-makeover the courts also have emerged stronger. In matters of middle class aspirations such as environmental issues and pollution the courts seem to be proactive. However, on issues relating to the lives of the marginalized such as displacement, mega projects which are deemed to be under the 'economic policy' of the State, the courts have hardly stood by the poor.

Gadbois (2011:376) documents in the only available biographical sketches of the SCI judges (upto 1990) describes an archetypal judge as:

“[h]e was a son of a lawyer, often born into a family where the practice of law had been a tradition for generations. He was a Hindu and, more likely than not, a Brahmin. He was born in an urban area into a wealthy or upper middle-class family...He may have met the usual criteria of merit - integrity, professional competence, incorruptibility, and neutrality towards litigants - but was not selected for that reason. His religion, seniority, state and region of origin, among other considerations, were more weighty than merit as traditionally defined...”

Given the caste-class background and insulation from the issues of the disadvantaged communities, of late, PILs have tended to privilege the issues of the elite such as pollution and cricket over those that affect the masses. Hostility of many judges towards PILs and the continued antagonistic -adversarial approach of the State, have increasingly frustrated the efforts for speedy and effective justice. Being litigated in the highest courts of the states and the country, the litigants have to depend on the services of lawyers, among whom socially sensitive and pro-bono lawyers are a rarity. Court delays, change of bench, routine adjournments, dependency on lawyers, costs involved in attending the courts etc. are further diminishing the spirit of social justice from these litigations. Above all, scepticism has grown even among activists who once believed in the usefulness of PILs, due to the unpredictable outcome even after pursuing such tedious process or lack of enforcement in case of favourable orders. For example, in several significant PILs, such as Narmada Bachao Andolan vs. Union of India, Bhopal Gas Tragedy, Javed vs. State of Haryana (against two-child norm), Naz Foundation vs. Union of India (questioning the Constitutionality of IPC 377), the SC let slip ample opportunities to deliver social justice. The oustees of mega projects, victims of industrial disaster, rural populations aspiring for political equality and persons of alternative sexual orientations, could perhaps better appreciate the spirit of social justice enshrined in the Constitution. Petitioners fighting issues of health and health care such as All India Drug Action Network (AIDAN) vs. Union of India (for drug pricing) have had to wait for over a decade and half for outcomes.

The change in the procedural rules, propelled by judicial reforms, also meant speedy justice and tangible justice to the disadvantaged. However, with lack of reforms in the courts and the hostile mind-sets of judiciary, the scope of PILs is limited only to admission where the requirement of the locus standi of the petitioner is relaxed; beyond this, it has to go through the grinds of court process, though the rules of admission are relaxed. Lack of legal reforms, judicial reforms and the vacuum of social justice ideals with growing insensitivity to the issues of the poor mean means that apart from an entry level flexibility, the issues of social justice are similarly treated as other

adversarial and matters of contestations. The trends of non-admission, dismissal, penalties on PILs seen as 'frivolous' to judges is on the rise.

Conclusion

Social justice ideals had launched PILs to deliver justice to the poor. As such a spirit has dwindled among the judiciary, the aspirations of social justice cannot be sustained. Reform in legal, court and judicial institutions need to take place keeping with the spirit of social justice. PIL suffers the weight of procedures of the Anglo-saxon jurisprudence which progressive judges like Justice P. N. Bhagwati and Justice (late) V. R. Krishna Iyer strove to eliminate. The courts, police and prisons still carry the colonial legacy in substance and form which require a radical reform before PILs die a natural death, devoid of the spirit of social justice.

E. Premdas Pinto works at Centre for Health and Social Justice, Delhi and is a PhD Scholar at Centre for Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, Delhi.

Email: e.premdas@gmail.com

Notes

1. Such a perception of the judiciary led both Nehru and Indira Gandhi, to place all the land reforms legislations in Schedule IX of the Constitution which is beyond the purview of judicial review. In fact a number of land reforms measures were scuttled by the judiciary through indiscriminate injunction orders on the legislations. (Gadbois 2011)
2. The rules of standing, or locus standi, refer to the ability and necessity of the individual to prove to the court that he or she was in imminent threat of harm due to the action being challenged. Absence of locus standi would result in dismissal.
3. S. P. Gupta v. Union of India (1982) 2 SCR 365, 520
4. Francis Corelie Mullin vs. Delhi Administration (1981) 1 SCC 608
5. For detailed narrative ref. Jain, Public Interest Litigation 2003.
6. Hussainara Khatoon vs. State of Bihar AIR 1979 SC 1360
7. Khatri vs. State of Bihar AIR 1981 sc 928
8. Sant Bir vs. State of Bihar AIR 1982 SC 470
9. Bandhua Mukti Morcha vs. Union of India (Several Cases)

References

- Baxi, U. (1988). Taking Suffering Seriously: Social Action Litigation before the Supreme Court of India. In Law and Poverty: Critical Essays, ed. Upendra Baxi (pp. 387-415). Bombay: N.M. Tripathi Pvt. Ltd.
- Cassels, J. (1989). Judicial Activism and Public Interest Litigation in India: Attempting the Impossible? *The American Journal of Comparative Law*, 37(3 (Summer)), 495-519.
- Deva, S. (2009). Public Interest Litigation in India: A Critical Review. *Civil Justice Quarterly*, (1), 1-23.
- Pinto EP. Decoding the politics of the Supreme Court judgment on sterilisation camps. *The Wire*, New Delhi, September 23, 2016 [Internet] [cited 2016 Oct 10]. Available from: <https://thewire.in/67590/decoding-politics-sterilisation-judgment/>
- Gadbois, G. H. (2011). *Judges of the Supreme Court of India, 1950-1989*. New Delhi: Oxford University Press.
- Jain, S. (2003). *Public interest litigation*. New Delhi: Deep & Deep Publications.
- Kothari, R. (2002). Masses, Classes and the State. In *Social movements and the state*. Ed. Ghanshyam Shah (pp. 68-90). New Delhi: Sage Publications.
- Tigar, M. E., & Levy, M. R. (2005). *Law and the Rise of Capitalism*. Delhi: Aakar Books.

Demonetization and its impact on health - a response

Tarun K George, Amit Tyagi, Krupa George, Anand Zachariah

Introduction

On November 8th, 2016 when the Government of India demonetized the Rs 500 and 1000 notes, did they envision the possible impact of such a policy(1)? Did they foresee the "health" implications?

We tend to graciously accept a national policy or a government decision to be for the welfare of the people. But is this really so? How do we sift through the information to decide for ourselves? How do we as citizens respond to such a scenario? This spurred us to look deeper into the issues around demonetization. We set off reviewing the background, gathering data from hospitals and practitioners from rural and urban India, we also studied trends in our own hospital, Christian Medical College, Vellore (CMC) and reviewed information in the media on demonetization's impact on the health of people.

Mahatma Gandhi once said, "I will give you a talisman - Recall the face of the poorest and the weakest man (woman) whom you may have seen, and ask yourself if the step you contemplate is going to be of any use to him (her)." Was this a talisman used? Should it have been used?

The Background

The primary motive of demonetization, as was stated, was to target black money and tackle the problem of counterfeit notes. On that November, India was a country with about 1.32 billion people with around 70% being rural(2). The proportion of employment in the unorganized sector was 80%(3). About 95% of all transactions were in cash and the per capita income was Rs. 8500 per month(4). Regarding the health scenario, the out of pocket input into health expenditure was more than 80% and almost 8 out of 10 doctors were in the private practice (5,6) . Less than 20% of people (predominantly urban) had health insurance coverage(7) . So, when 86% of the available currency was deemed invalid, what health effects did we see?

Health impact

The evident stress that people went through has been widely covered in the news and social media. People panicked that their hard-earned money was deemed useless. Livelihoods were lost due to informal industries running out of payment options. The stories of hardships that many endured while standing in queues and the woes of even the bank employees were abundant. India's 263 million farmers who also live mostly in the cash economy were unable to buy seeds and fertilizers for their winter crops causing delay in sowing, all of which would also affect their savings and further access to health care.

When seen from the health perspective, the demonetization affected health access in four ways - Primarily at the hospital level, cash became useless - pharmacies, labs and scan centres were practically card based. Secondly even if hospitals were willing to subsidize treatment the dire need to exchange and deposit scarce currency made people leave. Thirdly, patients' access to hospitals was affected - either because they did not have the money to arrange transport or they chose not to due to the pressing economic struggle that occupied the rest of the family to make monetary arrangements. And finally, the decision to demonetization caused grievous mental and physical stress to the population at large - There were increased reports of heart attacks, depression, and exhaustion and so on.

In a country where 72% of population in rural areas and 79% in urban areas depend on private healthcare, during this period, only government hospitals could accept old notes. It was assumed that allowing private hospitals to accept old currency notes could be a passage for laundering. But couldn't this have been audited? Even if we assume that private hospitals would create a space for laundering, emergency access and a cap on depositing old notes could have been planned to avoid miseries to common people. Thus, patients who were admitted for surgeries were requested to pay only via bank transfer. Advances collected were returned and surgeries were cancelled. Many who travelled long distances with money from selling property were stranded with almost useless notes and their relatives were left struggling to get money exchanged. Opportunists exchanged these notes often with a commission that was around 30% of the value. Many who travelled from other nations like Bangladesh were not even able to exchange money or only able to exchange enough money to go back. Even if hospitals could subsidize treatment many patients and relatives did not have money to buy food and pay for the lodging and hence were discharged prematurely at request. In many hospitals, even emergency cases were not tended to due to unavailability of cash and digital payments. Most hospitals reported a drop in outpatient, inpatient and emergency attendance by 20 to 30%. Many patients mentioned that they chose not to get treated for their chronic illnesses during this period to save on cash. Regarding psychiatric illnesses, there were varying trends from increased reports of adjustment disorders, depression, flare of illnesses due to inability to buy medicines and in some cases a lack of any adverse trends. For hospitals in remote areas card-swiping machines were delayed in delivery by months and often the internet connectivity was so poor that it did

not work. Many hospitals offered counter-measures such as providing credit based treatment and free food for relatives. Some private doctors even practiced on barter payment. During this time, it was noted that there was an increase in access to the government hospitals. The media did a good job of covering the many stories of hardships endured and deaths attributed to the demonetization. The number of deaths quoted in a parliament statement was around 100(8). But from a pragmatic point of when one examines the processes where access to care was affected and realizes that there was a drop in 30% in most hospitals, we can anticipate that the collateral death count is bound to be much higher. In the review of information from media and other sources, what was glaringly missing was robust data of health trends during this time. Data was scarce and the true impact needs to be studied systematically. There was inadequate government or industry data to compare numbers from previous years, show changes in patient flow or income variations.

As we approached the deadline

It is very difficult to find Gandhi's talisman in stories of demonetization. In the reports of demonetization, the common people's sufferings, miseries, and their helplessness were in footnotes. However, on 23rd March, a new talisman was used by the finance minister while presenting the finance bill which removed cap on corporate donations (the limit of 7.5% of net profit of the last three financial years), and it also removed clause of disclosure of beneficiaries' name (9). It seems that not only old notes but Gandhi's Talisman also became invalid after demonetization. It was said that the demonetization was started as a queue to end all queues, but the "last queue" was observed outside Reserve bank of India in the last week of march when the limit of exchanging old notes was to be over (31st March, only for NRIs). Other than NRIs, "Last queue" was also filled with tearful common people who were ill or underwent surgical operation in previous months and they could not get chance to exchange their old notes, had a death in the family and the cash was later found stashed in an attic or somewhere else in clothes and boxes. Among those, one eighty-year-old man also came with old notes of 13000 rupees which he forgot after keeping in box due to dementia and found it some days later, he came by bus from Rajasthan paying forty-five rupees, stayed there for 3 days sleeping at railway station with hope of exchanging notes but his incessant flowing tears from emaciated hopeful eyes could not convince the officials and system, and these same stories of demonetization were also buried with old notes on 31st march.

So, what came out of this exercise? 97% of all the demonetized money was returned. About 14 lakh crore cash was demonetized to target undeclared wealth. To note, that of all undeclared wealth, only around 5% is saved as cash. The second objective was to target the

Rs 400 crore of counterfeit money. Would one demonetize 14 lakh crores to target a 400 crore sum? The successive goals that the government proposed were to digitize the economy, increase the proportion of the population paying tax and bring about a behavioural change in people. According to a MasterCard analysis in 2013, on a scale of readiness scores for going cashless (0-100), India is merely 29 points and is at an inception stage (10). After the initial enforced digital payments, we have already seen a reversal of trends with resurgent usage of cash payments. At this time it has now reverted to pre-demonetization trends. As for these other objectives, could there have been better ways to bring about them, rather than this exercise of demonetization?

Questions that remain

So, was the cost borne worth it? Is it too early to tell? In any case, it's health impacts were significant. It was like a natural calamity, but different. If a similar adversity like an earthquake had struck there would have been help that reached out but that was not the case here.

Why? Was it because People saw it only as an economic policy? Was there was a dissociation between their suffering and the decision? Did the health system react with preconditions? Were they looking out for their self-interest?

What can we as citizens do about a government's economic policy that impacts us all? What can we as a health system do about something like this? How do we respond? How can a decision for a greater good cause so much harm? If a state of chaos that was averse to health prevailed, how could those of us in power mitigate its effect? As the majority health-care provider what was the response of the private sector? When lives were at stake were we cutting losses or cutting off lives? Should we have a policy to be pro-people when such similar calamities arise in the future even if it is at expense of a transient economic loss?

We don't offer directives or solutions but hope to stimulate a thought. We offer encouragement to look around, study the problem, make them known and address it. Next time it may not be demonetization but something else that begs for a response. How will you respond?

The authors teach at Christian Medical College, Vellore

Email: tarunkg@gmail.com

References

1. Withdrawal of Legal Tender Status for Rs.500 and Rs 1000 Notes: RBI Notice- Reserve Bank of India - Press Releases [Internet]. [cited 2017 Jun 4]. Available from: https://rbi.org.in/scripts/bs_pressreleasedisplay.aspx?prid=38520
2. 70% Indians live in rural areas: Census | Business Standard News [Internet]. [cited 2017 Jun 4]. Available from: http://www.business-standard.com/article/economy-policy/70-indians-live-in-rural-areas-census-111071500171_1.html

(contd next page)

Reproductive "rights" in politics, programs, and implementation: Probing abortion ethics through the NRHM in Kadapa, Andhra Pradesh

Neha Reddy

Abstract

India's National Rural Health Mission was implemented in 2005 as a means to provide comprehensive health care to rural populations. One of the key elements of the program is the promotion of reproductive and maternal health care services. This study investigates the integration of rights-based frameworks and feminist values within the language and activities of the program, seeking to understand how reproductive "rights" get translated when they enter into the sphere of governmental health policy. By focusing primarily on the experiences of healthcare providers such as Accredited Social Health Activists (ASHAs) in Kadapa district, Andhra Pradesh, this study investigates abortion rights and family planning in the context of India's population control efforts and amidst community norms that dictate perceptions of the family, the state, and sexuality.

Introduction

As a Fulbright-Nehru research scholar, I arrived to India in August 2016 to study the role of healthcare providers under the National Rural Health Mission (NRHM) in combatting sex selection. I wanted to understand how community-level healthcare providers engage in issues beyond the provision of biomedical services, believing that health practitioners are uniquely positioned to identify and intervene in cases of gender-based abortions. I selected Aarti for Girls, an organization based in Kadapa district, Andhra Pradesh that sensitizes community members and professionals to combat discrimination against girls, as my official research affiliate.

Soon after coming to India, I realized I lacked the perspective to adequately understand the public health and women's rights climates that each contribute to a health practitioner's experience. By selecting sex

selection as the main object of my research, I failed to consider the larger contexts surrounding abortion rights and family planning in India. I read scholarship on the history of reproductive control and the disciplining of women's bodies under the guise of national progress in India, and explored the avenues through which a discourse of "rights" entered into government language as a means of justification for intervention. Between regular visits to Anveshi Research Centre for Women's Studies and field visits in Kadapa with Aarti for Girls staff, I developed an informed direction for my research.

My project examines the intersection of feminist politics and the structure of government healthcare by investigating the governmentalization of feminist values and rights-based frameworks under initiatives and language of the NRHM. I explore points of contention between feminist theorists, the state, and the community in relation to notions of reproductive "rights," which shape the contexts through which reproductive health care is delivered.

Background

Transformations in the Indian reproductive rights' movement

Activism around reproductive rights in India dates back to the 1970s, with the rise of women's organizations that sought to fight population control policies of the state. During The Emergency, the government imposed family planning measures on men of the poorer classes through forced vasectomy procedures. This imposition soon shifted away from men to focus on women through the institutionalized promotion of tubectomies by healthcare providers as an integral component of women's reproductive health care needs.[1] Women's bodies represented the ideal citizen that could meet nationalist aspirations of population control and regulation.

(contd next page)

(contd from previous page)

3. India Labour Market Update July 2016 - wcms_496510.pdf [Internet]. [cited 2017 Jun 4]. Available from: http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-new_delhi/documents/publication/wcms_496510.pdf
4. India GDP per capita | 1960-2017 | Data | Chart | Calendar | Forecast [Internet]. [cited 2017 Jun 4]. Available from: <https://tradingeconomics.com/india/gdp-per-capita>
5. Deo MG. "Doctor population ratio for India - The reality". *Indian J Med Res.* 2013 Apr;137(4):632-5.
6. Out-of-pocket health expenditure (% of private expenditure on health) | Data [Internet]. [cited 2017 Jun 4]. Available from: <http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS>
7. Less than 20% of population under health insurance cover: Report - Times of India [Internet]. [cited 2017 Jun 4]. Available from: timesofindia.indiatimes.com/india/Less-than-20-of-population-under-health-insurance-cover-Report/articleshow/49082784.cms
8. Demonetization: Government not mourning over 100 deaths due to cash-crunch, says Opposition | Latest News & Updates at Daily News & Analysis [Internet]. dna. 2016 [cited 2017 Jun 4]. Available from: <http://www.dnaindia.com/india/report-demonetization-government-not-mourning-over-100-deaths-due-to-cash-crunch-says-opposition-2280902>
9. Political funding: Finance Bill removes cap on corporate donations [Internet]. [cited 2017 Jun 4]. Available from: <http://www.indiatvnews.com/politics/national-political-funding-finance-bill-2017-removes-cap-on-corporate-donations-373791>
10. MasterCard_Advisors_Cashless_Journey_IND.pdf [Internet]. [cited 2017 Jun 4]. Available from: http://www.mastercardadvisors.com/cashlessjourney/content/MasterCard_Advisors_Cashless_Journey_IND.pdf

In the 1980s, autonomous women's organizations came out in force to fight coercive family planning policies and incentivization schemes of the state. The government promoted hazardous forms of contraceptives for women, including injectables, implants, and anti-fertility vaccines that had not undergone ethical trials.[2] The decade characterized a period during which feminist critique shifted towards challenging the patriarchal state.[3]

Following the 1994 International Conference on Population and Development (ICPD), which shifted the global focus in developing countries away from population control towards comprehensive reproductive health care for women, both governmental and nongovernmental activity on gender proliferated.³ In the process, many autonomous women's initiatives of the 1970s and 1980s were coopted into civil society organizations that partnered with the state on projects of development.[4] As exemplified by the Reproductive and Child Health (RCH) I Programme (1997), ideas of "rights" became increasingly government-mentalized, or to put it in other words, became part of an administrative agenda. By engaging with the state, women's organizations gained legal-institutional power; but in the process, feminist struggles for autonomy and justice were subsumed under state projects of women's development. Population groups like "pregnant women" and "girl child" became state priorities and gendered targets of intervention in a new era of developmental feminism.[5]

These transformations are reflected in the language and programs of India's National Rural Health Mission.

Priorities of the National Rural Health Mission

Launched in 2005, the National Rural Health Mission (NRHM) proclaimed its goal of providing comprehensive healthcare services in rural India. A follow-up to the RCH-I Programme, one of the core initiatives of the NRHM is Reproductive, Maternal, Newborn, Child, and Adolescent Health, or RMNCH+A. The key difference between the NRHM and the RCH-I Programme is the importance placed on developmental markers, with a return to a target-approach. The utilization of schemes like Janani Suraksha Yojana (JSY) and Janani Suraksha Karyakram (JSSK), which provide incentives such as cash assistance for post delivery care and food for pregnant women who undergo childbirth in government facilities, became synonymous with the program as a whole, representing a key metric of

success. One of the main initiatives of the NRHM is the recruitment and training of female Accredited Social Health Activists (ASHAs) to serve as resources for women in their communities, particularly pregnant women. ASHAs are tasked with accompanying pregnant women to primary health centers (PHCs) for monthly antenatal care (ANC) checkups and ensuring that they deliver in facilities, receiving incentives for carrying out these targets.

The mission of the NRHM is stated publicly on its website, as well as in IEC materials and training manuals. Despite its developmental indicators, the website states that the program is "based on a rights framework" to "provide quality health care to the rural population, particularly the vulnerable sections."⁶ The ASHA, as the first point of contact between the community and the formal health care system, is conceptualized as the agent through which people can be mobilized to access their health rights- as illustrated by the following screenshot from the ASHA training manual found on the NRHM website:

An "Activist" is person who actively leads her/his community for a particular cause. Before we discuss your role in detail, you should read the real life examples of activism in **Annexure 4**.

As an ASHA you are expected to play the role of an activist primarily to reduce inequities and improve the access of marginalised and disadvantaged to public health care services. To do this you should work "along" with them and not "for" them, and make them understand their health needs, rights and subsequently avail services. Mobilising the community takes time and is energy consuming. As you mature in your work, with continuous training and support, you will gradually learn to mobilise your community for accessing their health rights. In the meanwhile, try not to lose patience and hope.



ASHAs do not receive a fixed salary, but are instead incentivized for completing certain discrete tasks, such as registering all pregnant women and accompanying pregnant women to the facility for ANC checkups and institutional deliveries.

Nongovernmental actors partake in monitoring of various activities of the NRHM. The Advisory Group on Community Action (AGCA) is comprised of researchers, NGO leaders, and public health specialists that work to strengthen processes of community ownership under the NRHM. This is one primary way that civil society stakeholders engage with the program.

Methodology

I selected Kadapa district, Andhra Pradesh as my district of study. Within the district, I chose 15 mandals (village clusters) and identified two villages within each mandal, prioritizing "low-caste" communities in order to consider the impacts of caste-based discrimination on the provision of healthcare.

Over a four-month period (November 2016- February 2017), I conducted key informant interviews assisted by Aarti for Girls counselors utilizing semi-structured interview guides with the following stakeholders: 20 ASHAs, 6 Auxiliary Nurse Midwives (ANMs), 40 pregnant women, 10 unmarried 18+ year old girls, 14

married men, and 8 village leaders. Additionally, I shadowed healthcare providers, district health officials, and NGO staff at various programs and meetings around the district. I focused on elucidating the following major themes through our conversations:

- 1) The extent of incorporation of rights-based language and programming within reproductive and maternal health programs of the NRHM.
- 2) The ways in which reproductive "rights" are transformed by the state in order to meet developmental agendas, and the resulting points of contention with feminist theorists.
- 3) The role of healthcare providers under the NRHM, particularly ASHAs, in both actualizing developmental goals of the state and promoting reproductive "rights".

Findings

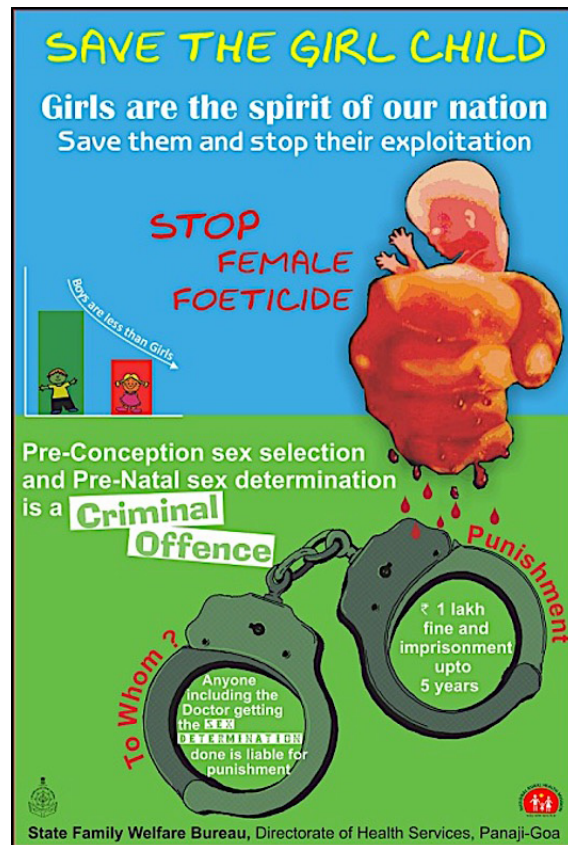
Reproductive health care provision in India must be contextualized within the nation's history of family planning policies, which have ranged from legalizing abortion services to introducing tubectomies as a norm for women. The state of abortion rights in India is an issue that healthcare providers, community members, and the state all engage with.

Abortion in the Indian sociocultural context

On the one hand, abortion has been legal in India since the Medical Termination of Pregnancy (MTP) Act of 1971 was put forth as a solution for population control desires rather than as a means to promote women's reproductive freedom.[1] On the other hand, today, abortion is contextualized within a national imperative of preventing sex selection, under the governmental initiative *Beti Bachao Beti Pado* (2005). The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act (1994) criminalizes healthcare providers that perform and reveal the results of sex determination tests, advertised heavily in IEC materials and healthcare centers.

The MTP Act and PCPNDT Act oppose each other significantly; the former is a piece of gender-neutral legislation that legalizes abortion, while the latter criminalizes MTP in situations when the reason for abortion is a female fetus. This opposition shapes the discourses and practices surrounding abortion in India. Though most women have abortions in order to limit and space children, the staunch emphasis placed on promoting the PCPNDT Act and opposing abortion dominates much of the discussion, so much so that abortion in India has become equated with the "killing" of girls.[7] Even physicians are influenced by the law and fear punishment for performing abortions, subjecting women to scrutiny and refusing to provide otherwise legal services.[7]

The PCPNDT Act uses the term "female foeticide"[8], which has been heavily criticized by feminist theorists for placing blame on a woman who has an abortion and positing it as an act of killing, rather than acknowledging her autonomy and rights. This language is not only mentioned in the legislation, but is present in many promotional materials created by the state and NGO actors to oppose gender-based abortions. The following image exemplifies this:



(Poster prepared by Aarti for Girls; Material prepared by the State Family Welfare

As the material depicts, the governmental emphasis placed on promoting the PCPNDT Act and preventing sex selection manifests itself in strong fetal-rights messaging. The viscerally-charged image depicts a bloody hand crushing a fetus, suggestive of a gruesome act of killing, alongside the "stop foeticide" slogan. Materials like this argue for the sanctity of the fetus as a human life, rather than advocating against the deliberate determination and abortion of girl fetuses. Though this distinction may seem minor, the impacts on the abortion debate as a whole are undeniable. These ideologies directly conflict with abortion activists who advocate for a woman's right to choose.

Through my fieldwork, I gleaned a significant anti-abortion discourse not only in developmental materials, but also in the sentiments of community members I spoke with. The following quotes highlight common beliefs:

How can a woman have an abortion? That is a crime. It is killing a child that God gave.
-Pregnant woman from Badvel mandal.

I will not tell a woman to have an abortion [if she comes to me for advice]. It is not right. A woman should be happy to have kids quickly.
-ANM from Obulavaripalli mandal

If a girl gets pregnant before marriage, she should marry the man. Otherwise, her future is shamed. If she was forced by a man, she should have an abortion to save her future.
-Pregnant woman from Lingala mandal.

The beliefs expressed above highlight the perception that having an abortion is immoral and should not be encouraged. The value placed on proof of fertility for a new bride and the perception that a married couple should have children as soon as possible make elective abortion in situations when there is no threat to the fetus or pregnant woman seem like an incomprehensible act.⁶ The only accepted scenario, many explained, is when an unmarried girl gets pregnant and is unable to marry the man who impregnated her.

The PCPNDT Act, with its fetal-rights and anti-abortion rhetoric, is more reflective of the attitudes and beliefs of people than the MTP Act. Therefore, it is more commonly promoted. NRHM healthcare providers partake in the state's mission to promote the PCPNDT Act and prevent gender-based abortions. Ensuring that pregnant women do not undergo abortions and providing counseling if they express interest is one of the main reasons that ASHAs track all pregnancies, accompany women for ANC checkups, and ensure that deliveries occur in a facility.

Influences of ASHAs' beliefs on the promotion of reproductive rights

Since ASHAs are conceptualized as "activists" who work alongside community members to access health rights, I wanted to understand the role that ASHAs play in promoting awareness of abortion rights. I quickly gleaned from my fieldwork that there is a significant lack of awareness about the MTP Act in rural communities, other than developmental risks for the fetus as a legal reason for abortion. This contrasts with a widespread understanding of the PCPNDT Act. There exists a clear need for ASHAs to spread awareness of the MTP Act to ensure that women are aware of their legal health rights. In the NRHM training manuals, ASHAs learn about the details of the act and are encouraged to support women in times of unwanted pregnancies:

A Woman Seeks Abortion Because

- She does not want more children and has not used a contraceptive method properly or the method failed.
- A pregnancy can endanger her life.
- She has no partner who will help support child.
- She got pregnant after rape.
- The child will be born with serious birth defects.

When a woman is faced with an unwanted pregnancy, she should be able to get a safe abortion.

Legality: In India, abortions are legal up to 20 weeks and if done by a qualified practitioner. Up to 12 weeks, one doctor can do it. After 12 weeks, two doctors need to sign the consent form. Abortion services are free in all government hospitals. Women over 18 do not need anyone else to sign a consent form.

Safety: In India, only a doctor can perform an abortion, and this should be done under clean conditions, and with proper instruments.

Safe abortion services are often difficult to get because, there are not enough service providers and facilities. Those providers who do provide abortion services may charge a lot of money or not even be legal providers of safe abortion services.

In conversations with 20 ASHAs, I inquired about their efforts to spread awareness of the MTP Act. Surprisingly, a majority expressed an unwillingness to discuss the legality of abortion, despite the training they had received.

I won't tell about the MTP law to people, it is not good to have abortion. It is taking the life of a child. If I tell about MTP then everyone will have sex freely because they can simply abort an unwanted pregnancy.

-ASHA from Yerraguntla mandal

A woman can only undergo an abortion if her husband and in-laws agree. I will not tell about it otherwise. It is not right.

-ASHA from Rayachoti mandal

The quotes illustrate the discomfort that ASHAs feel to talk about the MTP Act. For many ASHAs, promoting abortion goes against their own moral beliefs, reflected in language like "taking the life of a child." Furthermore, women could use abortion as a quick-fix solution for irresponsible pregnancies. The belief that women need the permission of their husbands and in-laws, even though the MTP Act does not require consent, suggests that having an abortion is not viewed as an autonomous decision for women. An ASHA's unwillingness or inability to perform certain aspects of her work does not only pertain to abortion. Another task of ASHAs is to provide family planning counseling and distribute contraceptives, as illustrated by the following screenshots:

Women's Need for Family Planning Differ

Different women and couples have different needs for contraception. When you counsel a woman on family planning, you should keep in mind the following:

- Marital status
- Unmarried: condoms or pills or emergency pills
- Newly married and wanting to delay the first child: condoms or pills
- Just delivered (post-partum) or just had an abortion (post-abortal):
- Wanting to space children: condoms, pills, IUCD, injectables. (Currently not available in the public sector, but being used in the private sector)
- Not wanting more children: Long acting (10 years) IUCD and sterilisation for the man or the woman.

It is important for you to build awareness on delay in the age of marriage, delaying the birth of first child and ensure spacing between children for overall healthy survival of women. The main focus of this chapter is to help you counsel woman to adopt the right method of family planning. You should be able to provide information about where, when and how to access services for sterilisation, Intra Uterine contraceptive Device (IUCD), Condoms and Oral Contraceptive Pills.

ASHAs are trained to encourage couples, both married and unmarried, to use contraceptives in order to delay the birth of their first child and ensure spacing between subsequent children. Through conversations with ASHAs, I learned that the ability to openly discuss family planning strategies requires working outside of the norms of childbearing and patriarchal decision-making, which are challenging dynamics to navigate:

I will not tell a newly married couple about condoms, oral pills, and other forms of family planning because they will become upset and offended. I will try to tell them about spacing between children, but many do not want. Men have the final decision.

-ASHA from Jammalamadugu mandal

The inability of ASHAs to engage with newly married couples or counsel men on topics of contraceptive use is a stark reminder that these women are native to the communities in which they work, and have been raised with the same customs and social capital. ASHAs understand that norms around fertility dictate that conversations about family planning are only acceptable at certain times, because couples must have children as soon as possible. Tubectomies remain the most widespread form of family planning. Alongside the incentivization they receive for promoting this procedure, ASHAs are more comfortable and have more success in encouraging this method of family planning as opposed to temporary ones.

ASHAs face constraints to promote some topics they receive training on, such as safe abortions and family planning. When it comes to these issues, many ASHAs cannot or choose not to work outside of dominant norms surrounding fertility, childbearing, and sexuality.

Discussion

For the purposes of this study, I have been unable to look at caste as a societal structure. Caste operates as a hidden marker of stratification that is often erased in the discourses of governmental agents. However, it inevitably shapes the contexts in which healthcare providers deliver care, along with structuring who does and does not have access to various forms of "rights". Furthermore, heteronormative patriarchy, which serves as a central implicit structure in this study, has a deep and intertwined relationship with caste through ideas of honor, status, and wealth in the family and subsequent views on childbearing and fertility.

The circumstances of reproductive health care provision in rural India today are embedded within national norms about the family, sexuality, and the state. The history of abortion rights in India perfectly exemplifies this intersection. The legalization of abortion occurred not through the efforts of the women's rights community, but as a result of conceptualizing abortion as a means of population control. Today, the abortion discourse is fueled by national imperatives to combat sex selection. In the

process, notions of women's choice and autonomy are overshadowed by ideas of fetal rights. These norms impact the work of healthcare providers like ASHAs, making them hesitant to spread awareness of the MTP Act and instead focus attention on the PCPNDT Act. Governmental emphasis on combating sex selection, backed and supported by community members who oppose abortion, contributes to the rise of anti-abortion sentiments and hinders a woman's ability to access safe abortion services. Through its messaging to "save the girl child", the state employs a rights-rhetoric that obstructs the reproductive rights movement in significant ways.

The state purports that ASHAs serve as "health activists" to encourage community members to access health rights. However, ASHAs are not government employees, and they do not receive a fixed salary. The "activist" label instead suggests that these women serve as voluntary social workers. The ASHA, who is intended to serve as a link for community members to access health rights, works in a context where she herself has been unable to access both workers' rights and reproductive rights; this is reflective of neoliberal ideologies that promote welfare-based, rights' rhetoric in a period of welfare state withdrawal. ASHAs receive compensation for discrete biomedical targets of the state, but do not receive incentives for promoting contraceptives, accompanying women to have safe abortions, or counseling women about spousal violence-- actions that fall under the "activist" title.

There exist different languages and interpretations of "rights" between women's organizations and political feminists, developmental state actors, and community members who are at the receiving end of government programs. The unwillingness of ASHAs to discuss contraceptives with newly married couples exemplifies this reality. I have always believed that awareness about family planning options is one of the most basic reproductive rights for women. Choosing when to have children is foundational to a woman's autonomy and claim to her own body. What I initially failed to consider, however, is the oppressive history of birth control in colonial and postcolonial India, targeting "low caste" and working class Indians, and the effect this has had on people's understanding of family planning.[9] When considering the contexts of birth control provision across Kadapa district, it is limiting to assume that access to contraceptives is always a feminist issue, and that ASHAs are not doing their job to spread rights; rather, one must acknowledge the sociopolitical norms that dictate behaviors at the village level, along with the historically oppressive uses of birth control that remain salient for many people.

I am left wondering about the intersection of feminist politics and the structures of governmental healthcare, and the inherent contradictions between the values

promoted in activist spheres and the realities faced in the field regarding accessing reproductive "rights". These contradictions arise at the crossroads of the state, the activist, and the community. The postcolonial nation state depicts the ASHA as a change agent to enact developmental goals that seek to modernize the lives of citizens. However, ASHAs operate in modalities of directional change that do not fully reflect this rhetoric. Does this indicate the state does not have a long-term, genuine commitment to health rights, particularly when considering what ASHAs are compensated for? Or do ASHAs, as women embedded within the sociopolitical currents of their communities, autonomously choose not to perform work that contradicts with their own beliefs?

Furthermore, as a feminist, how can I recognize and interpret the inherent incongruences between political feminist aspirations and the sociopolitical realities that affect people's understandings of "rights" at the community level? What place can feminist politics have in advocating for the reproductive rights of women amidst local realities that seem considerably tangential to feminist aspirations in many ways? And are there constructive ways for feminist theorists and state actors to work together on issues of women's health promotion, without cooptation or translation in the process?

Neha Reddy is a 2016-2017 US Fulbright Research Scholar in public health.

Email: nehareddy2016@u.northwestern.edu

References

1. Menon, Nivedita. 1995 'The Impossibility of Justice': Female Foeticide and Feminist Discourse on Abortion. *Contributions to Indian Sociology* 29(1-2): 369-392.
2. Agarwal, Gyan P., Sunil K. Choudhary, and Reenu Gupta. 2013 *Human Rights in Changing Times*. Newcastle upon Tyne, UK: Cambridge Scholars Publishing.
3. Ashford, Lori S. 2004 *What Was Cairo? The Promise and Reality of ICPD*. Washington DC: Population Reference Bureau.
4. Roy, Srila. 2015 *The Indian Women's Movement: Within and Beyond NGOization*. *Journal of South Asian Development* 10(1): 96-117.
5. Mukhopadhyay, Maitrayee. 2016 *Feminist Subversion and Complicity: Governmentalities and Gender Knowledge in South Asia*. New Delhi, India: Zubaan.
6. Ministry of Health and Family Welfare. 1994 *Framework for Implementation: National Health Mission*. New Delhi: Government of India.
7. Visaria, Leela, Shireen Jejeebhoy, and Tom Merrick. 1999 *From Family Planning to Reproductive Health: Challenges Facing India*. *International Family Planning Perspectives* 25: S44-S49.
8. Ministry of Health and Family Welfare. 2005 *The Pre-Conception and Pre-Natal Diagnostic Techniques Act*. New Delhi: Government of India.
9. Ahluwalia, Sanjam. 2008 *Reproductive Restraints: Birth Control in India, 1877-1947*. Urbana-Champaign, Illinois: University of Illinois Press.

Acknowledgments

My research would not have been possible without immense support. Very briefly, my gratitude to Dr. R. Srivatsan, Ms. Gogu Shyamala, Dr. Mithun Som, and Dr. A Suneetha at the Anveshi Research Centre for Women's Studies. Further, to Ms. Sandhya Puchalapalli and all of the staff at Aarti for Girls- especially Mr. Prabhu Charan, the project managers, and the counselors based across Kadapa. I am also grateful to Dr. Lakshmi Lingam, Dr. Prakasamma, Ms. Jashodhara Dasgupta and Dr. Shilpa Shroff. I thank the Fulbright program and the staff at the United States-India Educational Foundation for giving me this incredible opportunity to conduct research.

The Price of Air

Adithya Pradyumna

A few specks of dust from your car exhaust
Find their way into my lungs.
Such small specks!
How can I imagine I should worry?
It traveled easily through my nose and throat.
While some specks wandered with my blood,
Some just settled in my lungs,
Joining the ever-growing colony of specks there.
That army has beaten the former residents, my bodily cells.

The army is overwhelming; it keeps growing out of thin air.

But you go on, Sir, as you have important work to do.
Money does not grow on trees, does it?

You did get rid of the trees too, in any case.

Don't forget to thank me!

My lungs cleaned your smoke.

If a few more specks do get in, as they will,

Will I still have enough air in my lungs to complain?

We are already paying the price

For aspirations muddled by blinding light.

For something we thought was free.

Do we know the price of a life, or of several thousand?

Acknowledgements to Dr. Lahari S for her inputs.

Reviewing Goal 3: Ensure healthy lives and promote well-being for all at all ages

*A Civil Society Shadow Report by National Alliance for Maternal Health and Human Rights (NAMHHR),
Coalition for Maternal-Neonatal Health and Safe Abortion (CommonHealth)
and Jan Swasthya Abhiyan (JSA)*

The SDG Goal 3 on health and well-being, builds on the Millennium Development Goals (MDGs) in various ways. Four of the MDGs - MDG 1 (Eradicate Extreme Hunger and Poverty), MDG 4 (Reduce Child Mortality), MDG 5 (Reduce Maternal Mortality) and MDG 6 (Combat HIV/AIDS, Malaria and other diseases) directly addressed health concerns. However, the MDGs were rightly criticised for being too narrow and limiting. In contrast, the SDGs include only one goal on health (Goal 3), but its framing is far more holistic, covering a range of critical issues, including those from the MDGs as well as problems such as non-communicable diseases, road traffic accidents, substance abuse, pollution and more fundamental issues of universal health coverage, health system financing and strengthening the health workforce.

The Government of India (GoI), which adopted the SDGs has committed to align its policies with the sustainable development goals and targets. NITI Aayog, the GOI's policy think-tank headed by the Prime Minister, has been assigned to coordinate this alignment and monitor progress towards the SDGs. Towards this goal, in March 2017, the Ministry of Statistics Planning and Implementation (MOSPI), evolved national indicators for the SDGs, in accordance with the global indicators. The National Health Policy 2017 also explicitly states its purpose of alignment with the SDGs, and addresses several of the Goal 3 targets including communicable and non-communicable diseases, health workforce and universal health coverage. Since the commencement of the SDGs, the government has also passed legislation specifically around Mental Health (Mental Health Care Act, 2017), Disabilities (Rights of Persons with Disabilities Act 2017), HIV /AIDS (Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome Prevention and Control Bill, 2017) and maternity benefits (Maternity Benefits Amendment Act 2017). Despite the passage of these legislations and policies, however, concerns related to implementation and health system strengthening persist. Further, although there is a clear commitment to align policy priorities with achieving the SDGs, the indicators to monitor progress are inadequate.

This is an excerpt of a chapter which provides an overview of the current status vis-a-vis Goal 3, flagging key concerns and critiquing the GoI's approach to achieving and monitoring the targets. The excerpt discusses some of the universal concerns, which are likely to impede the fulfilment of Goal 3 especially in light of recent developments in health policy. It is important to acknowledge that several social determinants especially poverty, hunger, gender equality, livelihoods have a strong bearing on the targets under Goal 3. However, these are not explicitly discussed in this chapter, as they have been analysed

in detail in other parts of this report.

Overarching Concerns

Financial commitments

If the SDGs as envisaged are to be achieved, India will have to increase its budgetary allocations towards health. Currently, health financing in India is characterised by over dependence on household out-of-pocket payments (OOPs) and consequent lack of financial protection. It is worth noting that annually 55 million people in India are pushed into poverty

Target 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Indicators:

1. Include indicator on total public spending on health as proportion of GDP.
2. Include indicators on whether persons who used public health facilities received free services.

just to cover health expenses (2011).¹ Global experiences suggest that India's quest for universal health coverage (UHC) cannot be realised unless public spending is expanded significantly, at least to the level of comparable developing countries. For instance, every other BRICS country government spends more than three percent of GDP on health, while India is hovering around 1.15%.² Unfortunately, neither global nor national SDG indicators talk about increasing public spending on health to a certain desirable level. Increase in health spending has been a demand of the health rights movement in the country as well as India's commitment in forums such as the Universal Periodic Review of the Human Rights Council, where it had committed to increase spending to 3 percent of the GDP. The National Health Policy 2017 envisages an increase in spending to 2.5% of the GDP by 2025, which is far too little and too delayed. Meanwhile, instead of showing commitment to increase public investment, the Union government is continuously cutting back the health budget; what has been allocated for 2017-18 is even less than the expenditure for the year 2011-12, when adjusted for inflation³.

Health system strengthening

Robust and well-equipped public health services, are the backbone of a health system, if it is expected to achieve the ambitious targets that the SDGs set out. As of 2015, Rural Health Statistics (2014-15) indicate that there is still a shortfall in the required number of Sub-Centers, Primary Health Centers and Community Health Centers, despite the investments in NRHM over the last decade. Similarly, there is a shortfall of human

resources, particularly specialists in rural areas. The achievement of many of the SDG targets is contingent on the availability and quality of services at primary, secondary and tertiary care levels. For instance, in order to reduce maternal mortality and child health, it is imperative that health facilities be equipped to handle deliveries and neonatal complications. However, this is not the case at present, which is why even an increase in institutional child births has not had the expected impact on maternal mortality. The failure to provide much needed emergency obstetric care has been a significant barrier in this regard. Similarly, the diagnosis and treatment of communicable and non-communicable diseases, and ensuring psychosocial health and well-being, requires well-equipped, comprehensive and appropriate care at all levels of the health system, which is grossly inadequate today. The National Health Policy 2017 does call for strengthening of primary care in the form of developing "health and wellness centers". However, the poor financial outlays for health in the

SDG Target 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

Indicators

There is a need to monitor - 1) the extent to which facilities can provide emergency obstetric care as well as conduct safe and respectful normal deliveries 2) outcomes like maternal morbidities and near misses 3) Number of pregnant women who receive the NFSA mandated amount as maternity benefit. Indicators of safety such as, completeness of antenatal care, technical aspects of care like Active Management of Third Stage of Labour and provision of postpartum care must be included.

last budget seem inconsistent with this ambitious vision. Further, although several indicators in the SDGs address outcomes, there are few that actually reflect health system strengthening. For instance, with respect to maternal mortality (target 3.1), none of the indicators monitors the proportion of facilities that are equipped to provide safe and respectful delivery services.

Access to essential medicines

Target 3C Substantially increase health financing and the recruitment, development, training and retention of the health workforce.

Implications:

1. Need for massive efforts in recruitment of health workers by the public sector and deployment to rural facilities.
2. The creation of mid-level service providers and tasks shifting to cadres such as nurses are proven reforms in human resources proposed for India, but needs necessary political will to effectively implement.
3. Promoting a culture of problem solving and accountability, responsiveness and team functioning.

Indicators:

Examine availability of workforce in a disaggregated way (across states, districts and geographic location) and have a single database which facilitates data gathering on a regular basis.

The National Health Policy 2017 has reinforced the idea of free medicines and diagnostics for all in Public Health facilities, which is in keeping with target 3.8 (Universal Health Coverage) and means of implementation target 3B. This is a good development - as medicines continue to form almost half of total treatment costs and around 70% of household expenditure in India,⁴ and experiences from Tamil Nadu and Rajasthan show that if free generic medicines are dispensed from public facilities, it can effectively contain OOPs on account of medicines. However, this is achievable if central Government funding is available instead of this being left entirely to the states. Another positive development has been price control of essential medicines which is being done through the Drug Price Control Order 2013. However, this covers only 12% of the total domestic market of more than 1 lakh crores.⁵ Cardiac stents have been brought under price control and other medical devices are to be brought under price control. However, a ceiling price on related medical procedures needs to be in place for medical device price control to have any meaning. Meanwhile, the NITI Aayog has advocated restricting price control and delinking it from the list of essential drugs, whereas the need of the hour is to extend the coverage of price control to more essential and life-saving drugs.⁶ The NITI Aayog has also recommended disinvestment of government owned pharma companies, a move that will rob the Government of a vital tool to promote affordable access to medicines.⁷

Reining in the Private Health Sector

India's large and unregulated private sector continues to operate without proper strictures, but policy developments indicate an unwillingness to take effective measures in this regard. Even as the Clinical Establishments Act remains unimplemented, the National Health Policy 2017 talks of "strategic purchasing", which indicates a push towards privatisation. Government sponsored insurance schemes continue to remain popular among policy makers and politicians even though evidence suggests that the impact on financial protection has been minimal if not detrimental. People are being driven to private facilities with the lure of 'free and quality' care and in the process incurring heavy expenses. Only three out of 100 people covered under government sponsored insurance receive free treatment in private hospitals.⁸ Further, irregularities in the private sector which are evident in publicly funded insurance schemes such as the Rasthriya Swasthya Bima Yojana show that, there is an urgent need for regulation.⁹ Attainment of targets such as the elimination of communicable diseases requires the private sector to comply with treatment guidelines and reporting requirements. For instance, in 2012, India started the web-based reporting system -Nikshay for implementing a policy of mandatory TB notification. Yet, despite the progress made, India still needs to track

one million missing cases of TB annually, especially in the private sector. With growing threats of infectious diseases, it is imperative that private providers be reined in so that they comply with reporting requirements.

Private interests in other areas such as vaccines also

Target 3B Support the research and development of vaccines and medicines for the communicable and non-communicable diseases.

Indicators:

1. Availability of free medicines and diagnostics in public health facilities;
2. Elimination of wasteful, irrational FDCs and all useless, harmful medicines;
3. Strengthening of Government Pharma companies and self-reliance in API production;
4. Transparency in clinical trials and vaccine related decisions; Monitoring of safety and efficacy of new vaccines being introduced.

need careful examination. It appears that the government is keen on introducing new vaccines without due diligence and transparency. The GoI has introduced pentavalent vaccines even as there are doubts about their safety,¹⁰ and there is lack of transparency in clinical trial data related to the rotavirus vaccine on the basis of which the vaccine has been introduced in the public health system.¹¹ On a more positive front, the GoI has initiated fresh legislations to regulate the laissez faire clinical trial scenario that was prevalent and that led to deaths of innocent trial participants. However, pharmaceutical companies, especially MNCs, have spread disinformation that such regulation is against an investment friendly atmosphere.¹²

Factoring in Inequities and Vulnerabilities

Learning from the MDGs which looked at aggregate progress of indicators at the national level, the SDGs recognize that gross inequities exist within countries, and have therefore emphasized the principle of "leaving no one behind". In a large, unequal and diverse country such as India, this takes on even greater significance. As MDG indicators have been tracked over 15 years, it is clear that overall improvements in indicators have masked regional and socio-economic disparities.¹³ "Leaving no one behind" implies reaching out to neglected populations using different strategies to address their unique concerns. For example, even with the rise in institutional child births, one in four deliveries in rural areas still occur at home, and these have been systematically neglected. Disrespectful treatment of women, especially those from marginalized communities, during childbirth has been reported from various parts of the country, but is not acknowledged as a problem. Women report facing physical abuse and verbal abuse, particularly use of derogatory, sexually explicit language. This makes them reluctant to use public health facilities, thus,

impacting access. Similarly, migrant workers face unique challenges due to loss of social security linked to place of residence. Accessibility to health facilities is a significant challenge for this group, with studies showing low immunization and continued home births among migrant construction workers even in urban areas. The strategies employed to reach out to these populations must recognize their unique problems and be tailored to their needs. Further, despite overwhelming evidence of disparities in indicators, the GoI has not published recent disaggregated data on these. In fact, three rounds of the Annual Health Survey, which were conducted in high-focus states with the expressed purpose of contributing to meaningful tracking of progress towards MDGs have not published any kind of disaggregated data on these critical variables. The same mistake is being made with the SDGs; none of the indicators, across targets are disaggregated and will render it impossible to track progress of marginalized communities towards the goal.

Reporting, Transparency and Accountability

Tracking progress towards the SDG targets will require a robust and reliable monitoring system, as well as a strong accountability mechanism, both of which are currently lacking. Several of the indicators proposed by MOSPI are premised on the assumption that reliable data will be available, however this is not the case, as demonstrated by the existing discrepancies in data related to incidence of HIV and malaria. These discrepancies are due in part to under-reporting, which makes it difficult to estimate the true burden of populations at risk and are likely to be a significant challenge in determining progress towards the SDG targets. In some cases, it may be useful to consider development of registries (as has been done in the case of Tuberculosis reporting) or in the reporting of road traffic accidents (as has been done through the Road Accident Data Management System (RADMS) in Tamil Nadu) and strengthening surveillance programmes such as the Integrated Disease Surveillance Programme (IDSP).

However, establishing accurate and robust data systems is only a first critical step. Ultimately, it is the manner in which the data is used to determine problems, identify risks, develop strategies, set targets, allocate resources and fix accountability that will matter. A lack of transparency and will to seriously implement such accountability measures, has been a significant barrier in this regard. In case of maternal health, although monitoring and accountability mechanisms exist, they have yet not been fully operationalized. The status of MDR Committees, reports of audits and actions taken to address the gaps leading to maternal deaths are not in the public domain. Thus, despite mechanisms being created, there is lack of will and investment necessary to make them functional.

Target 3.7 Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Indicators:

1. Include safe abortion in indicators. The number of safe abortion facilities available and accessible must be tracked.
2. Monitor and report complications arising out of family planning procedures, and adherence to quality and ethical protocols in facilities.

Conclusions and Recommendations

The Government of India, since the passage of the SDGs has made efforts to align its policies with the new global agenda, through including issues addressed in Goal 3, in its new policies and programmes. However, unless fundamental concerns around the organizing, financing and delivery of health care services are addressed, it is likely that these efforts will be little more than token measures. A fund starved, poorly equipped, non-transparent and unaccountable health system cannot be expected to fulfil the ambitious targets that the SDGs have set. Learning from the experience of the MDGs, it is therefore critical that these long-standing concerns be addressed with urgency. Towards this end, the following recommendations are proposed:

1. Increase public spending on health to at least 5 percent of the GDP. Following changes in the federal fiscal architecture where there is greater budgetary devolution to the states, the Centre must ensure that health and other social sectors are not neglected by States.
2. Provide publicly financed health insurance through an accountable, rational and regulated health care system.
3. Strengthen health facilities at all levels to ensure comprehensive provision of appropriate preventive and curative services, especially emergency preparedness including availability of free transport and streamlined referral systems. Ensure availability of life saving drugs and supplies.
4. Ensure that ethical and medical standards of care are strictly adhered to and implement Quality Assurance mechanisms as laid down in policy
5. Implement the Clinical Establishments Act without further delay. Public Private arrangements including those seen as "strategic purchasing" must not be entered without sufficient regulation of the private sector. Before such arrangements are implemented, sufficient evidence must be built on their impact on promoting improved access and equity.
6. Increase participation of communities and civil society organizations in different stages of policy and programme formulation, implementation and monitoring (for example through inclusion of CSOs in technical and decision-making bodies, capacity

building of community volunteers and social audits of programmes).

7. Make available disaggregated data on all indicators, based on critical variables such as spatial location (urban rural), caste, religious community, class and age, and systematically track progress across vulnerable groups.
8. Strengthen accountability - both vertical and horizontal accountability within the health system, as well as social accountability of the health system to the community, through existing mechanisms such as maternal death reviews and community based monitoring, as well as implement grievance redressal mechanisms. Make these mechanisms transparent and subject to regular audits.

This report has been prepared with contributions from:

1. Sana Contractor (CHSJ/NAMHHR),
2. Renu Khanna (SAHAJ/CommonHealth/JSA)
3. Indranil Mukhopadhyay (JSA)
4. S. Srinivasan (AIDAN/JSA/LOCOST)
5. Smita Bajpai (CHETNA)
6. Radha Holla (JSA)
7. Yogesh Jain and Anjali Mohite (JSS)
8. Bhargavi Davar (Bapu Trust)
9. Siddarth David (TISS)
10. Adithya Pradyumna (SOCHARA)
11. Jagdish Patel (PTRC)
12. Upendra Bhojani (IPH) and Pragati Hebbar (IPH)
13. Joe Varghese (PHFI/JSA)

Email: sana@chsj.org

Notes

1. Source: Author's calculation, based on NSSO CES Unit records (68th round), cited in: Indranil Mukhopadhyay (2016): "Bitter bill of health care"; Pulse, Business Line, July 8 2016; <http://www.thehindubusinessline.com/specials/pulse/the-bitter-bill-of-healthcare/article8824855.ece>
2. 2 National Health System Resource Centre. (2016). National Health Accounts Estimates for India (2013-14). New Delhi: Ministry of Health and Family Welfare, Government of India.
3. Indranil Mukhopadhyay (2017). "In budget 2017, Arun Jaitley gave flailing public health programmes little hope", Scroll, Feb 06, 2017: <https://scroll.in/author/12694>
4. Selvaraj S.; I Mukhopadhyay et al. (2014) "Universal access to medicines: experience from Rajasthan, India" WHO South-East Asia Journal of Public Health, Volume 3, Issue 3-4, July-December 2014
5. Pharmatrac, October 2016, Industry Highlights
6. "If Modi Really Wants Affordable Medicines, Why is his Niti Aayog Pushing in the Opposite Direction?" at <https://thewire.in/131449/niti-aayog-modi-affordable-medicines/>, accessed May 18, 2017. Also see Niti Aayog's 3-year Action Agenda, 2017-18 to 2019-20, p.144.
7. "Niti Aayog recommends 12 PSUs to be put on block" India Infoline News Service, Mumbai, March 23, 2017 http://www.indiainfoline.com/article/news-top-story/niti-aayog-recommends-psus-niti-aayog-recommends-12-psus-to-be-put-on-block-117032300272_1.html

(contd next page)

Healthcare Industry in India: Private capital and corporations in the hospitals sector

Indira Chakravarthi

Abstract

This article is a summary of a study on the healthcare industry in India. The study was intended to be an illustrative one, to focus attention on the transformation in the private healthcare sector in India. It gives a brief overview of the features of the industry, such as ownership patterns of large private/corporate hospitals, their locations, the nature of financial investments, kind of services provided, etc. An important finding is that the healthcare sector in India has become an attractive area for investment by private equity funds, large global investment firms and high-net-worth-individuals.

Background - Transformation of the private healthcare sector

It is well-known that since mid-1980s the Indian government has actively encouraged the private hospital sector in India through direct and indirect concessions and policy measures. The poor performance of the public healthcare sector, which has occurred largely due to inadequate funding, is conveniently used by the private sector and also policy makers to increase private sector participation. What has gone largely unnoticed is the significant shift, since the adoption of neo-liberal policies and health sector reforms in the 1990s: that of the organized promotion of healthcare as a big business opportunity and the rise of the healthcare industry,¹ wherein provision of health services is projected as a viable economic

venture, a revenue / profit generating activity. There has been transformation of the private healthcare sector with penetration of the business ethos and of business enterprises. It is pertinent to recall here the influential 1993 World Bank report: Investing in Health, which advocated that government spending be re-directed away from specialized care, toward a minimal package of cost-effective activities; and encouraging diversity and competition in the provision of health services by fostering greater involvement of nongovernmental and other private organizations, and regulating insurance markets [1]. The Healthcare Sector section of a High Level Group on Services Sector (set up by the erstwhile Planning Commission in 2007) stated that 'with no regulatory impediments on the expansion of healthcare, the expectation is of sizable private investment by private players in the sector in the next few years'[2]. Soon after, the Confederation of Indian Industry (CII) projected healthcare sector as one with immense importance for the national economy, due to its rising contribution to GDP and the potential to be an engine of growth for the nation as it could create 70 to 80 million jobs by 2020 [3].

The CII National Healthcare Division, comprising hospitals, diagnostic centers, and medical equipment companies, is active in carrying out market surveys in hospitals and healthcare sector, and in policy discourse on universal health coverage in India. They also regularly organize the India Health Summit since 2002

(contd next page)

(contd from previous page)

8. Indranil Mukhopadhyay (2016): "Bitter bill of health care"; Pulse, Business Line, July 8 2016;
9. See for instance Nandi S., et al (2012) "The Implementation of RSBY in Chhattisgarh, India: A study of the Durg district." Health Culture and Society, Volume 2, No. 1 (2012) | ISSN 2161-6590 (online) DOI 10.5195/hcs.2012.61.
10. Jacob Puliyel "237 deaths by Pentavalent vaccine and still counting", Sunday Guardian, 13 November, 2016.
11. Bhaumik, S. (2013). Rotavirus vaccine in India faces controversy. CMAJ?: Canadian Medical Association Journal, 185(12), E563-E564. <http://doi.org/10.1503/cmaj.109-4543>. See also: <https://scroll.in/pulse/807243/is-the-indigenous-rotavirus-vaccine-safe-for-children>, accessed June 25, 2017.
12. "New government regulations water down clinical trial safety norms" at <https://scroll.in/pulse/813560/new-government-regulations-water-down-clinical-trial-safety-norms>, accessed June 25, 2017. Also see "India's attractive again for clinical trials: Quintiles CEO" at <http://timesofindia.indiatimes.com/business/india-business/Indias-attractive-again-for-clinical-trials-Quintiles-CEO/articleshow/51716878.cms>, accessed June 25, 2017.
13. For instance, India's Maternal Mortality Ratio has declined from 254 (2004-06) to 167(2011-13) per 100,000 live births and institutional births have increased from 39 percent in 2005-05 to 79 percent in 2015-16. However there are large inequities and variations between states (for example, currently the MMR ranges from 300 in Assam to 61 In Kerala) and across rural-urban categories (for example, only 75 percent of women delivery in health facilities in rural areas as compare to 89 percent in urban areas).Further, social location (class, caste, religion, tribe) plays a role in determining access to services and outcomes. For instance, UNICEF also notes that there are gross disparities in mortality indicators with Scheduled Castes, Scheduled Tribes and minorities having a higher IMR and U5MR.
14. For instance, according to the Global Burden of Disease Study report, India had 196,000 new cases of HIV infection in 2015 whereas the report by NACO states that there were 86,000 new cases of HIV in the same year. A similar observation can be made with respect to Malaria. According to the World Malaria Report, incidence of malaria in India in 2014 was 0.89 per 1000 population at risk per year, however, multiple independent reports suggest that the numbers of cases are highly under reported by the NVBDCP (National Vector Borne Disease Control Programme).

to promote private investment in the healthcare sector and lobby for concessions and favourable policies.² Other industry bodies are similarly active and several business intelligence firms such as Pricewaterhouse Coopers, McKinsey, KPMG, etc put out reports on the Indian healthcare sector. Analysis of National Sample Survey Organisation (NSSO) data on healthcare enterprises in India points to an increasing trend in small, medium and large sized enterprises³ and a declining trend in single/individual run enterprises; large-sized enterprises were increasing at a much faster rate as compared to medium and small sized health enterprises [4:10]. Of the 1048 large hospitals listed in the National Hospital Directory of the Ministry of Health and Family Welfare for 2015, 873 were private corporate hospitals [4:17].

Empirical observations as well as business news and reports indicate that for almost two decades now there has been much activity and "investing" in the healthcare industry from various quarters [5,6,7]. The overall healthcare market in India was estimated to be US\$ 100 billion (2015), and expected to grow to US\$ 280 billion by 2020, an annual growth rate of 22.9 per cent; healthcare delivery, which includes hospitals, nursing homes and diagnostics centres, and pharmaceuticals, constitutes 65 percent of the overall market [8]. There is, thus, a 'robust' healthcare industry now, with a double-digit growth, generating revenues and employment, as noted by the National Health Policy 2017 (NHP), in its opening paragraph [9,10]. This NHP calls for engaging with the private sector through measures such as strategic purchasing of services and for encouraging "the private sector to invest - which implies an adequate return on investment i.e on commercial terms which may entail contracting, strategic purchasing, etc" [9:19].

While businesses (and government) are rather optimistic about such developments, there is little information beyond their ratings, figures, and forecasts of growth and investments in healthcare. There is no systematic, rigorous documentation of the features of this healthcare industry in India, of companies in the hospitals business, their organizational structure and activities, spread etc. There is also no attention, from a public health and health systems perspective, on the consequences of business enterprises for the larger healthcare system, on the services offered, on medical practice, on access, affordability, quality of care, on availability of doctors and other health care personnel, on employment and working conditions in the sector, on doctor-patient relationship, etc. Worries prevail among sections of physicians about the "growing corporate culture", and the difficulties and threats from emergence of large and corporate hospitals to small

hospitals, which were being advised "to try to work as corporate hospitals and improve services and provide quality healthcare" [11]. Concerns have been also expressed about the difficulties of ethical medical practice and autonomy of medical professionals in this scenario [12].

Features of the hospitals sector of the healthcare industry

The following section summarizes the findings of an exploratory study on the hospitals sector of the industry, with specific focus on size, investment, location and ownership patterns, services provided etc. The study was intended to be illustrative rather than comprehensive, the purpose being to draw attention to this critical yet under-researched component of the health system in India.⁴ The information is from industry sources, such as business newspapers, industry intelligence reports, Prowess database of Center for Monitoring Indian Economy, annual reports and web-sites of companies in healthcare-private equity firms-International Finance Corporation (IFC) etc.

Services, Ownership and Governance

Overall, it emerges that there is a significant number of business /for-profit private enterprises in healthcare in India: it is no longer the scenario that there are a handful of corporate hospitals confined to the some metros, or that they are into only providing specialty and super-specialty medical care. There is now for-profit presence in all segments of healthcare: in primary, secondary care also; in "newer" segments such as diagnostics, single-specialty care, short-stay surgery facilities, home-based care providers, hospital management, and IT-enabled services/ online platforms for locating doctors and making appointments, accessing medical records, etc.

There are significant changes in the ownership of healthcare facilities - ownership is no longer confined to medical professionals/doctor entrepreneurs, nor is it local. There is individual entrepreneurship, as well as presence of large private firms, including multinational corporations. Healthcare companies/hospitals are no longer being set up solely by medical professionals; regional groups with diverse businesses (such as HCL or those in real estate, consumer goods, etc) and non-medical entrepreneurs are also in the fray. There is a diverse ownership pattern of the companies setting up hospitals. While there are many Indian companies (owned by Indians, registered in India), there are also those owned by Indians and registered in another country (Fortis), those owned by NRIs and registered in Gulf countries, foreign companies and joint venture between Indian and foreign companies. (between Max and Life Healthcare of South Africa)

There is direct foreign investment and ownership, (eg. Sakra Hospital Bangalore by Japanese companies and Columbia Asia) as well as investment by global private equity funds such as Abraaj of Dubai and IHH Berhad Malaysia. With influx of substantial amount of private equity investments in healthcare, managers of investment firms are becoming part of the ownership, governance and control of healthcare companies and hospitals.

While there are few companies with thousands of beds and a pan-Indian presence, (AHEL, Narayana Hrudayalaya, Manipal) there are several with regional presence, as well as those with presence in a single state. While several multinational healthcare companies have entered the healthcare market in India (such as Columbia Asia, Parkway Pantai, DaVita), at the same time Indian companies too have an overseas presence, such as Apollo and Fortis and diagnostic companies Thyrocare and Metropolis in Bangladesh, Narayana Hrudayalaya in Africa and Cayman Islands, Aster DM in Gulf countries, Manipal in Malaysia, and Medanta in Nepal. Some companies are focusing exclusively on the secondary and primary care segment, such as Columbia Asia, Vaatsalya Healthcare Bengaluru, Glocal Hospitals Kolkata, Be Well Hospitals Chennai, Wellspring Mumbai, etc. There are also a large number of smaller regional companies providing care, such as CARE Hospitals, Rainbow Hospitals, and Global Hospitals in Hyderabad, Sahyadri Hospitals Pune, Vikram Hospitals Mysuru, Sterling Hospitals Gujarat, Rhea Healthcare Bangalore, Ivy Hospitals Chandigarh, Regency Hospitals Kanpur, Medica Synergie Kolkata, Medanta and Deep Chand Dialysis Company Delhi, BSR Hospitals in Chhattisgarh, etc.

Companies often have multiple sources of revenue: such as, owned, operated, leased and managed healthcare facilities, as well as pharmacies. Some hospitals also provide nursing and para-medical training and education, while some also perform clinical trials for pharma companies. For companies with such multiple businesses in healthcare, hospitals contributed the largest share in revenues. Some of these companies are entering into arrangements among themselves for provision of specific services, such as referral from outpatient clinic to a hospital, or for diagnostics, setting up dialysis services in a hospital, etc (private-private partnerships).

Expansion and Diversification into new areas and services

The objective and strategy of bigger companies, such as Apollo-Narayana-Fortis and others, is to not just deliver quality, affordable healthcare services, but also to generate 'a strong financial performance and deliver long-term value for their shareholders through business strategies'. These strategies basically are to grow and strengthen presence in different parts, to enhance economies of scale, cost efficiencies, and

ultimately expand their revenue and profitability, to increase share of available hospital beds. Most companies are seen to be increasing their activities across the country, including previously uncovered regions in eastern (Narayana Hrudayalaya) and central (Apollo Health Enterprises Limited with BSR of Chhattisgarh) India. Health care companies are now focusing on low-cost models and Tier II, III cities due to the high competition and high land costs in Tier I cities, such as the Apollo Reach Hospitals. Low-cost models including single specialty centres requiring a smaller area and hence lower investment, asset light models such as hospitals based in rented premises with equipment on lease, hub and spoke models, where the smaller hospitals (spokes) refer patients to a large hospital (with multi-speciality facilities), and day care/ambulatory centres are emerging as new investment mode.

Stand-alone hospitals set up by doctor-entrepreneurs in smaller cities are gradually being acquired, either by PE funds or by bigger companies as part of brownfield expansion and consolidation strategies: AHEL increased its presence in the secondary care segment by acquiring the 11 Nova surgical centers of Nova Medical Centers, entering cities like Jaipur and Kanpur; Manipal Health Enterprises Ltd acquired SK Soni Hospital in Jaipur in early 2014; Max acquired 340-bedded Pushpanjali Crosslay Hospital, Ghaziabad, etc.

Private Equity

While some of these companies have gone public (AHEL, Narayana, Healthcare Global Enterprises Ltd, Thyrocare), nearly all have private equity investments to a small or large extent. Healthcare has become an attractive sector for investment by venture capital and private equity funds⁵ with investments coming from domestic and global investment firms and high-net-worth-individuals (HNIs). Healthcare is considered to be recession proof and a blue-eyed sector for investors, partly because of the large profits that had been made by some PE firm exits. Abraaj Group Dubai has invested in Rainbow Hospitals Andhra Pradesh (with CDC UK), Apollo Bhilai Scan and Research Group, Quality CARE Hospitals Hyderabad; Temasek, sovereign wealth fund of the Singapore government has invested in Healthcare Global Enterprises Ltd (HCG) Bengaluru, Global Health Private Ltd (Medanta Medicity Gurugram Haryana), Nationwide Primary Healthcare Services Bengaluru; IHH Healthcare Bhd Malaysia/Singapore - sovereign wealth fund of Malaysia government has invested in Global Hospitals and Continental Hospital, Hyderabad, Vikram Hospitals Bengaluru; etc. Investments in hospitals have been made also by domestic firms such as I-Ven Medicare of ICICI, IVFA, and former CEOs of Infosys.

A notable development is the support by international development institutions, through loans and equity investments, for the growth of private sector

companies in healthcare, in the name of creating employment opportunities and promoting growth. International Finance Corporation of the World Bank group (IFC), the largest multilateral investor in private health in emerging markets, has invested in a large number of companies such as AHIL, Max, Fortis, Global Hyderabad, HCG, NephroPlus and Portea Medical Bengaluru, EYE-Q Haryana, Ivy Hospitals Punjab and Regency Hospitals Kanpur. Commonwealth Development Corporation of UK (CDC) has also invested in Narayana Hrudayalaya and Rainbow Hospitals.

Competition

With increasing number of companies, there is increasing competition. Older trust hospitals are turning to management companies to retain their place, (eg. Nanavati Mumbai) or looking to sell off. Organised marketing as well as creation of brand value is looked upon as a necessity. Advertising and marketing expenses form a significant portion of the expenses of corporate hospitals.

Closing Remarks

The healthcare system in India, specifically the private sector, has moved into a distinct new phase and is getting rapidly transformed from an 'unorganised' to organised sector, a process being facilitated by powerful institutions such as IFC and the government. Provision of medical care has become a highly sought after sector for capital investment and accumulation, with a growing network of companies supplying medical care for profit. Public health-health system-health economics and policy researchers need to document these changes taking place in India and study their consequences for medical care. Experience of the pharmaceutical and vaccines industry provides ample evidence of the influence that can be brought by businesses and corporations that have the resources to raise finance, hire marketing expertise to create, package and sell new demands, to influence medical practice, the nature and pricing of services offered, and the kind of technologies used. Extensive research from the US points to the adverse and pernicious effects of corporate investment, of private capital, as well as of having a system of public funding, private provisioning and purchasing healthcare: increase in financial and management bureaucracy, and in costs of care by diverting money for profits [14, 15]. It is the economic perspective that dominates, leaving little space for welfare measures or for the idea of health as a social good.

Indira Chakravarthi is a public health researcher, currently Consultant with SATHI Pune.

Email: indira.jnu@gmail.com

Notes

1. The term "healthcare industry" is used as an umbrella term while referring to hospitals, diagnostic centers, drugs and pharmaceutical-

medical equipment and devices and the insurance industries. The hospitals sector is reported to be the major segment, and hence the term healthcare industry is often used while talking about corporate and other big private hospitals.

2. <http://www.cii.in/> Sector Healthcare
3. Enterprises were classified as very small having individual/single worker/owner, small (two to five workers), medium (five to 10 workers) and large (more than 10 workers).
4. This study was undertaken by this author, Bijoya Roy, Indranil Mukhopadhyay, and Susana Barria in 2016, and a paper has been submitted for publication.
5. For more on private equity as 'a new form of investment, ownership and power that has rewritten the rules of the financial sector at the time of its greatest dominance over the world economy', see [13].

References

1. World Bank (1993) World Development Report 1993: Investing in Health. New York: Oxford University Press.
2. Government of India (2008) Report of the High Level Group on Services Sector. Planning Commission, New Delhi.
3. Bakshi, A., et al (2010) Gearing up for Healthcare 3.0. Background Paper for CII Seventh India Health Summit, 2-3 December 2010, New Delhi. McKinsey and Company.
4. Hooda, S.K. (2015) Private Sector in Healthcare Delivery Market in India. Working Paper 185. Institute for Studies in Industrial Development, Delhi.
5. Burns, L.R. (ed.) (2014) India's Healthcare Industry: Innovation in Delivery, Financing and Manufacturing. New York: Cambridge University Press.
6. Chakravarthi, I. (2013) The Emerging Health Care Industry in India: A Public Health Perspective. *Social Change*, 43(2), 165-176.
7. Chakravarthi, I. (2010) Corporate Presence in Health Care System in India. *Social Medicine*, 5(4), 192-204.
8. India Brand Equity Foundation IBEF (2017) Sectoral Report Healthcare. February. Downloaded from <https://www.ibef.org/industry/healthcare-india.aspx>, on 5.4.2017.
9. Government of India (2017a) National Health Policy 2017. Ministry of Health and Family Welfare.
10. Government of India (2017b) Situational Analysis: Backdrop to the National Health Policy 2017. Ministry of Health and Family Welfare.
11. Kate, A. (2013) Future of Small Hospitals in India. *Medicine Update* vol. 23, Chapter 155. Association of Physicians of India. Downloaded from: http://www.apiindia.org/medicine_update_2013/chap155.pdf, on 27.1.2014
12. Gadre, A and Shukla, A (2016) Dissenting Diagnosis: Voices of Conscience from the Medical Profession. Random House India.
13. Corner House (2008) The Global Consequences of Private Equity. Corner House Briefing 37 October 2008, www.cornerhouse.org.uk.
14. Silvers, J. B. 2001. 'The Role of Capital Markets in Restructuring of Healthcare,' *Journal of Health Politics, Policy and Law*, 26 (5): 1019-30: October.
15. Himmelstein, D., and Woolhandler, S. (2008) Privatization in a Publicly Funded Health Care System: The U.S. Experience. *International Journal of Health Services*, 38(3): 407-419.

Policy level changes in availability of essential medicines: a descriptive study of selected PHCs from Maharashtra

Shweta Marathe and Deepali Yakkundi

Abstract

In order to improve availability of essential medicines in public health system, the Maharashtra Government has taken some steps regarding medicine procurement and distribution (P & D) system. This descriptive study was conducted in three districts of the state to understand how policy level changes in medicine P & D system are being implemented and to understand situation of availability of essential medicines in the PHCs, in the view of implementation of these changes. The study reveals various shortfalls in implementation of policy level changes. Data regarding availability of medicines indicates, regular availability of essential medicines is still not at the level required. Given the findings of this study, it is important to expedite the implementation of state's crucial decision of establishing corporation for P & D system and ensure that the structure of this corporation- an independent body, retains the core positive features of Tamil Nadu and Kerala models.

Background

India ranks third in the World Health Organization's latest list of "countries with highest out of pocket expenditure on health" in the south-east Asia region[1] (World Health Statistics 2012). For millions of people in India, availability of essential medicines and access to affordable healthcare continue to be a challenge. 70% of healthcare expenses in India are incurred by people from their pockets, of which 70% is spent on medicines alone[2]. Recent surveys in the state indicate that even after a decade of launching the National Health Mission (NHM), the government has failed to keep its promise of ensuring availability of essential medicines in the rural Public health centers (PHCs)[3]. In Maharashtra, this issue is multifaceted and linked not only with inadequate budgetary allocation towards medicines but also with various missing linkages in medicine procurement-distribution system [4].

Over the last four-five years, Maharashtra government has taken some steps with regard to medicine procurement and distribution (henceforth referred as P & D) system with the aim of improving availability of essential medicines in PHCs. With this, the state claims to have improved supply in all public health facilities. In state mentoring committee meeting held in August 2012, it was promised by senior official from Directorate of Health Services (DHS) that 'we are improving the procurement system and after December 2012, Public health facilities will no longer face any shortage of medicines'. Given this context, the present study was conducted to understand how these policy level changes in medicine P & D system are being implemented at various levels and understand situation of availability of essential medicines in the PHCs, in the view of implementation of these changes.

Methodology of the study

This descriptive, concurrent mixed method study was conducted in three districts of Maharashtra namely, Pune, Nandurbar and Gadchiroli. Pune is considered as one of the developed districts of state with relatively better situation of medicine availability while other two districts are tribal districts of the state, with poor availability of medicines as per data available on DHS website. Hence to capture the variation in demand-supply system in the state, these three districts were selected. From the cohort of 15 PHCs with Community Based Monitoring and Planning (CBMP) under NHM, two PHCs in each district were selected using simple random sampling. Out of the list of 116 essential medicines for PHCs prepared by the DHS, 20 essential medicines were selected considering their frequency of use (drawing upon experiences from CBMP) in the selected PHCs and different forms. Quantitative data regarding medicine availability in PHCs was gathered in six successive rounds (September 2015 to March 2016) on monthly basis. Tool was prepared to seek information on actual stock in storage, list of indent-supply, date and quantity of latest received stock from ZP and local purchases of medicine.

The methodology for assessing medicine availability, has largely been adopted from a study conducted by SATHI (Raut-Marathe et al, 2015)[5]. Qualitative data regarding P & D system was mainly gathered through discussions with pharmacist from PHCs, District Health Officer, pharmacist from Pune districts and state level health officials from DHS. Secondary data involved news, articles from newspapers, magazines related to modifications in the medicine P & D system.

Challenges in data collection

Staff including medical officer in PHCs was quite reluctant to share data, especially regarding local purchase of medicines leading to non availability of that data for the study. Seeking data regarding P & D was equally challenging, as concerned state and district level officers seemed to be hesitant to share any gaps in the existing system.

Data analysis

Data on medicines availability was analyzed in excel, using three-month medicine requirement as a benchmark as suggested in state Government guidelines. The categories of stock availability were provided in Table no. 1. For analysing overall availability of the medicines, instances (total number of observations) of medicine availability were taken as the base. Stock of a particular medicine in each PHC over the six rounds of data collection is counted as one instance of availability. Thus complete data regarding 20 medicines in two PHCs per district for six rounds yielded 240 (20x2x6) total instances of medicine availability for one district. While for

analysing situation of stock-outs and pattern of supply of medicines from district level, total numbers of medicines (n=20) have been taken as a base.

Table no.1: Categorization of 'medicine availability' in terms of Stock level

Categories of medicine availability	Parameter used in terms of Stock level
Deficient stock	Stock for less than 3 month's requirement
Good stock	Stock for 3-12 month's requirement
Excessive stock	Stock of more than 12 month's requirement

Findings and discussion

A. How are the policy level changes regarding medicine P & D system being implemented?

a. E-tendering-

In July 2011, the state government has decided to employ e-tendering system to procure medicines. Apart from curbing corruption involved in the procurement; the government also claims that the e-tendering provides better quality and cheaper rate (Press trust of India, 2015) [6]. Decision of e-tendering is a step forward however is just a little modification in one of the steps of entire lengthy process of tendering. It has only enabled departments to reduce paper-based transactions and facilitated speedy exchange of information in the overall tendering process.

b. Implementation of e-aushadhi since year 2013-14-

As reported by district level officials, implementation of e-aushadhi has facilitated inter PHC exchange of medicines and helped monitoring medicine stock. However, range of challenges were also observed in its implementation. Due to absence of functional computers, erratic electricity supply and internet connectivity problems stock is not being updated regularly in most of the places which ultimately hampers stock monitoring at actual. Many times it is done when PHC pharmacist's visit to block or district level office. Though online system is implemented, paper work is still being continued. It was shared that, after sending indent to district, if there is no stock at district, then it takes minimum one to two months to actually get stock from empaneled company. In such situations, local purchases are made from PHCs using funds like RKS.

c. Quality Assurance (QA) of medicines-

According to the decision of provision of QA of medicines, after supply of medicines in the headquarter samples from each batch are sent for testing to the empaneled lab. Entries are made in e-aushadhi and only after receiving positive report from lab, medicines are distributed to PHCs. Prior to this decision, besides mandatory submission of the FDA certificate at the time of bid evaluation, there was no other system for QA. Hence, the decision is certainly positive. However to make it

more effective, following the system in TNMSC, samples should be tested in two different laboratories confidentially.

d. Modification in the list of essential medicine for PHCs-

List of 117 essential medicines for PHCs has been modified to 355 medicines. It's a positive decision however, it is crucial to ensure availability of essential medicines

e. Formation of warehouses in eight districts-

Till date construction of all eight warehouses have not been completed

f. Establishing corporation for medicine P & D system-

In July 2016, the Chief Minister of Maharashtra has taken a long awaited, important decision of establishing a corporation for the P & D of medicines for the public health system. As per information available in public domain, then after, government has not taken any move on this front.

B. What is the situation of availability of essential medicines in the Primary Health facilities, in the view of implementation of these changes?

a. Situation of availability of medicines in selected PHCs

Overall analysis of the medicines shows that, in Pune (46%) and Gadchiroli (58%), medicines were found to be deficient in stock in almost half of the studied instances respectively. Situation was quite worrisome in Nandurbar district with 64% instances of deficient stock, of which in 35% instances, there was a zero stock. The medicine availability was good on an average in only 29% instances in all three districts. Along with deficiency, a problem of excessive medicine also existed considerably. In the studied PHCs from Pune, in 23% instances and in remaining two districts in around 10% instances medicines were excessive. For example, In Gadchiroli, Albendazole was in excess by 22 times. In short, among the categories of analysis, the proportion of 'good' category seems to be lowest, with significant instances of 'deficient' category, which is indicative of a very poor inventory management.

Data from DHS[7] reveals even poor situation of medicine availability with stock-outs of on an average 60% medicines in all PHCs from Nandurbar, Gadchiroli and Pune. The same source indicates that stock-out figures for all the PHCs across Maharashtra, are also pegged at 60% (DHS, 2016)!

SMS survey conducted by SATHI showed that in 63% instances availability of medicines were not satisfactory (SATHI, 2012)[8] which clearly indicates that despite some improvements in the medicine P & D system, regular availability of essential medicines in PHCs has not improved as required.

b. Medicine stock outs

Out of 20 medicines, in Nandurbar 8-9 medicines were out of stock for almost five to six months,

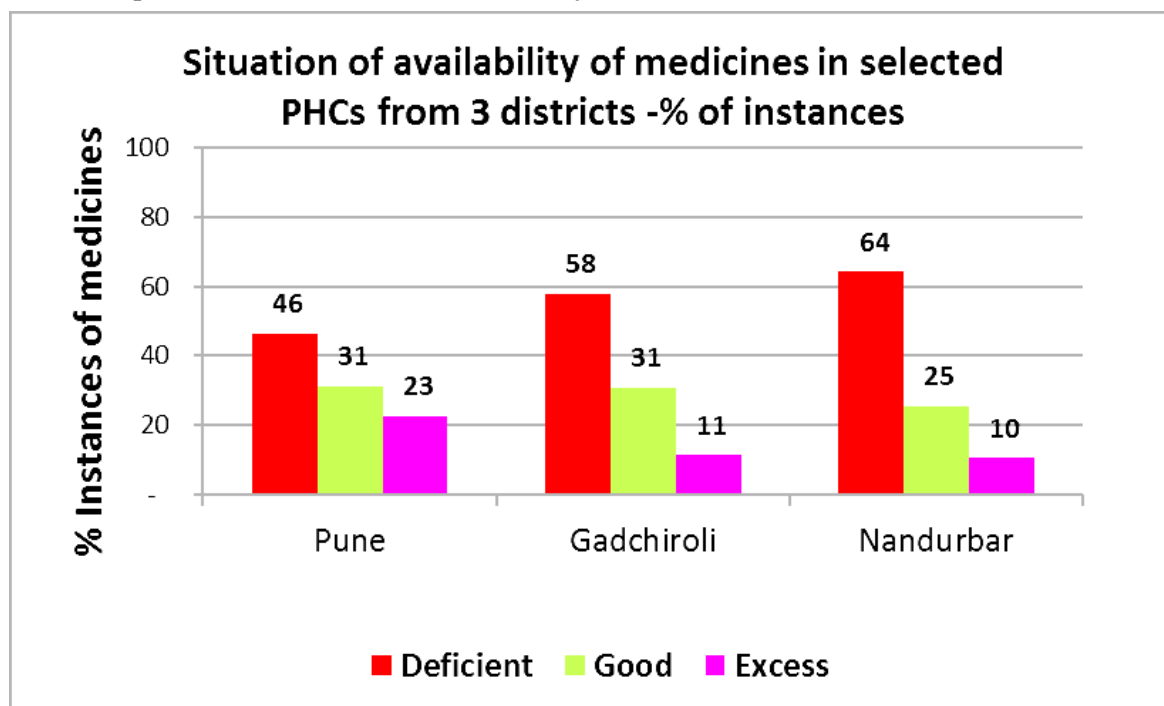
while in other two districts, on an average 3 medicines were out of stock for the same span. Essential medicines such as Metronidazole tablets, Injection Carboprost/Prostidine and Ringer lactate were out of stock for almost five to six months in studied PHCs across all three districts.

c. Pattern of supply of essential medicines-

Frequency of medicine's supply shows three broad patterns viz; medicines not supplied in six months, medicines supplied once in six months and regular supply of medicines. Out of 20, on an average 15 medicines were never supplied to studied PHCs from Nandurbar in last six months. On unpacking this data, it was noted that most of these medicines were also found in zero stock for all six months! And as a solution to this, local purchases have been done mostly using Rogi Kalyan Samiti funds. Further, in Pune and Gadchiroli, only three to four while in Nandurbar only one medicine was provided twice in six months, which is bare minimum, as per guidelines. Data from DHS, reveals that, in all three districts under study, only 40% of the medicines were supplied as against indented list (DHS, 2016) 9

shortfalls in its implementation. Data regarding medicine availability clearly shows that regular availability of essential medicines is still not at the required level. Despite implementing e-aushadhi, consistent deficient medicine stock suggests its limited role in improving inventory management as claimed by the government. Regarding e-tendering, the decision has only enabled a speedy exchange of information in the time consuming tendering process. While decisions of establishing eight warehouses and corporation for medicine procurement are still waiting for action. These policy level changes in the existing P & D system seem to be just a patchwork. Hence, to improve the P & D system and availability of medicines in PHCs in real terms, there is a critical need for complete overhaul of the system. In this regard, state's recent decision of establishing corporation for the medicine P & D system certainly stands crucial. Its pending implementation needs to be fast-tracked. Further, it's important to ensure that the structure of the corporation- an independent body, retains the core positive features of Tamil Nadu and Kerala models such as genuine autonomy of the corporation, transparency and demand driven supply etc., while making relevant innovations and considering specific conditions of the health system

Graph no. 1 Overall situation of availability of medicines in selected PHCs



Limitation of the study

Since data on availability of medicines is only from six selected PHCs, these findings cannot be generalized however, secondary data from DHS website for all 1800 PHCs in the state have been stated to address this limitation.

Conclusion

This study gives an overview of various policy level changes in the medicine P & D system and reveals

of state.

Acknowledgements:

Authors would like to thank Dr. Shirish Darak for methodological inputs, Dr. Abhay Shukla for inputs in analysis of data and the members of CSOs- Amhi Amchya Arogyasathi, Narmada Bachao Andolan and Rachana for their cooperation in facilitating data collection .

(contd next page)

Ethics in allocating health care resources using cost effectiveness analysis

Rajesh Kumar Sinha

Abstract

For allocating resources in healthcare, there are competing criteria which are important to consider before making decisions. These are maximising general population health, reducing health inequity, ethics, appropriate response for acute care or curative care or preventive care, political priority etc. However presently, maximising general population health by choosing cost-effective interventions, has taken the centre stage for decision making in allocating resources in healthcare ignoring other criteria. While cost effectiveness analysis technique itself has too many unaddressed concerns, ignoring other criteria for decision making, particularly in the context of developing nations will further increase already existed inequity and is unethical. Relying on single criteria for allocating resources in the healthcare is inapt and there is a need to have a multi-criteria decision model, considering all the important criteria for decision making.

Introduction

In the context of developing nations, priority setting and resource allocation in healthcare is often done ad-hoc without following any systematic approach. This is because, taking decisions is complex due to various competing criteria which play a role. These criteria are, maximising general population health, reducing health inequity by giving high priority to interventions that cater the most vulnerable population like economically backward groups, women, children, elderly population etc., appropriate response for acute care or curative care over preventive care, budgetary

constraints, political priorities etc. For an effective decision making by encompassing all the above criteria, there is a need to develop a multi-criteria decision model by giving appropriate weightage to each of the criteria and developing a composite index.[1] Over the past few decades, in absence of having a context specific multi-criteria decision model and due to steep rise in the health intervention costs with countries having limited resources in health, cost effectiveness analysis has taken a centre stage for deciding how much resources should be allocated to which health intervention, keeping overall budgetary constraint in mind.

Cost Effectiveness Analysis (CEA)

To manage healthcare with the limited resources, rationing is required to do through a systematic process to set priorities. To prioritize resources in healthcare, cost effectiveness analysis (CEA) is normally done to compare aggregate health benefits secured from a given amount of resources. The principle behind using CEA for resource allocation in healthcare is to maximise the benefits from the given limited resources.

Cost effectiveness analysis (CEA) is done to compare costs and outcomes of two or more interventions [2, 3] which primarily assists in allocating competing resources to gain maximum benefits. [4] Cost effectiveness ratio is expressed with incremental costs as numerator and incremental effects as denominator where effects are measured in terms of health gains like mortality averted, undernutrition prevented or disability adjusted life year (DALY) averted. [5, 6] DALYs are a standard metric for disease outcomes

(contd next page)

(contd from previous page)

Shweta Marathe is a senior research officer and Deepali Yakkundi is a research officer with SATHI at Pune

Email:shweta51084@gmail.com

End notes

Chokshi, MR, (2008) Tamil Nadu Public Drug Procurement Model, New Delhi: pp. 21.

Singh PV, et al, (2012) Replicating Tamil Nadu's Drug Procurement Model economic and political weekly, vol xlvii no 39

References

1. World health statistics (2012), World health Organization Statistics, WHO Library Cataloguing-in-Publication Data
2. Golechha M (2015) Healthcare agenda for the Indian government. Indian J Med Res 141:151-153.
3. Update on Community based monitoring and planning process in Maharashtra (2015), SATHI, Pune

4. Raut-Marathe S., Yakkundi D., Sardeshpande N., (2015)What causes medicine shortages in Primary health Centers ?A case of availability and supply system of medicines in select PHCs from Maharashtra. Journal of health management,;17(1) 86-97
5. Raut-Marathe et al (ibid)
6. Press trust of India, business-standard.com. Decision on mandatory e-tendering to be reconsidered: Mahagovt, May 13, 2015, Available at http://www.business-standard.com/article/pti-stories/decision-on-mandatory-e-tendering-to-be-reconsidered-mah-govt-115031301253_1.html
7. Directorate of Health Services, Maharashtra, retrieved 24 Nov at 3.00pm at http://dwhphd.dcservices.in/DWH_PHD_OPEN/startup/loginAction
8. SATHI (2012) State level Community monitoring survey (based on SMS) regarding Availability of essential medicines in PHCs of Maharashtra.
9. Directorate of Health Services, Maharashtra, retrieved 24 Nov at 3.00pm at http://dwhphd.dcservices.in/DWH_PHD_OPEN/startup/loginAction

combining the years of life lost (YLL) due to premature mortality and the years lived with disability (YLD). [7] DALYs averted represent an intervention's ability to avoid or prevent negative health outcomes. [2, 8] Calculating cost per DALY averted facilitates comparison between health interventions which enables prioritising health interventions which are cost effective and allocating resources to such interventions [9, 10].

For calculating DALY, the standard formulae for calculating years of life lived with disability due to disease (YLDs) and years of life lost due to premature deaths (YLLs) due to disease are calculated. For calculating YLDs and YLLs, variables like disability weight, discount rate, life expectancy, age of onset of disease or death and age weighting are used. Finally, these two measures are combined to calculate DALY. [10]

How making CEA a sole measure for decision making is inapt

Cost Effectiveness is generally said to be not merely an economic concern, it is also an ethical concern. Cost effectiveness is mainly concerned with maximisation of benefits from the given amount of resources. If resources are not allocated based on cost effectiveness, it will produce fewer overall benefits which is unethical because the same amount of limited resources has potential to produce larger benefits if allocated based on cost effectiveness analysis. However, at the same time, allocation of resources should be equitable and just and should not only be guided from the utilitarian principle of maximisation of health benefits. Also, there are ethical and equity concerns associated with CEA which are needed to be addressed for ethical and equitable allocation of healthcare resources. Most of these ethical and equitable concerns are largely not been addressed due to which, it is recommended that, in developing nations' context, CEA should not be only used to allocate healthcare resources.

Evaluation of disability

One of the very important concerns for assessing cost effectiveness is how disability and other states of health should be evaluated? Under CEA, the commonly used summary measure of health benefits is Disability-Adjusted Life Years (DALYs) averted. The burden of disease is calculated as the sum of DALYs attributable to premature mortality and morbidity [7]. Here, DALY is not only used to calculate burden of disease but also to decide how much resources to be allocated to which disease depending on their burden. Also, for measuring burden of disease, not only age and sex information are required but other information regarding socio-economic status and other circumstances of individuals experiencing ill-health like public service support, support from private income, families and friends etc. [11, 12]

DALY measures are being developed by experts. There are serious concerns over underlying assumptions and

value judgements used to calculate DALY because professional expertise may not necessarily fully aware of providing DALY scores and may also have systematic biases by bringing their value judgement in assessing quality of life of ordinary persons. Other option is to take judgement from group of disabled persons themselves because they would have more informed understanding about quality of life of being a disabled and hence can evaluate it better. However, there is a chance that disabled persons, who have gone through such conditions may report less distress or limitations of opportunity and score higher quality of life than the non-disabled evaluating the same condition. They might also value preventive or rehabilitative programme low compared to what the non-disabled do. Also, when these measures apply to different socio-economic and cultural settings, their importance in different groups may vary greatly. E.g. in a setting where most of the workforce are involved in labour intensive jobs, they might give more importance to limitations in physical disability compared to those who are mostly involved in knowledge based jobs. So, it is very important not to ignore these and many more such differences while assessing disability weights which affect assessment of cost effectiveness and hence prioritising health resources if cost effectiveness is an important criterion. [13, 14, 15]

Costs and benefits

Another issue is, what costs and benefits should be counted in conducting cost effectiveness analyses of healthcare interventions? Since cost effectiveness analysis analyses costs and outcomes of any health intervention, it is important to decide which kinds of costs and outcomes should be covered in the analysis. From utilitarian principles, economic evaluation should consider all kinds of direct and indirect costs and benefits, so that it should reflect how the scarce resources have been used to produce maximum gains and even producing indirect benefits for others. However, argument against this is from the moral equality angle where preferences should not be given to those who have produced more indirect benefits compared to the groups who have produced less indirect benefits. So, even if direct benefits secured from both the groups are same, one group would get preference in resource allocation compared to other, mainly because the other group was unable to produce indirect benefits to that extent. Here, it might be possible that other group did not produce indirect benefits much because of their pre-existed disadvantaged conditions in the society [14]. E.g. among the tribal community, there is the most vulnerable community known as Particularly Vulnerable Tribal Groups (PVTGs). Because they are so disadvantaged that any health intervention, though would produce some direct benefits, may not produce enough indirect benefits to the society. So, if their indirect benefits would be compared with the indirect

benefits produced by the other advantaged groups to prioritize healthcare resources, then no allocation would be made for them. This may worsen the already existed inequity problem. This is against the Kantian moral injunction of health intervention with people solely as means for benefits of others.

Using discount rate to the health benefits is another area of concern with the cost effectiveness analysis and its use in allocating healthcare resources. This is a standard practice in conducting cost effective analyses to assume a time preference by applying a discount rate to both costs and outcome measures. Though applying discount rate to costs is understandable however, the ethical question arises when discount rate is also applied to health benefits. Applying discount rate on health benefits means giving less weightage to future health benefits than the benefits accrue in the current year. Now if any health program which gives health benefits in later stage of one's life e.g. vaccination or preventive intervention or public health programs, then by this principle, their net benefits would be lesser compared to the program which accrue the same benefits but in the early stage of one's life. So, if the health budget allocation would be made based on this, then such programs, whose benefits would accrue later will get less allocation compared to the programs whose benefits would accrue early. Hence, allocation for better quality of life of future generation would be less and hence not ethical. It is logical to discount for the uncertainty related to future health benefits about whether potential beneficiaries will receive the future health benefits in their entirety. However, these uncertainties are generally get reflected in the expected future benefits and hence not required to discount future benefits. [15, 16]

Life Expectancy

Another issue is with the life expectancy used for calculating health benefits. Life expectancies are different for different gender, race, ethnic and socio-economic groups within the country and they are also different in different countries. So, if different life expectancies will be used for different groups with the same health intervention, different health benefits would be produced. The group which has life expectancy lesser will produce less health benefits compared to the group whose life expectancy is more. Due to this, the latter group will get priority in resource allocation over the former. [13, 14] In India, the life expectancies of Particularly Vulnerable Tribal Groups (PVTGs) is much lower compared to the national average. So, with the same amount of resources allocated, the health gains will be very less among PVTGs compared to the general population and hence allocation for PVTGs will be very less from the efficiency perspective. This will result into discrimination against groups like PVTGs, people with disabilities etc. which is ethically wrong. Also, with the same principle, different life expectancies between

different socio-economic groups may lead to less resource allocation for the resource poor group compared to the rich.

For cost effectiveness analysis, single uniform measure of life expectancy of Japanese women is being taken for calculating DALY averted, which is ethical in the sense that different life expectancies should not make the same health intervention more cost effective for one group and less for another group. But using the standardised life expectancy implicitly assumes that only health intervention alone can achieve the maximum life expectancy. It fails to assume that there are other important determinants which need to be addressed like improving socio-economic status, income, education, water supply and sanitation, road safety and reducing accidents, violence including all forms of gender based violence etc. and only reducing burden of disease will not help achieving the desired life expectancy. [11]

Age weighting

One of the important aspects of calculating DALY is age weighting and giving different weights to different life stages of human life. Less weights are given in the cases of children and elderly population compared to youths for calculating DALY. The justification provided for this is that human, being at different life stages, play different social roles and social role played by youths is maximum. This means that any intervention which improves quality of life of children and elderly population will be less cost effective compared to the intervention with the youth population, even if the improvement in the quality of life would be the same. [17] This might also be linked with productivity and may allow one to impute monetary value to this gain. This is ethically not acceptable and linking people's lives on a money metric is very hard to defend ethically. If the interventions will be decided based on the social values of individuals then one might also argue that compared to other professions, doctors and nurses' lives are more valuable or those individuals, who contribute more amount of money through taxation, are more valuable compared to those who contribute less or don't contribute. [15]

Prioritization

From equity perspective, for allocating health resources, priority should be given to the worst off such as those who are extremely poor and vulnerable or those who are sickest. For example, in India, PVTGs are extremely poor and their population is also on the verge of extinction. Their life expectancy is very low and death rates are very high. They mostly stay on hill tops and in remote locations and their population is also sparse. They also face discrimination and very limited government health services reach to them. Their health condition is so precarious that if things cannot be done immediately, their morbidity and mortality will further be on the rise. Also, because they stay far off where hardly any government services

reach, costs will be very high to serve them and gains will be marginal and slow because of their overall disadvantaged situation. So, the intervention may not be that cost effective if compared with similar health interventions with other population groups having relatively advantageous position and hence will not deserve budget allocation for their healthcare if cost effectiveness will be the only criteria for allocating resources. But from ethical and equity dimensions, a substantial amount of health care resources should be allocated for them to raise the health profile.

For allocating healthcare resources using cost effectiveness analysis, generally competition arises between providing small benefits to a large group of population versus large benefits to a small group of population. In such cases, the former result into greater total benefits due to aggregation of benefits of a large group of population and this may deny intervention or allocation of resources for the small group who would have enjoyed large benefits individually but their aggregate benefits would be lesser than the former group. Here also, ethically it is important not to deny individuals or small group of population, the great health benefits or extreme lifesaving interventions, merely due to not having aggregate benefits more than what a larger group would have.

Another issue arises when resources are targeted with higher priority is given to those who can be treated more easily and cheaply. This means that, some of the patients, whose needs can be met with difficulties and their treatment are more expensive will lose out. Hence, the cost effectiveness will be higher for the former group compared to the latter and this will have implications in resource allocation, if cost effectiveness will only be taken as the basis. This seems unfair because it will further compound existing inequalities. [13, 14] For example, screening homeless population for tuberculosis, the group with the highest incidence and greatest risk of mortality will not get preference over other general population in the city. This is because as homeless population are transient, it's very difficult to do follow ups with them on treatment unless strong mechanism is in place which involves huge costs. However, in contrast, enrolling patients from general population other than homeless would require less follow up activities and they have a better chance to comply with the treatment protocol with lesser amount of costs for following them up. Due to this, the tuberculosis program with homeless population would become less cost effective compared to the same program with the non-homeless population. If the cost effectiveness would become the only basis of allocating health care resources, then program with the homeless population will get the least priority. However, if the homeless patients are not enrolled for this reason, it will only compound their existing unjust deprivation and is unethical.

Summary

The above points highlight that, allocating limited health care resources using cost effectiveness analysis is the most efficient way of allocation to gain maximum overall benefits. However, there are number

of ethical and equity concerns, which are not taken into consideration under the cost effectiveness analysis and hence this should not become the sole criteria to allocating healthcare resources into different health intervention. Another consideration which support spreading some resources to even such program which are less cost effective is that everyone should get hope that their healthcare will be met even if they are less cost effective or resource intensive. Channelizing all resources to the cost-effective programs may lead to no or very poor allocation of limited healthcare resources to such programs which are not cost effective but important to deliver from equity or ethical perspectives.

Also, there are certain program e.g. early childhood care and development (ECCD), which not only have short term health benefits, but also have huge amount of non-health sector returns. Similarly, other public health programme like the provision of clean drinking water not only reduces prevalence of diarrhoeal disease but also substantially reduce time spent by women in fetching drinking water from distant sources. However, evaluating these public health interventions solely from the health perspective would lead to ignoring large amount of non-health benefits. This means that, it is also very important to account for non-health benefits alongside analysing health benefits for allocating resources in healthcare atleast for the large scale public health interventions. Also, equity must play a central role in allocating resources in the healthcare particularly in the resource poor countries.

Conclusion

Efficient allocation of resources is a desired objective however, as explained above there are other equally important criteria which need to be considered while allocating resources for healthcare. Ideally, there should be multi-criteria decision model taking all the criteria into account simultaneously and should not work in isolation from each other. Prioritisation decision should be based on multidisciplinary knowledge bases, incorporating economics, social sciences, public health, ethics, clinical science etc. and not only based on the knowledge in one area. This will not only help in allocating resources efficiently but also ethically and equitably.

Rajesh Kumar Sinha works at Ekjut, Ward Number 17, Plot 556B, Potka, PO-Chakradharpur, District-West Singhbhum, Jharkhand, 833102, India.

Email: rajesh.ekjut@gmail.com

References

1. Edejer TTT. 2003. Making Choices in Health: Who Guide to Cost-Effectiveness Analysis, Vol. 1. Geneva: World Health Organization
2. Drummond MF, Sculpher MJ, Torrance GW, O'Brien BJ, Stoddart GL. Methods for the Economic Evaluation of Health Care Programmes. Third edition ed. Oxford: Oxford University Press; 2005.
3. Berger ML, Teutsch S. 2005. Cost-effectiveness analysis: from science to application. *Medical Care* 43: II-49.
4. Walker SP, Chang SM, Powell CA et al. 2006a. Effects of psychosocial stimulation and dietary supplementation in early childhood on psychosocial functioning in late adolescence: follow-up of randomised

(contd next page)

Healthcare good and bad

R Balasubramaniam

A few years ago, a watchman at the apartment that I am living in Mysuru, approached me and consulted me on his son's illness. He wanted me to refer him to a good physician. I immediately told him to go to a doctor that I knew in the government run KR Hospital at Mysuru. He did not appear convinced and politely told me if I knew of any doctor in the private sector. My explanations that a government hospital was as good or better than that of many private hospitals that I knew did not seem to impress him. Well this may not be a isolated story. Most of us today have lost faith in the public system - whether it is a school or a hospital. We are convinced that we cannot expect 'quality' in the government system and that 'private' always means better. Is it always true? I can specifically remember a few incidents that left me further convinced that we not only need an efficient public delivery system, but they do indeed serve a valuable societal function in the Indian context.

Dinesh (name changed) was a 20 year old living with his parents and a brother and a sister in Mysuru. Coming from a poor family meant that he had to discontinue his studies after completing PUC and start working as a waiter in a hotel to support his family. He was one day traveling with two of his friends on a two wheeler and unfortunately met with an accident. Not wearing a helmet meant a severe head injury and his skull was damaged and badly fractured. He was admitted to a private hospital in Mysuru and was kept there for more than 2 months. After getting this family to spend more than Rs. 8 lakhs, the hospital authorities

informed them that the treatment was still incomplete and that they would need another 1.5 lakhs for the same. The poor family felt cheated, angry, let down and helpless. Not only did they not have the money, but they had also not received the complete and appropriate treatment. The family turned to everyone for help and the Chief Minister's Relief fund granted them Rs 30,000. The hospital was adamant that no treatment could be initiated with partial payment and insisted on receiving the full amount before starting treatment. A local NGO provided palliative care to Dinesh who was now bed ridden and kept at home. On his condition becoming serious, they took him to a teaching hospital locally who advised the family that his condition was serious and that he would not live more than a few weeks. Dinesh died in October that year, a victim of poverty, callous attitude of medical personnel and the indifference of a heartless private health care system that is not truly regulated and held accountable for delivering quality health care.

While this example may seem extreme, Raghu (name changed) a 32 year old poor farmer had a different kind of experience. He had fallen from his bullock cart in his village in Mysuru district and suffered a spinal injury. He was bed ridden for the past 3 years and was also receiving palliative care from the same NGO. A year ago, the staff of the NGO noticed that he was developing very deep bedsores and they took him to the Government run KR Hospital. The nursing and medical staff at the KR Hospital provided full support and took care of this patient with compassion

(contd from previous page)

- controlled trial. *BMJ* 333: 472-6.
5. Engle PL, Fernald LCH, Alderman Het al. 2011. Strategies for reducing inequalities and improving developmental outcomes for young children in low-income and middle-income countries. *The Lancet* 378: 1339-53.
 6. Murray CJL. 1994. Quantifying the burden of disease: the technical basis for disability-adjusted life years. *Bulletin of the World Health Organization* 72: 429-45
 7. Creese A, Floyd K, Alban A, Guinness L. 2002. Cost-effectiveness of HIV/AIDS interventions in Africa: a systematic review of the evidence. *The Lancet* 359: 1635-42.
 8. Murray C, Lopez A. 1996. *The Global Burden of Disease: A comprehensive assessment of mortality and disability from diseases, injury and risk factors in 1990 and projected to 2020*. Boston, MA: Harvard School of Public Health.
 9. Fox-Rushby J, Hanson K. 2001. Calculating and presenting disability adjusted life years (DALYs) in cost-effectiveness analysis. *Health Policy and Planning* 16: 326-31.
 10. Baltussen R & Niessen L (2006). Priority setting of health interventions: the need for multi-criteria decision analysis. *Cost Effectiveness and Resource Allocation*, 4:14 doi:10.1186/1478-7547-4-14.
 11. Anand S & Hanson K (1997). Disability-adjusted life year: a critical review. *Journal of Health Economics*, 16, 685-702.
 12. Barker C & Green A (1996). *Opening the debate on DALYs*. Health Policy and Planning, Oxford University Press; 11(2):179-183
 13. Brock, D (1988). Ethical Issues in Recipient Selection for Organ Transplantation. In *Organ Substitution Technology: Ethical, Legal, and Public Policy Issues*, ed. D. Mathieu. Boulder, CO, and London: Westview.
 14. Brock D W & Wikler D. Ethical Issues in Resource Allocation, Research, and New Product Development. *Disease Control Priorities in Developing Countries*.
 15. Kapiriri L, Arnesen T, Norheim OF (2004). Is cost-effectiveness analysis preferred to severity of disease as the main guiding principle in priority setting in resource poor settings? The case of Uganda. *Cost Effective Resource Allocation*, 2:1
 16. Arnesen T & Nord E (1999). The value of DALY life: problems with ethics and validity of disability adjusted life years. *BMJ*, 319, 1423-1425
 17. Barendregt JJ, Bonneux L & Van der Maas PJ (1996). DALYs: the age weights on balance. *Bulletin of the World Health Organisation*, 74(4), 439-443

and with no expectation of any 'out of pocket' fees. Having worked in the Lok Ayukta investigating complaints of corruption and mal-administration in the Government Health care System, I did not believe that this could be possible. I decided to dig deeper and understand what was happening. This was when I realized that the patient was in the hospital for the past 7 months and had 4 surgeries. The doctors felt that he would fully recover after one more surgery. Most of his sores had healed after the plastic surgery that was done on him. This NGO had trained his wife in making small handicraft articles and the hospital authorities did not mind her preparing them beside the bed of her husband itself. Raghu grew in confidence and returned home fully recovered from his sores and the rehabilitation therapy that he is now getting will make his life more livable. All this would not have been possible without the constant support, treatment and compassion that he and his family received from all the staff at this government run hospital.

These are not just isolated incidents. Many years ago, I had referred a 8 year old tribal child with a treatable heart condition to a famous private hospital at Bangalore. They were claiming to offer free heart surgeries to poor and deserving children. Hopeful of getting high quality care at no cost, this child had been referred to this hospital. Sadly, they sent the child back to its tribal hamlet without any surgery and I never really learnt the reason why. All that I know is that this child died untreated a couple of months later. Last year, the field staff of SVYM (www.svym.org), a local NGO had identified 6 tribal children who needed surgery to correct their heart anomalies. Having been bitten once, I decided that I needed to explore other equally good and cheaper options. I spoke to Dr Manjunath, the Director of the Jayadeva Institute of Cardiology. He simply asked me to send these children to his center at Bangalore. Within 10 days all these children were back after receiving the highest possible care and not a single rupee had been spent. One only needs to visit this government hospital at Bangalore to be convinced that it is no different from any of the other private hospitals offering similar services. Only difference is that it is very affordable and even free for poor and deserving patients. This hospital in my view is truly a 'heart hospital with a heart in the right place'. It is such hospitals that lend credibility to Government hospitals across the state and one must recognize the silent work that they do for the millions of poor who approach them for care. While I am not claiming that all Government hospitals are good and live upto the required standards nor am I saying that all Private hospitals are not so good and are heartless. I am sure that there are good government and private hospitals across the state as much as there are poorly run hospitals in both these sectors. What I am trying to point out is that we cannot carry a stereotypical impression that all Government hospitals will not be delivering quality care as much as private

hospitals will be giving them. We need to also be concerned at the number of people using the public health facilities. Surveys show that in Karnataka, more than 80% of the health infrastructure is in the public sector while only 34% of patients use them. While we need to worry about this poor utilization of Govt facilities, we also need to ask ourselves how can private hospitals with a mere 20% of the total health infrastructure in the state cater to 66% of the state's population. Government run institutions hire and appoint only qualified personnel unlike the private sector where personnel need not be appropriately qualified. There are several nursing homes that run with nursing and laboratory personnel not having the required qualifications. Merely wearing a white saree or a apron does not necessarily bestow the required qualification on a person. Very few private hospitals have a rational and well defined pricing policy. Many of them do not provide and disclose information about the services that they are expected to render to patients. Most patients are not aware of their rights and very few of them demand to know all this. Despite notifying the Karnataka Private Medical Establishments Act in 2009, one is unable to enforce either quality or cost regulation on many of these private hospitals. The Government which is also supposed to play the role of the regulator sees this act as merely registering these establishments and collecting the required fees. This means many Private hospitals get away with poor and unethical practices and charge exorbitant sums of money for services that need not cost so much. This severely restricts access to the middle class and the poor who have no recourse but to seek out Government facilities.

People need to understand that quality need not be directly proportional to the money we spend. As Dr Noshir Antia remarked, "things that are expensive, need not necessarily be the best." Patients have their rights and they need to be more discerning and empowered with the information that can help them make the right and appropriate choice. We need to have a Government that not only ensures that standards in the private sector are followed but also enforces them on its own hospitals. This will help build faith amongst the common people in the Government health care system. Only when the Government walks the talk can it demand accountability and performance from the poorly regulated private health sector. Only then will the interests of the patient be protected.

R Balasubramaniam is a development activist, public policy advocate and the founder of Swami Vivekananda Youth Movement. He has lived and worked with indigenous tribals in Karnataka State for nearly 3 decades.

Email: drrbalu@gmail.com

Contents

<i>Vandana Prasad</i>	Pediatric Perspectives	1
<i>Organizing committee</i>	Health workforce in India: background note MFC annual meet July 2018	2
<i>Adithya Pradyumna</i>	Air pollution, well-being and equity	5
<i>Abhay Shukla/Maharashtra UHC group</i>	A state specific, civil society-led UHC framework	7
<i>Nilesh Mohite</i>	Mental health care Act 2017: A Critical Appraisal	11
<i>KS Jacob</i>	MHA 2017: Comment on appraisal by Nilesh Mohite	14
<i>E Premdas Pinto</i>	A History of public interest litigation in India	15
<i>Tarun K George, Amit Tyagi, Krupa George,</i> <i>Anand Zachariah</i>	Demonetization and health	19
<i>Neha Reddy</i>	Reproductive "rights" and abortion ethics in NRHM, Kadapa, AP	21
<i>Adithya Pradyumna</i>	The Price of Air	26
<i>NAMHHR, Commonhealth, JSA</i>	Reviewing SDG Goal 3: A shadow report	27
<i>Indira Chakravarthi</i>	Private capital and corporations in hospitals	31
<i>Shweta Marathe and Deepali Yakkundi</i>	Policy/availability of essential medicines at PHCs in Maharashtra	35
<i>Rajesh Kumar Sinha</i>	Ethics and cost effectiveness in allocating health care resources	38
<i>R Balasubramaniam</i>	Healthcare good and bad	42

Subscription Rates					
Membership type	Indian Rs			US \$	
	Individual (online)	Individual (Hard copy)	Institutional (Hard copy)	Asia (online)	Rest of the world (online)
Annual	100	300	500	20	20

The Medico Friend Circle bulletin is the official publication of the MFC. Both the organisation and the Bulletin are funded solely through membership/subscription fees and individual donations.

In addition to these subscriptions above, we will need to raise Rs 12,000 per year as donations to subsidize the full expenses of generating three issues of the bulletin per year.

Cheques/ money orders/DDs payable at Pune, to be sent in favour of Medico Friend Circle, addressed to Manisha Gupte, 11 Archana Apartments, 163 Solapur Road, Hadapsar, Pune - 411028. (Please add Rs.15/- for outstation cheques). email: masum@vsnl.com

MFC Conveners: Jashodhara Dasgupta and YK Sandhya ; Address: SAHAYOG, A-240 Indira Nagar, Lucknow 226016 UP India. Website - www.sahayogindia.org. Phone Numbers: Mobile +91-99102 03477; DELHI- +91-11-26851101, 41660314; LUCKNOW - +91-522-2310747, 2310860, 2341319

MFC website: www.mfcindia.org

Editorial Committee: V. R. Raman; Dhruv Mankad; Devaki Nambiar; C.Sathyamala; S. Srinivasan (Chinu); Adithya Pradyumna; Mira Shiva; Anant Bhan; R.Srivatsan; Sunil Kaul.

Editorial office: c/o Anveshi; 2-2-18/2/A Durgabai Deshmukh Colony, Amberpet, Hyderabad 500013 Phone number 040. 2742 3690; Mobile 0 77027 11656; Email: r.srivats@gmail.com OR

c/o the ant, Udangshri Dera, Rowmari, P O Khagrabari, vial Bongaingaon Dist Chirang (BTAD) Assam-783380 Phone number 03664293803; Mobile 0 94351 22042. Email: sunil.theant@gmail.com

Edited and Published by R. Srivatsan and Sunil Kaul for Medico Friend Circle, 11 Archana Apartments, 163, Solapur Road, Hadapsar, Pune 411028.

Views and opinions expressed in the bulletin are those of the authors and not necessarily of the MFC.

Manuscripts may be sent by email or by post to the Editor at the Editorial Office address.

MEDICO FRIEND CIRCLE BULLETIN PRINTED MATTER –PERIODICAL

Registration Number: RN 278565/76

If undelivered return to Editor c/o Anveshi, 2-2-18/2/A Durgabai Deshmukh Colony,
Amberpet, Hyderabad 500013.

