Jeevan Dhara Pharmacy: Trump card benefiting the patient in the fight against the patent

Out-of-pocket expenditure on medications forms a major part of the expenditure in the monthly budget of many Indians. This is because most doctors prefer to prescribe ‘branded’ drugs as opposed to generic drugs. Branded drugs are more expensive than their generic counterparts. The Andhra Pradesh government has been taking steps to make medicines affordable for the common man through Jeevan Dhara Pharmacy outlets.

The ‘Jeevan Dhara’ concept was the brainchild of J. Syamala Rao when he was the District Collector of Vishakapatnam. In January 2009, he initiated the setting up of a pharmacy selling generic drugs at Vishakapatnam with the help of the Indian Medical Association and the Red Cross Society. Through the Jeevan Dhara Pharmacy, quality medicines from reputed pharmaceutical companies were made available at an affordable cost to the public. The success of the Jeevan Dhara experiment prompted the Andhra Pradesh government to issue an order in March 2011 to all teaching hospitals, district headquarters and area hospitals to open a generic drug store on their premises. Thirty-six such outlets have come up in several parts of the state, and the process is ongoing. Further, a directive was issued to government doctors in the state to prescribe only generic drugs instead of specifying brand names. The Andhra Pradesh Medical Services and Infrastructure Development Corporation is the nodal agency for the procurement and distribution of generic medicines to Jeevan Dhara Pharmacy outlets.

However, despite the availability of cheaper drugs, this is yet to catch up with the public. Though these outlets have registered an increase in their sales, it is only a fraction of the sales of the pharmacies selling branded products that are often located in the vicinity. Apprehension regarding the quality of generic medications and the aggressive promotional campaign by the pharmaceutical industry are probably the reasons for the underutilization of this facility. The speculation about the quality of generic medications seem unfounded as many of these medications are manufactured by the same companies that manufacture the branded products. Furthermore, there are no separate standards for generic and branded drugs. There is a need for creating increased awareness regarding this facility.

ALLADI MOHAN, Tirupati, Andhra Pradesh

Reproductive tourism: Boon or bane for Indian women?

According to a recent report in the Guardian, a young surrogate mother, Premila Vaghela, died in Ahmedabad in May 2012 as she was arrested. The baby was delivered prematurely by a caesarean section developed complications during delivery and suffered cardiac arrest. The baby was delivered prematurely by a caesarean section and survived.

Stringent adoption laws, lengthy, time-consuming adoption procedures and the red tape inherent in the bureaucratic system have all contributed to the rise of surrogate motherhood and reproductive tourism in India. What began initially as an altruistic gesture to help out a loved one who could not enjoy parenthood due to a medical condition has now turned into a fully commercial exercise, at times violating all ethical norms and putting the individual involved at a high risk of complications and even death.

Infertility clinics have become a hub for reproductive tourism, both for Indians settled abroad as well as for foreigners. They are not restricted to just the metropolitan cities, but flourish even in small cities and towns. More and more couples who are unable to reproduce biologically are opting for surrogacy in India because vulnerable, poor, illiterate and ignorant Indian women are soft targets and readily agree to become surrogates as it provides them (for a brief period of time), financial support for the basic necessities of life. Getting paid well for something that is within their control is a tempting lure, and women rent their wombs without worrying about their own health. Moreover, surrogacy in India is cheaper than that in the West and interested parties need to pay only one-tenth of the money for the same service.

Most surrogate mothers are already undernourished, anaemic and fragile. Many of these surrogate deliveries end up being caesarean sections to coincide with the preferred time of birth pre-decided by the genetic parents, or to coincide with their time of arrival in India, thereby putting these mothers at increased risk of complications and morbidity. There have been cases where some surrogate mothers have even lost their lives, because the staff at the clinic and the paying party are just interested in the outcome of the pregnancy—the precious child, caring little for the surrogate mother. Even this knowledge of possible complications does not deter these poor women from going ahead with surrogacy, as they are assured that their families will be provided with monetary help even if they themselves have to suffer or die.

Although there have been efforts to put legal measures in place, the lack of strict implementation and various loopholes in the system have hardly been a deterrent and have failed to check this harmful practice from spreading its tentacles in the economically weaker sections of Indian society.

What we need is strong political will and commitment to curb this menace and drafting of stringent laws along with stricter implementation of the existing ones if we are to protect the rights of our vulnerable poor.

BHAVNA DHINGRA, New Delhi

Indian Medical Association strikes against government’s usurpation of autonomy of the medical profession

The much-publicized nationwide token strike by the 220 000 member strong Indian Medical Association (IMA) against promulgation of the National Commission for Human Resources for Health (NCHRH) Bill, 2011 (http://164.100.47.5/newcommittee/press_release/bill/Committee%20on%20Health%20and%20Family%20Welfare/nation%20com%20humn.pdf),
proposed amendments to the Clinical Establishment Act, 2010 (http://mohfw.nic.in/index3.php?lang=1&level=0&depth=40) and the demand to reinstate the elected Medical Council of India (MCI) evoked sharp responses from many quarters. A non-governmental organization (NGO) named ‘People for better treatment’ filed a public interest litigation in the Supreme Court of India to get a stay order. While the Supreme Court refused to stay the strike, the ethics of the strike were questioned and IMA was issued notice to respond within 4 weeks (http://courtnic.nic.in/supremecourt/temp/wc%2025312p.txt).

The decision to go on a general nationwide strike was taken at a meeting of the Central Working Committee of IMA on 22 April 2012 at Mumbai to protest the perceived threat of loss of autonomy of the medical fraternity and the shoddy treatment meted out to the medical profession. The IMA gave an assurance that emergency cases would not be affected, a promise which was adhered to. The strike had a mixed response, with many states seeing paralysis of services whereas in others the response was lukewarm.

The NCHRHR bill was approved by the Cabinet on 13 December 2011 and conceives a national-level common regulator which will amalgamate and replace the MCI and other paramedical bodies such as the Nursing Council of India, the Dental Council of India and the Pharmacy Council of India. IMA contends that the super-archeing NCHRHR which is ‘of the government, by the government and for the government’ will be governed by bureaucrats instead of doctors and will simply execute orders given by the central government. Since the bill does not have a provision for representation from professional organizations, this will lead to vested interests exploiting doctors, increasing red tape and shunning the voices of healthcare providers. The bill also proposes that registration in state councils would be valid for the state concerned only and registration with the national council would be a prerequisite to practice anywhere in India. The provision that engagement of medical professionals in other occupations would be considered as misconduct is being seen as an infringement of the basic rights of a citizen of the country to earn his desired livelihood.

The Clinical Establishments (Registration and Regulation) Act was assented by the President of India on 18 August 2010 after both houses of Parliament ratified it (though without a word of discussion). The Act has already come into force in Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim and all Union Territories from 1 March 2012, while it has been ratified by the assemblies of Rajasthan and Uttar Pradesh. It has been made mandatory for all clinical establishments to provide necessary stabilizing medical care and treatment to any individual who comes or is brought to the clinical establishment in an emergency medical condition, particularly parturient women and accident cases. All clinical establishments including diagnostic centres and single-doctor clinics across all recognized systems of medicine both in the public and private sector, except those run by the defence forces, have to undergo mandatory registration failing which fines can be imposed. The fine would be recovered as an arrear of land revenue if a clinical establishment fails to pay it. The registering authority has the district magistrate as its chairman and does not have representation from medical associations, a move which is being opposed by the IMA.

The MCI, which was constituted by Parliament through the Indian Medical Council Act 1956, was dissolved in 2010.

SANJEEV KUMAR, New Delhi

Tuberculosis is now a notifiable disease The Ministry of Health has added tuberculosis (TB) to the list of notifiable diseases such as plague, polio, bird flu, swine flu, etc. All healthcare providers, including clinical establishments run or managed by government (including local authorities), private or NGO sectors and/or individual practitioners now need to keep complete records of patients taking treatment for TB from them. Every TB case now needs to be notified to the local authorities, i.e. district health officer/chief medical officer, etc. every month, in the given format. This move is expected to ensure proper TB diagnosis and case management, reduce transmission and address the potential of emergence and spread of drug-resistant TB. The move is especially meant for the private sector which is usually the first point of contact for the majority of Indian patients, and where accountability is often patchy. The move seems to have stemmed from the recent emergence of completely drug-resistant TB at a hospital in Mumbai.

Weeks after the notification, most private caregivers still seemed ignorant about it. Even though the ministry’s notice was served to all state/Union Territory TB officers, the information had not reached private providers. Some government officials wanted district magistrates to be made the implementing authority.

The ministry’s circular dated 7 May 2012 (http://www.tbcindia.nic.in/pdfs/TB%20Notification%20Govt%20Order%20 dated%2007%2005%202012.pdf) has defined TB as when a patient is diagnosed with at least one sputum specimen positive for acid-fast bacilli, or culture-positive for Mycobacterium tuberculosis, or Revised National Tuberculosis Control Programme (RNTCP) endorsed rapid diagnostic molecular test positive for TB or the patient is diagnosed clinically as a case without microbiological confirmation and has been initiated on antitubercular drugs.

SANJEEV KUMAR, New Delhi

Diesel engine fumes declared carcinogenic by the International Agency for Research on Cancer The International Agency for Research on Cancer (IARC) has classified diesel engine exhaust as ‘carcinogenic to humans’ (Group 1) in June 2012. This upgrade by IARC from the previous classification of ‘probably carcinogenic to humans’ (Group 2A) comes after publication of a large, statistically robust study termed ‘Diesel Exhaust in Mines Study’ (DEMS), which reported sharply higher cancer rates in miners exposed to high levels of diesel exhaust. The study, which takes care of other confounders such as tobacco for analysis, added to the growing body of evidence about the carcinogenic potential of diesel fumes.

DEMS was started way back in 1992 and involved more than 12 000 miners. However, DEMS scientists, who are government employees, had to share data with Mining Awareness Resource Group (MARG), an industry-funded body, and were prevented from publication of their study in peer-reviewed journals since 1995 owing to an extensive legal and political battle against them by industry lobbyists in the USA. In February 2012, several leading international medical journals also reported receiving ‘warning’ letters from MARG warning them against ‘publication or distribution’ of the study. The letters warned the journals of ‘consequences’ in case they did not refrain from publication of this study until a court case and congressional directive was resolved. However, the study was published in the Journal of...
WHO warns about mercury in cosmetics

The obsession for fair skin seems to be taking its toll on the health of Indians. In June 2012, the WHO issued a warning against skin lightening creams, soaps, eye cleansing products and mascara containing mercury. More than 61% of the dermatological market in India consists of skin lightening products as per the WHO document. Mercury in cosmetics has been found to be associated with kidney damage. The warning also mentions about a study where nephrotic syndrome was seen with as low as a month of use of mercury-laced cosmetics in African women. Also, contrary to popular belief, such cosmetics are detrimental to the skin itself as they have been known to cause skin rashes, skin discoloration, scars as well as decreased ability of the skin to ward off bacterial and fungal infections. Some other serious effects mentioned in the WHO warning are anxiety, depression, psychosis and peripheral neuropathy.

The European Union and many African nations have already banned mercury laced cosmetics (except in eye area products). On the other hand, the US and Philippines Food and Drug Administration (FDA) stipulates a maximum limit of 1 mg/kg and Health Canada an upper limit of 3 mg/kg. However, India has no such ban or upper limit prescribed by its regulating agencies. Public awareness about such products has been advocated by the WHO. They have also warned against the use of other skin lightening products that do not contain mercury, as they might contain other hazardous substances.

Tobacco lawsuits in Canada

In the past decade, few countries have witnessed such a dramatic reduction in prevalence, or a shift in public attitudes towards tobacco use as Canada. The key objectives of the Federal Tobacco Control Strategy, such as ban on second-hand smoke, decrease in the prevalence of smoking, decline in smoking among the youth and sales of tobacco products to the youth have been achieved.

In spite of this progress, however, smoking continues to remain a leading cause of preventable death. Since healthcare in Canada is publicly funded, the staggering cost of treating smoking-related illnesses—over Canadian $17 billion a year—are an unsustainable burden for Canadian provincial governments.

On 31 May 2012 (WHO’s ‘World No Tobacco Day’), Saskatchewan and Manitoba joined the provinces of British Columbia, Ontario, Newfoundland and Labrador, New Brunswick, Nova Scotia and Prince Edward Island in suing major tobacco companies to recover the costs that provincial healthcare systems have incurred as a result of the tobacco industry’s misrepresentations and deceptive practices. Alberta has also declared its intention of suing tobacco companies for $10 billion.

In addition to action by the governments, some 2 million people in Quebec have, as recently as March 2012, sued Canada’s major tobacco companies in a historic class action lawsuit for an unprecedented $27 billion in damages they claim they suffered after taking up smoking. The lawsuit alleges smokers were deceived into smoking through advertising and misleading information, and wants the companies to compensate people who have either become seriously ill from smoking or cannot quit smoking.

As per a recent report by the Non-Smokers’ Rights Association on tobacco-related litigation in Canada, such litigations will not only serve as a deterrent to prevent industry misconduct in future, but will also allow governments the opportunity to recover financial losses caused by such misconduct.

World meets Millennium Development Goal (MDG) target for sustainable access to safe drinking water and sanitation

The world has achieved remarkable success in the sphere of providing safe and improved drinking water sources. The Progress on Drinking Water and Sanitation: 2012 Update reports that 6.1 billion people (89% of the world population) have access to safe drinking water. This is 1% more than the MDG target of 88% that was to be fulfilled by 2015. The projected increase by 2015 is now 92%. The concerted efforts of all stakeholders have brought the provision of improved water sources to over 2 billion people between 1990 and 2010. Access to safe water will reduce the incidence of diarrhoea and other water-borne diseases, primarily in children.

However, disparities remain, with safe water still not available to 11% of the population. Only 61% of the population in sub-Saharan Africa has access to improved water sources; most countries with coverage less than 50% belong to this region. The overall coverage in the developed and the developing world are 99% and 86%, respectively, while that in the least developed countries is only 63%. Further, approximately 96% of the urban population has access to an improved water source in comparison to 81% of the rural population.

The world still lags behind in provision of access to improved sanitation; 63% of the world’s population presently has access to improved sanitation facilities. Going by the current trends, it is projected that 67% of the population will have access by 2015, which is well short of the MDG target of 75%.

SOUMYADEEP BHAUMIK, Kolkata, West Bengal

MEENAKSHI KASHYAP, Toronto, Canada


National Cancer Institute in March 2012 as soon as the 90-day pre-publication review period as stipulated by the US District Court in Louisiana ended.

Though specifically applicable for lung cancers, the IARC upgrade notes that diesel fumes also have ‘a positive association with an increased risk of bladder cancer’. It also specifically mentions that reducing exposure to diesel fumes vide ‘marked decrease in sulfur content, changes in engine design to burn fuel more efficiently and reductions in emissions through exhaust control technology’ would benefit the general population.

The move is particularly important for India where there is a skewed pricing of fuel—diesel price is half the price of petrol—owing to heavy subsidy on diesel by the government. The higher subsidy on diesel is aimed at farmers using pump sets for agriculture but it is also enjoyed by diesel guzzling cars, etc. Soon after the IARC recommendation, there have been concerns about more advanced and stricter implementation of pollution control norms for diesel, as well as ending of government subsidy on a carcinogenic substance.

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