COVER STORY

Public health crisis

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The goal of universal health care requires an overhaul of the public health system, medical education and regulatory mechanisms.

At the children's ward of the King George Hospital in Visakhapatnam on June 21, a scene typical of most government hospitals in the country.
At long last, public health is on the agenda of the country’s policy makers. The Prime Minister’s Republic Day speech mentioned that the Twelfth Plan would focus on health just as the Eleventh Plan had focussed on education. But the manner in which the education sector has been messed with does not give much cheer on the prospects for public health at the end of the Twelfth Plan. Nevertheless, it is encouraging that in the last one year universal health coverage (UHC) has emerged as a goal for the planners. Both the High Level Expert Group (HLEG) set up by the Planning Commission in October 2010 and the Planning Commission’s Steering Committee on Health for the Twelfth Plan have discussed public health related issues from the perspective of achieving UHC by the end of the Thirteenth Plan.

However, while the reorientation of the approach and the overall premise suggested by the HLEG in its report of November 2011 are sound and many of its recommendations are worthy of implementation, setting a tight deadline of a decade to achieve UHC may be infeasible given the many ills of the public health care system and the largely unregulated market-driven situation in which it functions. The Steering Committee has incorporated some elements of the HLEG report within an altered framework that differ on key aspects from the HLEG’s perspective. It is the Steering Committee that will have a definitive influence on the decision-making process.

But before the government begins to implement the Steering Committee’s recommendations, there is the need for a wider public debate on them because at least some of the recommendations would let the private sector continue to play a prominent role in health care and make the objective of UHC difficult to achieve. More pertinently, in many key components of the health care system the regulatory framework is either lacking or ineffective and hence a complete failure. Appropriate policy instruments and regulatory and institutional frameworks should be put in place in the immediate term to correct the serious maladies that plague the health care system so that measures for UHC are easily implemented.

This edition of Frontline discusses some of the areas requiring urgent regulatory reforms. Issues highlighted in the reports of the HLEG and the Steering Committee will be taken up in later editions of the magazine.

The unrestricted growth of all facets of the health care industry has to be regulated. K.M. Shyamprasad points out in his overview on the regulatory deficiencies that public health has to do with the health of populations, while health care has to do with the curative aspect and focuses on the health of individuals. Thus, medicine and public health have contradictory interests.

The implementation of health policies has always been by medical professionals, people from the curative medicine background. This has led to the absence of a public health approach in our health care, points out Shyamprasad. He also emphasises the need for a public health law similar to what most developed countries have. A National Health Bill has been in the draft stage since 2009. Clearly, there is no political will to take it forward and enact it into law. The reports of the HLEG and the Steering Committee have emphasised the need for a National Public Health Act and State Public Health Acts on the lines of the Tamil Nadu Public Health Act, which has demonstrated its effectiveness.

The Clinical Establishments (Registration and Regulation) Bill, 2010, was passed by Parliament nearly two years ago but it could be notified as an Act only on February 28 this year as it was being repeatedly challenged by the medical fraternity in courts. The Bill seeks
to register and regulate clinical establishments (including hospitals and clinics in all recognised forms of medicine) and any laboratory
offering pathological, chemical and other diagnostic services, so as to ensure that they meet the minimum standards of space and
infrastructure (equipment and paramedical staff) as laid down by the government. Two writ petitions filed by the Indian Medical
Association (IMA) are currently pending in courts.

The opposition to the Act is driven largely by the interests of the large number of private practitioners who function out of places that do
not meet the standards. Among the demands of the IMA, for which it has called a nationwide strike on June 25, is exemption from some
of the provisions of the Clinical Establishments Act, which it feels are draconian. One particular concern with regard to this Act – that it
does not provide for any compensation to doctors who are statutorily mandated to provide emergency medical services – seems to be
valid, as Shyamprasad has pointed out in his article.

The IMA generally opposes any kind of regulation and, as Shyamprasad says, as an organisation of health professionals it has failed the
society by not observing effective self-regulation. It is also a fact that unethical practices abound in the medical profession resulting in
rash commercialisation of health care. The IMA’s recent endorsement of commercial advertisements making claims of medical value in
non-medical products is just one example.

In a recent open letter to the IMA, the Medico Friends Circle (MFC) and the Forum for Medical Ethics Society (FMES) wrote:

“The IMA should seriously try to reverse the current widespread unregulated commercialisation of health care in India, and should
contribute to the process of health system reforms for eliminating the distortions in medical practice. This would be immensely beneficial
to patients and would also raise the dignity of the medical profession manifold… [C]ut practice and commissions, irrationality in
investigations and surgical practices, distorting influence of pharma industry on prescribing by doctors, and inflation of patient bills
consequent to all of these, are extremely widespread. This has resulted in massive problems relating to both cost and quality of medical
care for the people. Besides the evidence from various studies on caesarean section rates, injection practices, prevalence of
hysterectomies and sex selective abortions, most practising doctors admit in private that malpractices are a pervasive trend, not limited to
a few isolated individuals. In fact, distortions in medical practice induced by unregulated commercialisation have become systemic
problems.”

Unethical practices in the form of a nexus between the regulators and the pharma industry were highlighted in a recent report of the
Parliamentary Standing Committee on Health. The assurance of access to quality, safe and efficacious drugs at affordable prices is the
minimum prerequisite for an effective health care system before one can think in terms of cashless treatment under a UHC system.
Non-essential and unsafe drugs have flooded the market because of an ineffective and corrupt regulatory system on the one hand and the
doctor-pharma business on the other. Hundreds, if not thousands, of unlawful and undesirable drugs, including drugs banned elsewhere in
the world, have entered the supply chain because corrupt functionaries in the Central Drugs Standard Control Organisation (CDSCO)
under the Ministry of Health and Family Welfare have allowed them to without applying mandatory regulations such as appropriate
clinical trials and without safety and efficacy data of these drugs (story on page 8).
With India increasingly becoming a hub for clinical trials for institutions and companies abroad, even where drug trials are done they are not regulated properly in terms of the recruitment of subjects and the protocols followed. India is witnessing an unprecedented growth in its drug trials market – from Rs.423 crore in 2005, it is expected to cross Rs.2,721 crore, according to Sama, a non-governmental organisation. It recently brought out a report on ‘Regulation of Drug Trials’ following a National Consultation workshop. The report says, “India has a huge ‘treatment naive’ patient base, low-cost advantage and ‘efficient’ conduction of trials, ‘improving infrastructure’ and strong state support for outsourcing and privatisation.”

At present, as elaborated in the story by T.K. Rajalakshmi (page 26), the infrastructure for regulation, ethics review and monitoring of clinical trials is insufficient and ineffective. “In this situation,” says the Sama report, “the government’s push to encourage clinical trials must be viewed with concern. There is an urgent need for a policy that truly engages with, and respects, the public by according the highest priority to transparency in clinical trial procedures, as well as protection of the rights of the participants…. India… requires a more stringent regulation, and effective implementation, in order to ensure the highest standards of independent inquiry, good clinical practice, enforcement of protocols, monitoring and follow-up, so that a strong and pro-people policy can be put in place.” It is high time the government enacted an appropriate umbrella Act for clinical trials and linked it to the existing guidelines on biomedical research of the Indian Council of Medical Research.

The reports of the HLEG and the Steering Committee have highlighted the critical issue of Human Resource for Health (HRH). In fact, one of the terms of reference of the HLEG was to prepare a blueprint for HRH. One of the serious problems facing medical education in the country is that it has become highly commercialised, with entry into a medical course depending on one’s capacity to pay (from several lakhs of rupees up to a crore and more) rather than a transparent examination-based merit assessment. This is the result of unregulated growth of the private sector in the field of higher education, with the statutory body entrusted with evaluating, assessing and monitoring medical colleges and institutions, the Medical Council of India (MCI), itself becoming an active collaborator in promoting such dubious degree-churning grounds.

The legislation aimed at replacing the MCI with an overarching statutory body covering medical, dental, pharmaceutical and nursing courses, called the National Commission for Human Resource in Health (NCHRH), introduced in 2010, is currently being examined by the Parliamentary Committee. If it had been enacted in time, there would have been no need to grant two extensions to the MCI, which, following charges of corruption, is in suspended animation, propped up by an ad hoc Board of Governors (BOG) since May 2010. More pertinently, there is evidence to suggest that corruption within the MCI continues in the matter of setting up new medical colleges. However, the proposed NCHRH Bill, too, is not without problems, a major one being concentration of power at the Centre while health remains a State subject. This would only result in continuing corruption in medical education (story on page 17).

Another important deficiency in respect of HRH is the huge gap in demand and supply for rural health services, particularly at the primary health care level. A well-conceptualised short-duration (3½-year) degree course called the Bachelor in Rural Health Care (BRHC) is yet to become a reality though it was recommended by an expert body of the Ministry in 2007. Such initiatives proactively put in place by States such as Assam and Chhattisgarh have been successful. But the Centre is seen to be dithering and there are signs of a
stand-off with the MCI (now BOG/MCI), which is required to develop the curriculum and syllabus for the course.

The largely urban-centric medical fraternity of doctors, who mostly are unwilling to serve in rural areas, is opposed to such a course. In fact, calling the course “substandard”, the IMA has objected to its introduction. Following petitions in the Delhi High Court by public health professionals, there seems to be light at the end of the tunnel with the MCI assuring the court in March that the course will be ready by April. But the matter will not be resolved fully as the Parliamentary Standing Committee is not through with examining the issue (story on page 21).

The above are only some of the deficient regulatory frameworks in the area of health. There are many more which the Frontline Cover Story has not covered. All these have to be put in order – with new pieces of legislation where none exists or rectifying existing deficient ones – before policy makers even begin to think in terms of implementing a UHC programme.