HEALTHCARE IN THE ANDAMANS

In 1993—forty years since I entered Madras Medical College—I organized a reunion of my classmates. Seventy-six of us got together and enjoyed ourselves so much that it was but natural to attempt to recreate the event to celebrate the Golden Jubilee. I followed the same pattern in 2003, but there were two variations, one good and one sad. Age had taken its toll. Many of us had departed for better worlds in the decade past, and many of the survivors felt they were too ill to travel. However, the majority of us felt that the pleasure of meeting old friends made up for the discomfort, and we had many cardiac patients, some with arthritis, and even one patient on continuous ambulatory peritoneal dialysis who came with bags of dialysate and a cycler, and was dialysed overnight in the hotel. We were 53 classmates, 93 in all including the spouses of many of us.

I followed the same pattern I described to you ten years ago. The happy difference was an ambitious extension, a 4-day visit to the Andamans. I will not give you the details of the sights we saw, except to say the Andamans are a wonderful holiday destination. The Andaman and Nicobar Islands Integrated Development Corporation runs reasonably priced hotels, comfortable if not luxurious, and organizes sightseeing excursions. My message today pertains to our profession. One of my classmates warned me in advance, ‘The Andamans are endemic for malaria. You must advise all our friends to take prophylactic chemotherapy before they come.’ However, I sought a second opinion from the one best qualified to give it. One from our group is a native of the Andamans. He came from there to study medicine, and returned to the Andamans medical services. After retirement, he now has a general practice in Port Blair. He reassured us that malaria has been almost eradicated. Screening of blood from all patients with fever, thus detecting and treating all cases of malaria, has removed the parasite though the vector remains on the Islands. Malaria is now rarely seen.

I did not have the time to study the health situation of the Andamans myself, but my local classmate gave us some information. The population is around 350 000 distributed over 572 islands. However, only 8% of the area is inhabited, the rest is covered by forest. There is only one town, Port Blair, and 120 000 live there. There are 132 doctors, providing one doctor for around 2700 people, a far better ratio than most of India. There are 147 health institutions, of which three are hospitals and the rest dispensaries and primary health centres. Thirteen of them cater to the tribals who comprise around 10% of the population. While the hospitals are not equipped for the higher specialties, the government airlifts all patients who need further attention to the government hospitals in Kolkata or Chennai, free of charge. If the patient chooses to go to a private hospital at that destination, he or she has to meet the hospital expenses, but air transport is still provided free.

The health of the tribals is a cause for concern. Some tribes (the Sentinelese being the major one) are hostile and resist contact with outsiders, which is perhaps best for them. Those who have interacted with immigrants from the mainland have suffered drastic mortality. The Great Andamanese, who were once the tribe, the Jarawas, is relatively friendly and has been well studied. Respiratory infections (63%) and abdominal diseases (21%) account for most of the deaths of the tribals; 49% test positive for hepatitis B surface antigen, and 71% have anti-HBs antibodies, though only a fraction have any clinical features of liver disease; 6.5% have elevated liver enzymes. Vertical transmission is common. Forty-four per cent of those afflicted by the virus are below 14 years of age. Of special interest is the fact that diabetes and hypertension do not exist among the Jarawas. They do not use salt in their diet, and none of 180 individuals studied had either of these diseases. Contact with ‘civilization’ has led to some of them adding salt and spices to their food. Since sodium-dependent hypertension requires genetic predisposition as well as a high sodium intake, it would be interesting to see whether they develop hypertension in the years to come.

A plan is afoot to link 7 islands by telemedicine to the central hospital in the capital, Port Blair. This will in turn be linked to Chennai or Bangalore. Doctors in the Andamans will then have access to consultations with specialists in these cities, which one hopes will improve the medical care of the people of the Andamans. Even now, with the existing arrangements, the islanders seem to be doing better medically than the rest of the country. Surely, it should be possible to duplicate these results on the mainland.

One of our excursions was to the island of Jolly Buoy, uninhabited except for the daily influx of tourists who are all taken off the island in the evening. This island is ringed by a beautiful coral reef, which one can see through glass-bottomed boats. The more adventurous can go snorkelling, for which equipment is available on hire. The striking feature of the excursion to Jolly Buoy was that all plastic bags were confiscated when we boarded the ferry to the island. Even plastic water bottles were enumerated, and we had to show them to the guards on our return. The beach was spotlessly clean. Unfortunately, these strict measures are not applied on the mainland. Corby’s Cove is another much touted beach on the largest island, South Andaman, on which Port Blair is located. We were there the next afternoon, and we could hardly see the sand for the plastic bags, bottles and other trash strewn on it. It just goes to show what we can achieve with a little firmness and the will of the authorities. The entire Andamans could be made into a litter-free zone, but only if all of us were forced to make it so.

Tail piece: one of our lady classmates announced afterwards that she enjoyed Jolly Buoy. ‘Shame on you,’ said another, “and at your age too.’

THE COST OF MEDICAL CARE

While inaugurating a clinic at an eye hospital in the city, Mr P. S. Ramamohan Rao, Governor of Tamil Nadu, advised hospitals to acquire the latest equipment to provide better healthcare in the state. Medical technology has developed greatly, he said, and this advance should be extended to the people. I wonder whether that is sound advice. Equipment costs money, and that money has ultimately to be provided by the patient. We hear the constant complaint that the costs of medical care are soaring. While doctors are often blamed for this, the fact remains that consultation fees and hospital charges lead, and drugs not far...
England’s famous victory over Australia’s rugby team.

Minister for Sport, Richard Caborn, from Australia, thus missing the government’s nervousness was such that it recalled the Bill; however, they later relented and passed it. After the loss of many of its most important clauses, the House of Commons passed it with (for this government) a record low majority of 35.

The scheme for ‘Foundation Hospitals’ has proved divisive; the government’s timid approach to important but contentious issues has been neatly illustrated by legislation enacted by the devolved Scottish Executive (Parliament). In 2000 the Scots voted for free National Health Services (NHS) residential care for the elderly, scrapped tuition fees for university students in 2001, and banned hunting with dogs (fox hunting and hare coursing) in 2002; they are now considering banning smoking in pubs, restaurants and other public places.1 The Westminster Government has continued to support the unpopular tuition fees, failed to pass a ‘fox-hunting’ Act, and prevaricated over a smoking ban.

Certainly, the Scots need action on their smoking habits; they have the worst figures for lung cancer and the lowest life expectancy in western Europe. The average Scottish 15-year-old starts smoking at the age of 12 years and has a 40-week habit.1 Public support for a ban has increased after people have seen the success of legislation in New York and other American cities. In a recent case in the Court of Appeal, a mother who had been wrongly convicted of killing her two infant sons was freed: the Court rejected the opinion of an expert witness at her trial, Sir Roy

TAKING THE BULL BY THE HORNS

We have just celebrated Pongal, the harvest festival. Newly harvested rice and jaggery are cooked in milk and offered to God in prayer, before being enjoyed by us mortals. The next day, cows are honoured by being richly decorated and led round the town. On their way they are fed by people grateful for the bounty received through the year. The day after is the festival of Jallikattu, or the Tamil Nadu version of the bullfight. Perhaps in days of yore it was single combat between an unarmed man and a bull, but as long as I can remember it was a crude contest between one bull and hundreds of young men. A grand uncle of mine had deep scars on his thigh, where he had been gored by a bull during the Jallikattu. The animal, sometimes made to imbibe alcohol before the event, is let loose on the streets of a village. It is teased and beaten till it goes berserk, and then the matadors fling themselves on it and try to subdue it, or ride it as long as they can. They may be injured or even killed during the fracas, but often the bull runs wild and spectators become victims of the frenzied animal. I see no sport, no special skill in this unequal contest. It is cruel to the animal, and dangerous for humans. I believe both participants and spectators display inhuman bestiality. Not a year passes without headlines of injuries and deaths as a result of the Jallikattu. This year’s newspapers were no exception. Prizes were offered to whoever could hang on to the horns or the hump of the bull for a distance of 20 metres. There were roosters, gold coins, steel cupboards, electrical goods, cash on offer this year, and the newspaper carried headlines: 187 injured in one place, 17 of them grievously, needing admission to hospital; 48 injured in another, 6 seriously and now in hospital. Every once in a while, we will hear of someone dying, leaving old parents or young children to fend for themselves.

Not all that is traditional is good. We have banned many barbaric customs that were once regarded as acceptable and even laudable. This is one which should go the same way. Sadly, the Tourism Department is promoting Jallikattu as a tourist attraction. Ahimsa is dead.

REFERENCE


M. K. MANI

Erratum

In the Letter from Chennai published in the November/December issue (Mani M.K. Letter from Chennai, Natl Med J India 2003;16: 331–2), the second sentence of the first paragraph should read: ‘Every now and then it is introduced, and in a few years it is withdrawn as finance ministers realize there is money in alcohol.’ We apologise for the error.

—Editor

Letter from London

During the past few months the government has not had an easy time. The credibility of the Prime Minister, Tony Blair, has been permanently damaged by his now ridiculed excuse for going to war in Iraq on the grounds that Saddam Hussein possessed weapons of mass destruction, which is generally accepted as false.

The government’s timid approach to important but contentious issues has been neatly illustrated by legislation enacted by the devolved Scottish Executive (Parliament). In 2000 the Scots voted for free National Health Services (NHS) residential care for the elderly, scrapped tuition fees for university students in 2001, and banned hunting with dogs (fox hunting and hare coursing) in 2002; they are now considering banning smoking in pubs, restaurants and other public places.1 The Westminster Government has continued to support the unpopular tuition fees, failed to pass a ‘fox-hunting’ Act, and prevaricated over a smoking ban.

Certainly, the Scots need action on their smoking habits; they have the worst figures for lung cancer and the lowest life expectancy in western Europe. The average Scottish 15-year-old starts smoking at the age of 12 years and has a 40-week habit. Public support for a ban has increased after people have seen the success of legislation in New York and other American cities. In a recent case in the Court of Appeal, a mother who had been wrongly convicted of killing her two infant sons was freed: the Court rejected the opinion of an expert witness at her trial, Sir Roy
Meadow, a past President of the Royal College of Paediatrics and Child Health, describing his evidence, in favour of murder, on statistical grounds, as ‘wholly erroneous’. There is now a general view that more than one ‘cot death’ in a family may be due to as yet unrecognized disorders of metabolism or immunity. A shortage of paediatric pathologists has not helped. This case is likely to have far-reaching consequences and a review of similar convictions based on Sir Roy’s evidence is almost certain. This is a sad development in an otherwise brilliant career; Sir Roy was the first person to recognize Munchausen by proxy in which the mother (invariably) manufactures spurious evidence of illness in her child.

An interesting development in the drugs industry has been the announcement by Allen Roses, head of the pharmaceutical giant GlaxoSmithKline that the failure of a drug to produce its desired result may be due to a genetic abnormality in the patient. According to Roses, as many as 30%–50% of patients with a range of disorders such as Alzheimer disease, rheumatoid arthritis and schizophrenia may fail to respond to treatment. A recently introduced technique, ‘single nucleotide polymorphism’ may identify individuals likely to have a dangerous reaction to a drug, and also those in whom the drug may be inactive.

Fruit juices, hitherto regarded as a health-promoting source of vitamin C, have come under a cloud. A recent ‘Drugs Point’ in the BMJ suggests that cranberry juice may interact with warfarin, causing prolongation of the international normalized ratio (INR). There is now evidence that grapefruit juice may interact with a small number of drugs, such as some of the ‘statins’ (simvastatin and atorvastatin) by interfering with their partial breakdown in the intestine, causing higher than expected levels in the blood and, hence, side-effects.

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JOHN BLACK

Letter from Sri Lanka

A TALE OF TWO POLLS

Sri Lanka is in the throes of another serious—and sadly, all too frequent—outbreak of election fever. Over here, it is a malignant malady carrying a high mortality and morbidity. A general election is scheduled for 2 April 2004, to be followed by elections to the Provincial Councils in the ensuing weeks and months. Rowdy and often violent political rallies, tumultuous and disruptive processions, fierce speeches, and deafening firecrackers fill our days. Indian readers will be familiar with this sort of stuff. By the time the dark clouds of obscuring dust have finally settled on these exercises in democracy, and we are able to see clearly whether we have elected asses or donkeys to govern us, conservative estimates are that at least 100 lives would have been lost and many times that number seriously harmed by shooting, stabbing, arson or clubbing in this small island of just 20 million inhabitants. Up to the time of writing, over 230 incidents of election-related violence, including two murders of rival Tamil candidates, strongly suspected to be the handiwork of the Tamil Tigers, have been recorded. Against this sombre backdrop we have two opinion polls that indicate what people really think about their rulers.

The first poll was by ORG Marg Smart in January 2004, on a random sample of 2000 people from all parts of Sri Lanka, excepting the areas under the yoke of the Liberation Tigers of Tamil Eelam (LTTE). Before I tell you about the results of this poll you need to know that the all-powerful executive President of the Republic, twice elected directly by the people, is Ms Chandrika Bandaranaike Kumaratunge. She is also the leader of the coalition called the People’s Alliance (PA). But the elected Prime Minister, Mr Ranil Wickremesinghe, who is also the leader of the coalition called the United National Front (UNF), had the majority in Parliament elected by the people, until it was dissolved on 3 December 2003 by the President in a surprise move. It had become increasingly clear to most people that the ‘co-habitation’ between the executive President (and PA leader) and the UNF government led by Wickremesinghe, which had lasted a little over 2 years, had finally reached breaking point. The two protagonists seemed incapable of agreeing on practically everything that mattered to the people, including a political solution to the LTTE’s ruthless hegemony in the northern and eastern provinces.

While the PA and UNF leaders are playing evidently partisan political games, the people are clear about what they want their leaders to do. Here are the people’s responses to the most crucial issue facing the nation today.

Question 1. As a citizen of Sri Lanka, if you had one request to make from the Prime Minister, what would it be? Over 70% of the respondents (including those from the troubled north and east) selected, ‘Make a compromise with the President and continue peace talks (with the LTTE),’ over other responses such as ‘Build up the economy,’ ‘Improve the quality of life (of the people)’ and ‘Solve the unemployment problem.’ These last three responses together polled only about 8% of the responses.

Question 2. As a citizen of Sri Lanka, if you had one request to make from the Prime Minister, what would it be? Over 75% of them selected, ‘Make a compromise with the Prime Minister and continue peace talks (with the LTTE).’
The second poll was by the Lanka Monthly Digest (LMD), a leading Sri Lankan business magazine. Its February 2004 issue reported a readership survey of 100 people on the state and private health services in Sri Lanka. The results of the survey surprised no one. Ninety per cent of the respondents thought that the ministry of health was not doing its job properly, and 49% and 12% identified, respectively, weak management and a dearth of trained personnel as its chief deficiencies. Fifty-one per cent judged that the state-run health services were in a dreadful condition requiring urgent measures for resuscitation, and another 47% felt that much more than what was being done at present could be done to enhance its quality.

Even a brief inspection of any of the major state hospitals and other healthcare facilities will show their pitiful state: dilapidated and unplanned buildings, lack of basic treatment facilities, acute shortages of trained staff and essential drugs, lack of discipline among certain categories of staff, and almost unmanageable overcrowding of patients seeking treatment.

The Sri Lankan government has, over the past decade or so, allocated only about 1.4% of its gross domestic product (GDP) annually for expenditure on health. By no stretch of imagination can this be thought to be adequate, as most developed countries spend about 6%–9% of their GDP on health, and some countries allocate 12%–15%. Successive governments have failed to understand that good health cannot be achieved with inadequate resources relative to the rest of the economy. The Minister of Health, P. Dayaratne, has also identified the entrenched, outdated and stifling bureaucracy as one of the factors slowing down progress: ‘It (the bureaucracy) has definitely retarded (progress). Just as an example, the whole system is steeped in bureaucracy, and I find it very difficult to get anything implemented (speedily). Most of our senior management comprises doctors who are rather set in their ways.’

There have been over 50 strikes by state health workers in 2003, with the powerful trade union, the Government Medical Officers’ Association, leading by example. The power of these unions resides solely in their ability to hold the lives and sufferings of patients to ransom. Of course, lip-service is paid to keeping emergency services running during these appalling strikes, merely to stave off public wrath and media criticism, but the tragic experiences of patients are different. In a sense, the seemingly endless strikes are only one manifestation of weak management and archaic rules that shield errant or corrupt employees from any kind of disciplinary action.

Rabies continues to kill people in Sri Lanka, as it does in most other Asian countries. Eliminating it ought to be easy in a small island nation, at least in theory. However, some parochial socio-cultural notions and behaviours stand in the way of implementing easy solutions.

First, some figures. An estimated 400 000 people are bitten by dogs each year, but only about 200 000 seek post-exposure treatment (PET). The rest presumably remain at risk of getting rabies and certain death. The number dying annually from the disease has fallen from 151 in 1995, to about 110 in 2000 and 70 in 2003. That is only one side of the story; the other is the rising cost of providing PET to those who seek it.

Government spending on tissue culture antirabies vaccine rose from US$ 247 600 (for 68 000 single-dose vials) in 1992 to over US$ 970 750 (for 357 750 vials) in 1996—a 300% increase in 4 years. For 2003, the figure is about US$ 1 830 000 (for 750 000 doses). The spending on antirabies immunoglobulin has also seen a meteoric rise from US$ 14 859 (for 1800 single-dose vials) in 1992 to over US$ 125 850 (for 14 300 vials) in 1996, and US$ 811 000 (for 125 000 vials) in 2003. These figures, and the number of people dying from rabies, may seem trifling when viewed in the Indian context, but we have a population of about 20 million, whereas India has over 1025 million. The point is that there must surely be a more sensible approach to the problem of rabies than allowing rabid dogs to flourish and then spending so much of the total government allocation on drugs (US$ 45 million) on PET.

Dog bites are responsible for a little over 97% of all cases of human rabies in Sri Lanka. Cat bites account for about 1.8% and mongoose bites for the rest. But why not just immunize all pet dogs and destroy the strays? Neither is easy in Sri Lanka. Destroying stray dogs is not easy for at least three reasons. The first is that the largely Buddhist ethos in the country and increasing sensitivity to animal rights is unlikely to tolerate killing of dogs, unless they are obviously rabid or at least highly suspect, even though rabies kills humans and several hundred million rupees are spending protecting people with dog bites. The second reason is that most of the unlicensed stray dogs are actually fed and looked after by a single ‘owner’ or a group of them, mostly at bazaars, market places or near places of worship, where discarded food is often plentiful. A more appropriate way to describe this category of strays is, ‘dogs owned but inaccessible to destruction or vaccination’. The third reason is that people are generally unaware of the danger of death they are exposed to from stray dogs, ‘owned’ or otherwise.

Even if most of the unlicensed dogs are killed, the sylvan reservoir may not become extinct anytime soon. An interesting study recently reported in the Ceylon Medical Journal found that 22% of free roaming mongooses trapped in the southern province of the island were positive for rabies. Mercifully, none of the 100 domestic rats studied were found to be positive.

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