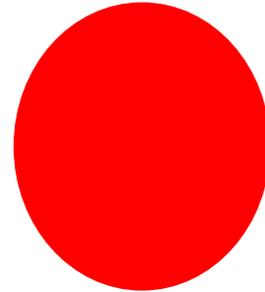


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Jul-Aug 2000



Editorial

The Responsibility to Do and the Responsibility to Know

Undoubtedly, this century will spawn its own share of truisms. Among them, we are likely to count this one - if you want to bury an issue, make it a Right. The struggle for Rights is increasingly beginning to appear like a parody of the real thing. Never before have had people struggled so hard to articulate their rights in front of governments which have lost so rapidly, the will to govern. Worse still, governments that demand the status of private individuals, who can not compelled to bear losses and who can choose to stay out of enterprises which show no promise of profitability (health being an obvious example). Never before in the history of political struggle, has the act of a State acceding a Right meant so little.

We find that government has become an end unto itself. The sustenance of the state machinery is an objective to which not only the state's resources are put to work, but that of the society as well. In fact, as the struggle for Rights gains momentum, the individuals and institutions of civil society are beginning bear a more onerous share of the responsibility than ever. Not only are they expected to organise and struggle to establish a right, they are expected to protect it, enforce it and, moreover, to ensure that the working of government does not make it a farce.

The most tragic aspect of the state's withdrawal from governance has been its search for its own irrelevance. By default of by design, the state is eroding its own system to such an extent that it becomes incapable of accomplishing even the most whittled down goals that it commits itself to. While its own systems are collapsing, the state has scarce control over the rest. The final withdrawal of the state has been the escape from the *responsibility to know*. The lack of information about basic aspects of health such as nutrition or the prevalence of ill health has been long lamented. But the problems in gathering information are not always logistical.

More often, they are administrative. The laws have helped to make much of human existence invisible. Thus, the invisible poor live in unauthorized settlements, they work, but do not find mention in any wage muster, seek care from practitioners who do not exist in the government's records, and fall sick, get injured and then die, uninsured and uncompensated.

In fact, public health has been one of the silent victims of the state's abdication of responsibility. Public infrastructure is collapsing, the environment is changing and new dangers to health are emerging, unnoticed. One would like to demand the right to information, but preferably from a government which *knows*. In any modern state, one assumes that the state's wide sphere of activity will equip it with the knowledge to understand its problems, and that it will share this knowledge with the society. However, as the state abdicates the responsibility to do, it automatically destroys its capacity to know. Understandably then, for a government, which does not have the capacity to forewarn the public, and does not possess the means to identify, treat and control a disease in the normal course of its work, techno-political solutions like one-shot campaigns for universal Hepatitis B vaccination are very attractive, regardless of their rationality. More so, if they are being conducted at the public's expense.

The death of an idealist reminds us of the fact that even the moral responsibility of welfare has been assumed by individuals. This bulletin reprints a tribute to the Argentinean surgeon, who ended his life in despair for his country. It also carries an appeal by a former administrator, who wishes to remind the government of its responsibility to run its own institutions sincerely. The search for the Right to health seems to be drawing us inexorably to the courts of law, in the hope that the ideals of a nation will serve us better. An article examines the intricate relationship between the law and the actual provision of the Right to health care, while another article reminds the world community not to sacrifice social justice at the altar of free trade

Achieving Right To Health Care: Experiences of Some Developed Countries

Amar Jesani

Our limited survey of the right to health care suggests that in all market economies, including in those where strong National Health Service or national health insurance systems exist, there is no absolute and unlimited right to health care. In other words, none of these countries, despite legislation for establishing national health services, provide any legally enforceable right to health care actionable by an individual patient for his or her own health care benefit. To this extent, it is correct to assert that translating policies into legislation does not automatically provide more right to people than in those situations where policies are not legislated, as is the case in India. Then, what does the legislation achieve in providing right to health care? To what extent does legislation help? And lastly, what types of legislation are essential in order to expand people's right to health care?

National Health Services in the UK

Margaret Brazier (1992: 20-22) while reviewing the national health service (NHS) of the UK and the right to health care, explains that the NHS Act, the Health and Social Security Act and the NHS and Community Care Act, are largely concerned with the constitution of services. The Acts create authorities; for administration the health services and provides for the services available and payment to those who administer them. A mass of administrative orders or circulars produced continuously by the authorities cover a number of issues affecting patients' rights. Although such a mass of circulars is less accessible to common people, they are important for patients for initiating malpractice action. Besides, if any of the circulars is found to be in violation of certain rights, it could be challenged in the court of law.

The NHS confers a duty on the Secretary of State for Health to promote comprehensive health care. He or she is supposed to provide services to such extent as he or she considers necessary to meet all reasonable requirements for a whole range of services. This does not mean that a patient can compel the authority or the minister to provide a particular service for which resources are not available, or shorten the waiting time or compensate for the pain and suffering due to unduly lengthy waiting time. The courts have held that the financial constraints to which minister was subject had to be considered in assessing what mounts to reasonable requirement for hospital and medical services; the decision as to what was required was for the minister, and the court could intervene only where a minister acted utterly unreasonably so as to frustrate the policy of the Act.

Litigation against the local health authority to compel it to

provide service otherwise not normally provided by the NHS in a particular locality or institution, have failed in the Court.

Thus, in the British NHS, the absence of any right to health care has many adverse implications. Under the plea that funds are not available. It could withdraw existing services and refuse to start new services even if they are really required. The NHS Act, it seems, also does not define minimum components of services, which the authority must provide under any financial or other difficulties. However, the existence of the Act has certain legal advantages. While the Court have refused to compel the authority to provide services, it has the right to scrutinise the reasonableness of health authority's decision. This has been possible because there is a specific legislation providing scope to the court to interpret policy behind the act. Unfortunately, the available literature suggests that the scope and readiness of the court to scrutinise reasonableness of authority's decision has not tested much in litigation. This is perhaps because most of the cases demanding right to services were for certain high cost services or their provision necessitated establishment of costly infrastructure. Basic services, it appears have not, so far, been significantly compromised by the authorities. However, it would be interesting to know, how the court would interpret "reasonableness" in the event of the authority deciding to allocate extra funds to a high cost super-speciality services to the detriment of the low cost services in general wards (as it seems to be happening in India). Since the existence of the Act provides scope to the court to scrutinise reasonableness of the decision taken by the authority, enthusiastic litigants and the active judiciary have a scope to expand the boundary judicial intervention in the decisions of authority.

The second important power retained by the court is that once patient is admitted for care, the health authority is duty bound to provide adequate care. If it does not provide necessary care and the patient suffers from some injury, the patient can demand compensation. Clearly, the existence of the NHS Acts could bring the courts in the picture in certain cases. The same would have been difficult in the absence of such an Act.

Canada: National Health Insurance

As is the case in many countries, the Canadian constitutional law does not contain specific reference to health and health care. The only reference that is made in some articles is related to the distribution of powers between the federal and provincial governments regarding

certain public health matters. In fact, in the Canadian federal set-up, historically, the courts played an important role in defining powers of the federal and provincial governments on various matters including health. In this legal debate, and in its orders, the courts invoked the constitutional clause, which put all matters of local or private nature within the domain of provincial governments and thus, prevented the federal government from making organised intervention in the field of health and social welfare. For instance, during the Depression period, the federal government passed a law on employment and social security, 1930, but the courts invalidated it using these provisions. In fact, this law had also empowered the federal government to appoint a commission to study health insurance.

The situation changed when the Constitution Law of 1940 amended the Constitution Law of 1867, and granted, (1) the parliament an exclusive power concerning, unemployment insurance, and (2) the federal and provincial governments powers to enter into agreement(s) concerning health. Thus, without including health as a right of people in the Constitution, a way was cleared for the federal government to make laws for providing health care to people and get support for them from the provincial governments. The rest of the history of Canada revolves around the political process, which ultimately made it possible for it to usher in the national health insurance. This process was not easy, though. In 1940s, the provinces thwarted attempts made by the federal government, as they did not agree to the proposals on sharing of the expenditure between the federal and provincial governments. However, some provinces went ahead with the hospital insurance, and the federal government supported them. Ultimately, after long process of give and take, and after overcoming strong resistance from the medical profession, the Law of Hospitalisation and Diagnostic Services Insurance, 1957-8, and the Law on Medical Care, 1966-7 were passed by the parliament and brought into effect.

At formal level, these laws did not confer any constitutional fundamental right to health care to Canadian people. However, in their scope and in practice, they actually did. According to these laws, the federal government committed to share half of the cost of providing universal health care by the province. They also laid down the preconditions to be met by the provinces in the field of health care in order to join this programme and to continue getting the federal share. This in effect, motivated provinces to upgrade and reorganize their health care services in order to join the programme. Thereafter, the federal-provincial relationship ran into trouble only on the questions of rising cost of health care and its sharing by the federal government and on some provinces charging for a part of the service from patients. This necessitated adoption of a comprehensive federal law called Canadian Law on Health on April 17, 1984. This law replaced the earlier two laws. Accordingly, in order to receive the cash contribution from the federal government for the cost of health care the provinces must comply with the following conditions:

(a) Public management of the provincial system of

non-profit health insurance.

(b) Comprehensive coverage by services included in the insurance under the federal law.

(c) Universal coverage of all inhabitants of the province under uniform conditions, with certain exceptions.

(d) Possibility of transferring benefits of the insurance system from one province to another.

(e) Accessibility of health services without any conditions, such as billing the insured.

These five conditions form the core of the Canadian system, and all provinces of the country have entered into an agreement with the federal government to abide these conditions. The condition (a) clearly rules out the role of private for-profit and non-profit organisations or insurance companies. This condition has historical roots in the pre-national insurance Canada where, like in the USA there were many health insurance organisations, including those run by the medical profession. Interestingly, the medical profession had in the 1940s and 1950s, fought bitter battles to channelise the financing of new system through such organisations. This condition thus shows economic and political wisdom of keeping out such organisations. The condition (b) provides for the quantity of services to be given on uniform basis and its standards. The comprehensiveness of health coverage ensures that a certain quantity of service is available to all, and that, under any pretext it is not diluted by any province. The condition (c) provides that all people are covered. Interestingly, it uses the term inhabitants and not citizens. The condition (d) takes care of inter-province migration of people without losing benefits. And lastly the condition (e) prohibits user and other fees at the point of delivery. This removes the financial barrier at the point of delivery to access almost completely.

Thus, for the subject of our discussion, such system provides for the creation of services, as well as entitlement for people covered by the system for a minimum level of hospital as well as Medicare services. However, the entitlement is subject to available resources. Thus, the problems associated with spreading a service too thin (long queues, delays etc.) are not dispensed with. Also, the decisions to provide new services or withdraw existing services are taken at the political level. And such decision cannot be taken unilaterally by the federal or provincial government.

Thus, in both the above systems, the authority is not legally bound to make available a service that it cannot afford. At the same time, the decision of the government not to provide a service on financial ground cannot be arbitrary as the courts could be invoked to consider any demand made. In any case, in both cases, it seems that the right to already available service is implicit, more so in the Canadian model where the statute itself ensures a minimum provision.

This right to the already available service is again tempered by certain factors. Except for emergencies, the patient may have to wait in a queue, say for a planned operation. The

position in the queue is determined by the medical criteria, and not by one's ability to pay. Thus, in essence, these systems do create a legal or statutory (and thus, even constitutional) entitlement to health care, but such entitlement for the individual is not absolute and unlimited. This goes well with the liberal democratic ethos, where the democratic rights are always circumscribed by reasonable constraints, particularly to avoid infringement of others' rights. Apparently, such an arrangement providing for the legal entitlement to health care without giving unlimited and absolute right to health care to individuals is not uncommon in other Western European countries. (Fuenzalida-Puelma, Scholle, 1989).

Lastly, it must be understood that legal entitlement to health is not possible to codify. For health is much wider concept, the attainment of it is not possible merely by making provision for health care. What is important to understand is that the creation of uniform barrier-free legal entitlement to health care, through some legislation or by making it fundamental right in the constitution, is a step forward in legal recognition of the right to health.

Private and Market Provision System in the USA

As we know, unlike Canada and many Western European market economies, the United States has opted for private sector based health care provision. A lot has been written on the burgeoning cost of health care in the US. It is interesting to note that the proportion of health care expenditure to the GNP in Canada and the US were almost identical (at about 7%) in 1971. The expenditure in Canada has since then stayed around that proportion only, but that of US has almost doubled. Despite having Medicare and Medicaid programmes started way back in 1965, an increasing number (millions) of citizens are uninsured or under insured. While health is a hotly debated issue in the US politics, the political leadership has not been able to exhibit necessary will to reform the system to make it easily accessible to all citizens of the country irrespective of their level and capacity to pay for it. Thus, the most modern and the most expensive health care system in the world promises everything except access to a sizeable proportion of its citizens!

The US constitution and legal system are historically tied to an economic philosophy, which emphasises private markets and limited governmental intervention in the economy. As a consequence, the health care, like most other aspects of living, has been treated as a consumer item sold by private parties. Due to lack of a single guiding hand, many subsystems have developed, creating what has been called a fragmented, overlapping and unplanned delivery pattern. The components of the delivery pattern are so diverse that, Morgan Capron (1989: 503) finds it difficult to call it a system, for the term system may be too elaborate for the manner in which health care is provided and funded in the US.

Curran and Hyg (1989) has briefly but succinctly summed up the existing situation on the constitutional right to health

care in the US. While Medicaid and Medicare are statutory programmes, they are aimed primarily at the indigent and aged. Further, they only provide a pre-decided range of services. Thus, there is no specific statute in the US, to make it legally obligatory on the authority appointed by law to make uniform provision of health care services to all citizens of the country. Earlier in the 20th century it was established in the courts of law that the US constitution contained no provision, either in the body of the document or in the Bill of Rights, for citizens of the country to claim a minimum level of health care services. Interestingly, the Medicare and Medicaid programmes were not established in 1965 by passing any specific statute for them, but were extensions of the Social Security Act of 1935 which has established the concept of federal grants- in-aid to the states for health purposes.

There are three other fields of health where some legislative measures have been taken in the US.

Firstly for planning of health care. However, these attempts have not yielded substantial positive results as they had little regulatory authority and political will to back them up.

The second area of legislative and policy concern in the US has been the cost containment. The establishment of professional standards review organisations, 1972 and the development of health maintenance organisations for this purpose have also not yielded desired results.

The third area of increasing competition in health care was highly talked about in the 1980s. In fact, till 1970s, using legal means to promote market competition in health care was not heard of. But in 1980s, the deregulation policies were in ascendance and the courts cleared way for the application of antitrust laws to promote competition. But soon the deregulation and competition came under attack, for they hindered cost containment and quality.

In brief, in three fields, the legislative and policy measures initiated to control negative impact of market based private provision of health care have not succeeded in creating desired balance. This only shows that without creating a political and legislative framework for the universal access to health care, the laws passed and policy measures initiated in a reflex and piece-meal way do not help in reforming the health care for desired ends. Further, the US law does have provisions for making it legally obligatory on the government to provide optimum and adequate level of health care services free of any cost to certain type of individuals, viz. (1) Convicted and confined prisoners, and (2) Involuntarily committed mental patient. The free service to the latter also includes right to psychiatric care.

Thus, in the US one ought to be a criminal who is caught or a mental patient who is a public nuisance, in order to have a right to free and adequate health care! The ordinary citizens even the taxpaying lot cannot have it as a right. The criminals and the insane are given such right as by

confining them, their liberty has been snatched away. That makes them incapable of having private initiative to provide for their own health care.

Curran and Hyg (1989) have lamented the fact that very few lawyers have, in the US, attempted to prove through litigation that there is a general constitutional entitlement to health care services. The courts have on the other hand, resisted raising the issue on their own.

Nevertheless, though the citizens in the USA do not have a legal right to health, nor the government a legal obligation to provide health care, howsoever minimal, on demand, the development in case laws and enactment of statutes in few states have created some space for the needy citizens. This right is for the emergency services. The entire position may be summarised as follows:

(1) In a case needing emergency services, it was argued that since the county was providing emergency services, the patient has a constitutional right to medical services at the hospital of patient's choice and by the doctor of patient's choice. The court did not entertain such a demand and the right. The court made it clear that the fact that the county had made "some ambulance service" available to the public did not constitutionally oblige it to perform whatever emergency services, the plaintiff requested or desired. (Curran and Hyg, 1989: 789).

(2) The US law makes distinction between a situation in which county government itself placed the person in danger and one in which the county merely failed to help someone already exposed to peril for no fault of the municipality. Thus, the emergency condition of danger to life did not give rise to constitutional right to adequate emergency medical services.

(3) Some of the States in the US are indeed improving their legislation. For instance, the Illinois Medical Emergency Treatment Act legislatively imposes obligations on general hospitals, both public and private, to offer emergency services to the public (Curran, Shapiro, 1982: 650). While such statutes legally create obligation for providing emergency medical care, some cases fought in the courts have helped develop case law for establishing such an obligation. Curran and Shapiro cite a case (Wilmington General Hospital vs Mairiove) in which the court imposed duty as a common law obligation based upon the voluntary effort of the hospital in operating and publicly displaying an emergency ward. The public could therefore rely upon receiving needed service and could not be turned away. Thereafter, in *Guerro vs Cooper Queen Hospital* case, where the private hospital argued that it is under no obligation to accept any individual who applies as a patient, the court held that in emergency, refusal to accept a case by hospitals, including private hospitals which are maintaining emergency ward(s), would lead to worsening of the seriously ill or injured person, because of the time lost in a useless attempt to

obtain medical aid. If such a refusal had led to aggravation of injury and suffering, it would be a case of the negligent termination of gratuitous services, which creates a tort liability. (Ibid, 644-5)

Thus, the development of case law, and of course in the peculiar US characteristic of fear of huge monetary damage due to malpractice litigation, a right to emergency medical care to needy patient has been established in the US. However, the court decisions in such cases are very forthright in stating that the public authorities have no legal obligation to provide health care services to all citizens, except those with whom the authority has entered into a "special relationship", namely, divesting them of their liberty.

Curran and Hyg (1989: 789) say that court judgements in various cases have put strong barriers in the way of those who would argue for the establishment of a constitutional entitlement to health care services. They have created barriers in forcing reluctant legislatures, state and municipal agencies to provide more adequate, widely accessible programmes of health care. They conclude, by saying that the only other constitutional or legal remedy remaining in the USA would be to amend the constitution formally to establish such a new civil right.

Constitutional Right to Health Care: A Survey of the Americas

The Pan American Health Organisation published in 1989 an extensive analytical comparative Constitutional study of right to health in Americas, edited by Fuenzalida- Puelma and Scholle Conner, and covering all Latin countries. Barring Canada and the USA, the rest of the countries are underdeveloped countries. Their findings and conclusions are of great interest:

Accordingly, in 20 out of 35 countries surveyed, a right to health and/or state's duty to protect health has been enshrined in their constitutions. A right to health or health protection is included in 13 constitutions (Bolivia, Chile, Cuba, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Paraguay, Peru, Uruguay and Venezuela). The duty of the state to protect health is found in all those countries that speak of a right to health and directly or indirectly, in six others (Brazil, Dominican Republic, Ecuador, El Salvador, Panama, Surinam). However, the wording of provisions related to health show little uniformity, either among themselves or to international context. Only one country case study author (Venezuela) claimed that the constitutional right to health is subjective and immediately judicially enforceable (Fuenzalida- Puelma and Scholle Conner, 1989: 622-3).

Analysing the country case studies, the editors concluded that the actual implementation of these constitutional guarantees was, however, a matter of regulating law and public policy. Effectiveness depends on legislation, political will and commitment of resources.

A right to health as an objective of the state's long term goal, stated in the text of constitution, as it is in the constitution of India, would qualify the country having constitutional right,

but without any operating law and political will and resources to translate the right into practice. On the other hand, the practical legal right, whether enshrined in constitution or not, backed up by commitment of resources, would create a ground for actual realisation of that right, fully or partially.

Concluding remarks

What is useful for our country from these examples of developed countries? One issue is clear that, although efforts are not made by lawyers in our country to develop case law for ensuring partial or full, legal or constitutional entitlement to health care, we should not expect more to come out of those efforts. Some legal experts told us in discussion that if we could get what people got in the US for the emergency services, we should be thankful to courts. They added further that, given lengthy delays in obtaining justice, high cost, blind faith in doctors and their costly equipment, and social stigma attached to the litigant status, the case law has not adequately developed even on medical malpractice. Not enough number of litigants for medical laws have been around till recently to make that possible. And given the tardiness in implementation of anything, law and judgements included, some of such judgements would not instill fear amongst private and government providers to change their ways. This is a highly depressing scenario indeed.

Another thing we learn is that given the inadequacy of constitution of ours on the issue of right to health care, the easiest way to create some right is by enacting a law. The point is, a legislation creating some right to health care, or imposing some obligation of providing health care services on the government, would give a socio-political advantage to the needy people. The focus of the debate would radically change. Today, we are spending reams of papers to discuss Right to Health Care. A legislation would change it to Right to how much of health care, as is the case in the UK and Canada and in many other countries. As explained by us above, it is unlikely that there would ever be a right to absolute and unlimited amount of health care in all cases and in all situations. Every right, including right to health, is circumscribed by certain reasonable limits, including fundamental rights. Yet, a legislation making health care accessible would create popular pressure and participation for improving access and also the access to the adequate health care. There is no reason to believe that an underdeveloped country like ours cannot provide at least basic health care services as a right. The present day in-access to health care is not due to scarcity of resources for basic health care services, and therefore it is unjustified.

The Medico Friend Circle (MFC) is an all India group of socially conscious individuals from diverse backgrounds, who come together because of a common concern about the health problems in the country. MFC is trying to critically analyse the existing health care system and to evolve an appropriate approach towards developing a system of health care which is humane and which can meet the needs of the vast majority of the population in our country. About half of the MFC members are doctors and medical students, the rest include researchers, health and gender activists, community health experts, public health professionals and academicians and students from different disciplines. A loosely knit and informal national organisation, the group has been meeting annually for more than twenty five years.

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MFC Convenor's Office:

S. Sridhar; ARCH, Mangrol 393145, Rajpipla Taluka, Narmada District, Gujarat. Email: sridhar.mfc@softhome.net

Editorial Office:

Neha Madhiwalla; B3 Fariyas, 143 August Kranti Marg, Mumbai 400 036. Email: mfcbulletin@rediffmail.com

Initiatives

Reproductive Health Programme for Survivors of Bhopal Gas Disaster

The Sambhavana Clinic provides free medical care [through modern medicine, Ayurveda and Yoga] to the survivors of the December' 84 Union Carbide disaster in Bhopal. Since September 1996, we have offered care to over 9000 chronically ill survivors from the severely affected communities. The clinic is committed to working for the improvement of the health and health care condition of the survivors, carrying out research and documentation activities to monitor the long term health consequences of the disaster and campaigning on issues concerning the health and well being of the survivors. In view of the exposure induced injuries to women's health and the official neglect towards health and health care of women survivors, the Sambhavana Trust has decided to pay special attention to women's health.

In late 1997 / early 1998, much because of the initiative taken by volunteer doctor Jayshree Chander from San Francisco, in response to a large number of complaints of excessive vaginal secretions, we started carrying out Pap's smear examinations. Not having facilities for biopsy we had to send women to the government hospitals. We found that cervical biopsy facilities are unavailable at the hospitals meant for survivors, including the 150-bed Indira Gandhi Hospital built specially for women survivors. It is not just the problems of diagnosis, facilities for treatment of cervical cancers, particularly for women from low economic background, are also near absent in Bhopal. Where such facilities exist, they consist of hysterectomy, which is known to be an overkill in majority of cases. Given such a situation we decided to start Colposcopy and LLETZ [Large Loop Excision of Transformation Zone] or LEEP [Loop Electrosurgical Excision Procedure] facilities at the clinic. These surgical procedures allow excision [through electrosurgery] of abnormal tissue, while sparing the rest of the reproductive organs. Mr. Dominique Lapierre, author of City of Joy has agreed to donate about Rs. 25 lakhs from the royalty of his books towards our proposal for a gynaecological clinic with special attention to screening, diagnosis and treatment of cervical cancer. We have already received half of his contribution. We have very recently purchased a colposcope [Takagi CS5], L & T electrosurgical unit with a set of reusable electrodes and other accessories required for this procedure. A room has been specially renovated to accommodate this work. Our health workers have started on health education campaigns focused on gynaecological health problems.

Satinath Sarangi

For the Sambhavana Trust

Postbox

Sambhavna Clinic, Bhopal Needs a Socially Committed Gynaecologist

The gynaecologist would be expected to be involved in the treatment of patients (including use of colposcope) documentation of case histories, develop treatment protocols (including the possibility of treatment of specific problems through Ayurveda and Yoga). Carry out focused studies (such as on anaemia) related to the project - Prepare fortnightly, quarterly and yearly reports - Do quarterly internal evaluation of the project - Provide assistance in the production of community health education material

Specifically, we are looking for a woman with: - A post-MBBS degree or diploma in gynaecology - At least two years experience of seeing patients independently - At least one year of independent experience with investigative and surgical procedures - Knowledge of spoken Hindi. Additionally the following would be desirable: - Experience and/or demonstrated interest in epidemiological/clinical research - Involvement with or exposure to community situations particularly socially and economically disadvantaged communities. - Computer literacy and familiarity with statistical packages. What we offer - Rs. 10,000 per month - Entitlement to up to 38 days leave in a year - Laboratory facilities - A team of committed and competent medical and other workers - Encouragement and support to research activities - A participatory and nonhierarchical work environment.

Those interested, please contact Sambhavana Trust.

A word of caution about Depo-Provera

Pharmaceutical companies have been making systematic efforts to push Depo-Provera an injectable contraceptive in to the Family Welfare Programme. We suspect that the injection presently available in the open market has not picked up its sales as expected by the manufacturers. Hence this desperate effort!! Government too, is desperate to control population at any cost hence may overlook the courts stay order and get the injection into the programme from the back door.

We need to stay alert knowing the side effects of Depo-Provera, which is anywhere from menstrual disturbance to increase risk of breast and cervical cancers, not to mention the other effects on a woman and her progeny's fertility. An exhaustive account of the side effects is given in Dr. C. Sathyamala's book - '*AN EPIDEMIOLOGICAL REVIEW OF THE INJECTABLE CONTRACEPTIVE, DEPO-PROVERA*'. This contraceptive cannot be considered a safe method of choice for any woman.

We will appreciate if you can send us the addresses of any

known Depo users whom we could follow up and get direct information.

Forum for Women's Health,

C/o VACHA, Tank Lane Municipal School,
Santacruz West,
BOMBAY -400054.

Save Public Health Care Campaign

In response to the article on the Save Public Health Care Campaign (Mar-Jun 2000 issue) Mr. J.B D'Souza, former municipal commissioner of Mumbai wrote a letter to his ex colleagues, also former municipal commissioners.

To
B.G. Deshmukh, Sharad Kale, D.M. Sukhtankar,
S.S. Tinaikar

I

As a youngster in Khotachiwadi, Girgaon, my mother would take me for my ailments to the BMC's Foras Rd. dispensary. Very occasionally we would go to the provincial government's JJ Hospital.

Both facilities were free. They were all we could afford. Those were British days.

II

The Medico Friend Circle Bulletin for March-June 2000 contains the following paragraphs:

"Mumbai has 80 municipal and state government hospitals and nursing homes Municipal hospitals have not been 'free' for many years. Poor people have had to pay for disposables, tests, and even drugs which are out of stock. Those who cannot afford to pay are deprived of life-saving treatment.

The new user charges will increase the pressure on people. They are levied at every stage, from case papers to diagnostic tests. People must pay Rs.10 for a new OPD case paper and another Rs.10 for repeat visits after more than 14 days. Tests such as the stress test, and life-saving super-speciality operations such as heart surgery, earlier done free, are now charged an astronomical Rs.500 and Rs.5000 respectively. Existing user charges for most tests, ICU bed charges and various treatments have been hiked by between 67 and 233%, and are expected to rise further.

Article 12 of the International Covenant on Economic, Social and Cultural Rights asserts that 'Health is both a fundamental human right in itself and an indispensable precondition for the exercise of other human rights'

III

I am not even sure that the figures the Bulletin has quoted

are right. Like many of our private hospitals, the Jaslok Hospital enjoys tax concessions. One of the conditions of those concessions is the provision of a certain percentage of its facilities cost-free to poor patients. When I worked for Jaslok in 1993, I discovered to my dismay that we were excluding from the free facility expensive treatments like heart surgery, dialysis, etc.

Just then I happened to hear of a poor patient at the BMC's Sion hospital who was being denied heart surgery because he could not pay Rs.45000.

I persuaded Jaslok's Trustees to drop the costly treatment exclusion for at least 5% of its in-patients. The Sion, patient came to Jaslok, was treated (valve replacement, if I remember rightly), and left the hospital without paying any fee.

IV

Sec.61 (G) of the BMC Act requires the Corporation to establish and maintain public hospitals and dispensaries. Sec.62A allows it to charge fees for these facilities. Consequently, the BMC fees can't be dismissed as invalid or illegal. Yet it is quite clear that "people who use [these] services are those who have no other option. It is known that user charges keep people from seeking life-saving care. People already overburdened with other expenses are forced to ignore critical health problems. When they eventually seek care, they must borrow money to pay for treatment, whether in public or private facilities", as the MFC Bulletin points out.

V

Nearly every annual BMC budget laments the shortage of medical service revenues vis-a-vis expenses on these services.

(i) Much of this deficit is due to expenditure on medical *education*, which is not a statutory responsibility. The Corporation has undertaken many other nonstatutory tasks.

(ii) The medical section is an insignificant part of the BMC's total budget. A body that so easily gives away nearly 70% of its revenues to its staff and is ready to waste money on the comforts of its Mayor, the Committee Chairmen and its senior officials can hardly complain of resource stringency. (Judging from the quality of its service, it seems, in fact, to be little more than a mechanism to transfer a vast amount of money, larger than any other local body in the sub-continent can command, from 13 million unwilling citizens to 150,000 BMC staff, beneficiaries of a generous welfare system.) A simple effort on the part of its administration to tighten revenue collection and curtail wasteful expenditure — like the inadequate road repairs done repeatedly — would

more than offset the medical deficit. On this topic Sadashiv Tinaikar, who has recently studied BMC finances in detail, is much better informed than I, and can make a valuable contribution.

VI

I write to ask that of the former Municipal Commissioners, we five undertake an effort to persuade or compel the BMC to return to its earlier dedication to service of the poor of Bombay.

I believe that a persuasive effort by a group of MCs (led perhaps by B.G. Deshmukh, because of his stature in the civil service), with appropriate publicity and the prospect of our approaching a court for a writ of *mandamus*, may succeed.

Do let me know how you regard this suggestion, and how you think we can act on it.

J.B. D'Souza

Maternity services in public hospitals in Mumbai

Dear friends,

It is a known fact that women in the city of Mumbai have to pay a fine of Rs 500/ when they come to the public hospital for their third and subsequent deliveries. How this punitive action actually provides "forced rest" for women who cannot pay this amount is worth mentioning.

In the 1980s, the number of days that a woman could stay in a public hospital after delivery was 15 days in case of normal and in cases where women were weak it was extended to about a month also. With the constraints of space and resources the hospitals have reduced this period to a maximum of 3 days. Most are discharged on the very next day after childbirth. Traditionally too, women were confined to 45 days of rest after delivery at home. This has been most often the only period of compulsory rest for women. With the increased load of housework as well as paid work, women today are forced to reduce this period of rest and get back to "work" within a week of delivery. Needless to say that this has a negative effect on women's health in the long term. Presently, in the hospitals, when women don't pay the fine levied for the third and subsequent deliveries, they are not discharged from the hospital till they pay up- thus in fact providing the necessary rest that they so desperately need!! What should be their right comes to them as a penalty!

This is not in any way to advocate for such a fine. It is only to point to the callousness with which policies are made. Women who are unable to pay are the ones who cannot afford to rest and HAVE to get back to paid work. Most often they have younger children to look after too! Thus, the state

has thought up a novel scheme to punish them with 'forced rest.

Padma D.

CEHAT, Mumbai

MFC Annual Meet 2001

Announcing Annual MFC meet on the theme:

Universal Access to Health Care through Insurance: Problems and Alternatives.

Date: 18-20th January 2001.

Venue: Yatri Niwas, Sevagram

The MFC invites papers for Annual Meet, 2001 on the above theme. Papers will be tabled at the meeting, there will be no presentations.

Last date for receiving papers: 15th December 2000

The papers must be sent to:

*Convenor's Office Medico Friend Circle
C/O ARCH, Mangro1393145, Rajpipla Taluka,
Narmada District, Gujarat.*

Petition for patients Rights to medical records

Dear All,

Here is a request from a crusader against medical malpractice and for patients rights. His name is Mr. Raghunath Raheja. His wife died in Nanavati Hospital, Mumbai allegedly due to medical malpractice. The MFC Bombay Group has provided him support in his struggle for justice. He has written his story in "Market, Medicine and Malpractice" - the book that documents campaign against medical malpractice and the work of MFC. Although in his legal battle he did not fully succeed in disciplining errant doctors in his medical malpractice case, he succeeded in getting a judgement from the Mumbai High Court stating that patients have a right over a copy of the medical record. The court also directed the Maharashtra Medical Council to inform all hospitals and nursing homes to supply a copy of medical record on payment of photocopying charges. This has become a landmark judgement.

However, for last many months Mr. Raheja has been getting numerous inquiries from Maharashtra as well as from other states (from patients or their relative) requesting him a copy of the judgement so that they could obtain a copy of the medical record. While a copy of the judgement has helped many patients in Maharashtra to force hospitals to give medical record, it has not been so easy for patients in other states. For instance, a patient had to file a petition in Allahabad High Court and use the

Mumbai High Court judgement to obtain a copy of the medical record.

Obviously all patients can't keep approaching their respective High Courts to get a favourable order.

Mr. Raheja is now retired, and he has been actively involved in various kind of social welfare activities. He wants to reach out to those who are not able to obtain medical record and help them. He therefore thought of filing a petition in the Supreme Court on this subject and tries to get a favourable judgement so that all patients all over the country could benefit. He is ready to finance this work, and so he approached the lawyers (Mr. Colin Gonsalves and India Centre for Human Rights and Law). A petition has been prepared, but since Mr. Raheja was the original petitioner at Mumbai High Court, and that Mumbai and UP courts have already issued orders for provision of medical record, the lawyers have opined that for Supreme Court petition, they need petitioners who are not from Maharashtra and UP. So Mr. Raheja cannot become a petitioner, nor any individuals or organisation from Maharashtra and Goa.

Mr. Raheja has sent a copy of the petition to me, with a request to mobilise friends from states other than Maharashtra and UP, to be petitioner in this case (individuals and organisations). Through his Mumbai lawyer, he would be hiring a Supreme Court lawyer and would finance the cost, but Mr. Raheja himself would not be one himself.

So friends, would it be possible for few of you who are from states other than Maharashtra and UP to be petitioners?

If you are interested, please write to Mr. Colin Gonsalves, Advocate at the following email address:

huright@giasbmOl.vsnl.net.in

with a copy to Mr. Raghunath Raheja, at:

s_raheja@hotmail.com

Mr. Colin Gonsalves has promised that he would send a copy of the full petition to anybody interested in becoming the petitioner in the Supreme Court case.

Personally I am immensely interested in this process and would recommend all concerned to respond favourably.

Amar

Mumbai

Reprint

Doctor's Suicide Strikes at Heart of Argentina's Health Care Crisis

By Anthony Faiola

Washington Post Foreign Service

Friday, August 25, 2000;

Page AO 1 BUENOS AIRES, Aug. 24 -2000

After a light lunch of apples and tea on a chilly afternoon last month, Dr. Rene Favaloro, 77, walked into the bathroom of his Buenos Aires home and shot himself through the heart.

The heart was an organ the world-renowned surgeon knew well. On a miraculous day in May 1967, the gifted Argentine, then on the staff of the Cleveland Clinic Foundation in the United States, had placed his long, delicate fingers into a patient's chest cavity and became the first to plan and perform a heart bypass operation—pioneering a procedure that has saved countless lives over the years since then. But Favaloro, who had returned to his native Argentina to champion the cause of universal health care, had grown distraught, believing only the affluent were enjoying what he once called "the right to live."

His peers, his family and his own writings suggest that he had come to blame globalisation and the free-market revolution of the 1990s for "a growing callousness" toward health care for the poor. Arid his suicide, they say, grew from a failed struggle by one of the greatest minds in medicine to save the heart foundation here that he had built into a symbol of altruistic health care in the developing world. Favaloro was a man of dignity who did not show his desperation. Accordingly, his suicide shocked friends and relatives, who said he was not being treated for depression and did not give any sign that he was preparing to take his life. The elegant gentleman with the wellcoiffured silver mane and the sure gait of a TV surgeon opened his Buenos Aires-based Favaloro Foundation in 1992. It was the culmination of a dream to offer the best trained hands and most modern equipment to the grandes dames who could pay and the street urchins who could not.

The facility quickly became Latin America's most advanced and modern heart institute, conducting groundbreaking research as well as sophisticated organ transplants and coronary surgeries. It trained more than 400 doctors now scattered around the region. But as Argentina and much of the rest of Latin America made free-market reforms in the 1990s, government subsidies to Favaloro's foundation were slashed and private insurance companies reined in costs—even adopting from U.S. health maintenance organisations the controversial practice of paying doctors incentives to order less costly treatments. At the same time, millions of Argentines, pushed out of work by public and private downsizing, lost health care coverage altogether. Favaloro refused to turn away the increasing number of

uninsured patients whose conditions were so chronic that only his clinic could offer hope.

At the time of his suicide, after unsuccessful pleas to the government and private business for donations, his medical utopia stood at the brink of financial ruin. "I am living one of the worst moments of my life, just as the rest of this nation," he wrote a friend just before his death. "I have become a servant knocking on doors looking for money to keep the foundation alive." Favaloro blamed free-market economics in another letter, this one to his staff, three weeks before he put a .38-caliber bullet through his heart on July 29. Echoing a controversial speech he made before the American Heart Association in Dallas in 1998, he attacked globalisation, adding that free-market reforms are "better referred to as a neo-feudalism that is bringing this world toward a social disaster where the rich are getting richer and the poor are getting poorer."

"Rene felt [the reforms] had left Argentina morally bankrupt, that the growing number of poor people were being ignored, that the government had become increasingly corrupt and that local companies and new multinationals simply didn't feel a responsibility to contribute to philanthropy," said Mariano Favaloro, the foundation's chief of surgery and Rene Favaloro's first cousin. "Rene had fought hard to give his patients equal treatment. He felt this new world we live in could no longer permit it, and he ended his life." Although extreme in his reaction, Rene Favaloro was emblematic of a deepening resentment in Latin America and beyond to globalisation and the free-market revolution in the post-Cold War era. As inequality and unemployment have increased in the region while the reforms proceed at a sometimes brutal pace, strikes and demonstrations also have surged. Against that backdrop, Favaloro's suicide has deeply affected Argentina. It has caused soul-searching about the rise in poverty and the collapse of social services as the role of government has diminished, corruption has soared and state companies have been sold off. His death also has reverberated internationally, underscoring one of the biggest challenges of globalisation: providing quality health care in developing countries.

Argentina has become a case study. The public health system here, long the richest nation in Latin America, is code blue. The national medicare system is virtually bankrupt; its former directors allegedly demanded bribes from Favaloro to disburse payment on patients' bills. For years, most Argentines received their health care from any of 296 union-related cooperatives. But today, 80 percent of those co-ops are in dire financial straits-collectively \$2.6 billion in debt-as their clients have lost their jobs and been unable to pay their dues. Public hospitals, relied upon by about 44 percent of Argentines compared with 37 percent two years ago, are overburdened.

Those Argentines who have been successful in the free market economy have been loath to step in and replace state subsidies with donations to philanthropic foundations such as Favaloro's. Favaloro's critics retort that his foundation was poorly managed and did not do enough to collect fees. Favaloro, a single-minded widower with no children, also

insisted on importing only top quality equipment from the United States and Europe, rather than the Brazilian-made diagnostic equipment and medical supplies common in many Argentine hospitals. Most of all however, he has been accused of being unrealistically intransigent. The son of a poor carpenter and seamstress from the nearby city of La Plata, Favaloro spent his life pursuing medical breakthroughs and fairness in public health. After earning his medical degree, he lived in the rural town of Jacinto Arauz in the pampas during the 1950s to work with some of the nation's most poverty-stricken patients. In the 1960s, his revolutionary ideas on coronary surgery were recognized by the lauded Cleveland Clinic in Ohio, which invited him to be a visiting resident. There, he would make history by inserting a sinewy leg vein around a coronary obstruction. The clinic tried to woo him to immigrate permanently. "We tried to get him to stay, but he loved Argentina-he would never stop talking about it," said Floyd Loop, a surgeon at the clinic and now its chief executive, who calls Favaloro his mentor. "He felt he was needed there. It was a calling, unfinished business he needed to get done." Inside the Favaloro Foundation, the fruits of the doctor's calling are undeniable. Delicate surgeries, from organ transplants to quadruple bypasses, are routinely performed. A research arm is noted for several advances in the study of arterial operations. In the 260-bed, high-tech center not far from the National Congress building, a complicated and rare type of liver transplant from sister to sister was successfully completed just last week.

In one room, Ismael Garcia, a 57-year-old farmer from Patagonia who is not insured and whose local doctors did not have the skills to perform a procedure on his carotid artery, wept when asked about Favaloro's death. Garcia's operation cost \$8,000-roughly three years' income. But Rene Favaloro accepted him as a patient even though Garcia could not pay. The government, after eliminating a \$10 million annual subsidy to the foundation in 1995, only covered the cost of such medical supplies as surgical thread and gauze. "I wanted to meet the man who allowed my life to be saved. I wanted to at least shake his hand," Garcia cried as his daughter held his bandaged neck. "But I never got a chance to do it. Favaloro was too good for this world."

Unlike so many other South Americans who gain international acclaim, Favaloro became a symbol of someone willing to buck the brain drain. He was among those Argentines who believed the nation had a shot at returning to its glory days of the 1920s, when Argentina was one of the world's 10 richest nations. His real objective lay in raising the bar of domestic health care. Although 80 percent of the patients the foundation accepted were insured, they were housed in roughly similar rooms as the 20 percent who were not. But as more and more Argentines lost their health care coverage, the percentages shifted and the foundation fell deeper and deeper into debt. By the time Favaloro shot himself, board members say, the foundation owed \$70 million, largely because of uncollected bills. He was being pressured by his employees to be more selective about patients. But the passionate man with a temper not uncommon in brilliant surgeons exploded with a public memo to his staff only days before his death: "I have always practiced medicine with a profound social pledge. For me, all patients are equal.... For this, I tell you

that this foundation is for everyone. Every patient, paying or not, will continue receiving the same attention!" His peers say they are sure Favaloro was trying to make a statement with his suicide. "I honestly believe he felt his death would be a wake-up call both here and internationally about the plight of health care for the poor," said Hector Alejandro Machain, a friend of Favaloro's and a surgeon at the foundation. "Because of who he was, what he had accomplished, he felt he could do more with his death than he could alive." Since his death, calls to the national suicide line have doubled. In a headline, the newspaper La Nacion heralded his death as part of "The sad fatherland of psychoanalysis and Tango." Public commentators have cited Favaloro's death as one reason for a massive increase in visa applications to leave the country. "You cannot know what Rene meant to this nation unless you are an Argentine," Machain said.

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United Nations Body Warns of Conflicts between Intellectual Property Rights and Human Rights: Could influence 'Patents for Drugs, Biotech Seeds

Geneva - On August 17, 2000,

An important UN human rights body unanimously adopted a resolution calling into question the impact of the World Trade Organization (WTO)'s Agreement on Intellectual Property Rights (known as TRIPS) on the human rights of peoples and communities, including farmers and indigenous peoples worldwide. The surprising resolution signals a growing concern about an industry-driven intellectual property agreement that protects corporate patents around the world, sometimes at the expense of national economic and health concerns. The TRIPS agreement sets international rules to protect patents in a whole host of sectors, but it is particularly important for pharmaceutical and biotechnology companies. In the unprecedented resolution, the UN Sub-Commission for the Protection and Promotion of Human Rights pointed out the dire consequences on the human rights to food, health and self determination, if the TRIPS Agreement is implemented in its current form. Reminding governments of the primacy of human rights obligations over economic policies and programs, the resolution states that there are "apparent conflicts between the intellectual property rights regime embodied in the TRIPS Agreement, on the one hand, and international human rights law, on the other."

"This is a path breaking resolution in more ways than one," stated Miloon Kothari from the International NGO Committee on Human Rights in Trade and Investment (INCHRITI), an alliance of eight human rights coalitions that advocated action by the Sub-Commission on TRIPS. First and foremost this timely resolution signifies the resolve of the UN human rights programme to monitor the work of the WTO. Basing itself on the provisions of both the UN Covenant on Economic, Social and Cultural Rights and the UN Convention on Biological Diversity, "this historic resolution has affirmed the primacy of human rights and

environmental obligations over the commercial and profit driven motives upon which agreements such as TRIPS are based." added Kothari. According to Peter Prove of the Lutheran World Federation, a human rights analysis of the interpretation and implementation of the TRIPS Agreement reveals that TRIPS has skewed the balance inherent in intellectual property law systems away from the public interest and in favour of intellectual property rights holders. He said that, contrary to some analyses, intellectual property rights do not have the character of fundamental human rights, but rather of subordinate or instrumental rights. Simon Walker of the Office of the United Nations High Commissioner for Human Rights noted that the TRIPS Agreement's requirement that pharmaceuticals be patented by all WTO Members "might be appropriate for countries with high levels of investment in medical research. But," he asked, "is it suitable for countries with a high level of HIV / AIDS, malaria and tuberculosis infection that have not yet developed a pharmaceutical research base? For these countries, access to drugs -rather than innovation of drugs - is the imperative. Given that there is a link between patent protection and higher prices for pharmaceuticals, the grant of private property rights could be detrimental to public health - and development in general- in these countries." The UN Sub-Commission's resolution marks the beginning of what promises to be an intense monitoring of WTO work by the UN human rights system. The resolution asks the WTO, in general, and the Council on TRIPS during its ongoing review of the TRIPS Agreement, in particular, "to take fully into account the existing State obligations under international human rights instruments." It also asks the UN Secretary General Kofi Annan to prepare a report on the implications of the TRIPS Agreement and options for further action by the Sub Commission. The resolution has also called upon the UN High Commissioner for Human Rights and other relevant UN agencies to undertake an analysis of the human rights impacts of the TRIPS agreement. The resolution comes at a time of intense questioning by developing country governments of the TRIPS Agreement and its interpretation and implementation, and of calls by numerous national and international civil society alliances for the TRIPS Agreement to be brought in line with human rights and environmental imperatives. Stressing that intellectual property rights have to serve public benefit, and concerned by the true motives of the TRIPS agreement, the resolution calls upon governments to integrate into their national and local legislations, policy provisions that, in accordance with international human rights instruments and principles, protect the social function of intellectual property.

The bulletin invites all readers to contribute to the bulletin.

Full length articles

Postbox - News about MFC's activities programmes held, being planned, actions taken (Public Interest Litigation filed, signature campaigns etc.) Personal news that you may wish to share with the MFC.

Initiatives - Small write-ups on activities conducted by MFC members and their organisations

Reprint - Articles published elsewhere, which may be of interest to readers. (Will be printed subject to copyright restrictions)

Inclusion of Hepatitis-B Vaccination in the Expanded Programme of Immunisation without a Thorough Scientific Debate

As reported in the previous issue, the MFC participated in a press conference organised by Akhil Bhartiya Grahak Panchayat and CEHAT on 5th July 2000 at the Mumbai Marathi Patrakar Sangh to oppose the move to include Hepatitis B vaccination in the Universal Immunisation Programme and also condemn the manner in which the campaign is currently being conducted by politicians. The press conference was well attended and on the succeeding days, several articles, especially in the Marathi, Hindi and Gujarati dailies were published. However, it is clear that the political mileage to be gained out of the issue has effectively sidelined all efforts to question the rationality of the ad hoc campaign being conducted through camps by youth groups and local residents group all over the country. On the day of this bulletin going to press, (Sunday 3rd September 2000), the Times of India, Mumbai reported that the Hepatitis B campaign which is being led by Kirit Somaiya of the BJP is going to spread to all parts of Maharashtra and also outside the state. Moreover, arguably the most influential politician from Maharashtra, Sharad Pawar (whose party is part of the ruling coalition in the state), is going to lend his 'blessings' to the campaign and inaugurate the campaign in Pune city. A case of sworn political rivals burying the hatchet in the Cause of 'public good'.

-Editor

Printed below are excerpts from the press release circulated at the press conference

It is learnt that the Central Government is about to include Hepatitis-B vaccination in the Expanded Programme of Immunization (EPI), and the Expenditure Finance Committee has recommended an allotment of Rs. 2825 crores during the 9th Plan for this vaccination. This decision involves an annual expenditure of Rs. 565 crores, whereas the Central Government's allotment in 1998-99 for control of Malaria and Tuberculosis was Rs.290 and Rs. 105 crores, respectively. In our view, the decision to commit hundreds of crores of rupees of the taxpayers' money is being taken without critically assessing the risk due to Hepatitis-B in the overall health scenario in our country; without estimating the cost-efficacy of this vaccine; without adequately studying its protective efficacy in Indian infants and without seriously considering the ways to substantially reduce the cost of the programme. Indeed, this can be called as 'fixing' of the National Health Programme!

It is a matter of great concern that the manufacturers of this vaccine have launched a very aggressive and unethical campaign in favour of universal vaccination. As a result, Hepatitis-B vaccination is being made almost compulsory in schools, doctors are being given one vial free for buying ten, claims are being made that Hepatitis-B is an important Public Health Problem compared to AIDS. Recently some prominent politicians like Kirit Somaiya and Uddhav Thakare have joined this aggressive campaign initiated by vaccine manufacturers. It seems that many experts have been consciously or unconsciously unduly influenced by this campaign and the above decision is being taken at the behest of the vested interests...

It has been claimed that 4.7% of the Indian Population is a carrier of HB- Virus and 25% of these carriers will die due to the effects of this carrier-status. These claims appear to be highly exaggerated. Alternative, detailed estimates suggest that only 1.4% of the Indians are carriers of

this virus. Secondly though, some carriers of Hepatitis B virus in later years develop some serious chronic liver diseases, majority of the 'Carriers' eventually eliminate the virus from their body and only miniscule proportion of the carriers develop cirrhosis or cancer of the liver in later years. Liver cancer takes 40 years to develop. As a result, untimely deaths due to long term consequences of Hepatitis B are comparatively very few. It is estimated that not more than 0.1 % of the newborns in India will die of hepatitis B during their lifetime! (7% of the newborns die of other diseases during the first year!)

The following highly cost saving and effective measures need to be considered: ***Use of intradermal technique and Selective Immunisation***

In the consumers' and National interest we demand that:

There be adequate Public Debate on this issue in the various form, the statistics presented by experts should be cross checked. In addition, guidelines also need to be formed and strictly implemented on the relationship between medical experts, medical conferences, and the drug industry.

Different experts, consumer-representatives from various organisations should be properly consulted before taking this decision about Universal hepatitis B vaccination in India.

Signed: Akhil Bharatiya Grahak Panchayat, CEHAT, ACASH, National Medicos Association, Forum for Medical Ethics, MFC, MASUM (Pune)

Dated: July 5, 2000

Report of the MFC Mid-Annual Meet

Sewagram, Wardha, July 20-22, 2000

The mid-annual meet was held as scheduled, and was attended by about 35 members. The PHC and Women and Health Cells met first concurrently, followed on the second day by a plenary that discussed other points on the agenda. The respective coordinators are circulating summaries of the proceedings of the cell meets. Here, a brief report of the general matters discussed is presented.

As planned, the issues related to Sahayog were discussed in an informal sharing session on the first evening. Abhijit and Satish from Sahayog were present, and presented a first-hand account of the ordeal they went through. A long discussion ensued, but in the time available, satisfactory attention could be paid only to the human-rights violation angle, about which members unequivocally expressed their sense of outrage. Possibilities for independent groups to go to Almora, assess the situation first-hand and help set in a healing and recovery process were discussed. Abhijit welcomed any such possibilities and reiterated that Sahayog was open to criticism and suggestions from other individuals and groups on all aspects of the issue. The dynamics of responses by different individuals and groups in such situations (starting with MFC's response to the crisis) were also discussed. Various suggestions were made, such as filing complaints to the law commission, filing a PIL, involving the press council, examining ethical aspects of the doctor's behavior, among others. No formal resolutions were passed.

Those issues formally discussed are reported below. Some issues could not be discussed for lack of time on the last day: editorial guidelines for the bulletin and other MFC publications (Padma has drafted some preliminary guidelines, which she will post on the forum soon), details of e-archiving of bulletin and the issue of invitation to ministers / bureaucrats to MFC meets (on which the Organising Committee for the next meet can take a decision).

Planning for Theme Meet 2001

At the last meet in Jan 2000, the tentative theme decided for the next annual meet was "Health Rights and Health Insurance". About half a day was devoted to discussing the ramifications of this theme' in preparation for the next meet.

Sunil Nandraj made a brief presentation on health insurance. He outlined the different kinds of insurance possible and of various health insurance schemes (other than life insurance) currently operational in India. This includes the ESIS, CGHS (both of which have limited coverage), the schemes of mc (Mediclaime with small variations) and a few community-based health insurance schemes run largely by NGOs. Mediclaime is the only one that is general purpose, and available to all, but having limited clientele so far (1.67 million insured under it currently) due to poor marketing.

It is an indemnity type insurance, excludes many health problems and conditions, and disbursement of claims tend to be delayed in many cases. NGO-run schemes are highly variable and are often dependent on additional funds from other sources; they may involve premium in cash or in kind. All schemes put together cover some 30 million Indians so far.

The passage of the Insurance Regulatory Development Authority (IRDA) bill last year marks the entry of private interests in the insurance arena. It allows private enterprise, subject to certain important conditions. The company can be exclusively Indian or may have a collaborating transnational partner who may own upto 26% of the company. It must have a paid up capitalisation of at least Rs 100 crores and a detailed business plan before it begins operations. Transfer of funds out of the country is prohibited. Many aspects, particularly about the rules and regulations and the exact shape of the insurance schemes and their coverage are still not clear. Some concerns are _ what happens to existing health insurance schemes? What about those who cannot afford the schemes? Would it support primary health care? What would be the impact on provision of health care and cost of care? What kind of regulatory controls would be appropriate? What about consumer information and redressal mechanisms? What kind of exclusion clauses would operate, and how would they affect coverage? How do we handle hazards of overutilisation, supplier-induced demand for unnecessary investigations and procedures, prolonged admissions, etc.? There is also the problem that health insurance falls under the Ministry of Finance rather than Health. All this seems to make universal access to health care farther than ever before.

Amar spoke at some length on the issue of right to health. At the outset, he pointed out that we would have to decide from what perspective to discuss the theme. One way would be to discuss right to health care and to discuss insurance from that perspective only. Else, to discuss health insurance, so that the "technical" aspects of it could get discussed, but in the context of universal access to health care. He talked about three generations of human rights, and explained that right to health and health care are different from the political rights in the sense that they cannot be achieved without creating enabling conditions, i.e. the universal access to health care service. These enabling conditions are difficult to create. Even in those countries that have nearly universal access to health care, health care is not a fundamental right. But all of them have done this by enacting enabling legislation, and carried out radical reforms in health financing. He suggested that in the next annual meet some background material on cross-country comparisons should be prepared.

The group then discussed the issue from the perspective of planning the theme meet. After much discussion, a consensus was reached on the final focus: **Universal Access to Health Care through Insurance: Problems and Alternatives.**

A tentative structure for the next meet's theme discussion was arrived at:

1. Private insurance - current developments - impact
2. Problems and possibilities for interventions
3. Universal Health Insurance - is it possible?

Of a list of possible background papers needed, the following commitments were made:

- a... Health Insurance and existing legislation (3 papers): Amar Jesani
- b... Universal Health Insurance - other country experiences: Ravi Duggal
- c... Glossary of Health Insurance Terms: Sunil Nandaraj
- d... Health Insurance in India - an Overview: Sunil Nandaraj
- e... Regulation of health insurance: Sunil Nandaraj
- f... Implications in terms of health Access and behaviour: Neha Madhiwala
- g... Exclusion clauses: Ravi Duggal
- h... The Sevagram experience in Health Insurance: Ulhas Jajoo
- i... Microcredit Insurance: Shashikant Ahankari
- j... District Financing: Dhruv Mankad
- k... Basic Assumptions of Health Insurance: Sunil Kaul
- l... Tools used in insurance planning / risk assessments: Ritu Priya
- m... Restructuring rural health services in view of universal health insurance: Sham Ashtekar

In addition, the following possibilities were considered:

- a... IRDA Bill- Niranjan Pant / Narendra (Padma to follow up)
- b... Health insurance and Voluntary Sector: Vijayan Das (Anand to follow up)
- c... Indian Experiments - SEWA, Tribhuvandas Foundation: Ken Ranson (Sunil Nandraj to follow up)
- d... SEWA experience: Anil Gumber (Padmini to follow up)
- e... ACCORD experience: Devadasan
- f... Tribhuvandas Foundation Experience: Chinu (to follow up)"

Deadlines for submission of these papers were decided. Some of these papers will appear in the bulletins before the meet, some will be separate backgrounders.

The next few issues of bulletin will carry announcements of the meet along with a call for papers, and a circular will be sent out about 10 weeks before the meet.

e-forum and Website

Arun Dolke and Sridhar briefly laid out the current state of functioning of the MFC e-forum and website. Both are currently on free internet sites. The e-forum is an

unmoderated email exchange forum using free services of e-groups, an internet site specialising in hosting such for a service. At present mfriencircle@egroups.com has about 70 members. Initially the exchange was being moderated / facilitated manually by Arun Dolke, but is now automatic - all members listed receive any of the mail that is posted by any member. It has been quite enthusiastically used in the past few months, particularly during the Sahayog episode, and members seem to find it useful for sharing news and views. It was decided that, to help members make best use of it, a simple list of guidelines will be drafted and circulated by Arun. The list will remain unmoderated, but members can refer to Arun in case of problems.

A "trial" website has been created on a free site by Nobhojit Roy. Members who have visited it have found it easy to access and uncluttered. Being a free site, it has certain limitations of space and unwanted advertisements, besides an element of uncertainty. While there are technical solutions to such problems, they demand a fair degree of competence with internet programming, which the group at present does not possess. An alternative is to have a paid website, which will cost something to buy and maintain. Concrete offers have come from individuals to sponsor the website, and help finish its construction, provided members of MFC help maintain it (update it from time to time). The maintenance would require very little programming skills, and can be a responsibility shared by a number of members. The website can have a number of sections, including the announcements of dates and agenda of meets, plans and activities of each cell, part or whole of the bulletin and its archives, and linkages to other sites, etc. The e-forum can also be hosted from this site instead of the e-groups site. After some discussion, the consensus was that MFC should have a website; a concern was raised about the cost of paid websites in the long run. Some alternative names (URLs) for the website were suggested, since some of the obvious ones (mfc.com or mfc.org) were already taken: possibilities could be mfc.net.in or medicofriencircle.com or .org. The discussions about the content mainly revolved around the issues of how much of the bulletin could go on to the website to be available free to all. How would free availability affect circulation, which was unsatisfactory anyway? Would it make sense to have all archives online? Strong views were expressed for both; having the bulletin available free, and otherwise. At the end, it was decided to make a conservative beginning, and review periodically. The current issue will be announced on the website, but the full text will not be available till the next issue is announced. Selected articles could be made available, but not the entire archives. A postbox could be created for visitors to communicate with the editor. These decisions would be reviewed in the next meet.

Bulletin

Neha briefly talked about her plans for the bulletin and the problems she is facing. As before, the limited number of regular subscribers (apart from the 130 or so life subscribers) is making the bulletin financially unviable, and a sustained effort is needed to remedy this. Since the bulletin

is being refurbished and a renewed effort being made to ensure regularity, members felt it would be quite possible to raise the number of subscribers over time. There are problems reaching old subscribers, and ways to make this possible with the help of active members were discussed. It was decided to form a support group in Bombay constituted by local MFC members who could help the editor in production. Similarly, to ensure contributions from a wider variety of subjects and people, the constitution of an editorial board made up of members from around the country was mooted. It was strongly felt that both these groups should be formal entities, to be announced in appropriate for a, and from which names of members not actively participant be deleted after a brief trial. The local support group will be constituted in Bombay. The EC and a couple of members who volunteered would constitute the editorial board till the time of the next meet. Neha would refer to any / all of them as needed. Some problems regarding registration of the bulletin also needed to be sorted out.

People Health Assembly (Jan Swasthya Sabha) and MFC

Sridhar briefly gave an overview of the People's Health Assembly (PHA) process so far and MFC's involvement in it. As decided at the end of the last meet, the convenor represented MFC at two PHA planning meets in Bangalore and Hyderabad. In the process, MFC became part of the National Coordinating Committee, and the convenor is formally on the National Working Group of Jan Swasthya Sabha. Forthcoming events are another working group

meet on 12-13 August and the National and International assemblies in Calcutta and Dhaka in December. MFC as an organisation will at some point be expected to make a financial contribution to the process. The issue of any necessity for a formal MFC presence in the PHA process was raised, since many members as individuals were actively involved. After some discussion, it was decided to ask the convenor to continue to formally represent MFC through to the Dhaka meet. Several other members expressed their willingness to attend the National and International Assemblies,

People's Health Charter

Anant and Abhay Shukla had drafted a manifesto and a charter for the PHA process, which has been widely circulated. A revised draft was sent to Anant and after further modifications, it was placed at the meet for discussion. The Women and Health cell discussed it at length in their cell meet, and then a detailed discussion (largely in the form of feedback) took place with the larger group. It was pointed out that the role of MFC here is in helping PHA put together a credible charter, which will be finalised in the PHA process. This is not meant to be MFC's vision of a charter. It was suggested that it was time for MFC to put together all the wisdom from past debates and come up with a vision for health that was MFC's own. This would, of course, take time. It was decided not to present the feedback given as MFC's consensus, but rather as feedback from individual members and from the Women and Health cell. Anant will forward the suggestions and comments to the concerned body in the PHA process.

(Minutes prepared by Sridhar, with inputs from Padma, Sunil, Neha and Amar)

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