Health e-Letter

Letter from the Editor

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One visit to the Patna Medical College Hospital is convincing evidence that reforms have yet to touch its vast stagnant pools of humanity. The newly-introduced user charges have not made the wards any cleaner and the conditions any less unhygienic. Bihar's new chief minister can at best hold out chimerical hopes of reforming the crumbling health systems. But the poor of Bihar are so resigned to this reality that no one complains.

Free medical care exists only on paper. User charges have made healthcare inaccessible for the poor. Our story from Bihar illustrates the impact of these charges. Many hospitals in the state have not even set up the patient welfare committees that have been authorized to grant fee waivers to the poor.

Private hospitals, many with few ethical concerns, have brought in vast amounts of money, manpower and state-of-art equipment. Even in Bihar, where they may appear incongruous, such hospitals have come up with unique marketing skills to wring the last penny and land from the poor.

Rushing to the private provider is no longer a matter of choice but rather of necessity. Surveys show that in 1986, 60 per cent of in-patient care was in public health institutions. A decade later, in 1996, this had declined to 45 per cent.

The private sector now accounts for 67 per cent of the 30,000 hospitals and 33 per cent of 10 million beds. Sixty per cent of the five million doctors in India work for the private sector. Most of these doctors get their medical training in the very same premises that they choose to leave once they get their post graduate degree or a few years' experience at the most. Over 75 per cent of medical graduates come out of public medical schools and enjoy a highly subsidized training in medicine. Yet, there is no policy that makes it mandatory to work in public hospitals for some years.

Despite a poor infrastructure, the strength of public hospitals was the presence of some of the finest doctors. Gradually this strength of public hospitals is diminishing. Our story from Lucknow is a shocking revelation of how just a handful of specialists remain at the public hospitals and this is not limited to UP. The finest medical institutions across the country are feeling this onslaught by private establishments.

In the present context, the rising anger of people in the interiors of Maharashtra against shortage of health care facilities is encouraging. Our story from Nasik brings out the discomfort of the health care workers who have never before been questioned. As a result, they are forced to bring up the issues before the authorities. Perhaps, what we need is more demand.

Kalpana Jain
Editor
Health e-Letter

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Lured by big bucks, UP hospitals can't retain doctors

By Sudhir Mishra

Lucknow: Big bucks in the private sector are depleting specialists in the government sector. After getting a post graduate degree at a government medical college, most doctors allow themselves to be lured into working at swanky private hospitals that promise five-figure salaries and state-of-the-art facilities.

"After studying hard for 11 to 13 years, who would like to opt for government employment with paltry remuneration?" says the state head of Provincial Medical Services Association, Dr. D P Mishra. ``What these doctors earn in a month is equivalent to about five days' earning in the private sector,'' he adds in support of doctors joining the private sector.

Of the 70 districts in UP, 68 do not have a pediatric surgeon. There is no gastroenterology surgeon in 67 districts and no neurosurgeon in 59 districts. Of a total number of 121 specialist posts, only 14 have been filled.

As a result, hospitals in UP have been almost depleted of specialists. Look at these grim statistics: Of the 70 districts in UP, 68 do not have a pediatric surgeon. There is no gastroenterology surgeon in 67 districts and no neurosurgeon in 59 districts. Of a total number of 121 specialist posts, only 14 have been filled. The rest lie vacant.

In the Provincial Medical Services there is only one pediatric surgeon and no endocrinologist within the state capital, Lucknow. Pediatric surgeons are available only at the King George Medical University (KGMU), Sanjay Gandhi Post Graduate Institute of Medical Sciences (SGPGI) and Banaras Hindu University (BHU). Many who claim to be heart specialists are only diploma holders - a one- year study course that teaches them the basics of a specialized course. This is only a poor substitute for post-graduate training.

Director General for health, Dr. SS Srivastava, agrees that government hospitals are facing a severe shortage of specialists. However, he says, the government is helpless as specialist doctors show no interest in these posts which have been advertised repeatedly. He says currently there is no strategy to fill these posts.

Dr. Harjeet Singh, senior professor in the department of psychiatry at KGMU, says that approximately 5 per cent of people are presently in need of treatment. But there are so few doctors that treating all patients seems impossible.

The shortage of heart surgeons is what is leading to a real crisis. Around 18 lakh people in the state are estimated to be suffering from heart diseases. Of these, at

STATE OF THE HEART IN UP

1,80,000	**People estimated to be suffering from heart disease**
15-18,000	**patients need to undergo bypass surgery**
Only 9	**government doctors qualified to perform cardiac surgery**
Only 1500	**operations are performed annually in government hospitals**

DISTRIBUTION OF SUPER SPECIALISTS IN GOVERNMENT HOSPITALS

Department	PGI	Medical university	PMS	Total
Gastro surgery	5	3	None	8
Pediatric Surgery	1	8	None	9
CVTS	3	5	1	9
Nephrology	6	9	None	15
Neuro surgery	4	11	1	16
Urology	5	11	1	17
Neurology	4	14	1	19
Psychiatry	None	15	7	22

least 10 per cent need bypass surgery. However, with the present strength of doctors, only 1500 surgeries are performed in the government hospitals every year: 800 surgeries in SGPGI; 600 in Kanpur Medical College and 100 between KGMU and BHU.

The entire burden of these surgeries is shouldered by nine doctors: three doctors each in the cardio vascular surgery Department of SGPGI and Kanpur Medical College, one in KGMU and two in BHU. Chief Medical Officer at SGPGI, Dr. AK Bhatt, agrees that there is an urgent need to increase the number of doctors.

At the same time, private hospitals have been doing around 15,000 to 18,000 bypass surgeries every year. The minimum cost of a heart surgery in a private hospital is Rs 2.25 lakh. In government hospitals it is less than half of this cost, but with a waiting time of six months or more, patients are pushed into seeking care at private hospitals.

Voices from grassroots: Health matters

By Deepti Raut

Nasik: In a first of its kind, people in the villages of Maharashtra have started demanding better health services and accountability from community health workers. Such is the anger amongst people that health care workers are asking authorities for protection while bringing up legitimate demands.

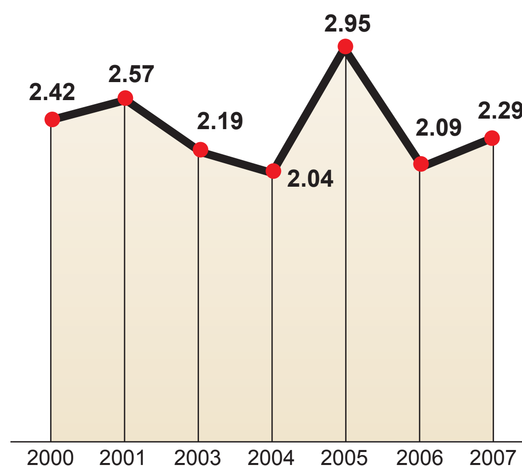
Health care workers, who interface with the community on a day-to-day basis, find they can no longer make excuses for the system. As result they are being compelled to bring up the issues. During the community needs assessment survey for the National Rural Health Mission, health workers voiced complaints about the lack of medicine, insufficient supply of vaccines, outdated instruments, lack of water, erratic electricity supply, a non-existent drainage system, absence of residential quarters for staff and inadequate facilities for providing health services.

"People do not cooperate with us any more," said some health workers. Some were of the view that "local politicians were instigating them." And some complained that people have started threatening them by using the names of local politicians.

While Maharashtra is a progressive state, public health systems have not shown much improvement here. In fact, a study conducted by a non government organization, Samarthan, indicates large amounts of pilferage of health funds.

ALLOCATION BY THE STATE ON PUBLIC HEALTH

(% of overall budget)



The state's own budget for health is showing a decline in proportion to its overall budget. Allocation by the state on public health is only 2 percent of the state budget. The state government had made a commitment in its manifesto that it will increase public health budget to 5 per cent of the total state budget. This has not happened.

A survey conducted by Samarthan revealed that 71 per cent of public health institutions have not been conducting any regular annual audit of the funds they received and utilised. There are 871 queries by auditors in 433 reports during 1998 to 2004, which have not been answered by the state government.

There are various other irregularities as well. Public health projects have not been completed and many remain on paper alone. For instance, Samarthan found 35 per cent of public health institutions that had received sanctions for construction, have not been completed. Around 3181 sub centers, 280 primary health centers and 92 rural hospitals sanctioned five years ago exist only on paper. The state requires another 4125 sub centres, 582 primary health

centres and 92 hospitals in rural areas.

It's not that lack of resources is delaying these projects. Through the National Rural Health Mission alone, Maharashtra will receive Rs. 700 crores during the coming year. The National Rural Health Mission also stipulates that unused funds of the previous financial year can be carried forward to the next budget year. This would be applicable from the coming budget year.

The state's own budget for health is showing a decline in proportion to its overall budget. It was 2.42 per cent in 2000, 2.57 in 2001, 2.19 in 2003, 2.04 in 2004, 2.95 in 2005 and 2.09 in 2006. It is 2.29 in 2007. The state government had made a commitment in its manifesto that it will increase public health budget to 5 per cent of the total state budget. This has not happened.

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According to the economic survey conducted by the government, Maharashtra government is spending only Rs 148 per person per year on health. Chief Minister Mr Vilasrao Deshmukh did accede at a public programme at Thane district that the public health system of Maharashtra was not functioning well.

It is ironic that while people from other countries are coming to Mumbai to avail of the state-of-the-art health facilities provided by the private sector, the people here do not have access to such services. The public health system of the state on which the masses are dependant is itself malnourished.

User charges force poor out of public health system

By Manoj Pratap

Bihar: Bihar chief minister Nitish Kumar's ambitious plans of revamping the public health system seem to have achieved results only in official files. While infrastructure remains as decrepit as ever, the woes of the poor have only increased as they need to furbish a certificate proving that they live below the poverty line or pay to access the threadbare services.

Bihar government claims that there has been such remarkable improvement in services rendered at the primary health centres that the number of people coming for treatment has gone up by 30 per cent. Non government organizations call these numbers misleading.

The state government did make services free for people living below poverty line when it introduced user chargers. A patient welfare committee set up by the health centre was to provide financial assistance to the poor. However, Dr Rahman says a number of hospitals have yet to constitute such a committee.

Forty two per cent of the population in the state lives below poverty line, says Dr. Shakeel-ur- Rahman, acting director of Centre for Human Action Research and Management (CHARM), a non government organization in Patna which works on improving health conditions of marginalised communities. This large percentage of the population can barely manage to get two meals a day. How can they afford any medical treatment?

SUB CENTRES

- **It is the lowest rung of a three-tier set up consisting of the Sub-centre established for every 3,000-5,000 population with referral linkage to the Primary Health Centre (PHC) and the Community Health Centre (CHC).**
- **A Sub centre is expected to provide all the primary health care services such as immunization, antenatal, natal and postnatal care, prevention of malnutrition and common childhood diseases, family planning services and counseling.**
- **A Sub-centre should have a female health worker commonly known as auxiliary nurse midwife (ANM), one male health worker commonly known as Multi Purpose Worker (Male).**

The Bihar government introduced the concept of public-private partnership in the state in July last year. Under this, government health facilities ceased to provide free services. The government partnered with private laboratories for medical investigations such as x-ray and pathological tests. It also brought in private providers for hospital maintenance, providing power back-up and ambulance services.

The government argued that the treatment remained highly subsidized as the fee for all the procedures was only half of that of prevailing market rates. In the last six months, district hospitals and primary health centres too have been included in this public-private partnership concept.

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A look at patient profiles from Phulbarisharif, a block adjoining Patna city, is enough to explain the impact of new policies on the underprivileged masses. At the primary health centre in this block not a single person certified as living below poverty line had come for treatment to this centre in eighteen months.

Rahman explained that conditions had not changed much all over the state. At the subcentres - over 9000 across the state-curative services are not available. There are no medicines, doctors or even paramedical staff at these sub centres. In the Indian public health systems, sub centres constitute the first rung of health care, where minor ailments could be easily addressed.

Due to unavailability of services, people move to the primary health centres for treatment, which then comes up in government records as increase in registered cases. There is overcrowding even at the primary health care centres. Instead of 30,000, one single PHC is catering to a population of two lakh people. A sub centre too is looking after a population of 9,000 instead of the stipulated 5,000. Added to this is the fact that posts of doctors and nurses remain vacant.

Finally, in a number of districts there are no hospitals. Only 23 of 38 districts in Bihar have district level hospitals. At the tertiary level, of the 101 referral hospitals, only 70 are equipped for treatment.

COMMUNITY HEALTH CENTRES

- **A Community Health Centres (CHCs) is the secondary level of health care that essentially includes First Referral Units (FRUs) and the district hospitals. 4 PHCs are included under 1 CHC. It was intended to cater to a population of 80,000 in tribal/hilly areas and 120,000 in plain areas .**
- **This was designed to provide referral as well as specialist health care to the rural population like routine and emergency care in Surgery, Medicine, Obstetrics and Gynaecology and Paediatrics in addition to all the National Health programmes.**
- **A CHC should have an anaesthetist, a public health programme manager, a surgeon, obstetrician and gynaecologist, a paediatrician, a public health nurse and an auxiliary nurse midwife (ANM).**

PRIMARY HEALTH CENTRES

- **PHCs act as referral centers for the Community Health Centres. Each primary health center covers a population of 20,000 - 30,000.**
- **Primary Health Centres provides primary health care services which include basic medical care, mother and child health care, safe water supply, basic sanitation, prevention and control of local diseases.**
- **This cornerstone of rural healthcare should have a medical officer, block extension educator, one female health assistant, a compounder, a driver and a lab technician.**

NEGLECTED DISEASES

THE STORY OF KALA-AZAR: Few care for a disease that mostly affects the poor

By Mammen Mathew

Patna: During Operation Desert Storm against Iraqi dictator Saddam Hussein, a paratrooper commando contingent came down with high fever and splenomegally (enlargement of the spleen). Initially, the best doctors failed to give it a name.

Eventually, it was found to be a variant of kala-azar. French scientists are now studying this strain. Even so, kala-azar remains a third world disease largely "irrelevant" to the rest of the world. Ninety per cent of cases are found in Jharkhand, Bihar, in small banana Republics in Latin America and remote interiors of Africa.

Sadly, kala-azar has not just been neglected by the rest of the world, but also by the rest of India and even the government of Bihar. Like HIV, it weakens immunity and makes a person vulnerable to a host of other diseases. It targets mainly the under nourished, the poor and children. Therefore, mortality is high.

The lack of seriousness with which it is treated by the political leadership in Bihar was aptly summed up when the former chief minister, Laloo Prasad Yadav, while speaking at a conference organized by the Association of Physicians of India said, "I fail to understand how a sand fly which can fly no more higher than six feet could travel over the Ganga to Patna and afflict us." As a preventive measure, he recommended a measure that often leads to its spread -- use of cow dung.

It seems the former chief minister was not aware of a study conducted by the Calcutta School of Tropical Medicine which found that kala-azar cases were more common where khatals - or cow pens - were in close proximity to residential areas. Often, the poor in Bihar share sheds with the cattle. Within homes, a common practice was to resurface the walls with cow dung paste soon after DDT was sprayed in the area to kill the vector.

KALA-AZAR FACTS

Researches suspect there are now several and region- specific-kala-azar variants in Bihar
-DR. C.P. Thakur, WHO Consultant

The same drug, as prescribed for the vector, Phlebotomus argentipes, may not be able to cure all variants of the disease
-Calcutta School of Tropical Medicine

Forty per cent of the deaths in Kala-azar are due to rising toxicity levels and medicines
-Dr T. K. Jha

Kala-azar parasitic indicators identified in cerebro-spinal fluid (CSF)
-British Medical Journal: Dr Sandeep Sen

Kala-azar in combination with TB & AIDS is potentially the biggest threat facing people in Bihar and Jharkhand this century
-National Institute of Communicable Diseases Data

Kala-azar targets the poorest socio-economic groups and children
-ICMR

There is a co-relation between cow pens and the presence of sandflies
-Calcutta School of Tropical Medicine

Former Union Minister for Health, Dr C.P. Thakur, who has considerable work to his credit on kala-azar, is now concerned about Jharkhand. He believes that Jharkhand with its high migration levels and slowdown in malaria control efforts may soon be in for "big trouble". The directorate of health services confirms that seven of the 22 districts in Jharkhand are seriously affected. Among them the Sahebganj and Dumka-Deoghar areas are the worst affected. Interestingly, in 1984, when Sahebganj was spraying DDT three times a year to control malaria it also managed to control kala-azar.

The Union government directive to form committees and entrust village heads with spraying work failed to work as DDT was sprayed in economically well off localities in the village while the hamlets of the poor were given short shrift. Spraying too was irregular. DDT was either sold in the market or left to expire in government godowns. Malaria workers or casual labourers drafted for spraying were not paid either. This was the main reason why they shirked work.

In 1992, Union Health Minister, M L Fotedar, made kala-azar a notifiable disease. However, there has been no effort by either Jharkhand or Bihar to encourage doctors to report kala-azar cases. Experts also point out that there is no reason for Jharkhand to believe that its mainly hilly and fresh forest cover, lesser waterlogged bodies than in the plains of North Bihar would save it from the menace.

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In 1989, the Centre proposed a shared outlay of Rs 8 crore

THE ITALIAN LINK

It might have been Leishman Donovani, an Italian who isolated the Ph. Argentipes and after whom the deadly disease Lieshmania Donovani got its doll like name in the West. But then pharmaceuticals, driven by the business of profit, have not been able to come up with an answer to the disease which never affected Europe or the Americas.

Popularly known in the 19th century as "Burdwan fever", Kala-Zar (Black Fever) claimed over two lakh lives in the 1880's in Assam, Bengal and Purnia. Around 1974, 25,000 people succumbed in undivided Bihar, with Sahebganj, now in Jharkhand a victim too.

for spraying the then undivided Bihar. However, the state failed to meet its share. In 1990, the spraying cost for the same undivided area was pitched at Rs 22 crore. In 1995, the National Institute of Communicable Diseases proposed a whopping cost of Rs 125 crore for spraying and peripherals.

The failure of the kala-azar strategy as realized in a 1996 meeting hosted by Indian Council of Medical Research (ICMR) and the National Institute of Communicable Diseases (NICD in New Delhi, were mainly due to this partial implementation of the spraying calendar as also unplanned and haphazard spraying, leaving out the loci or potential sand fly populated areas, non-treatment of water logged areas and failure of the Revised Malaria Control Strategies.

In fact, the meeting pointed out that besides cerebral malaria and quinine resistant malaria, newer trends were visible where malaria of industrial areas and rural areas of Jharkhand differed. Short and uneven spraying was responsible for newer-resistant malarial strains which were coming up with a vengeance.

As a result of this neglect, the number of untreated and resistant cases continued to climb. Treatment by quacks, dilution of doses or wrong treatment contributed to this increase. Dermal leishmaniasis or skin kala-azar reservoirs have never been estimated or identified wherein a person could have the kala-azar vector lodged in his skin and could spread it while remaining immune himself.

As it remained confined to the third world, no multinational pharmaceutical company invested in research on effective drugs. Drugs came up largely through efforts of local medical scientists. Urea Stibamine is believed to have saved a lot of lives during the fifties and sixties. But the medicine died with the death of its inventor Dr U.N Brahmachari. In the seventies, sodium stiba gluconate (SSG) came to be prescribed.

But this too is proving to be ineffective as well as highly toxic. Renal failure (liver failure), myocarditis, (heart attacks), loss of hair and impairment of vision are among some of the toxic effects. Dr T.K. Jha, an expert at Muzaffarpur, after a ten- year study pointed out that over 40 per cent of patients were dying due to side effects of the drugs.

Few realize that migrant workers from Bihar have taken the disease as far as Chennai, Pune, J &K, UP Terai, Ghaziabad, Mirzapur and Varanasi in UP, Bengal, Rajasthan and New Delhi, where hundreds of cases have been reported. The Jharkhand Government could do well to learn from the mistakes of Bihar and implement the strategies correctly and on time.

Free ARVs across the country just a 'smart card' away

By Manish Srivastava

Lucknow: Amitabh Awasthi, a marketing executive with a private firm in Lucknow has been living with HIV for the past five years. He travels frequently. At times, when the stock of his antiretroviral medicines runs out, he either uses his savings to buy the drugs or just skips a couple of doses.

The National AIDS Control Organisation and the Confederation of Indian Industry have come up with a plan to address the needs of these busy executives. NACO and CII are planning to bring out 'smart cards' through which people living with HIV will have easy access to ARV from any ART centre across the country.

The World Health Organisation's National Consultant, Dr. BB Rewari, during his visit to Lucknow a few months ago, said that until now an HIV positive person was denied access to ARV if he was not registered with that specific ART Centre. However, 'smart cards' would enable positive people to now obtain ARV free of cost from ART centres located anywhere in the country.

The card, with an embedded microchip, and a secure medium for identification (individual specific) will consist of a

The card, with an embedded microchip, and a secure medium for identification (individual specific) will consist of photograph and other personal details (like name, age, blood group etc.) of the client at its back. It would enable the doctor to get detailed information of the HIV positive person such as test details, CD4 count and other general information

photograph and other personal details (like name, age, blood group etc.) of the client on the back. It would enable the doctor to get detailed information of the HIV positive person such as test details, CD4 count and other general information.

As a part of security mechanism to check any misuse of resources, the card will have the thumb impression of the HIV positive person which would act like a code without which it would be rendered useless.

The thumb impression will also help provide detailed information about the person through a thumb reader system. The e-card will be inserted into the card reader and then the positive person as well as the doctor will authenticate it by giving their thumb impressions. After this exercise the medicines will be handed over.

This would allow a positive person living in Uttar Pradesh to access ARV drugs in any ART centre - be it located in Mumbai, Delhi or Kolkata. The following day, information regarding his ARV drug procurement would be sent to the ART centre where he is originally registered. This would help monitor treatment and ensure adherence to treatment without skipping a single dose.

There are approximately five million people living with HIV/AIDS in India. Those on ARVs need to take their medicines everyday and on time or they could develop drug resistance. This 'smart card' would be particularly useful for those on the move - either self employed or service class, who until now have been forced to either buy ARV drugs at prohibitive prices or forego medication when their stock was exhausted.

HIV stigma: False positive report too can wreck a life

By Sudhir Mishra

Lucknow: Despite the intense awareness programmes, the pronouncement of an HIV positive status can wreck a person's life. It does little to help even if subsequent reports establish later that the initial reports were incorrect.

A young couple in the city has lost their means of livelihood, their home and their friends after a pathology report labeled the wife HIV positive. The report was given after conducting only one Elisa test. When the couple got themselves retested, the report was negative. However, the subsequent report has done little to ease their problems.

No sooner did the laboratory pronounce the wife as HIV positive that her husband Raghavendra Singh Chauhan, a driver, was removed from his job. As soon as their landlord learnt about it, he asked them to pack their belongings and leave.

Ostracised by the community they were left with little option but to pack their belongings and live in a make-shift hovel on the side of a busy road.

No sooner did the laboratory pronounce the wife as HIV positive that her husband Raghavendra Singh Chauhan, a driver, was removed from his job. As soon as their landlord learnt about it, he asked them to pack their belongings and leave.

Chauhan has written to chief minister Mayawati demanding action against diagnostic centres that give out such incorrect reports. He has also appealed to her for supporting his wife's treatment.

This instance shows that while people may be aware of HIV/AIDS, the stigma is all too acute in Uttar Pradesh. Chauhan told this correspondent that doctors advised an HIV test for his wife as she had been falling ill frequently. On 5 May last, she was diagnosed HIV positive.

His employers paid for the diagnostic tests. The diagnostic centre did make it clear to the couple that they would need to go for more tests for a confirmation of the HIV status. For instance, they said they could get a Western Blot

Test done.

In fact ELISA is a preliminary test. A single Elisa test cannot confirm the presence of HIV. Chauhan did not understand this and his employees were so stricken by fear that they ignored the rest of the report. His only hope now is action by the chief minister.

What should be done before confirming an HIV positive result?

National Consultant, World Health Organisation, Dr B.B Rewari says, the blood sample of a person is first subjected to either ELISA or Rapid test, the latter being a more common practice. A negative test result obviously rules out HIV infection, while a positive result necessitates a second test which is done using a different antigen.

If a person is asymptomatic and the second test shows a positive result, the blood sample is put to the third and final test, a confirmatory one, which rules out any 'false positive'. However, if a person is symptomatic and the second test is positive, then this is taken to be a confirmatory result.

In cases where the first and second test result is positive but the third turns out negative, the sample is subjected to yet another test called Western Blot test. He adds "every next test performed involves the use of a new and different antigen".

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