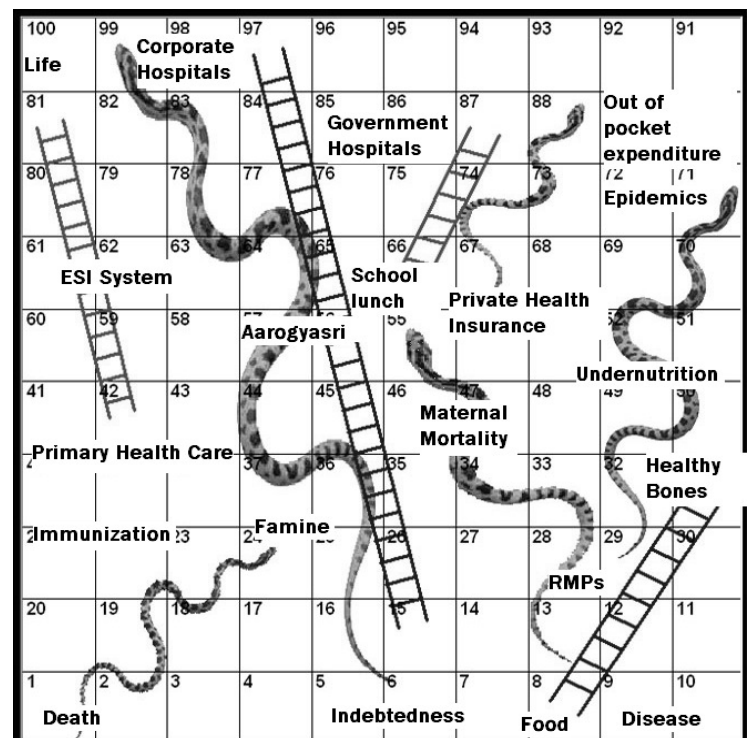


# Health care on the agenda Crisis or opportunity?

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# Editorial

Health care in independent India was originally imagined as a comprehensive three-tier system of primary health care, (including public health and preventive medicine), secondary level care in the district hospitals, and advanced tertiary medical care in government hospitals in cities. This imagination of health care was first stated in the Bhole committee report (1946). For nearly two decades after, the hope of the people was that health care should be provided by the government. Primary health centres (PHCs) were set up, partially manned and provided with minimal supplies of essential drugs. Very soon, cost benefit analyses privileged national programmes like small pox, tuberculosis and malaria control programmes, etc., at the cost of curative health care in the PHCs. The PHCs were gradually appropriated by the national programmes.

*The Employees State Insurance Act of 1948 was designed to provide social security (along the model of the British system) to the working population. It was originally planned to provide benefits for medical care, disablement, maternity benefits, care to dependents, and financial assistance in other circumstances including death. The ESI scheme has been working erratically, but has been able to provide a modicum of health care to the organized sector of employees, depending on the employers' payment of premiums. Thus, the reach of this scheme has been limited to a very small percentage of workers in the country. However, unorganized workers depend on the good will of the employer to get registered. Their deductions and the employer contributions must be regularly deposited with the ESI. Because their employment is erratic by definition, different employers short change all benefits including ESI payments. Under these conditions, less than three percent register and manage to get ESI benefits. Self-employed persons would find it next to impossible to get coverage. In addition the ESI has a surplus fund of several thousand crores, that it is investing not in increased health care coverage, but in nursing and medical colleges.*

Meanwhile, the mid-1960s saw one of the worst famines in the country that led to food aid from the USA with conditionalities that India would push family planning (FP). The family planning programme was now implemented through the PHCs and targets were set for each government employee, regular sterilization camps were held and new devices and contraceptives were introduced, some of them at the level of clinical trials. This

was accompanied by propaganda which convinced the nation that birth control was the solution to the nation's problems. The allocations for the FP programme were as large as the allocations for the health sector as a whole. They were centrally administered with strict accountability. By the 1970s the primary health centres thus became non-functional under the sustained onslaught of the centrally driven targeted family planning programme. This led to the withering away of all the national disease control programmes, resulting in a resurgence of malaria, which had almost been eliminated. All earlier programmes like those to control tuberculosis and malaria were abandoned. Thus the utopian dream of the Bhole Committee was extinguished. In practice, there never was any significant and truly effective curative care for those among the poor afflicted by serious ailments.

By the 1980s there was an uneven, urban biased, erratically growing network of corporate hospitals and nursing homes dotting the landscape. The elite had moved on to the private sector (the small nursing homes and hospitals) and the mission hospitals. Some government hospitals survived providing services to the poor in towns and cities. The rural areas bore the brunt of this transition. Apollo and Owaisi hospitals were the earliest of the corporate hospitals that began to mushroom in Hyderabad. Studies in the late 1980s confirmed that 80% of the health care needs were being accessed in the private sector. There were many who used other systems of medicine provided by skilled practitioners of Unani, Ayurveda, Siddha, nature cure, bone setters, etc., of whose contribution to health care there is no record.

Today, the nation spends around 6% of its GDP on health care, of which the government pays a meager 1%. The balance of 5% expenditure is being paid out of the pockets of the patient. On the aggregate 60% of this private expenditure is on diagnostics and medicines, while 40% is incurred on hospitalization, most of which is in the private sector. This is a catastrophic burden on low-income families often leading to perennial indebtedness and pushing them below the poverty line. This condition, which has become worse today, is characterized by near autocracy of private hospitals, no protocols or audits to assess their practices, irrational treatment and medical bills that depend on the whims of the hospital industry. The government hospitals are still the last resort for patients who have been turned away from the

corporate hospitals for inability to cover bills, and have exhausted their money to pay for visits to different specialists, diagnostics, transport, and high costs of living in the city.

In this situation, there has been since about 2000 a renewed interest in medical care. One of the factors leading to this interest has been the corporate agenda of expanding the market. Another driving factor has been the appearance of dismally low health indicators on several fronts in a nation otherwise projecting a rosy picture of economic development. One such initiative was stimulated by the high maternal mortality rate, which has led to the establishment of the National Rural Health Mission, in 2005, in order to increase institutional deliveries. Another has been the establishment at the national level of the Planning Commission's High Level Expert Group (HLEG) on Universal Access to Health Care led by Dr. Srinath Reddy. This initiative looked at health care as a national responsibility. At the same time, the Rockefeller Foundation, the World Bank, international capital and the top government officials were overjoyed that the resultant expansions in the health sector would contribute to the second phase of growth of the Indian economy. To this end, the Planning Commission announced that it would double its health care budget from 1% to 2% of the GDP, which is yet to be fulfilled. Their expectation of the HLEG report was that it would recommend fully privatized insurance based health care. Such a recommendation would provide an expert vindication of the privatization of the health care responsibility of the state. Corporate and governmental concern seems thus to be more interested in the growth and profitability of the medical and health care industry than the well being and health of the people of India. It is another matter that the HLEG report has recommended that health care administration be retained in governmental control and private providers are used where necessary to meet the gap in capability.

Andhra Pradesh had stolen a march on the health care front with the establishment of the Aarogyasri state funded insurance programme in 2006 by the then Chief Minister Dr. Y.S. Rajasekhara Reddy. This programme, which has been designed to provide the most advanced form of tertiary care free to those below the poverty line, has two distinctive public profiles: a profile that is admired and acknowledged by many including the World Bank as bringing together the needs of health care and corporate interests; another profile where the poor see Aarogyasri as a programme that provides them life support in times of need. It marks on the one hand the

emergence of health care on the political agenda of many political parties; on the other hand, its structure is characteristic of ineffective, badly prioritized, lop-sided orientation of advanced medical care that furthers the wealth of corporate hospitals through specialized medical and surgical procedures. These procedures are performed on patients, who come to these hospitals in a desperate condition with little or no medical support during the early stages of their ailments, no preventive care, and no emphasis on promotion of good health through nutritive food that meets the metabolic need of working bodies. It is almost as if the complete abandonment of the general health of the population by the government acts as a system that feeds patients to corporate hospitals so that they may access government funds. Today Aarogyasri covers over 950 specialties that are available in large corporate hospitals, but does not cover blood pressure, malaria, dengue or diarrheal diseases unless they lead to advanced, life threatening complications that need tertiary care. This programme of insurance driven medical care has been attractive enough for other states to emulate (Maharashtra, Tamilnadu, etc.)

The fragmented health care system as it emerges in India today between the governmental efforts to manage its health indices and to turn medicine into the engine of economic growth has some bemusing results. For example, a person on the street has to remember a) she needs to go to a government dispensary for common illnesses like colds and coughs; b) the Janani Suraksha Yojana for healthcare during pregnancy and childbirth; c) the national programme for TB care; d) the Women and Child Welfare department for nutrition during pregnancy and six months after delivery; e) use the school lunch programme for food for her school going children; f) access Aarogyasri for her tertiary care procedures; g) and use her RMP to guide her through this labyrinth. Rizwana's story illustrates one aspect of this chaos in health care. When her husband who worked at Airtel had tremors and seizures, she took him to a traditional practitioner who gave him an elaborate regimen that did not provide relief. She then took him to the government ESI hospital, which promptly saw him as a case of alcohol withdrawal and delirium tremens (apparently all workers who come to that hospital are first treated for alcohol addiction!).

It took an unofficial consultation with another doctor outside the system to ensure that he was referred to a corporate hospital, which resulted in a diagnosis of brain tuberculosis now under treatment. Fortunately he was covered under ESI, and his payments were up to date. He got paid leave for three months and it helped him buy eggs and milk. However he had to go to the TB centre to collect his drugs! This is a result of the completely chaotic, un-coordinated, system of health care in India today. It is extremely likely that without the outside intervention and their networks in the city Rizwana's husband would have died.

The essays in this broadsheet are a small attempt to examine some symptoms of the crisis of health and health care in Andhra Pradesh in the above context. There are papers dealing with Aarogyasri, interviews with health professionals and politicians and studies of different mechanisms of health care provision. It is hoped that this collection of analyses and information will enable the reader to ask the question where we go from here, and participate in the emerging politics of health care in India.

*The Editorial Team*

**Primary Health Care:** Primary care is the term for the health care services which play a role in the local community. It refers to the work of health care professionals who act as a first point of consultation for all patients within the health care system. Such a professional would usually be a primary care physician, such as a general practitioner or family physician, or a non-physician primary care provider, such as an ANM, ASHA worker, etc. Depending on the nature of the health condition, patients may then be referred for secondary or tertiary care.

Primary care involves the widest scope of health care, involving preventive and promotive care along with basic curative health care. The beneficiaries include all ages of patients, patients of all socioeconomic and geographic origins, patients seeking to maintain optimal health, and patients with all manner of acute and chronic physical, mental and social health issues, including multiple chronic diseases. Consequently, a primary care practitioner must possess a wide breadth of knowledge in many areas. Continuity is a key characteristic of primary care, as patients usually prefer to consult the same practitioner for routine check-ups and preventive care, health education, and every time they require an initial consultation about a new health problem. A health system with a strong primary health care system is the most cost-effective mechanism of investing in health and can handle almost 50% of the health care needs of the population.

Common chronic illnesses usually treated in primary care may include, for example: simple viral and bacterial infections, diabetes, asthma, etc. Primary care also includes many basic maternal and child health care services, such as family planning services and vaccinations.

**Secondary Care:** Secondary care is the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, medical specialists, surgeons, obstetricians and gynecologists, orthopedists, ENT specialists, ophthalmologists, dermatologists, etc.

It includes acute care necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services.

The term "secondary care" is sometimes used synonymously with "hospital care". However many secondary care providers do not necessarily work in hospitals, such as psychiatrists, clinical psychologists, occupational therapists or physiotherapists, and some primary care services are delivered within hospitals. Depending on the organization and policies of the national health system, patients may be required to see a primary care provider for a referral before they can access secondary care. In India, the weakness of the primary care network results in most people directly accessing and over burdening specialists for their illnesses. This leads to inefficient utilization of health system resources from the medical perspective and to an expensive form of care for patients.

**Tertiary care:** Tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities having superspecialty services, such as a medical college or medical institutes. Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions. The All India Institute of Medical Sciences, Christian Medical College and Hospital Vellore, and most medical college hospitals are tertiary care institutions. Corporate hospitals in Hyderabad, especially those who have their specialized procedures empanelled in the Aarogyasri programme are tertiary care hospitals. In Andhra Pradesh, as argued in other contributions in this broadsheet, the dominance of tertiary-care hospitals and the absence of a well-regulated primary care network have resulted in a lop-sided, expensive and sometimes unnecessary form of medical care.

**Other systems of health care in India:** In the Indian context, the modern system of medicine was introduced during colonial rule and is paralleled by other traditional systems and practices of health care that are utilized by different people according to their needs and assessment of the situation. Thus for example, Ayurveda, Yoga, Unani, Siddha, Homeopathy and traditional bone setting are forms of knowledge and practice that are available through skilled practitioners in different parts of the country. These practitioners are accessed at all the three levels mentioned above, and in addition, they are often also put to use in palliative care.

Much more can be said about this subject, but for an introduction this should do!

# What do people need from Aarogyasri?

## Is it delivered?

## How comprehensive is treatment under Aarogyasri?

### ■ Rajan Shukla

*What does a common citizen expect from the state in terms of health care?*

As an individual, Sreya would want her and her family's health care needs to be taken care of. Whether it was the delivery of her first child; or the breathlessness that her father is suffering from for the last one year for which no doctor seems to have a cure; or her backache or bodyache which seems to have a mind of its own, flaring up without warning; or the sugar which her mother-in-law suffers from and requires her to spend Rs. 2000 every month on drugs and investigations (she is often without any medicine); or the fever which her son suffered last month (some doctors said it was dengue and they had to spend Rs. 8500 for the different investigations and treatment the doctor ordered). Can she afford all this from her family's combined earnings of Rs. 10,000 per month? She wanted to educate her son in a private English school, but now he is unable to go to any school because he attends to his grandfather when they have gone to work. After much planning and anticipation, she was able to purchase gold earrings two years ago but had to sell them off to the moneylender to be able to afford treatment for her son's illness. Does she get the health care she and her family need? Can she afford it? What is the quality of health care her family received? These are the questions our public representatives need to ponder on and understand before they advocate any major policy change in our health care delivery system. Around 80% of the families in Andhra Pradesh would have an

annual income less than Sreya's.

*How much of this expectation does the AP state meet through Aarogyasri and the public health system?*

All of us like Sreya's family need appropriate affordable treatment without incurring any catastrophic health expenditure. This means quality health care should be available within reach both geographically and financially. It should be adequately supported by a referral system for secondary/tertiary care and have a mechanism of financial protection. To the advantage of AP's BPL population, the state does have a financial protection mechanism for health care expenditure, the Rajiv Aarogyasri health insurance scheme, but it only covers the tip of the iceberg in terms of catastrophic financial burden of the needy population. Aarogyasri does not cover sugar problems, BP, backpain, dengue, or common things like fever, malaria, loose motions, eye infections, ear infections, headaches, vision problems, injuries, joint pains, coughs, burning in the urine, white discharge, and treatment of anemia—which is said to be prevalent in over 70% of women and children. It does not cover burning and acidity in the stomach, piles, infertility—but we still believe that Aarogyasri is so important for AP!

*So who gets any benefit from Aarogyasri?*

When the condition of the people suffering from all the above problems gets worse, when complications set in and they get admitted into a hospital, then at that point, maybe

Aarogyasri helps. That is, only if malaria turns out to actually be cerebral malaria or dengue goes on to cause bleeding disorder, or the cough in a child becomes a pneumonia with respiratory failure, or long standing acidity in the stomach leads to perforation, or the recurrent white discharge becomes a cancer, is one eligible to access Aarogyasri. By this time the patient would have spent Rs. 30,000 to Rs. one lakh, the family is in a desperate situation, having exhausted their saving, mortgaged their land and indebtedness looming on the horizon. This is despite the fact that basic medical courses teach how such problems can be avoided: malaria can be prevented by public health measures like mosquito control, early diagnosis and treatment of fevers; a cough of 3-5 days duration can be treated successfully with antibiotics in the child, or in old people; acidity or ulcers diagnosed in the early stage can be treated and healed, etc.

The problem is that Aarogyasri is useful for some listed conditions which need hospitalizations. It is not for many others. Outpatient expenses like initial consultations, drugs and diagnostics are not covered under Aarogyasri. These account for 2/3 of the patients' out of pocket expenditure (OOP). Many studies have documented that hospitalization expenses account for only about one-third of the overall OOP expenditure. OOP is globally recognized as the major cause of catastrophic health expenditure which wipes the patient out financially. Almost 26% of the households incur catastrophic health expenditure at one time or the other. It has also been established that 40% of the households experiencing hospitalization incur catastrophic health expenditure, and a majority of these hospitalizations are due to health care needs not covered under Aarogyasri. What the scheme does cover is 953 procedures (170 medical and 783 surgical) which are mostly tertiary care. So a poor patient has to either incur OOP expenditure or wait till his condition deteriorates so that he has complications which can be effectively covered under Aarogyasri.

A classic example is a person suffering from dengue fever. The scare of dengue fever provokes so much anxiety that every fever is suspected to be dengue. Early dengue can be difficult to differentiate from other viral infections. Sophisticated and expensive tests

make detection more accurate in the first seven days but are not easily available. Routine tests are not reliable in early stages and in case of patients who have had repeated episodes of dengue fever over the years. The risk of complication is higher in persons suffering from repeated episodes. In this scenario, instruments called cell counters have become the mainstay of diagnosing and predicting dengue complications. The rate of progression of the dengue is unpredictable. Thus, even a slight normal fluctuation in WBC or platelet

counts against the backdrop of the dengue scare has resulted in both physicians and public seeking over-investigation and over-treatment. The health care industry has exploited this scare to the fullest. Even in genuine cases of a drop in platelet count, most of the cases respond to symptomatic treatment and maintenance of proper fluid balance. Packed cell transfusion or platelet transfusion are required only in high-risk patients having a very low platelet count (below twenty thousand). Such treatment is also useful when

there is a higher platelet count (twenty one to forty thousand), but there is risk of bleeding. In an endemic area, it is found that only 30% of patients having low platelet counts will require packed cell or platelet transfusion. However all cases of suspected dengue fever are advised admission to hospital, for active observation with IV fluids and other supportive treatment. Aarogyasri covers only the management of low platelet counts requiring platelet transfusion. Routine hospitalization is not covered under Aarogyasri.

Some examples of irrational coverage under Aarogyasri are given below

Cause and symptoms	Possible diagnosis	Range of treatments available	Coverage under Aarogyasri
Consumption of harmful substance which causes vomiting, drowsiness, loss of consciousness, etc.	1. Corrosive poisoning, (Vasmol, acid poisoning)	Stage 1: Hospitalization, to minimize damage, maintain vitals, and nutrition. Stage 2: Ventilator support, reconstruction of upper GI Tract after primary healing. Stage 3: Prolonged hospitalization, until primary healing or death.	Not covered under Aarogyasri
	2. Non corrosive poisoning which could be rat poison, pesticide poison, or drug overdose (Paracetamol, etc.)	Stage 1: Stomach wash, specific antidotes, close observation. Might need short 24-48 hrs observation in ICU, maintenance of vital functions, nutrition, etc. Stage 2: Prolonged hospitalization for 5-20 days in some cases. Stage 3: Approximately 25% of hospitalized cases will need ventilator support.	Only OP poisoning (Stage 3) cases <b>requiring ventilator support</b> are covered. Coverage needs to be renewed every week. Treatment for other cases of poisoning is not covered.
Unexplained vaginal bleeding, change in menstrual cycle pattern, blood tinged vaginal discharge during sex.	Cervicitis, pelvic inflammatory disease (PID), vaginal carcinoma, cervical cancer.	Stage 1: Antibiotic & personal hygiene for cervicitis and PID. A strong screening program is required for early detection of cervical cancer. Stage 2: Hysterectomies for cervical cancer. Stage 3: Anti cancer treatment with chemotherapy and radiation therapy.	Stage 1: Treatment like PAP smear for screening for cervical cancer can prevent or allow early treatment, but is not covered under Aarogyasri. Antibiotic treatment of cervicitis, PID – not covered. Stage 2: Hysterectomies are covered only in government hospitals. Stage 3: Only management of cervical cancer is covered under Aarogyasri.
Snake bite, local rash, local necrosis, shallow breathing, bleeding, etc., or scorpion bite.		All snake bite cases require hospitalization for observation. Poisonous snake bites require anti-snake venom and hospitalization for 3-10 days. Some types of snake bites require ventilator support. Others may require prolonged hospitalization and surgical treatment in case of massive tissue damage.	Medical observation and treatment is not covered. All medical management of snake bite and only scorpion sting requiring ventilator support are covered under Aarogyasri. Surgical procedures are not covered.

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# A record of SMS conversations regarding an Aarogyasri Patient

■ K. Sajaya

## DAY 1

It all started with Dr. Revathi's call to Dr. Sinha on 12th August, around 1 pm. She said an Anveshi activist Vijaya working on farmers' suicides has been trying to get treatment for a young boy Ravi Babu belonging to a farming family in a village near Medak town. The boy, 13 years old, had been affected by tumor on the spinal cord and paralysis of both lower limbs. The parents had tried to get him covered under Aarogyasri since 2007. The doctors at the Gopala super-specialty hospital had been saying that the family would have to spend an additional Rs. 80,000 to get the surgery done. The patient's family was told that while the expense for removal of the tumour was covered under Aarogyasri, the artificial implant in his spine and the follow up treatment was not, and therefore extra money had to be paid. The parents did not understand. In 2012, Vijaya, an activist helped the parents get their son treated. She approached her friend Dr. Revathi, who asked Dr. Sinha, a doctor with some knowledge of Aarogyasri, whether he could help in the matter.

Subsequently Vijaya met Dr. Sinha and gave him detailed information about Ravi Babu, the patient. Dr. Sinha assured Vijaya that he would help her in whichever way he could.

Dr. Sinha was traveling to Bombay for 2 days and on return he contacted Dr. Narayana, the executive officer of the Aarogyasri trust. Dr. Narayana assured Dr. Sinha that complete treatment was covered under Aarogyasri and asked Dr. Sinha to send him the details of Ravi Babu.

The following exchange of messages will give the reader an idea of the persistence required

on the ground to get an Aarogyasri coverage for medical treatment of this kind.

## DAY 4

**From: Dr. Sinha**

Thu, Aug 16, 5:17 PM

**To: Dr. Narayana**

Sent details of patient Ravi Babu

## DAY 7

*19 Aug: Dr. Narayana spoke with the Aarogyasri person at the hospital, and suggested Vijaya follow-up with Dr. Satyam, a doctor at Gopala hospital.*

## DAY 9

**From: Vijaya**

Tue, Aug 21, 1:32 PM

**To: Dr. Sinha**

Dear Dr. Sinha, I spoke to Dr. Satyam, he processed the papers and due to heavy rush patient's admission will be on Saturday 25th Aug, thank you very much, I will call you again after they admit-Vijaya

**From: Dr. Sinha**

Tue, Aug 21, 1:37 PM

**To: Vijaya**

Good to know that the treatment can be initiated. In case there is any delay in admission let me know. Also keep me informed about progress. Dr. Narayana (Aarogyasri) said that the hospital will be admitting the child this week.

## DAY 13

*25th August- Vijaya got a call from the hospital at 1:30 PM to report by 3:30 PM for admission. The child's family was in Medak. Vijaya pleaded in vain that the time was too short to make the arrangements and to come from a remote village. They said, "If you do not report by 5 PM we will not be able to help in admission". The parents spent*

*Rs 1500 on a taxi and brought the boy to the city. Vijaya and the boy reported by 5:30-5:45 PM and the hospital sent them back saying that the beds are full again.*

## DAY 17

**From: Vijaya**

Wed, Aug 29, 1:19 PM

**To: Dr. Sinha**

Dear Dr. Sinha, can u pl help us to get the admission in Gopala Hospital, he is unable to get admission, I'm continuously following it up, but they said not possible immediately in children's ward-Vijaya

*According to Vijaya, the hospital kept insisting that the boy should be admitted in the children's ward, but was ultimately admitted in the general ward.*

**From: Dr. Sinha**

Wed, Aug 29, 1:21 PM

**To: Vijaya**

I will try

**From: Vijaya**

Wed, Aug 29, 1:21 PM

**To: Dr. Sinha**

Thank you

## DAY 22

**From: Vijaya**

Mon, Sep 03, 4:17 PM

**To: Dr. Sinha**

Dear Dr. Sinha, still this boy Ravi Babu didn't get admission at the hospital. Could you please talk to Aarogyasri people there-Vijaya

**From: Dr. Sinha**

Mon, Sep 03, 4:43 PM

**To: Dr. Narayana**

Sir, thanks for facilitating approval of this boy. But he has not been able to get admission at Gopala hospital for last 10 days. Can you kindly help? The details of the child are as below. Sent details of Ravi Babu

## DAY 25

**From: Vijaya**

Thu, Sep 06, 9:18 AM

**To: Dr. Sinha**

Hello Dr. Sinha, I met the concerned doctor that day, he said he will instruct the staff regarding admission, but concern staff r in leave, others not responding, at present I'm out of station, will be back on Sunday-Vijaya

## DAY 32

**From: Vijaya**

Thu, Sep 13, 5:34 PM

**To: Dr. Sinha**

Pl give me the executive officer Dr. Narayana's number. The boy has reached now-Vijaya

*Dr. Sinha tried calling Dr. Narayana but he was in a meeting and hence did not pick his phone. When Dr. Sinha tried again at 7 PM, Dr. Narayana was busy and assured that he would call Dr. Sinha once he was free.*

*At about 9 PM, Dr. Sinha called Dr. Narayana again and he said to pass on the details of the child Ravi Babu and he will talk with medical superintendent of the hospital for Ravi Babu's admission.*

*Dr. Narayana called Dr. Sinha back at 9.30PM saying that he spoke with the medical superintendent of the hospital, and the superintendent said he would try, but since senior staff had left the hospital, it would be difficult to get admission at night. They will definitely admit Ravi Babu in the morning only if the family could stay some place at night.*

**From: Dr. Sinha**

Thu, Sep 13, 9:15 PM

**To: Dr. Narayana**

Details of Ravi Babu sent

**From: Dr. Sinha**

Thu, Sep 13, 9:18 PM

**To: Dr. Narayana**

Sent details of Ravi Babu again since previous message didn't reach.

*By this time, after discussion with Sinha, Vijaya had made arrangements to take care of the patient's family overnight, since admission seemed impossible. Suddenly, at 9:45 pm they gave the boy a room.*

**From: Vijaya**

Thu, Sep 13, 9:48 PM

**To: Dr. Sinha**

Now they have given a bed in Aarogyasri ward

**From: Dr. Sinha**

Thu, Sep 13, 10:28 PM

**To: Vijaya**

Good to know

**DAY 34**

**From: Vijaya**

Fri, Sep 14, 4:00 PM

**To: Dr. Sinha**

Doctors examined patient. Said things will be done.

**From: Vijaya**

Sat, Sep 15, 10:45 AM

**To: Dr. Sinha**

Patient blood taken for tests. Awaiting results.

**From: Vijaya**

Sat, Sep 15, 4:15 PM

**To: Dr. Sinha**

Patient blood results OK. Awaiting Aarogyasri clearance. Can you give me Aarogyasri official name?

**DAY 36**

**From: Dr. Sinha**

Mon, Sep 17, 2:12 PM

**To: Vijaya**

Dr. Narayana is the executive officer Aarogyasri

**From: Vijaya**

Mon, Sep 17, 2:13 PM

**To: Dr. Sinha**

Thank you

**From: Vijaya**

Tue, Sep 18, 4:00 PM

**To: Dr. Sinha**

Awaiting clearance and surgeon availability. Duty doctor said things will be all right.

**From: Vijaya**

Wed, Sep 19, 3:57 PM

**To: Dr. Sinha**

Surgery fixed for tomorrow. Thank God.

**DAY 39**

**From: Vijaya**

Thu, Sep 20, 3:11 PM

**To: Dr. Sinha**

Ravi Babu's surgery was a success. Met Dr. Satyam of the hospital just now and he gave us assurance that Ravi Babu could recover with physiotherapy. Thank you so much for your support and concern-Vijaya.

**DAY 52**

**From: Vijaya**

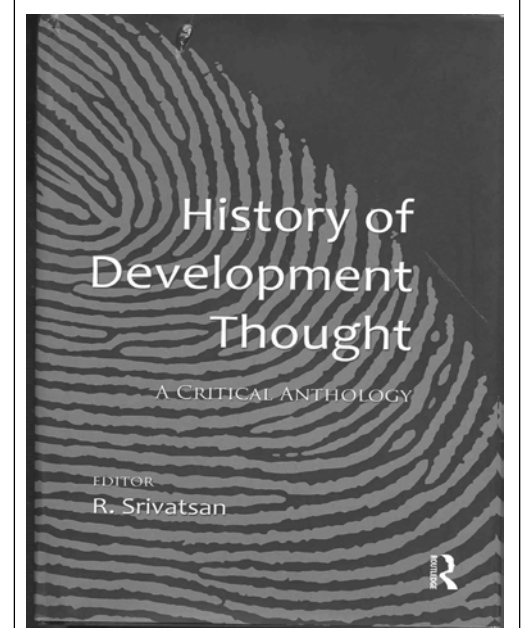
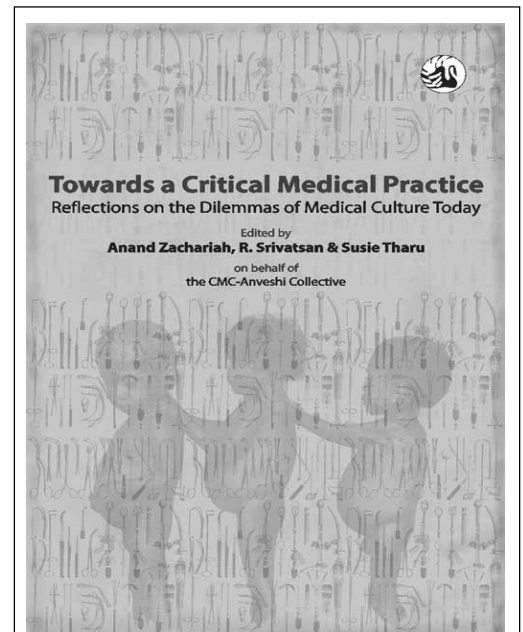
Wed, Oct 03, 2:24 PM

**To: Dr. Sinha**

Hello Dr. Sinha and Dr. Revathi, I would like to share Aarogyasri implementation at this hospital with you soon. The attitude towards these patients is careless and they are not given proper guidance about rest, food, physiotherapy, follow-ups after the surgery. Vijaya

*The reason for Vijaya's annoyance was explained by her as follows:*

*The boy was discharged 3 days after surgery. The parents were told to bring the boy back in ten days so that the stitches could be removed. They came back to the city one evening after 10 days and Vijaya helped them stay in the city at the Nature Cure Hospital through some contacts. They then went the next morning to Gopala hospital. The nurses removed the stitches, and were made to wait till the evening to meet a junior doctor. The advice regarding follow up, physiotherapy, etc. was not properly given. Vijaya says that the surgeon, and the senior doctor who met him were warm and courteous on the day of the surgery when they met the patient. At other times they were simply not available. On the other hand, the receptionist, the ward boys and the junior staff were rude and callous with respect to this patient. They did not see him as a paying patient saying that the government had paid for him. Vijaya feels that this kind of training should be given to the hospital staff and patients about the system.*



# Aarogyasri Healthcare Model

## Advantage Private Sector

(Abridged version)

■ Rajan Shukla, Veena Shatrugna, R Srivatsan

Over the past 50 years, Indian public health policy and administration has been mainly focused on family planning, immunization and specific disease eradication programmes. Programmes such as the oral polio immunization scheme are given high publicity in the media (often driven by the agenda of global agencies). However, there has been a silence in the media over the widening gap of availability of quality curative care in the healthcare system. It is common knowledge that 80% of healthcare expenditure in the country is borne by the sick person as out of pocket (OOP) expenditure. The complete deterioration of clinical care at the primary health centres (PHCs) is only one indication of a much larger governmental trend. It was in this scenario of poor quality medical care that the Rajiv Aarogyasri programme was launched in 2006 by the then Congress chief minister Y.S. Rajasekhara Reddy in Andhra Pradesh. It was promoted as a promise to provide the best quality scientific medical care to the poor. It has since been projected as a landmark programme, winning accolades from the World Bank, and drawing international financial speculators. It has also succeeded in convincing the electorate that such a step in health care is both possible and necessary. This article tries to provide the reader with the historical origin of the programme, its basic structure and its limitations.

### The politics of healthcare in Andhra Pradesh

We trace the Aarogyasri programme to a series of events that were selectively highlighted by the Andhra Pradesh (AP) government to build an orchestrated consensus for the project. The Jayati Ghosh Committee (2006) report on economic distress in the agricultural sector described the precarious condition of the

farmers. In its chapter on health and nutrition, the report discussed the poor health indicators, the failure of the public health system, and the cost of privatized care, that were contributory factors to farmer indebtedness, distress and suicide. It recommended that, "...immediate attention of the government should be on enforcing the provision of free care to the poor by the private hospitals, which have benefited from financial incentives, land grants, etc."

It is possible to speculate that this specific recommendation of the report was a convenient support to Y S Rajasekhara Reddy's scheme to provide healthcare for all through corporate hospitals. While there was a lack of adequate healthcare for the poor in AP, there was at the same time also uncontrolled growth of corporate hospitals. How did this happen?

From the mid 1970s onwards, there has been a strong presence of the post-green revolution entrepreneurial castes from AP in the lucrative medical profession in the US. These groups had the know-how and also a deep cultural attraction for sophisticated western science and technology. It is possible to link the presence of these groups to the establishment of private/corporate hospitals in Andhra Pradesh. By the 1980s, Hyderabad and Andhra Pradesh became major hubs of medical diagnostics (Vijaya Diagnostics and Medinova were pioneers) and healthcare (Apollo, Care, Medwin and Yashoda are the foremost examples). These private institutions began to provide 'world-class' super-specialty diagnostic and therapeutic procedures (indeed, also in the process trying to become a key destination for global medical tourism). In privatized medical care in India, there is no standardized treatment for diseases, nor are there any quality assurance agencies. All these

resulted in a small, but powerful group of corporates taking full control of advanced medical care. These super-specialty hospitals formed cartels to keep prices artificially high.

When Rajasekhara Reddy proposed his scheme, these hospitals were willing to accommodate the poor provided the costs were borne by the State. This state-insured business would surely help fatten their financial bottom lines.

From the year 2004 onwards, the political conditions were ripe for the introduction of some innovative health measures in AP. The newly elected chief minister (who was a qualified medical doctor) had a long-lasting interest and financial commitment to healthcare. Between May 2004 and June 2007, Rs. 168.52 crore were spent from the Chief Minister's Relief Fund to help 55,362 below poverty line (BPL) patients requiring hospitalisation. However, this aid was ad hoc, and given to those who had the resources and connections to tap into it. In addition, the patient had to spend a lot before availing this CM Relief Fund. Therefore the purpose of providing this money to avert a debt trap for the patients was not effectively met.

In 2006, Manda Krishna Madiga, one of the founders of the Madiga Dandora movement, undertook a padayatra to highlight the problems of young children with heart ailments. Shocking media visuals depicted parents carrying sick children on the city streets in the peak of summer, and they led to a focus on heart problems among the children of the poor. About 4600 such children's names were listed. Soon after, Rajasekhara Reddy announced free heart surgeries for these children and by August 2006, operations (it is not clear how many) were carried out under the Chief Minister's Relief Fund. It must be noted at this point that most of the children had preventable health problems such as rheumatic heart disease, or issues that could be taken care of in the long run through education (for instance about the link between congenital heart problems and consanguineous marriages). None of these contributory factors, preventive measures or health education strategies were discussed, but the magnanimous gesture of funding the heart operations on children set the stage for the Aarogyasri programme. The point to be noted is that Rajasekhara Reddy's political astuteness and understanding of healthcare were important factors that led to this scheme. In addition, he also needed ways to guarantee his re-election in the coming polls.

As we shall discuss, the programme by design does not address primary or secondary level



healthcare requirements, which are relegated to the public sector. In fact, Aarogyasri's focus on tertiary healthcare to the exclusion of all other forms of medical assistance has led to an inefficient medical care model. This model does not meet the health care requirements has a low impact on meeting the felt needs of healthcare and on the overall health of the population. At the same time, the enthusiastic popular reception of the programme has to be taken note of.

### **Rajiv Aarogyasri Scheme (2006)**

The scheme aims to provide medical care for BPL families up to a value of Rs. 2 lakh per year. This is for tertiary surgical and medical treatment of serious ailments. The stated aim is to help them avoid a debt trap. The scheme is run by a public-private partnership called the Aarogyasri Health Care Trust (AHCT, hereinafter the Trust) between the corporate hospitals and state agencies. The Trust has a supervisory role and it also ensures that the government departments help in implementation. It provides this care through an established network of corporate hospitals, 50 + bedded private hospitals, government medical colleges, district hospitals and area hospitals (and yet the programme has almost no role for the PHCs). The beneficiaries are the members of BPL families as enumerated and identified by the Rajiv Aarogyasri Health Card/BPL Ration Card. (The definition of BPL families for the Aarogyasri programme differs from that used nationally, and includes 80% of the population).

Each family is allowed a total reimbursement of Rs. 1.50 lakh per annum availed individually or collectively and a buffer of Rs. 50,000 meets expenses exceeding Rs. 1.5 lakh (up to Rs. 6.50 lakh in cochlear implant surgery and auditory-verbal therapy). There are a total of over 950 procedures that are covered under this scheme.

Some of these procedures have been recently earmarked for the government hospitals. The healthcare transaction is cashless at the point of service. Basic outpatient department (OPD) examination of potential cases is supposed to be free. Some diagnostic procedures to establish whether the conditions or proposed intervention is in the eligible list (even if they do not result in the patient undergoing any treatment under Aarogyasri) are supposed to be free. Network hospitals, i.e., corporate hospitals, are expected to conduct at least one free medical camp in a week, to screen patients in villages. The entire operational database including all transactions is paperless, real-time and online.

In theory, all the PHCs and area/district hospitals are the usual first contact points for the majority of the beneficiaries.

Aarogyamitras (qualified graduates appointed by the Star Health and Allied Insurance Company) are responsible for "hand-holding" patients lacking the confidence and the knowledge to engage with the care providers. In this hand-holding role, the Aarogyamitras function without checks and restraints from the local health administration since they are not accountable to them. There is anecdotal evidence of Aarogyamitras diverting cases from government hospitals (and even medical colleges) to private hospitals. Thus, in practice, these Aarogyamitras control the process of referral.

### **STRUCTURAL FEATURES**

#### **Focus on Tertiary Care**

The Aarogyasri programme is designed for advanced surgical and medical care. When the system was first implemented, this care was available only in corporate hospitals and medical colleges who had been empanelled in the scheme. However, in the second and third year of the programme, the list has been expanded to include smaller private hospitals and secondary government hospitals. The corporate hospitals continue to handle the biggest share of the Aarogyasri cases. There is no provision for outpatient treatment of everyday illnesses that affect the working capacity of the patient. This lack of early management of illnesses also often results in complications that are handled in the programme at a higher cost. In effect, the focus on specialty care results in a suboptimal use of healthcare funds. For example the list covers surgical treatment of gastric perforation, but does not cover gastritis and gastric ulcer, which in some cases are an earlier stage requiring simpler and cheaper medical treatment. Earlier and simpler treatment would have averted the need for surgical intervention.

#### **Medicine Costs**

Originally, the post treatment medication costs were covered only for a period of 10 days. Since about a year now, this coverage has been increased to one year. Research indicates that the cost of medications for in-patient treatment is more than 40% of the total cost of treatment. For complex procedures that may require lifelong medical support, one year's support is clearly inadequate and will need to be increased through some suitable mechanism.

### **Procedure-Driven**

It is an accepted fact that when health insurance schemes are planned, costing the treatment of each illness covered is essential to ensure rational and effective functioning. For this, the average duration of illness, the duration of hospitalisation, and a list of the investigations required are essential information. None of this information was available for the population in AP – in fact even the disease burden and morbidity profile of the BPL populations were not accurate. This "technical problem" was not of consequence to the Aarogyasri programme since it is simply designed on the basis of the cost of the procedures of surgical or medical intervention available at those corporate hospitals empanelled in the scheme. In other words, the programme subsidises the working costs of advanced equipment in corporate hospitals through the provision of patients who are supported by the insurance programme. Ideally the payment should be done for disease conditions rather than procedures so that hospitals have an incentive to provide the most cost effective treatment. As it stands, the scheme tends to provide (often unnecessarily) exorbitant treatment based on advanced equipment and technology.

There are three consequences to this unusual route of cost determination:

One, since the focal point is the medical or surgical procedure, there are no prescribed methods to determine the best way of treating the patient, and to determine whether the patient actually needs the procedure. There is only one thing to monitor, once the procedure is decided upon, whether the hospital follows the standard method for that procedure. Thus, in January 2010, it was discovered that several hospitals in the smaller towns in the state were performing unnecessary hysterectomies to benefit from the Aarogyasri largesse. The government has cracked down on this and has instituted regulations. However, the case of unnecessary hysterectomies is only one example of the possibilities of unnecessary surgical interventions that lurk on the horizon.

Two, as we have already noted, the procedures approved are often high cost interventions when compared to their less expensive conventional counterparts. For instance, gastrointestinal cases are funded for high cost laparoscopic (keyhole) surgeries rather than for the more conventional and cheaper abdominal surgeries; laparoscopic appendicectomy is funded rather than

conventional appendicectomy, the only advantage of the former being the avoidance of a two-three inches scar. Here it is important to note that conventional care has better penetration in rural/quasi-rural institutions compared to advanced high cost care which is sustainable only in metros and big cities. Hence, an insurance funding mechanism that covers only high cost procedures will bias the medical system towards an urban-centric specialty system and against a broader distribution of medical care throughout the state. It also restricts the local availability of treatment (as only advanced treatment is covered under Aarogyasri) in rural and remote areas.

Three, the cost of the procedure is determined at the beginning of the programme based on the costs prevalent at that time. The reduction in the cost of the procedure due to the increased patient base provided by Aarogyasri is not accounted for, leading to a profitable enterprise for the hospitals at the cost of state funds.

#### Health Impact

One of the difficult questions that the Aarogyasri programme raises is about the health impact it has on morbidity and epidemiological profile. While it is designed to take care of catastrophic expenditure due to serious illness, it leaves us wondering about how effective it is in improving the general level of health of people. How does one measure this, and how do we measure the relative effectiveness of treatment and prevention strategies? How do we decide on a health care strategy in situations where there is widespread morbidity on the one hand, and the need for sharply defined acute medical care on the other? For example, in 2009, the widespread outbreak of dengue fever resulted in the then Chief Minister Rosaiah declaring that dengue would be treated under Aarogyasri, only to be contradicted the very next day by the Aarogyasri minister, Satyanarayana on the grounds that it was not included in the list of 950 + treatments covered under the programme. The problem is that dengue needs focus at both the preventive and the curative level. The failure of the former and the refusal of the latter are together symbolic of the complete capitulation of healthcare priority to corporate hospital interests - with disastrous results that border on it becoming a medical atrocity.

#### No Focus on Epidemics and Region Specific Morbidities

One of the problems of the Aarogyasri programme is the lack of a comprehensive disease management protocol; but the other problem is that it has become impossible to bestow recognition on a disease as deserving attention if it does not fall within the list of problems covered under Aarogyasri. Thus, any disease that does not fall under the tertiary care profile, like malaria, typhoid, cholera, respiratory diseases is neither visible as a disease nor does it qualify for a procedure. If this tertiary care driven system becomes the sole engine of health care (as it is increasingly threatening to be), it would not allow us to recognize/treat the ailments of a large population that has no access to healthcare. It forecloses the possibility of any indigenous research about diseases that are not

epidemiologically important in the west, but are crucial in our conditions.


#### CONCLUSION

The Aarogyasri scheme has been revolutionary in placing health on the political map in the state. It is a major landmark in India's administrative approach to health and has emerged as a popular scheme among the masses. It has given hope to multitudes where none existed. However in its current form, the programme is a means to fund corporate hospital profit and distorts the pattern of healthcare in the state. A re-examination of the Aarogyasri programme is urgently necessary, especially in the context of its emergence as a possible model for universal healthcare.

Excerpted from full version published in *EPW*, December 3, 2011; XLVI, 49, 38-42

*Dr. S. V. Kameshwari*

**Smt. M. Chaya Ratan, I.A.S.,**  
Special Chief Secretary to Government



**Department for Women, Children,  
Disabled and Senior Citizens**  
L-Block, Room No. 210,  
A.P. Secretariat, Hyderabad-500022.  
☎ : Off : 040-23456852, Fax : 040-23450008  
E-mail : chayaratan@ap.gov.in

D.O Letter No.6134/WP.A /2010 Dt. 18.1.2011

Dear

Sub:- Hysterectomies under Aarogyasri Scheme – Reg.  
Ref:- 1. D.O Lr.No.36/PSP/2010 dt. 29.03.2010 addressed to the Pri. Secy. to Govt., HM & FW Dept. and copy marked to CEO Aarogyasri Health Care Trust, Hyderabad.  
2. D.O. Lr.No.6134/WP/A1/2010 dt. 30.09.2010  
3. Your D.O. Lr.No.1089/AS.II/F 31/2010011 dt. 16.12.2010

\*\*\*\*\*

Thank you for your D.O letter at reference 3<sup>rd</sup> cited and also for having deputed officers concerned to discuss the matter. In continuation of the request vide reference 1<sup>st</sup> cited and in the light of the report sent by you vide reference 3<sup>rd</sup>, I request you to please consider the following:-

1. As was also suggested to your Officers, patients must have access to their medical records through a password if required.
2. The patient should also give his/her feedback on the nature of the treatment and outcome of the treatment and the software facilitating collation of the same institutionwise for review and appropriate corrective steps.
3. The message that "Aarogyasri discourages organ removal and the same only as a last resort after all other attempts have failed," should be a clear message to all the network institutions. Only physiological indicatives should not result in organ removal including hysterectomies etc.
4. As seen from the report sent by you the age appears to be wrongly reported ex., the age of the woman as per voter card is only 32 years, but age mentioned in the surgical record is 40 years. Therefore, age based on verifiable factors need to be captured to ensure there is no manipulation of the ages.
5. In the case of hysterectomy the panel of doctors to be associated in Aarogyasri should have an established reputation of practicing medicine in an ethical manner with highest standards of integrity.
6. Pre and post operative counseling to both the partners (wife and husband) by a medico-social worker in case of Hysterectomy should be made mandatory.
7. Please consider including a reputed NGO, working with women on reproductive health rights in the panel/special committee to be constituted for coming up with specific recommendations.

In this regard I request you to please consider constituting a team of specialists duly including Dr. Kameshwari, Head of the Department, Women Health Unit, Life Health Reinforcement Group (NGO) and a reputed NGO working with women on reproductive health rights to go into the details of the entire matter and to come up with specific recommendations to minimize organ removal to the minimum essential level. This is perhaps warranted in the light of the percentage of hysterectomy ranging from 1.49% to 7.09% in Ananthapur alone.

I request an early reply in the matter.

Yours sincerely,  
Sd/-  
(M.Chaya Ratan)

Sri A.Babu, IAS.,  
Chief Executive Officer, Aarogyasri Health Care Trust,  
Dr.Y.S.R.Bhavan, Opp.:Dr. B.R.Ambedkar Open University,  
Road No.46, Jubilee Hills, Hyderabad – 500 033.

Copy to:-

1. Principal Secretary Medical & Health (name cover) – with a similar request.
2. Director, WD & CW,
3. All RDD's
4. All P.D's
5. State Programme Director, A.P. Mahila Samatha Society

} through the Director } for information & necessary action on promoting awareness.

*(M.Chaya Ratan)*

For G.Os and other information please visit our website : <http://wcdsc.ap.nic.in>

# Making a Difference

## A study of unindicated hysterectomies in AP

■ Dr. S V Kameshwari and Dr. Prakash V.

**L**ife-Health Reinforcement Group (Life-HRG), a non government organization, has been providing basic healthcare services to rural masses in the arid district of Medak, 100 kilometers from the state capital, Hyderabad in Andhra Pradesh. We have observed that a large number of young rural women undergo hysterectomy, recommended by qualified allopathic and even rural medical practitioners as a solution to many gynecological problems like white discharge, painful intercourse, heaviness in the pelvic region, etc. This is despite the fact that hysterectomy is not a standard recommended practice in modern medicine. It is to be carried out only as a last resort, because all the above conditions can be successfully treated with alternatives to hysterectomy such as antibiotics, simple procedures and treatment of the partner. Many times hysterectomy is done with bilateral salpingo oophorectomy (BSO), i.e., removal of the fallopian tubes and ovaries, which is supposed to prevent ovarian cancers.

Life-HRG has campaigned against unindicated (not considered necessary for treating the condition) hysterectomy since 2001, and presented these facts to The National Human Rights Commission in 2004. These facts have been presented in various medical and non-medical gatherings as an urgent ethical issue which must be addressed. In the next phase Life-HRG undertook a study to deal with the questions of early hysterectomy with/without BSO, in 15 villages of Munipalli mandal of Medak District of AP from May 2008-May 2011. 171 women between the age groups of 20-40 years, who had hysterectomies done between 1-14 years ago participated in the clinical study. Most of them had already been through family planning operations before the hysterectomy.

**Background of the women-** 82% of the study group women belong to BC/SC/ST/Muslim communities. Average age at hysterectomy in the study group was found to be 29.2 years. The average age at marriage was 14 years and average age at first delivery was 16 years. *In 80% of cases indication for hysterectomy was white discharge.*

**Early Menopause-** 41% of these women showed consistently high blood levels of the hormone FSH >40Iu/ml indicating early menopause. Of these women, 31% were still under the age of 30 years. (In natural conditions, premature menopause occurs only among 1% of women between 30-40y age group, while for those below 30 years natural incidence of menopause is 0.1%).

**Early Age at Hysterectomy and Bone Thinning-** Women who had total abdominal hysterectomy (TAH) with BSO before 30 years of age had 5% less bone mineral and 3% less bone density, when compared to women who had TAH with BSO after 30 years of age. The decision to remove ovaries at this young age should not be permitted because women are at a low risk of developing ovarian cancer at this age. It is important to note that the incidence of cervical cancer is 0.08 %. However in AP, 9.2 % of women in reproductive age group have had their uteruses and ovaries removed surgically, and the highest being 16 - 18 % in six districts of AP. In other words, about 10,000 to 20,000 % excess hysterectomies are being performed!

Furthermore, bones of women who are less than 30 years of age have not reached maximum mineral content, and bone loss due to hysterectomy starts even before the bone has been mineralized adequately.

**Duration since surgery-** All dual X-ray absorptiometry (DXA) parameters in these

women who had consistently high FSH above 40 Iu/ml, irrespective of whether ovaries were removed or not, showed progressive deterioration of bone parameters over time.

**Preserving the Ovaries-** The medical fraternity generally perceives sparing the ovaries as a wise medical choice to prevent early menopause. Our study found that despite retaining the ovaries during hysterectomy, 33% of women showed high levels of FSH hormone (menopausal levels). And among all those who had high FSH levels, 21% had ovaries conserved. Thus our study questions the medical wisdom of conserving only the ovaries to postpone menopause, because it is now known that the uterus along with the ovaries is necessary for appropriate hormone production (uterine-ovarian-pituitary axis).

All the above mentioned results point to the need for a thorough investigation into the relation between hysterectomy and early menopause in Indian women to estimate risk of early ovarian failure following hysterectomy. The issue has shifted from unindicated gynecological intervention and questions of how to retain the uterus, to iatrogenic (surgically induced) consequences of hysterectomies.

Our study on hysterectomy had thrown up gaps in medical practice pertaining to women's health care. The myth that "Surgery is the option" and "the only remedy" is impressed upon the patient, even for minor gynecological complaint. For that matter, hysterectomy is being recommended for any complaint/s in the body and also as a measure to prevent cervical cancer in due course. Thus an artificial, detrimental and unusual clinical situation is being created with these aggressive interventions, even as we are yet to understand how to deal with natural menopause.

The entire issue reflects the need to strengthen gynecological care at primary and secondary levels, and also to integrate cervical cancer screening into regular government programs. Secondly, there is also a need to bring the members of the medical profession on board so that they initiate a change in gynecological practice. Thirdly, it is important to note that a large number of women have already been hysterectomized without adequate reason, and that modern medicine has little to offer to women who undergo early menopause as a result. Since the government is liable for the iatrogenic morbidity of this unnecessary medical intervention, it should initiate measures to draw on parallel systems of

medical knowledge like Unani, Siddha and Ayurveda to alleviate the suffering undergone by the victims.

**Impact of this study** -The results of this study were shared with the medical fraternity and with NGOs on Jan 9<sup>th</sup> 2010 at National Institute of Nutrition. At one of these meetings the IAS officer Smt. M. Chaya Ratan, special chief secretary to Dept. for Women, Children, Disabled and Senior Citizens, intervened and held consultations with Life-HRG group. After several sittings, she recommended a ban on hysterectomies in the Aarogyasri program on 18<sup>th</sup> Jan 2011. In fact a ban was imposed on all organ removal surgeries. (See Government Orders reproduced). It was clear that "white discharge" could no longer be read as an indicator for hysterectomy.

**The chronology of Life-HRG's activism against hysterectomies**

**2006** - Aarogyasri is put in place and starts functioning.


**July 17<sup>th</sup> 2008** – Aarogyasri 2nd phase comes into force and allows laparoscopy assisted vaginal hysterectomy (LAVH) and vaginal hysterectomy (VH) with or without repair.

**July 17<sup>th</sup> 2008 to 30<sup>th</sup> Nov 2010** - 26,712 hysterectomies with repair are done in AP under Aarogyasri.

**Nov. 2010- March 2011** - After many meetings with IAS officers, Dr. Chaya Ratan, Special Chief Secretary (Women, Children, Disabled & Senior Citizens) issued a GO to stop ALL organ removals under Aarogyasri. These are

- Hysterectomy
- Appendicectomy
- Gall Bladder removal (Cholecystectomy)
- Tonsillectomy
- Removal of Thyroid glands

The social part of the study was done with the financial support of SET-DEV (Science, Ethics and Technological Responsibility in Developing and Emerging Countries, project funded by the European Commission under the 7th Framework Program). The clinical study is partly supported by DBT (DBT Project Title: Development of support systems to rural women who underwent early hysterectomies) & NIN –Government of India.




39/PSP/2010  
6134/WP/A1/2010

## Aarogyasri Health Care Trust

Government of Andhra Pradesh

Dr. Y.S.R. Bhavan, Opp: Dr. B.R. Ambedkar Open University,  
Road No. 46, Jubilee Hills, Hyderabad - 500 033.



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**Babu .A, IAS**  
Chief Executive Officer

Spl. Chief Secretary to Govt.  
D.W.C.D. & S.C.  
83/1 23 DEC 2010  
SECRETARIAT, HYD-22.

**D.O.Lr.No.1089/AS-1/F 31 /2010 -11, Dt: 16-12-2010.**

*Respected Madam,*

Sub: Aarogyasri Health Care Trust – Rajiv Aarogyasri-II – Hysterectomies under Aarogyasri Scheme – Reg.

Ref: 1) D.O Lr.No: 36/PSP/2010, Dt: 29.03.2010 addressed to the Prl. Secy. To Govt., HM & FW Dept and copy marked to CEO, Aarogyasri Health Care Trust, Hyderabad.

2) D.O Lr.No: 6134/WP/A1/2010, Dt: 30.09.2010.

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I am to invite your kind attention to the letters cited and to inform that in order to bring advancement in surgical procedures within the reach of poor women suffering from diseases in the State, certain Lap. Procedures such as LAVH were included in the list of surgeries under the Aarogyasri Scheme. Initially these procedures were not covered under Aarogyasri. When Aarogyasri-II was launched on July 17, 2008 the procedures were included under Aarogyasri-II as per public demand and after analyzing the inputs from experts. The Trust has taken adequate precautions to prevent any malpractice or misuse and has been strengthening the guidelines from time to time. As of now the following guidelines are in place.

*with ref. P  
Q/w.p.  
7/11 -  
Patient to be given unique code + have access to her/his medical records*

**A. Women Below 35 years: Preauthorization for HYSTERECTOMIES will be given only if she is suffering from:**

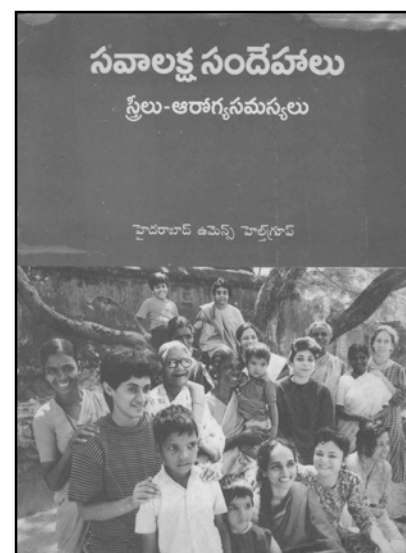
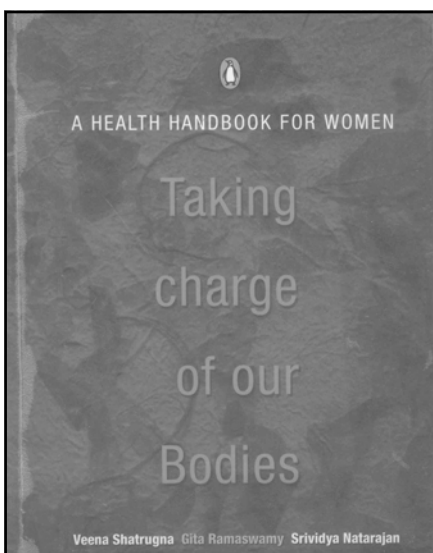
1. CIN III (Colposcopic picture and Histopathological Examination report are mandatory).

*select. of panel of doctors*

**B. Women in the age group of 35-40 Years: Preauthorization for HYSTERECTOMIES will be given only if she is suffering from:**

1. Cervical Intraepithelial Neoplasia (CIN III).
2. Symptomatic fibroid uterus: Objective evidence of Anemia or pressure symptoms.
3. Pelvic organ Prolapse III degree & Procidentia.

Ph : +91-040-23148000, 23148101, Fax: +91-040-23148100  
e-mail : ceo@aarogyasri.org website: www.aarogyasri.org



# Expert's view from the margins

## An interview with Dr. Vijay Kumar, Jana Vignana Vedika, on Aarogyasri in AP

### What is the impact of Aarogyasri on the functioning of private hospitals/nursing homes in AP?

The Aarogyasri programme has a varied impact on different hospitals depending on their size (number of beds), location (urban, semi-urban or rural) and technology level.

Consider 200 bedded hospitals (most of them are empanelled under Aarogyasri) – some of them would have closed without Aarogyasri. They are able to sustain their business because of Aarogyasri patients. Even 50 bedded hospitals which are enrolled with Aarogyasri have been able to survive and grow. In semi-urban areas the sustenance has become difficult for 50 bedded hospitals and smaller hospitals which have not been able to enroll into the scheme. Many un-empanelled hospitals had to either shutdown or scale down once Aarogyasri began. Surgical practices have reduced.

*I have a 50 bedded hospital with basic specialties services (Medicine, surgery—neuro and urology included, orthopedics, obstetrics and gynecology, pediatrics and anesthesia). The mainstay of my practice pre-Aarogyasri was surgical procedures including laparoscopic (keyhole) surgeries. Now our surgical practice has come down by 50%.*

### How easy is it for private hospitals/nursing homes to get empanelled under Aarogyasri?

The high technology requirement is a definite barrier. Most of the new hospitals which are established to take advantage of Aarogyasri find it difficult to enroll due to the technology intensive empanelment criteria. These are focused on high end technology for diagnosis and treatment, higher end specialists and super-specialists to conduct procedures. This requires a high initial investment.

*In my own experience, I tried to get my 50 bedded hospital empanelled under Aarogyasri. I submitted all the requirements and queries as per their specifications; their team instead of visiting my facility, came up with a totally new set of queries unrelated to the previous set. Most of these questions were about technology.*

*I had sought empanelment for pediatric care procedures. I met all the scheme's criteria for pediatric care. The Aarogyasri team after sometime insisted on neonatal (new-born) care requirements (which are different from those of pediatric care) like phototherapy units, etc. The same unpredictable demands come up in relation to operation theatre and diagnostic equipments. When I applied for empanelment for surgical procedures they also insisted on orthopedic procedures. This has not just happened to me but also to many other doctors who run 50 bedded hospitals.*

*We are not empanelled. We have adapted by strengthening and shifting to treatment of those conditions which require medical management (as opposed to surgical treatment), especially for conditions not covered under Aarogyasri. That programme only covers 953 procedures and luckily for us the list leaves many medical needs uncovered.*

It is not just high-end technologies that cause difficulties to hospitals, but also the pre-requisite of higher specialties in surgical skills that are being specified by Aarogyasri. The Medical Council of India does not prohibit surgery by an MBBS doctor. Initially, under Aarogyasri, the only criteria for doing laparoscopic surgery was some internationally recognized certification of the doctor's competence. Even a general surgeon needed this certification. Now they have specified that only general surgeons with a certification of having done at least 100 laparoscopic surgeries would be eligible to perform laparoscopic surgeries under the scheme. Now, in a rural

setting you don't find many general surgeons, it has always been MBBS doctors (without an MS degree but with surgical training and experience) who have been doing the basic surgeries and serving people.

*Take my case—I have been trained by Dr. Mitra (of Apollo Hospitals, Chennai and Hyderabad) in laparoscopic surgery. At that time, there were only 3-4 laparoscopic surgeons in AP of which I was one. I have trained many surgeons in laparoscopic surgery. I have certified for Aarogyasri that they have conducted 100/200 laparoscopic surgeries under my guidance. This certificate issued by me is valid for eligibility under laparoscopic surgery, but I am not eligible to do laparoscopic surgeries myself even though I have been trained by the country's leading laparoscopic surgeon, because I am only an MBBS doctor. So yes, there are many aspects of Aarogyasri that are biased against small hospitals in semi-urban/rural areas and towards large corporate hospitals in the cities.*

### How does Aarogyasri get operationalized and what is its effect on patient care?

Aarogyasri has had a series of deleterious effects on patient care as a whole. These may be due to technology effects, reimbursement limits, eligibility for funding, specialization criteria and due to diseases not being in the Aarogyasri list.

To look at the technology effect, take the example of laparoscopic gallbladder surgeries. Laparoscopic surgery provides a great advantage over traditional open surgeries in gallbladder removal. Hospital stay is 2-3 days and the patient can go to work in 5-7 days. Healing is better for many reasons. But sometimes the operating doctor decides to convert laparoscopic surgery to an open surgery with a wide incision to ensure safety of the patient after assessing the patient's gallbladder through the laparoscope. However, an open surgery is paid only Rs. 10,000 as against Rs. 30,000 in laparoscopic surgery even though the hospital stay and other expenses are more in the open surgery.

For an example of the difficulties caused by partial inclusion of a category in Aarogyasri, let us look at poisoning. There are many cases of poisoning in rural areas especially among women, but all poisoning is not covered under Aarogyasri. Only organophosphorous (OP, or pesticide) poisoning which requires putting the patient on a ventilator (breathing apparatus) is covered. This too is covered only initially for 7 days, after which the patient needs to re-apply

for further eligibility. In my hospital about 25% of OP poisoning cases require ventilator support. But any poisoning (both OP and non OP) case, even if ventilator support is not needed, requires prolonged hospitalization of 10-15 days, gastric lavage (flushing out the poison through water or saline pumped into the stomach), ICU stay for 3-5 days, medicines, medico-legal coverage, etc. In some cases of corrosive (Super-Vasmol hair dye) poisoning tracheostomy (making a cut in the breathing pipe) is required, but it is not covered under Aarogyasri. People do not prefer to take poisoning cases to government facilities, as they fear a police case; so most of them end up in a private hospital, incurring huge treatment costs. Scorpion stings are not covered but snake bites are.

Dengue fever is an example of non-coverage under Aarogyasri. The sale of (blood) cell counters has increased in the private hospitals. Every fever is now treated as a probable dengue case and a cell count is done. Platelet counts can fluctuate due to multiple reasons, dehydration, excess of dilution factor, or sampling error; platelet fluctuation because of dengue is rare. Even in cases where an abnormal count is shown by automatic cell counters, a manual verification is mandated before the results can be interpreted. But the patient is at the receiving end of arbitrary decision making. Any fever case can be made into a dengue case. The system can play on the psyche of the patient and expose him to unnecessary treatment, hospitalization and expenses. The worst thing is hemorrhagic dengue fever or dengues with serious complications are also not covered under Aarogyasri.

Finally, there is a learning curve for both the doctor and the medical system each time a new technology is introduced (e.g., laparoscopic surgeries). A lot of experimentation is done, and many inexperienced people try their hand at these technologies. Normally 1% injury to common bile duct is accepted in laparoscopic cholecystectomy (removal of the gallbladder through keyhole surgery), but the injury rates were higher under Aarogyasri. The treatment of these complications was not covered under Aarogyasri. Hospitals were supposed to bear the cost, but they shifted it on to the patients. So it would seem as if the Aarogyasri programme is also functioning as a paid skill development programme for surgeons at the risk of patients who need medical care!

To sum up, high end technology does provide value in some methods of treatment, but it also acts as barrier for entry of smaller hospitals into the scheme in semi-urban areas. It also lends itself to overuse/misuse because a basic volume of procedures needs to be done to sustain the technology, irrespective of whether it is needed or not in the best interest of the patient. The high cost of investment has to be recovered and technology has to be sustained.



(adapted in good faith from www.funnytimes.com)

In response to protests over such procedures, recently the Aarogyasri trust has restricted surgeries like hysterectomy (removal of uterus), cholecystectomy (removal of gallbladder), appendectomy (removal of appendix) and thyroidectomy (removal of thyroid glands) to government hospitals in order to restrict overuse/misuse of these procedures by private hospitals.

#### **Is there any difference in care between general patients and Aarogyasri patients in government and private hospitals?**

In government hospitals, the government surgeons and specialists can earn Rs. 1 lakh over and above their salary per month from Aarogyasri payments. The team (doctor, nurses, ward boys) treating the patient shares 30% of the Aarogyasri payments, of which a major portion goes to the doctor. This is an incentive for them to focus more attention on Aarogyasri patients. In addition the Aarogyasri patient can afford drugs and investigations not available in the hospital. So the Aarogyasri patient is rated higher than the general patient in government hospitals.

It is exactly opposite in a private hospital. The Aarogyasri patient is operated/treated upon

by the assistant surgeons/junior doctors (trainees) in most of these hospitals. Low end technology and inferior quality material are used. These patients are kept in separate general wards, which are less equipped and more crowded than the normal wards. They are under-served compared to normal private patients. The effort here is towards maximizing profits of the hospitals and doctors.

I think there is a provision under Aarogyasri for stay in the private wards (both in the government and private hospitals) at additional cost over and above that covered by Aarogyasri for patients who can afford it.

Initial expenses on tests required to arrive at a diagnosis acts as a barrier for the real poor in accessing services at private hospitals. Another issue is that patients referred to government hospitals are channeled to private hospitals.

*I have referred many patients to Osmania Medical College cardiology and surgery departments, but only one in ten referred patients finally reach there. Others are siphoned off by touts to private hospitals for a commission. Even in referral there is a system of cuts and kickbacks.*

Aarogyamitras in general have been of immense help to a poor patient trying to negotiate the complex system of a hospital and in receiving treatment.

#### **What is the nature of external/ political influence of private sector in policy and empanelment or other matters of Aarogyasri?**

Doctors have strong influence on politicians, but during YSR government there was very little political influence in empanelment and payment processing. Influential doctors who approached YSR were clearly told that he does not interfere with Aarogyasri operations. This sent out a strong message, "political influence is not useful in Aarogyasri". But this was true only of smaller individual/group-owned hospitals. The corporate sector would threaten Aarogyasri of withdrawal from the scheme if the trust did not comply with their collective request. Now things have changed, there is more access through third party lobbies (both politicians and otherwise).

#### **How would you want the AP health system and Aarogyasri to evolve?**

The public in AP has appreciated Aarogyasri. For a person in need of health care, coverage under the scheme has a big impact. But many conditions are not covered; only tertiary care is. It can be an excellent platform to offer universal health care. It has strong political appeal. What the health activists could not do over so many years, YSR did in a short time. Health is now on the political agenda of AP. Efforts should be directed to make Aarogyasri available to everybody.

*Our (Jana Vignana Vedika's) slogan is:  
Aarogyasri for all diseases, for everyone and only in the government hospitals. Not at the cost of public health*

Referrals to private hospitals should be allowed only for those cases for which government hospitals certify that treatment facility is not available with them. Different mechanism of financing can be established. Those who can afford it should pay a premium or tax.

The public health care system has been systematically brought down. The strategy has been to first squeeze funds, not appoint the requisite workforce leading to a lowering of performance of government health sector. This result has raised anger in public towards government facilities, and increasing frustration among public sector employees. Once this atmosphere is created, services can be shifted to private sector (through incentives, land grants, exemption from import duties, etc.). I think this strategy needs to be reversed, we have to strengthen public sector and use it to provide treatment through public financing. In my opinion, health and transport should not be run by private sector. Even CGHS (Central Government Health Scheme), ESI (Employees State Insurance) and Indian Railways are referring patients to private health facilities—we need to reverse this trend.

Increased emphasis should be laid on preventive measures. For example during British rule, there was a practice called Dry Friday. Everybody acted on Friday to keep the surrounding and drainage dry. This had virtually eliminated dengue as public health menace. But now government is not interested and health activists have failed to mobilize people.

**How do you now ask a poor beneficiary not to go to a private sector hospital? Isn't this a political question?**

Political will is required. Some amount of consent and coercion is also required. If we provide treatment for all ailments at government health facilities and invest in public health care, the reversal will happen. A poor person should feel that he is able to get treatment for all ailments at government hospitals.

**Will people realize that they are being taken for a ride through populist measures, not really benefiting them?**

Yes, there are many examples of such realization. Smoking has reduced in railway premises. Awareness, law, stigma, implementation, all have played a role. Sale of useless tonics has come down by 50%. Sale of cool drinks has reduced. Use of safe drinking water has increased even in rural areas. Village people are purchasing water cans. But it should be the duty of government to provide safe drinking water.

**A last comment on Aarogyasri?**

*Aarogyasri should not be scrapped. It is a knife that was used to stab the public health sector, now the same knife should be used to stab back at privatization.* There is no rationale for the focus on only high-end medical care cases under Aarogyasri. Many a time high end care is unnecessarily provided so that patient can be covered under Aarogyasri at an early stage. All this depends on the attitude of the hospital management - how profit driven they are!

*Dr. Vijay Kumar is a well known health practitioner and health care activist. He is a founder member of Jana Vignana Vedika, an organization that is committed to socialize principles of health care and public health. He is part of National Association of People's Movements. He heads a nursing home called Nellore Hospitals at Nellore. He was earlier working for seventeen years at Dr. Ramachandra Reddy Hospital, also at Nellore. This interview is the record of a conversation between him and Rajan Shukla, Veena Shatrugna, Sheela Prasad and R. Srivatsan.*

**Anveshi Public Panel**  
on  
**Health Care in Contemporary India: Strengths and Pitfalls of Current Strategies**  
**9th February 2013 Sundarayya Vignana Kendram Main Hall, 5.30 PM**

**Dr. Binayak Sen** (Health care professional and human rights activist)  
**Chairperson's remarks**

**Dr. Rajan Shukla** (Asst Professor Indian Institute of Public Health, thinker and activist)  
**The structure and experience of Aarogyasri in AP**

**Mr. Srikanth** (CEO Aarogyasri Health Care Trust)  
**The present and future directions for Aarogyasri**

**Dr. Kameshwari** (Practicing Gynecologist, Head, Women's Unit, Life-Health Reinforcement Group) **The case of excessive hysterectomies in Aarogyasri**

**Dr. Srinath Reddy** (President Public Health Foundation of India and formerly chief of cardiology AIIMS) **HLEG proposals for Universal Access to Health Care and current status**

**Dr. Abhay Shukla** (Coordinator SATHI Pune, public health professional and health activist)  
**The emerging directions of Universal Access to Health Care in India**

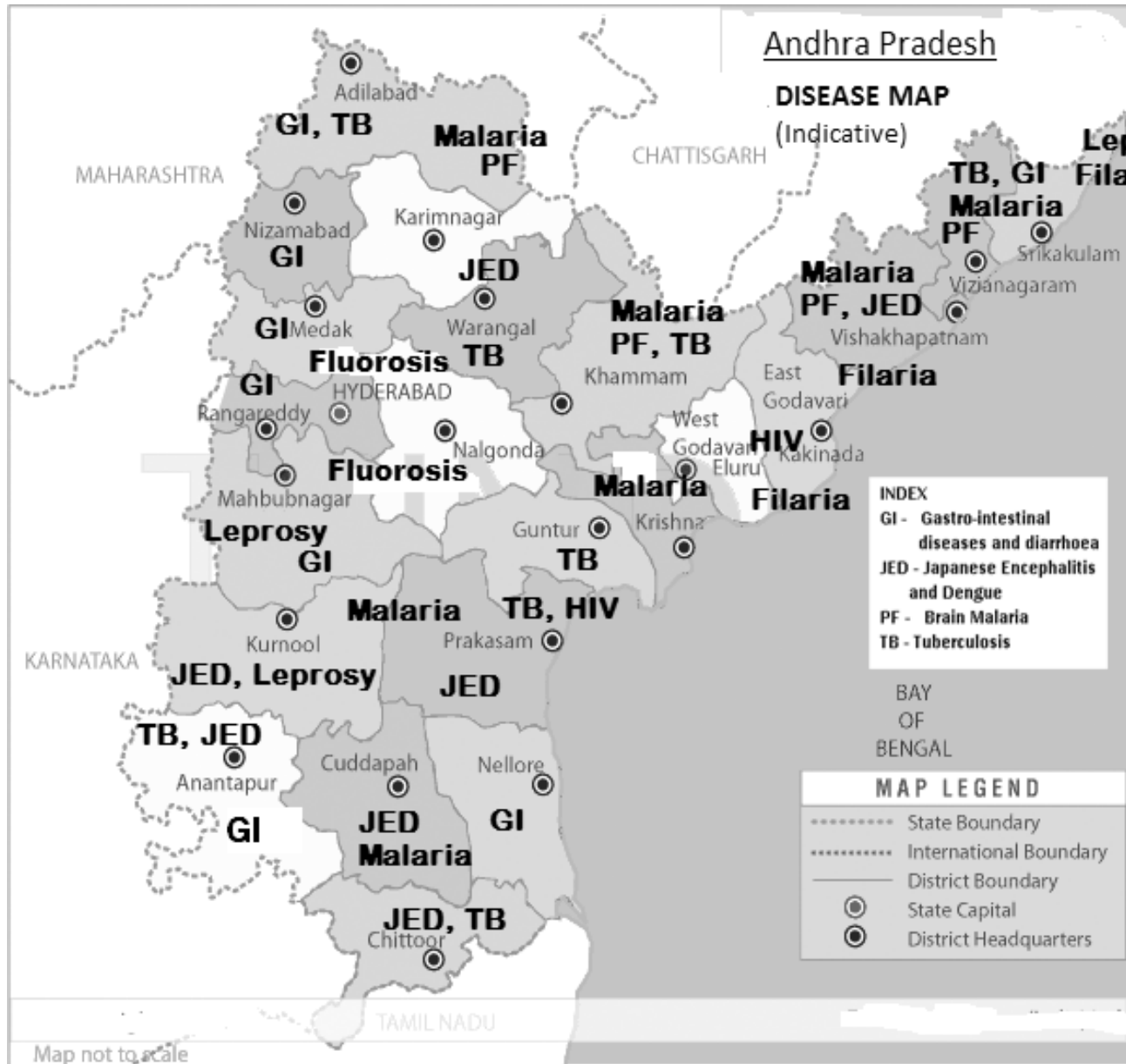
**Dr. Anant Phadke** (Co-convenor Jay Aarogya Abhiyan and founder member All India Drug Action Network) **Free medicines for all, experiment, experience and implications**

Against the backdrop of the abysmal failure of health care and critically low indicators of health, the past decade has seen the emergence of many initiatives to address the situation. This panel will discuss three such initiatives. One has been the establishment of Aarogyasri in Andhra Pradesh by the then chief minister YS Rajasekhara Reddy. This programme has been praised as the solution to India's health care problems by no less an institution than the World Bank. The second has been the proposal of the High Level Expert Group chaired by Dr. Srinath Reddy, established by the Planning Commission, on providing Universal Access to Health Care in India. This proposal has been widely acclaimed by many as a signal contribution to health care policy. Third there has been an initiative to provide free/cheap medicines for all, first in Tamilnadu, and more recently in a few districts in Rajasthan, which has been a huge success. All these initiatives have wide ranging implications for the future of health care in India. The lectures by this distinguished panel of speakers will explore some of the main pros and cons of each idea and its implementation, for the benefit of the audience. They will also reflect on the possible avenues of struggle for health care, which is emerging as an agenda for politics today.

**Anveshi Research Centre for Women's Studies**  
2-2-18/49, DD Colony, Baghamburpet,  
Hyderabad.  
Ph: **040-27423168, 27423690, 27407431**

# Disease Patterns in Andhra Pradesh

■ Sheela Prasad



It is well known that some diseases are endemic in specific regions due to unfavorable physical and social environments. An attempt is made to map the incidence of a few major diseases in AP to highlight the high prevalence vulnerable zones. It needs to be admitted that this map is largely indicative based on piecemeal district level morbidity and mortality data collected from different sources from 1995 to 2005. Minimal changes may have occurred since then.

The spatial pattern of disease incidence in AP shows some disturbing trends (see map). Most of the diseases mapped are communicable diseases as district level data for other diseases is not easy to collect. Also, the data available is only from government health sources and hence does not fully represent the magnitude of disease prevalence in the state. One needs to keep some of these limitations in mind in reading this map.

Malaria followed by TB affects the largest number of people in the state. While malaria is found across the state, endemic malaria zones are associated with the hilly, forested tracts covering Srikakulam, Vizianagaram, Vishakhapatnam, Khammam, and Adilabad. These five districts are also endemic to plasmodium flaciparum (PF) malaria (brain fever), a more virulent type of malaria with high death rate. These districts including the northern parts of the Godavari districts are characterized by high Adivasi populations and poor health facilities in the 'Agency' areas.

Of the other diseases shown on the map, filaria is endemic to the coastal districts with East and West Godavari, Srikakulam, Vizianagaram and Khammam reporting most cases. The earlier pattern of vector borne diseases prevalent in regions of higher rainfall and dense vegetation is changing. Japanese encephalitis and dengue cases in AP are today also found in large numbers in urban pockets (Hyderabad) and the Rayalseema and Telangana districts. Tuberculosis does not reveal any marked spatial preference, is reported across the state, though Prakasam, Adilabad, Anantapur, Khammam and Vizianagaram have a higher incidence. HIV prevalence which is linked to high TB incidence is noted in the interior districts compared to coastal Andhra, with Kurnool, Mahbubnagar, Adilabad, Srikakulam and Vizianagaram reporting most cases.

Water related diseases are a serious health problem in AP through the year and particularly, during the rainy season. Diarrhoea cases are high and reported from all districts, both urban and rural. Gastroenteritis epidemics are common during the monsoon months in Adilabad, Srikakulam, Vizianagaram, Nizamabad, Anantpur and Mahbubnagar. Fluorosis is a major health issue in large parts of the state, with Nalgonda and Mahbubnagar the worst affected. Viral hepatitis/jaundice cases are on the rise with Hyderabad and Ranga Reddy districts showing the largest number.

To summarise, some thoughts:

- Communicable diseases continue to pose a major threat to better health in the state.
- The spatial pattern of highest communicable disease incidence in AP coincides with the Adivasi / Agency belts which are areas of poor health facilities.
- A number of studies on AP inform us that the victims of epidemics and illness are mostly the poor in both urban and rural AP.
- Disease burden from diarrhoea is high, particularly for children, with AP accounting for about 14% of the diarrhoea deaths and 21% of cases in the country.
- From the map a tentative listing of districts with highest disease burden: Srikakulam, Adilabad, Vizianagaram, Khammam, Vishakhapatnam.
- In AP high disease burden is clearly correlated with districts/regions that are least developed and have poor health care availability.
- If the non-communicable diseases are included the disease picture gets further aggravated.
- News reports mention high rates of cardiovascular diseases, diabetes and cancers for the state as a whole.
- A recent study projects 10% of population in AP as being diabetic.
- AP also has 22.6% of the total snake bite cases of the country.
- A recent study on Burden of Disease in AP concluded the six major causes of death in both rural and urban AP were : lower respiratory infection; diarrhea; low birth weight; heart disease; accidents; TB.
- Most of these causes were linked to lack of nutrition, safe drinking water and sanitation facilities.

The map is based on data from 2005/6. The broad findings suggest a high disease burden from communicable diseases. These diseases account for the highest morbidity rates in the state. Most of them are seasonal and preventable. Their continued high prevalence speaks of the collapse of the public health system in the state. The above findings and the disease map force us to conclude that the disease picture of AP has not changed much in 2013.

The question is,

**If communicable diseases continue to contribute to the burden of disease in AP, why are they not covered under Aarogyasri, either when it began in 2006 or even today?**



# Interview with Mr. Raghavulu AP State Secretary CPI (M)

*Veena:* How would you help us understand Aarogyasri?

**R***aghavulu:* The Aarogyasri programme started with Y S Rajasekhar Reddy. However, the money for the programme came from the National Rural Health Mission (NRHM) budget. On one side it caught the imagination of the people, but on the other that imagination is a simple illusion. It included super-specialty hospitals with some operations that required huge amounts of money. It got the people's support through examples. In a village or in poorer section housing, one person may be treated for kidney disease, or some serious illness. The others in the village think that they will get the same treatment. But if you calculate how many cases, how many such treatments were given, you will find that the programme has become a drag on the general health sector. Because apart from the central funds, the remaining funds are siphoned from the state budget and the proportion of the health budget spent on general health care has reduced and has been diverted to Aarogyasri. That is one bad effect. The other is, what ever money is spent on Aarogyasri is cornered by the private hospitals with very little going to government hospitals. That too had a telling effect on the infrastructure and maintenance of the government hospitals which deteriorated. There is also anecdotal evidence that in a number of cases, hospitals thrive on Aarogyasri. The third problem is corruption, because private parties are influencing decisions, especially in orthopedic cases. So even if the programme ran properly it was a drag on the health budget, but with huge amounts of corruption there is a much greater drag. Many private hospitals, even mid-size ones have prospered. So what we feel is that in the long run, the Aarogyasri programme cannot survive. However, politically this opinion is not palatable, even to a section of the poor. However, we need to tell the truth.

That is why we termed this as Corporatesri, not Aarogyasri!

That is one element; the other element is the public health services, which are also distorted by this Aarogyasri scheme. Because wherever the public hospitals have the Aarogyasri scheme, a portion of the money is given to the doctors. Many of these doctors also concentrate on Aarogyasri cases because they get more money. This incentive reduces public health care for non-Aarogyasri patients. In addition, departments that don't get Aarogyasri money are also run down. This widening ineffectiveness is the reason why dengue and malaria are not taken care of and there is a general collapse of the health care system. Tertiary hospitals have survived, but primary and secondary levels have almost collapsed. Take for example in social welfare hostels, especially in tribal areas, eczema is rampant. Because of eczema, students are unable to concentrate on studies. The disease is easily treatable, and preventable with a small expense, yet it is neglected. CPM treated all these school children in Vishakapatnam district – all the mandals, we organized the teachers and doctors and gave the children clothes, washed sheets, etc., and it helped. It should be annual. That is it. Also preventing malaria is not too difficult.

*Veena:* Politically now, how should one argue about Aarogyasri?

*Raghavulu:* The public can't understand the nuances of the programme, but the general demand for inclusion of everything under Aarogyasri is one type of expression of discontent with the system. But if you give all health care under Aarogyasri, it means that we are talking about health care both private and public. We are demanding that we overhaul the health care system. When the government framed the NRHM it was formulated in such a way that everybody was covered. It had both

private and public, which is why privatized health care was introduced in this. We demand a level playing field, but this system today is biased toward the private sector.

*Srivats:* Level playing field between corporate and public sector, and also between rich and poor?

*Raghavulu:* Yes. In Kerala, though they can't exclude private sector because of the central government policy that if you exclude the private sector, funds won't be given. This is the linkage to the reforms. We were told in the Kerala model, they will fix the rates in such a way that the corporate hospitals are not interested.

*Veena:* Is that what is happening?

*Raghavulu:* Yes, when Prabhat Patnaik was the vice chairman, that system was set up in Kerala. There the public health system utilizes all the funds and it has improved because of the additional input. We are also asking for the same system. We are not immediately going to change the whole policy, but this kind of measure can be taken.

*Veena:* Recently in the CGGS, the corporate hospitals are charging a higher rate for CGHS patients than for ordinary patients.

*Raghavulu:* They are opening special Aarogyasri wards etc. The policy change can be done by state government.

*Srivats:* But you don't think that if you let it privatize like this the competition will build up and the rates will come down?

*Raghavulu:* As it is in our state, the private sector is an equal sector to the public. Rates are not coming down.

*Srivats:* No I am asking if there are enough funds, will more hospitals come in and there will be a larger number of suppliers, and in spite of this the rates still won't come down?

*Raghavulu:* As it is the number of private hospitals is increasing. Our hospital at Nellore, Ramachandra Reddy Hospital didn't take Aarogyasri. We said, "It is a government scheme, why can't you use those funds and improve your services?" They said that they couldn't indulge in the necessary malpractices – without a payback cut, the money wouldn't be released. If you bribe them they won't care about the conditions, but if you don't they will harass you – so they didn't take the Aarogyasri programme.

*Veena:* Does this mean that their patient load came down?

*Raghavulu:* No, our hospital has low rates. If they had taken the Aarogyasri money they may have benefited, by some funds. But the other things they can't do, that's why they didn't take the programme.

*Veena:* Would you agree that anyway Aarogyasri has come, and you cannot stop it now?

*Raghavulu:* Yes, Aarogyasri was originally intended to introduce general privatized insurance gradually through the government. As the full fledged insurance scheme comes, there would be no Aarogyasri. Once that happens, the government would pay the premium for some people, and other institutions would do so for other people—that is the way they want to go. But this process is not smooth. The initial idea of the government was: "it is a temporary phenomenon, we can run it for three, four or five years and then the private insurance schemes will take over". But it seems that this is not happening. People want it to continue, and the government has to see how to restrict it.

*Srivats:* So raising the expectations seems to be important?

*Raghavulu:* Yes, it is, but this kind of expectation is only in Andhra Pradesh, not in other states.

*Veena:* No, but other states are starting Aarogyasri, Maharashtra has its own version of Aarogyasri.

*Raghavulu:* If the government steps up its budget, it can't politically sustain the

programme. Malaria, dengue, filariasis are all increasing. They cannot withdraw the demand for Aarogyasri, but if the service increases how that demand will be met and the balance sheet will be drawn is not very easy.

*Veena:* But if it is possible to force the government to extend the Aarogyasri programme to primary and secondary care, it would be good, wouldn't it?

*Raghavulu:* That is what the people are doing. They are asking the government to include more diseases. But the government is not willing to extend the programme. Take for instance fever cases – like dengue cases – every case of fever was treated as dengue, until it was proven not to be dengue. By that time all the patient's money was spent. That is why the demand for Aarogyasri coverage for dengue is coming.

*Veena:* But it is true that every year, at this time after the rains, there is a huge increase of fever, diarrhea, etc.

*Raghavulu:* Not only tribal areas, also urban areas. This is because the municipal system has collapsed because of the reforms and privatization. They are asking the municipalities to raise funds, but they are not doing so. That is why in every town in the last few years, mosquitoes are multiplying.

*Veena:* Is it possible that preventive measures will be ensured?

*Raghavulu:* We have discussed this in the party also. The drinking water system has collapsed, as has the drainage system. Problems continue to exist not only in urban areas, but in large panchayats too. That's why there are fevers and diarrheas etc. Without government's intervention families cannot do anything about

diarrhea, malaria, etc. The unfortunate thing is that political parties are least interested in this. Mass organizations too are too busy.

*Veena:* Is CPM is the only party that has some connection to medicine?

*Raghavulu:* But even we feel that what we are doing is reactive, and episodic, not continuous. Not active. Now we are thinking about active continuous activity in the health sector.

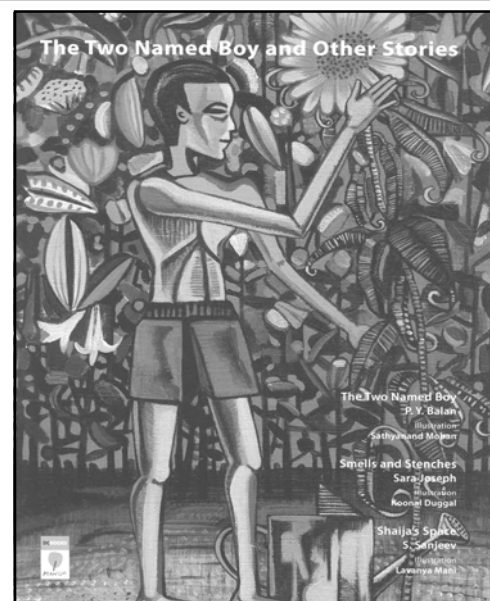
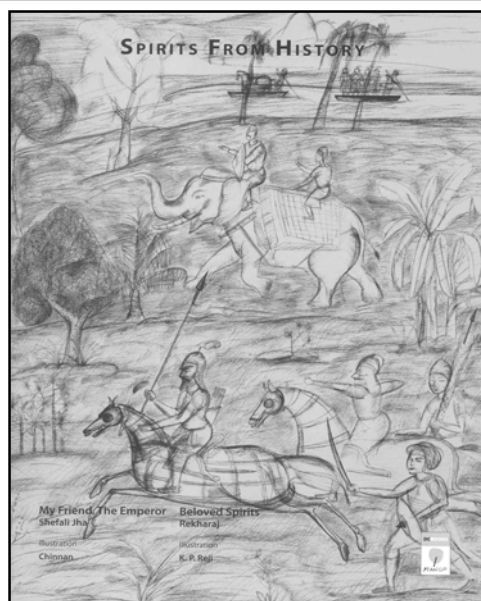
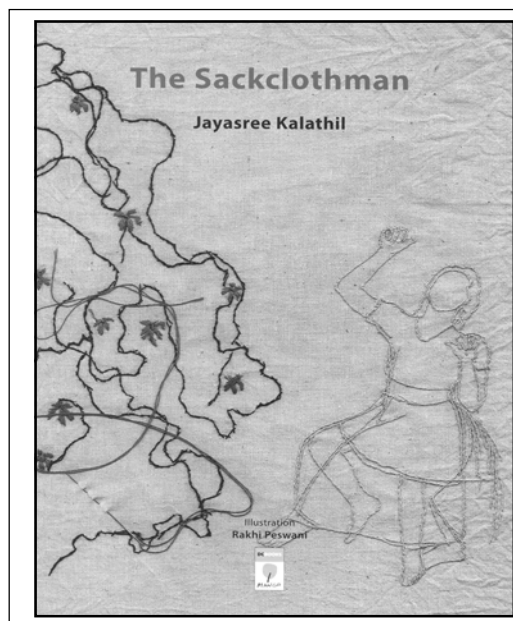
*Veena:* One of the problems is with the ESI sector. It is capable of working. But 95% of the people are in the unorganized sector!

*Raghavulu:* Our trade union movement is concentrating on ESI. The problem is, our CITU is relatively weak in the private unorganized sector. In organized sector and small scale sector, we are trying to be active. But wherever we are active we are forcing the managements to contribute to ESI. Even the public sector organizations are feeling that the general trend is towards private. Government authorities should force management to go to government hospitals and ESI. But managements do not think on these lines. We organized two major strikes in Hyderabad recently on ESI. One was held to protest that the hospital location was not convenient; another, to enforce provident fund and ESI.

*Veena:* The Aarogyasri idea it is spreading in different states. Corporates are well placed to push for fund sanctions. They run Aarogyasri.

*Raghavulu:* How to proceed with Arogyasri is a challenge that we are now addressing.

*This is the text of a conversation Mr. Raghavulu had with Veena Shatrugna and R. Srivatsan.*



# Employees' State Insurance Scheme

## A Preliminary Note

■ Mithun Som

### Introduction to ESI:

The Employees' State Insurance (ESI) Scheme, enacted in 1948 was the first major legislation for social security in India. Based on the principle of "pooling of risks and resources", it guaranteed to provide full medical facilities to the beneficiaries. In addition to this, it also promised adequate cash compensation to insured persons for loss of wages or earning capacity in times of physical distress arising out of sickness, employment injury or unemployment.

The main benefits provided by the ESI are sickness benefit, disablement benefit, dependent's benefit, maternity benefit, medical benefit and others like funeral expenses, unemployment expenses, etc.

ESI has the potential to become a full-fledged social security system in India. However, for that to happen, several lacunae must be addressed. This paper tries to outline the ESI structure, its operation, flaws and some directions for improvement.

### Who is eligible for insurance?

Any factory/firm/establishment where manufacturing process is carried on and which employs more than 10 persons have to register with the ESI. The establishments include shops, restaurants, cinema theatres, road motor transport undertakings, newspaper establishments, private medical and educational institutions, etc. Thus, in principle, permanent employees, temporary employees in the formal sector and employees in the unorganized sector are covered. The requirement is an employer-employee relationship in which the employer is expected to deduct from the wages of the employee, add his own contribution and make the payment to the ESIC. Thus, self-employed persons, e.g., people in the service industry, those who run auto-rickshaws, street vendors, etc., are not

covered. Employees earning not more than Rs.15,000 per month are presently entitled to it. They contribute 1.75% of their salary and the employers contribute 4.75% of the employees' salary. The state government also contributes 1/8th share of the cost of medical benefit. ESI gives unlimited treatment for the person and the family.

Recently ESI smart cards are being introduced since 2009 to enable the holder to access ESI hospitals across the country. There is one smart card for the entire family including the dependents—spouse, children, father and mother. A person is entitled for super-speciality care three months after getting the card. A dependent is entitled to the same after six months. A retired person and his/her spouse can also avail medical benefits on payment of a nominal amount of Rs. 120 per year. It remains to be seen how well they function.

### Employee State Insurance Scheme (ESIS) and Employee State Insurance Corporation (ESIC)

ESIS as laid down by ESI Act of 1948 is implemented by the ESIC, an autonomous body under the Ministry of Labour and Employment, Government of India. Till recently the ESI department of respective state governments administered the provision of care. Since about a decade there has been a move to establish hospitals directly run by the ESIC in each state. There is one such 'Model Hospital' in every state.

The Model Hospital at Nacharam, Hyderabad was the first in the country. A senior official at Nacharam said that the corporation run hospitals are expected to be better because the head of the hospital gets a free hand, which means better equipment, supplies and overall management. He also said that the state run ESIs however do not run as efficiently largely because of low priority and lack of funds and that the corporation is taking steps to improve these.

### Structure of ESI Health Care Network in India and AP:

The ESI health care system has a three-tier structure. At the first level are the dispensaries which have two to five doctors. ESI has a network of 1403 dispensaries in the country. At the second level are 146 hospitals (as on March 2011). Diagnostic centres function between the dispensaries and hospitals without any surgical facilities. There are some super-speciality hospitals at the third level. However, if Andhra Pradesh is taken as an example, the bulk of the tertiary care referrals go to the corporate super-speciality hospitals. Five zonal

Table-1: Income Expenditure Summary, ESIC

(Rs. in million)

	2005-06	2006-07	2007-08	2008-09	2009-10(RE)
Total Income	24,106	31,081	39,893	44,525	47,751
Expenditure Summary					
Total Benefits (cash+medical)	9,990	10,545	12,142	15,039	26,982
Administration	2,110	2,214	2,480	4,127	5,457
Total Expenditure	12,780	13,501	15,488	20,662	33,990
Surplus (Total Income – Total Expenditure)	11,326	17,580	24,405	23,863	13,761

ESIC, various Annual Reports – Source: PHFI, 2011

Table- 2: Summary of ESIC funds investment

(Rs. in million)

	2004-05	2005-06	2006-07	2007-08	2008-09
Reserve Fund					
Fixed Deposits with public sector banks	55,174	64,985	80,961	103,883	124,779
Special Deposit with Central Government	52,226	56,404	60,916	65,789	71,053
Total Funds	107,400	121,389	141,877	169,673	195,832

ESIC, various Annual Reports – Source: PHFI, 2011

occupational disease centres have also been set up in the country for early detection and diagnosis of occupational diseases.

In Andhra Pradesh there are eleven hospitals and 142 dispensaries. Hyderabad has three hospitals in Sanathnagar, Nacharam and Ramachandrapuram.

#### Finance

The tables 1 and 2 below provide a summary of ESIC finances. As table 1 shows total benefits that accrue to the beneficiary (medical and other cash benefits) amount to approximately 78% of the total expenditure, while the administrative cost is about 17%. However the total income of ESIC exceeds the total expenditure and the surpluses are very high. For example in the year 2009-10, the income was Rs. 4,452 crores while the total expenditure was Rs. 2,066 crores. This is a surplus of 54%. The surplus funds are kept as fixed deposits in nationalized banks or as special deposits with the central government. Thus as table 2 shows the total invested funds with ESI in 2008-09 is Rs. 19,583 crores.

#### Referrals:

ESI hospitals have tie-ups with super-speciality government and corporate hospitals. Any referral from the hospital has to be approved by the Referral Committee and finally approved by the Medical Superintendent of that hospital.

#### Patient information from the ESIC hospital, Hyderabad.

- ESIC Nacharam had tie-ups with 24 hospitals in November 2012.
- It referred 231 patients on an average in a month (2012) for admissions. Of the total referrals, 27% were referred to Nizam's Institute of Medical Sciences, followed by 16% to Bibi Cancer, 14% to Kamineni and 9% to Mediciti. This is an average of 22% of the total patients admitted in inpatient wards. These hospitals are at an average distance of about 10 km from the Nacharam Hospital.
- All medicines and tests are free for the patient.
- Apart from this, ESIC Nacharam refers approximately 25 patients each day for consultations with specialists.
- Outpatient data indicates that the cardiac department that was functioning intermittently till March 2009 has been shut down. Before 2009, in the months in which the cardiac department functioned, there were approximately 160 patients per month.

#### Insights into functioning:

1. The dispensaries function as primary care centres. It is seen from patient

experiences, that they are not operating effectively and people choose to go to other private practitioners at that level. For example, for Ramesh from Medak town, the nearest dispensary was in Alwal, Secunderabad. Even if he went to this dispensary, they would give medicines for simple ailments and generally refer him to Sanathnagar or Nacharam Hospitals in Hyderabad.

2. The interviews with patients and the data obtained suggest that the ESI hospitals are able to provide secondary level of care. Thus Ramesh (above) preferred to come to Nacharam for his wife's delivery. Another woman, Indira, who has had an ESI card for the last five years, has never used the services. But this time she has come for her delivery as she gets three months maternity leave as well as some cash benefit. It is obvious that the functioning is like a typical government hospital system. However the tests and medications, specially at the level of secondary care, are reasonably effective.
3. Again observation at Nacharam indicates that serious cases are referred to corporate hospitals for tertiary level care. Thus, Khadija, a dependent mother of a BPO worker, has been diagnosed with brain tumor in a corporate hospital when she first went with her MRI result. She was told that she needs a surgery. She has now accessed the ESI for the first time and hopes to ask the doctor to refer her to the same corporate hospital for her surgery.
4. People who access the services, come for cash benefits in situations of sickness, maternity, or handicap. For example, both Indira and Khadija (above) came to ESI to access these other benefits. Many also come for medical benefits for critical illnesses which may otherwise be extremely expensive.
5. Retired workers too seek to use the ESI system but things always don't work out. For example, Azam Khan retired two years back and has been paying a deposit of Rs.120 per year to keep the ESI coverage. When he collapsed at his home in Adilabad, he was referred to Sanathnagar hospital and was told that he is not entitled to super-speciality treatment in the corporate hospital.

#### Observations and Analysis:

1. My tentative observation is that at the primary level, dispensaries operate in unsuitable rented premises, handle high patient loads and are poorly

equipped with inadequate infrastructure, medicines, etc.

2. It is apparent that for the beneficiaries interviewed, the system is working fairly well at the secondary level, a little better than a government hospital.
3. The data indicates that at least for the Nacharam hospital, about 22% of the serious cases are referred to tertiary level corporate hospitals.
4. From the interviews of patients in ESI hospitals, we find that employees of BPO industry, health industry, reputed hotel chains also access the services. E.g., Pizza Hut, Ramoji Film City, VLCC, etc. Thus it would seem as if a wider segment of formal employees are accessing the ESI system. This has also been indicated by doctors who have said that more white collared patients are using the ESI.
5. The substantial surplus of income over expenditure also points to underutilization, a misplaced sense of thrift and overcautious control over the disbursement of benefits. Thus it would seem that there are opportunities to increase utilization of surplus funds for the existing catchment of patients.
6. However it is also clear from other contributions to this broadsheet that barely two percent of the workforce is covered under ESI. The reason for this is that workers are not registered by the employer. Sometimes, even though salary deductions for ESI are made, the employer does not pay the money to the corporation. In such a case informal workers and contract workers have no access to the ESI system. Thus, in spite of claims about its improving functioning, the ESI as it stands is not addressing the health needs of the working population.
7. In the absence of a continuous employment record, the relationship between disease or injury and occupations never gets established. Therefore, these patients don't get compensation due to them.
8. Thus, the larger question of how to bring the informal, unregistered workers, rural and urban, under the ambit of ESI will have to be answered by a change in the act itself.

#### Reference:

Public Health Foundation of India, "A Critical Assessment of the Existing Health Insurance Models in India" Research Study submitted in 2011.

# Unorganized labour, access to health care and ESI

## Interview with Mr. Pradeep, Ms. Padma, Mr. Praveen and Ms. Arunakka, representatives of IFTU

“In case of accidents leading to injury or death of the contract worker on the shopfloor, managements hush them up unless a strong union intervenes to claim compensation and care. The contract worker is helpless without a union.”

### Health problems, issues, calamities faced by workers in and around Hyderabad

There are many health problems and safety risks faced by workers in Hyderabad, and elsewhere. It depends on the industry, factory or sector that they work in. The accident and health hazards also differ depending on the industry. In Jeedimetla industrial area of Hyderabad, there are many different kinds of factories with various processes. In general, factories don't give protective gear to the workers, for example, masks, gloves, etc. Injuries and ill-effects of work place are not taken care of. Sometimes, it is difficult for the workers to even ask for protective gear - e.g., in a paint manufacturing unit, it is not clear whether it is an ordinary raw material process or a chemical industry. There are many chemical units in Jeedimetla and there have recently been accidents where a chemical reactor blast has occurred. Workers have died due to the direct force of the blast, and also due to the inhalation of the gases that come out after the blast.

### Workers' status and ESI provision

ESI usually works for permanent workers, but not for contract workers. Often, for the contract workers, it is the *daya* or mercy of the contractor which provides compensation. Legally ESI is supposed to apply, but since the

worker is not registered and no card is available to the worker, ESI is refused. Often the employer deducts the ESI payment from the worker's wage but does not remit the requisite amount in the ESI account. When this happens, the employee who needs ESI health care is turned away – she is punished for the failure of her employer. When the ESI is paid, they are immediately referred.

One example of health insurance related problems is with government educational institutions like HCU and EFLU. There are many jobs done by contract workers, under a dummy contractor so that the institution can avoid having these workers in the permanent rolls of the institution. Here the institution deducts money from the wages paid to the worker, but does not give the worker a pay slip with the deduction clearly marked. This is because if the worker collects the slips, it is possible to make a case for permanent employment. IFTU has struggled for 2 years to get these workers minimum wages. Now the task is to get ESI and PF for all the contract workers in these institutions. IFTU has also succeeded in getting contract workers the facility of health care treatment in the university health centre. Normally about 5% of the workers in such institutions will have ESI and PF. In general, when ESI and Medclaim facility is not there, and the contract workers don't have a union, it is convenient for the management. If there is no ID, there is no proof to pursue the case.

In the Beedi industry, which is largely home-based work, it is extremely difficult to get uniformity and surety of wages. It is also difficult to unionize because it is based on door to door canvassing. The risks to the beedi worker if she is found to attempt unionization are very high since the contractor can shut off raw material supply to the whole locality. Beedi work has lots of work related ailments such as nausea, breathing trouble, etc. There are no health care or health insurance schemes for beedi workers. ESI does not apply here as most workers are unrecognized. There is a Central Cess fund that is put aside, which is being used by the government to provide a doctor in the basti and some health care.

### Arogyasri for unorganized workers

Arogyasri cases are few and the scheme is used only in case of catastrophic illness. In slums these are heart, kidney, gynecological problems. The Aarogyasri programme is useful but the procedure is lengthy. The private sector makes a good benefit from this. However the government hospitals are weak. The Aarogyasri patients are treated better in private hospitals than in government hospitals. The latter have too many patients and are overloaded. Even if the government pays for the patient, attention is not available. In private hospitals it is better but paying patients are treated better than Aarogyasri ones. IFTU would like the government hospitals to be strengthened. In the industrial area they tend to discourage patients from coming more than once a year to a hospital on Aarogyasri, even if they are well below the maximum limit of expenditure.

### Advantages of ESI

ESI is working better now than previously. The advantage with ESI is that when the worker goes to ESI with an ailment, not only does she get treated, but she also gets paid leave according to the doctor's recommendations. This payment is made by the ESI itself. ESI doctors can recommend even six months leave and pay the worker some decreasing fraction of the wage. Workers need ESI, and in Aarogyasri they need the facility to take leave with pay. The trouble with most employees is that they don't know the existence of ESI. Education is necessary.

*Universities are a different category of institution. They are autonomous bodies in almost all aspects of their functioning including hiring workers and providing health care. The ways in which they deal with health care is different in each case and depends on that institution's history. Sometimes the universities are good in health care coverage for students, faculty and administration and discriminatory with respect to contract workers. In other cases the universities maintain an excellent record of health care even for contract workers. Union struggle strategies must be developed in each case with special attention to specific conditions.*

The ESI system itself has recently been conducting counseling centres and melas in the bastis to educate people about this but the process is slow. ESI should be made more efficient to handle small problems. Now there are so many private hospitals in Jeedimetla – they thrive because there is no ESI. If there is good ESI network, more people will benefit and these hospitals would reduce. In general the ESI and PF are not available to more than 2% of the working population.

#### Making ESI work for workers in unorganized sector

With respect to ESI, the strategy followed by IFTU is a uniform blanket implementation of all labour laws so that benefits are available. For example there are 70,000 pit loom workers in Panipat for whom the IFTU demand is to implement uniform labour laws.

There are different strategies to be followed for government contract workers and private contract workers. Some depend on ESI and others don't.

In the private sector:

1. Spreading awareness of ESI is an important educational activity for workers.
2. It is important to fight for an increase in the number of ESI hospitals.
3. The unique ID card system is not yet perfected – if this unique ID card is there, it is possible to keep track of the patient,

and in return the worker too can claim some identity and assistance on the basis of proof of membership. For this reason, IFTU would also support the current UID Aadhar card programme in the country – if the worker's identity card in the place of work is not given, he suffers because of that lack. If Aadhar is giving some benefits, why not accept them and make use of the card?

4. The unions or activists must fight for full implementation of ESI, and make Factories Inspectorate and Labour department work. The problem of health, worker welfare and management responsibility will improve only when these departments function well.

For government institutions:

1. There is no continuity of service in these institutions – workers are taken depending on need, resulting in general wage insecurity and a total lack of health coverage when they need it.
2. There is no compensation for death in these institutions. At least compensation for death should be there.
3. Contract workers with these institutions must fight for access to health centres for free medical aid.
4. Contract workers are only covered individually. We must fight for insurance for the family also.

5. It must be possible to have ESI or other insurance for health as long as one lives – it is like a pension benefit.

#### The elusive nature of social security in the informal sector—some insights:

- Construction industry is totally unregulated and has no health coverage, where there is a high risk of accidents and injuries. They have small health benefits – maximum 30,000 rupees if a person dies.
- In Hyderabad, there are 2 lakh autorickshaws and 3-4 lakh auto drivers with no ESI, no PF, no accident compensation and even third party insurance is sometimes too expensive to take.
- Brick kiln workers have no water supply, no medical assistance.
- Hamali workers – there are no laws for back breaking work.
- In the non-formal sector, migrant labour is more likely to be militant and better unionized.
- Workers who have a family to look after cannot stand up against the management malpractice.
- Most brick kiln workers come from Kalahandi – in many cases, this miserable work environment is better than their home environment from where they have migrated.

Father maybe an elephant and mother only a small basket, but...

gogu shyamala

Gogu Shyamala's stories dissolve borders as they work their magic on orthodox forms of realism, psychic allegory and political fable. Whether she is describing the setting sun or the way people are gathered at a village council like 'thickly strewn grain on the threshing floor', the varied rhythms of a dalit drum or a young woman astride her favorite buffalo, Shyamala walks us through a world that is at once particular and small, and simultaneously universal.

Set in the madiga quarter of a Telangana village, the stories spotlight different settings, events and experiences, and offer new propositions on how to see, think and be touched by life in that world. There is a laugh lurking around every other corner as the narrative picks an adroit step past the grandiose authority of earlier versions of such places and their people—Romantic, Gandhian, administrative—and the idiom in which they spoke. These stories overturn the usual agendas of exit—from the village, from madiga culture, from these little communities—to hold this life up as one of promise for everyone.

With her intensely beautiful and sharply political writing, Shyamala makes a clean break with the tales of oppression and misery decreed the true subject of dalit writing.

నేనే బలాన్ని

టి.ఎన్. సదాలక్ష్మి బతుకు కథ

నోగు శ్యామల

# Child undernutrition in India – a Myth?

## Excerpt from MFC e-group discussion

**B**ackground: In India, around half the children under five are underweight and stunted, 30% of newborns have low birth weight, and over 70% of the women and children in the country are anemic. Undernutrition among the SC and ST community is around 60%. These figures are worse than the current malnutrition figures from Sub-Saharan Africa.

This essay juxtaposes two different views of child undernutrition and health indices in India. One is a neoliberal economist's view on how the much-publicized view of child undernutrition is simply a wrong reading of statistics, and how we must now put this fetish behind us. The other is a narrative arguing that the reality on the ground is in fact worse than the bare statistics suggest.

### I

**Extract from Tehelka Interview of Arvind Panagariya by Akshai Jain (End November, 2012)**

<http://tehelka.com/once-we-do-our-malnutrition-numbers-correctly-we-will-find-that-india-has-no-more-to-be-ashamed-of-its-malnutrition-level/>

It's a series of statistics that have been repeated so often that they are now accepted as fact — nearly half of Indian children under five are malnourished, a proportion that is higher than that of most countries in Sub-Saharan Africa. And, more than a third of the world's malnourished children under five live in India. These statistics have been reinforced recently by the 2012 Global Hunger Index, according to which India ranks second to last on the number of underweight children — below Ethiopia, Niger, Nepal and Bangladesh. Arvind Panagariya, professor of Economics at

Columbia University and former chief economist at the Asian Development Bank, has been arguing that though malnutrition, both child and adult, is a problem in India, these figures are highly exaggerated. Ahead of the publication of his book *India's Tryst with Destiny: Debunking Myths that Undermine Progress and Addressing New Challenges* (co-authored with Jagdish Bhagwati), the economist elaborates on these claims and more in an exclusive interview with Akshai Jain. See below:

*Question:* In a series of papers over the past year, you have argued these statistics are a complete myth, a gross exaggeration at the very least. Why do you think so?

*Answer:* When two sets of indicators [mortality rates and undernutrition figures] lead to diametrically opposite conclusions, you either have a reasonable explanation for it or must reject one set of indicators. When we compare Indian children to those from Sub-Saharan Africa (SSA) in terms of life expectancy, infant mortality rate (IMR), under-five mortality rate and maternal mortality rate (MMR), they look significantly healthier than the latter. But the picture of India's development turns on its head when we compare them in terms of incidence of stunting (low height for age) and under weight (low weight for age). The contrast is nothing short of dramatic. Compare India with Chad, which has half of India's per capita income. Using 2009 data, Chad has life expectancy at birth of 48 compared with India's 66, IMR of 124 per 1,000 live births relative to India's 50, MMR of 1,200 per 1 lakh live births in relation to India's 230 and under-five mortality rate of 209 per 1,000 live births in contrast to India's 66. Every one of these indicators places the health of Indian children miles ahead of those from Chad. Yet, child malnutrition indicators say that the proportion

of children stunted and under weight is higher in India than in Chad!

Even more shocking is the comparison between Senegal and Kerala. With life expectancy of 74 years, IMR of 12 and MMR of 95, Kerala is the crown jewel of India when it comes to health. In comparison, Senegal exhibits a life expectancy of 62 years, IMR of 51 and MMR of 410. Yet, we are told that Kerala has a higher proportion of stunted and under weight children than Senegal. It cannot get more absurd than this.

*Question:* Where are we going wrong?

*Answer:* We have been applying a uniform World Health Organisation (WHO)-specified height to decide whether or not a child of a given age and gender is stunted. And similarly, a uniform WHO-specified weight to decide whether or not the child is underweight, regardless of the child's race, socio-cultural background, geographical location or time or vegetarian versus meat diet. Any failure to meet the WHO-specified standard is attributed to malnutrition and the child classified as malnourished. But what if Indian children are on average genetically shorter and lighter than the population from which the WHO standards are derived? Then, even perfectly healthy Indian children would be classified as malnourished just because they fail to meet the height and weight standards derived from the WHO population that is taller and heavier on an average.

*Question:* So well-nourished populations may not be similar in height and weight?

*Answer:* My reading of the evidence is — not by a long shot. Japanese men and women are about 12 cm shorter than their Dutch counterparts. The differences are not limited to adults. A 2006 study of infants born to Indian mothers in the US during 1995 to 2000 finds higher incidence of low birth weight and small-for-gestational age, and yet lower infant mortality rates for most part than the children of white mothers. A study of Moroccan children in the Netherlands show that the height gap between the latter and the Dutch children can be observed as early as two years of age. The gap eventually rises to as much as 9 cm.

*Question:* When did you first begin to doubt the Indian statistics? Why?

*Answer:* I'm not an expert on health, let alone child nutrition, by any stretch of imagination.

But soon after my 2008 book, *India: The Emerging Giant*, in which I reported vital health statistics with approval, I began to notice the exceptionally poor child nutrition statistics and felt they could not be reconciled with the former. But I seriously focussed on the issue only when I took upon myself to write the chapter on health in a jointly authored book on the performance of Indian states. That is when I noticed that Kerala showed worse child nutrition statistics than many SSA countries and that, in turn, led me to dig deeper into the methodology leading to these absurd comparisons.

[...]

## II

Dear Friends,

It is interesting how economists like Arvind Panagariya who profess they are not experts in the subject, anyway go ahead to decide that stunting/child underweight and mortality statistics should go hand in hand. When they don't go hand in hand, these 'non-experts' decide to reject one (stunting and underweight) in favour of the other (mortality) simply because they don't form a neat statistical picture. You do not find a correlation between undernutrition and mortality in India because of a health care system that has been set up to address acute and critical health problems. When a child or mother goes to the government health set up with a medical crisis, the system does the minimum job of keeping them alive. This is done by the curative system established to prevent maternal and child mortality. Even an undernourished child benefits from this system in so far as it is kept alive. However, this emergency machinery does not deal with the chronic issue of hunger, undernutrition, underweight and stunting. Here the poor are left to cope through their own meager resources. For this reason, the cause for death and malnutrition in India do not go hand in hand, and they can't be counter-posed or mapped on each other. These two indicators side by side expose the emaciated underbelly of the India Shining story.

The doubts about Indian standards reported by Panagariya have been resolved with the new WHO Standards where India was one of

the centers. The data which was generated on child growth in India, showed that given ideal conditions of food etc., Indian children grow tall and put on weight which is on par with other nations. His examples from Japan and Morocco and of Indians living in the US betray his ignorance of human growth and physiological development. It takes 30-40 years of elimination of dietary inadequacy for a population to achieve its maximum height potential.

I agree that there is a fatigue caused by looking at this data, and this is because we are looking at the wrong end. For too long we have these figures hammering us, with the UNICEF WHO pictures of clinging starving children making it worse. I can see that it distracts from the India Shining story. However the struggle of mothers to feed the kid a decent meal with wages that do not allow the luxury of even buying milk, has not been recorded (and some states which will not allow the use of eggs for kids in the ICDS in the name of Indian culture)!

Our economists like clean secondary data where everything is given to them on a platter, and we obliging nutritionists have simplified it for them with the concept of calories. We have pandered to their discipline, the result is that now these economists cannot be bothered about the starving face of the India Shining story. I think these economists should for once in their lives struggle to look at intakes in empirical descriptive studies (which also permit precise measurement of nutritive components). where the picture is messy. Read on for an observational, narrative account of what isn't captured by neat numbers:

7.00AM Gita wakes up, crying... mother puts her to the breast to pacify her (Gita is 2 1/2 years old and the breast is dry) and mother continues to do housework.

8.00AM Gita is whining... mother gives her a few sips of tea from her cup...and continues to do her work. Cleans the kid.

9.00AM Gita continues to whine... mother places a piece of roti in front of her... rushes to work, elder sibling Manga takes over. The roti is uneaten-in any case it was so dry.

10.00AM Child is carried around by Manga, and consoled with a packet of Tiger biscuits (Rs.2). God bless Glaxo, or is it Britannia?

12.00PM Mother returns, cooks rice and some tomato chutney (Gita is still whining). She sits down to eat, serves Manga, and shoves morsels into Gita's mouth. Gita eats as long as the mother does.

2.30PM Mother washes up and leaves for work. Gita is dozing off.

4.30PM Gita is up and crying, mother is back, scolds her, puts her on her breast, keeps working, hands her over to Manga... who plays with her friends, Gita on her waist.

6.00PM Gita gets a bun from the tea shop, stops crying, she is beaming and plays with other kids.

8.00PM Dinner is ready; Gita eats a few morsels as the mother serves rice and rasam to her husband and Manga. Mother eats and tries to give Gita a few more morsels... who has lost interest, and is running away.

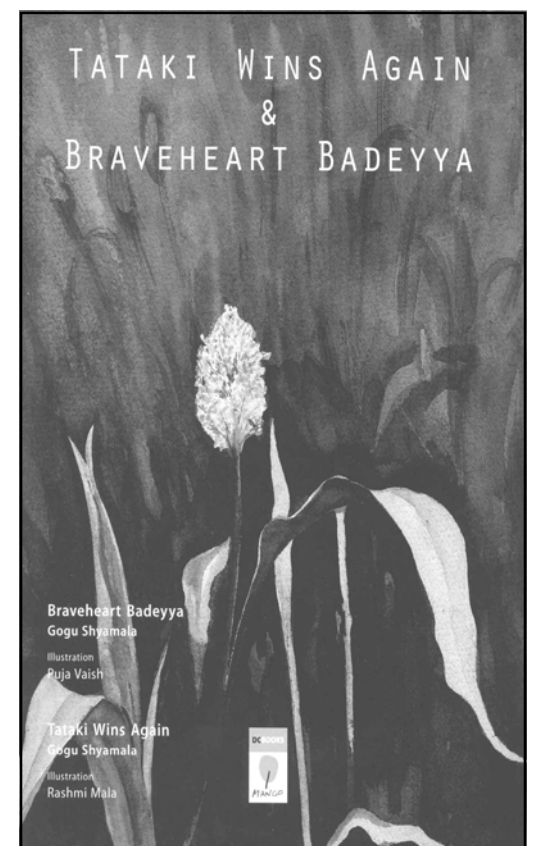
10.00PM Mother washes up, consoles a wailing Gita, puts her to her breast, and Gita is fast asleep.

11.00PM Mother goes to bed.

Now what do I say?

Warmly,

Veena Shatrugna





# Film Review

## Documentary: *Sicko* (2006)

Director: Michael Moore

### ■ R. Srivatsan

*People in the United States are less healthy, have more chronic disease and disability, and die at a younger age than people living in other wealthy nations, concludes a new report by a panel convened by the US National Research Council and the Institute of Medicine. The panel found that the US fell short in health outcomes at every age from birth to 75 years and that the deficiencies were found at all levels of society. Even high income, college educated, white Americans tended to be sicker and die younger than their peers in other rich countries. So many problems were identified in so many areas that it indicated that "something is fundamentally going wrong," said Stephen Woolf, professor of family medicine at Virginia Commonwealth University...*

British Medical Journal 2013; 346:f215

**S**icko is a two hour film that examines critically the abysmal health care system in the United States. It records, asks questions about, and analyzes the critical failure of medical care. It shows through comparisons with Canada, England, France and Cuba that it need not be so.

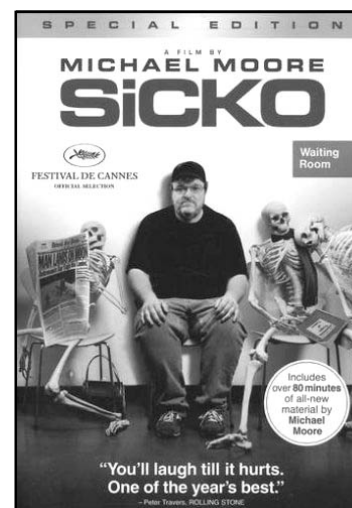
The film starts with a shot of Adam, a wageworker, on a chair in his shack. He has a gaping cut on his knee, which he is stitching by himself with a sewing needle and black thread. His cat watches and yawns. Adam has no health insurance and cannot pay for emergency medical treatment. Cut, to Rick a carpenter who has lost his middle and ring finger to an electric saw. He too has no insurance. The American medical system gives him a choice – pay \$ 60,000 to sew on his middle finger or pay \$ 12,000 and reconnect his ring finger. He chooses the latter. Fifty million people in America don't have health insurance, and 18,000 of them will die each year for that reason. But the soothing voiceover (Moore's) assures us that the film isn't about them. It is about the 250 million Americans who are covered by the health care system.

Larry and Donna, a once well to do elderly couple, are forced to sell their comfortable house and move to their daughter's spare den/work room. Larry's three heart attacks and Donna's cancer have caused insurance premiums and other expenses to literally go through the roof, destroying their homes and throwing them on the street. Cut to Frank, who at 79, continues to work as a janitor, in order to ensure that he has excess money required for his medicines which cost more than the senior citizen's health care reimbursement he gets. Four insured women, who have various life threatening ailments, are refused care by the major American health

insurance companies like Humana, Cigna, Blue Cross and Blue Shield on the basis of different trivial reasons. One of them dies. The movie traces the appalling callousness of the health insurance system that refuses medical care to insurance holders even if it means their destitution or death. An email appeal for such negative experiences with American health care brings Moore 25,000 responses in a week!

Having set the stage with these introductory stories, the film asks the question, what is happening? It suggests that the reason for this is that the medical insurance companies are profit-making businesses. They fatten their bottom lines by finding legal but unethical means to refuse cover to critical acute health care expenses of people who have insured with them. Their clerical staff is equipped with the stamped signatures of the company directors. They deny coverage in a routine manner for a targeted percentage, and the bureaucratic system has no sympathy for the people who lose their health and sometimes their lives. The film interviews three employees who leave the insurance companies due to the guilt caused by the cold heartedness of the system. One of them Linda Peno, Medical Director of the Humana insurance company testifies at a judicial hearing, how the system sets an average of 10% as the rate of denial of insurance payment sanctions, and how employees have incentives to deny more than 10% if possible. She expresses profound regret for the loss of lives due to these inhuman insurance policies. All these are due to the system of managed care in the USA through the Health Management Organizations (HMO).

The next part of the film traces the degeneration of health care to Republican politics in America. It starts with a



reconstruction of Richard Nixon's dubious and dishonest role in the establishment of the system of privatized health management organizations. It goes on to politicians like Ronald Reagan who see socialized medicine as a first step toward communism. The power of a health bureaucracy to determine where a doctor might practice and which hospital a patient might seek treatment in are portrayed as the first steps of governmental control over the sacredness of free enterprise and living freedom. Hilary Clinton, when she is First Lady, starts a Democratic campaign for free universal health care. This is shot down by Republican counter-propaganda, which uses the bogey of communism. The counter-propaganda is funded by the health management organizations and medical businesses to the tune of 100 million dollars. Ultimately, Hilary Clinton too is bought over. The finale of this section of the film is a documentary clip of George Bush, at the signing ceremony of the programme on health care for senior citizens, with a caricature twist. As each official walks on to the podium, the film shot carries an arrow showing who has been bought off, and by how much – Bush tops the list with a pay off of nearly 900 thousand dollars. The politician who steers in the new senior medical care programme, which in actuality makes it more difficult and expensive for senior citizens to get health care, joins an HMO with an annual salary of two million dollars.

After this expose of the rot in the US health system, with its espousal of economic liberty of the health care industry, Moore deals a series of body blows to the logic of US health care. He does this through vignettes of health care in Canada, England and France. In Canada, a US woman citizen who crosses the border and seeks treatment for her cancer under false pretence of Canadian citizenship is treated free of charge and with no fuss. The rumor of month long queues for medical care in Canada is a myth. In stark contrast, Moore's Canadian relatives take out health insurance even if they want to cross the border into the US for a few hours. He then goes to England to examine the home of 'social medicine'. Pharmacies there sell all drugs—any quantity of any number of

them—prescribed by the National Health Service (NHS), and charge a fixed bill of £ 6.65 (regardless of whether they are cheap antibiotics or costly anti-retroviral drugs). Social medicine takes a large chunk of citizen's salaries as taxes and provides medical care. It pays the doctors well enough for them to live in comfort in London. The NHS hospitals have cash counters, not to collect payment from patients, but to pay out money for transport if needed so that the patients can get back home after treatment. In Paris, Moore finds out to his (and our) surprise that the government has doctors who make free house calls to patients in times of need, within an hour of a request, 24 x 7. France also provides all young mothers with the service of a free nanny who will do the laundry for the whole house (and even cook at an extra charge)!

Why is there this difference between the US and these countries? Tony Benn, the English parliamentarian argues in the film interview that it is democracy, which from the nineteenth century takes power away from the market and to the ballot. Benn shows Moore how in the UK, there was immense loss of life and limb, and economic catastrophe during World War Two. This he says led to a common spirit between politicians, parties and people, setting the stage for universal health care. Even Thatcher didn't tamper with the NHS. French interviewees say that the reason for good health care in France is that the people are intensely political – they agitate for every thing (and have extremely high industrial productivity too). In France, political traditions of protest, revolt and organization make the government afraid of the people. The film suggests that in the US in contrast, the people are demoralized, indebted and afraid of government, and there is no common spirit. American liberalism has the citizen by the throat. The result is that the US has some of the worst health care indices in the developed world.

Has the US no socialized services? Moore shows us the many common socialized services that are overlooked in the everyday gaze – libraries, the fire service, the police service, etc. He wonders why the US doesn't have socialized medicine. And in a final thrust, he asks a simple question that brings the viewer to tears – “Who are we?” It is a question that perhaps took considerable time to craft and perfect to its absolute and deadly simplicity. “What kind of Americans are we who let our people die because they cannot afford health care?” And he continues, “It is usually said a country is best judged by how it treats its weakest citizens”, but perhaps the US could be understood by how it treats its heroes? The heroes of 9/11 were the professional fire servicemen and the many brave volunteers who went in to ground zero at time zero, just after the blast, to help the survivors and retrieve the bodies and parts of the dead. Those who did so suffered many

ailments (breathing, accidents, persistent nightmares and chronic stress) as a result of working through the rubble. It is characteristic that the system of compensation for these professionals and volunteers who risked their lives was clearly designed to deny many claimants if they couldn't prove with legal certainty that they had worked at ground zero.

At this point, Moore provides one more astonishing and ironic twist to his tale by asking the question, who in the US has universal access to health care? The answer is that the terrorists who perpetrated 9/11 in Guantanamo Bay, the US naval station in Cuba, have universal access to health care! Moore, in a representation of documentary activism, loads three boats with some of the heroes of 9/11 and some of his earlier sick interviewees and tries to take them to Guantanamo Bay for treatment. On approach, sirens sound out from the facility, and they quickly divert their boats to Fidel Castro's Cuba, the 'devil of communism' off the eastern seaboard of the US. All the sick people in Moore's contingent are treated free of charge, and the heroes of 9/11 are honored by the local fire department. No comment needed here. The film ends with a shot of Michael Moore carrying a basket of dirty clothes up the steps of Capitol, to ask the congressmen to do his laundry for him, French style.

From my perspective here in Hyderabad, there are many ways in which his picture of American health management organizations reflects what could happen in India if health insurance were privatized. Corporate hospitals and private insurance companies could find ways to refuse coverage after taking the insurer's money. However, the current picture is a little different. Firstly, there is very little health care to boast of. Secondly, as the papers on Aarogyasri in this broadsheet show, in a state financed insurance system with the government paying the premiums, the emphasis is on hospitals tapping government funds, even if the medical or surgical intervention may not be quite necessary. This is proved by the recent rash of unnecessary hysterectomies resulting in a scandal. Thus, rather than being refused medical care, the governmentally insured populations in India are likely to get risky medical care they don't need, suffer due to it, and at the same time, not have their basic needs covered. Thirdly, as the surpluses of the Employees State Insurance Corporation demonstrate (described in this broadsheet), even when a potentially good state insurance system exists and is financially robust, health care is not offered unless there is a political struggle to get into the system. This confirms in our own political language the correctness of Sicko's analysis – it is only when the government is afraid of its people that it will do some things right, and universal access to health care is one such.

We need to think more carefully about Moore's vignettes of different Western countries. How

have their diverse histories led them to different commitments to health care? What are the political and civic cultures of those countries? For example, the French and the British tolerate different kinds of socialism both of which do not see the communist variety eye-to-eye. Their welfare states provide general and medical care to citizens through taxation and state run insurance. Both countries are anti-communist, and have free economies. In Cuba, where there is a communist regime, health care has a very different structure. Cuba's health indices are nearly as good as those of the USA, at a fraction of the expense. Cuban health care works through preventive care (one of my problems with Moore's film is that all his examples of the US are for accident care or for advanced medical care – neither primary health care nor preventive medicine is focused on). The USA has long been the bastion of the spirit of free enterprise in the world, where all problems tend to be interpreted in terms of individual freedom. Moore is right in saying that the Republicans are the root cause of privatization and devastation of universal health care. However, it is important to realize that they are being voted into power by the people, and that means that the mood of a considerable proportion of the people is pro-free enterprise. There is staunch belief in 'each according to his ability' (including the access to medical care). There is no consideration of what people who are sick may need in terms of health care if they can't afford it. It is interesting that the difference between being socially responsible and being reliant on oneself results in two different civic cultures: one, in Canada, the UK and France (for example), where people consent to taxation and 'free' health care for all on the one hand; two, in the USA, where people have such a culture of fierce self reliance that they refuse and detest any form of state interference. Both these forms of conduct seem distant when we see them from India, but what will happen in India becomes clear.

What are we, here in India? How have we treated our poor? We have an inborn, implicit condescension for those beneath us in social station, a discrimination that has historically been legitimized by the operation of caste. For a long time to come, this subterranean disdain is bound to limit the way in which we think of our fellow citizens. We tend to think of them as lesser human beings who don't have a right to health care, but may be offered it as a charity. As long as such a perspective exists and tends to dominate our culture, we will have sub-standard health care with its enormous social costs in terms of population-wide morbidity. When and how things will change is any body's guess, but mine is that they are going to remain the same for at least the next fifty years – unless we have a socio-cultural revolution.



# Recovering from a Paralytic Stroke: a Diary

■ M.A. Moid

**4th:** My mother - aged 67, weight 80 plus kilograms, diabetic and having BP but generally an active lady, felt giddiness in the evening while going to the washroom, lost her balance and fell. She was made to relax for an hour, and then got up again to walk but this time could walk very slowly. She was embarrassed by her slowness. In the night she had her regular meals and slept well.

**5th:** In the morning she was taken to the family doctor, who after listening to her asked whether she was taking the blood thinner tablets regularly. My mother replied that she stopped since last fifteen days. It was mainly because of her carelessness rather than any other reason. The doctor asked her to immediately start taking it and said because of thickness of the blood, clots are formed in the brain that causes giddiness and headache. He found the blood pressure and sugar levels of my mother normal.

**6th:** In the evening her condition deteriorated. She was not able to get up from the bed nor able to move her left arm and leg to the full extent. The left side of her face was also showing a slight change. We were thinking of taking her to another hospital but before that

asked the advice of a doctor friend. This doctor preferred to come home and look for himself. He conducted some tests—asked my mother to lift her arms in particular ways, hold the key bunch etc—and announced that it is a paralytic stroke, cause by blood clots in the brain. He asked us to immediately admit her to a hospital and warned that her condition would deteriorate further if we didn't.

We took our mother to a nearby star rated private hospital at 10 pm where the duty doctor did a CT scan. He communicated the result to the neurosurgeon on phone who suggested her immediate admission. By this time her left limbs were completely affected and her face also was visibly changed. The duty doctor said that it is an evolving disease and reaches the final stage within twenty-four hours. Timely admission to the hospital won't make any difference. After being hospitalized she was given blood thinner injections immediately. Meanwhile my mother was constantly sleeping and not able to answer any questions properly.

**7th:** There was no improvement in her condition. She was constantly in a drowsy state and lost her control on her urinary and bowel functions. Urine and blood tests were

conducted and medicines were given. Outside food was stopped and she was fed a minimum hospital diet. A neurosurgeon and a doctor of internal medicine were supervising her.

**8th:** There was no improvement in her condition. The doctors were of the view that she should stay for two more days in the hospital, whereas our doctor friend said there was no point in wasting money. Her condition will not improve even after two days. Rather she would feel better in the home environment.

Meanwhile, our relatives who came to see my mother unanimously talked about the effectiveness of Unani medicines in this particular disease. Luckily we found a Unani doctor, expert in treating paralytic cases, known to some of our relatives, based at Charminar Government Unani Hospital. We were entertaining the idea of shifting my mother to Charminar hospital, but before that we thought we should see the hospital ourselves and meet that doctor. We found the hospital looked like a palace from outside but a ghetto inside, with bare minimum facilities at every level—nurses, assistants, ward boys, beds, medicines, supplies, toilets, drinking water and even electricity, but with an abundance of mosquitoes! We were told that 90% of the inpatients are paralytic patients from a poorer background and a few of them were staying since more than a year. We felt discouraged about bringing our mother here. The doctor very kindly offered to come and examine her at the other hospital.

The Unani doctor confirmed the diagnosis of the allopathic doctors and suggested to have my mother discharged. According to him my mother's drowsiness was also caused by the hospital environment, which allows a limited number of visitors only for two hours a day. He prescribed Unani medicines for fifteen days

and said that it can be taken along with allopathic medicines but with a gap of thirty minutes. However, Unani would take longer to show effect. When we inquired about the use of 'pigeon's blood' in this disease, he said that it was an old practice, but after the discovery of new formulas, not used any longer. It is also avoided because of infections.

My mother was discharged in the night after two days of stay and the total hospital bill was twenty six thousand rupees.

**9th:** My mother was completely immobile and was able to talk but with difficulty. She was not able to eat properly and the food particles fell from her mouth. We met the allopathic doctor (internal medicine) to understand the administering of the new medicines that he has prescribed. He advised that the fan should be off in my mother's room to keep it warm; that we continue the diabetic tablets, but stop the BP ones. According to him controlled higher BP is good for her. In the food he asked us to stop giving my mother meat, spices, and oily foods and instead give her more vegetables. He also suggested we start physiotherapy exercises. When asked about his opinion about the parallel Unani treatment, he refused to answer and said 'how can we say, it's up to you'. We felt that he was not encouraging it.

Later in the day we met the Unani doctor who explained how to take various powders, concoctions and capsules, which he was giving for fifteen days. We realized that these medicines were for improving digestive system, liver function, and strengthen the immune system. He said he would give medicines for paralysis after fifteen days. In food, he said that lemon, sour things, curd, brinjal, gongura (roselle) leaves, and all roots and tubers should be avoided. He asked us to defer physiotherapy for a few days because at

this stage it was likely to create more pain in the body. He also wanted us to massage the left limbs with Unani oil twice a day. He had no objections to taking Unani and allopathic medicines together. The allopathic medicines cost two thousand rupees for fifteen days and Unani eight hundred rupees.

**Fifteen days later:** After two weeks, both the doctors changed the medicines for the next fortnight, which cost nearly the same as it did earlier. My mother's movement of her limbs was improving along with her appetite. She developed a liking for oats, which the doctors approved. The house was always full of relatives in the first two weeks and made my mother comfortable even though she wasn't able to talk much. Her drowsiness was reduced and she was spending a lot of time watching TV.

**Now:** This is the third month now and the month of January; physiotherapy and massage, Unani and allopathic medicines were continuing and will continue for a month more. According to my mother she started improving fast when the second fortnight of the Unani medicine began. The average expenses were twelve thousand rupees per month. Now my mother is able to move her left limbs comfortably, walk with the help of a walker, climb a few steps, eat and go to the toilet on her own. She cannot yet change her clothes, take a bath or comb her hair. Her face is becoming normal though the effect of the stroke is still visible. Her voice is changed a bit and she looks an old woman.

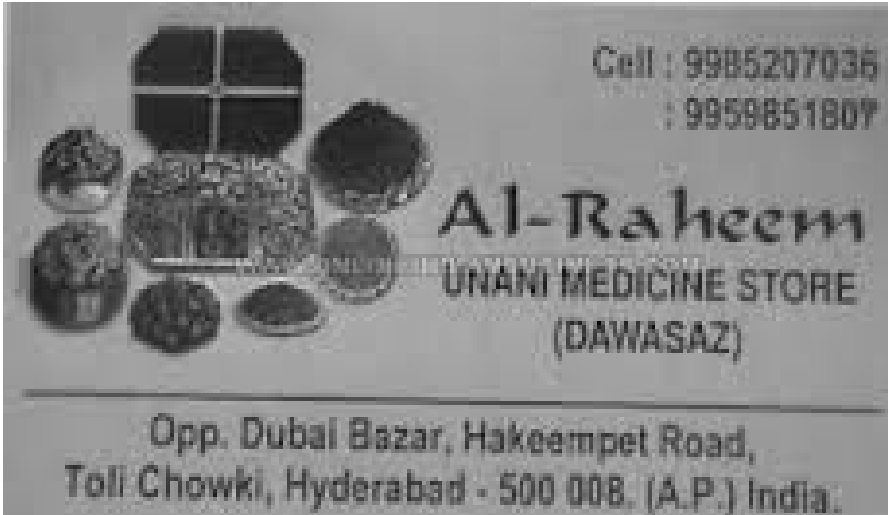
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*People adopt different practical strategies to deal with illness in their families. These strategies follow a pattern that more often than not crosses the boundaries of different systems of medicine*

*[allopathic, Unani, etc.] depending on several factors: perception of seriousness, expense, acceptability to the family, community, etc. In Moid's case above they sought allopathic care during the crisis. Once diagnosis and stabilization occurred, the family took a decision, keeping in mind the condition, age and prognosis to move the patient to a less aggressive system of care. This decision may not have been taken if the patient was deteriorating. There are definite benefits that accrue due to this strategy in Moid's situation (though not necessarily in all situations). The risks of continuing hospitalization in the current historical moment include: brain surgery which may not be very effective; prolonged hospitalization; secondary infections; referral to a government hospital by the corporate hospital as a final dumping ground; lack of information about the patient's actual status; many other new problems. Unani here gave hope and provided community endorsement to the caring process. It allowed the comfort of the family, a system of medicine that was relatively more gentle, a better control of other ailments and saved the patient from complication and prolonged hospitalization. However, it must be clearly understood that these are benefits that are specific to this case and not generalizable across illnesses.*

*These strategies are not just economic, but also indicate preference, comfort and an ethically valid form of care. People who would follow these 'unorthodox' strategies include those who can fly their patients to Kottakkal or Vellore as the situation demands. Woven into these strategies may also be pledges to the Gods with a plea to help a dear one to recover. On the other hand, a person like Hina Begum (the extract that follows) learns to use the allopathic system strategically for symptomatic care.*

*In any case, however, it seems as if in practice, whatever systems of care people adopt, critical treatment for life-threatening illness is invariably sought in an allopathic hospital.*



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# Glucose chadake aa gaye

## Quick fixes as a symptom of health care

### ■ Lakshmi Kutty

**H**ina Begum is a thin, reedy woman, nearing 40, living with her two teenaged children. Her eldest daughter, Shabana (married, has two young children) came home for the younger daughter Salma's marriage three months prior to when I met them, and had been staying with Hina since then. Shabana's husband, living in Parli in Maharashtra, has been suffering from a kind of degenerative illness because of which, over the last three years, he has lost the use of his limbs, and can communicate only through sounds from his nose. Shabana takes care of his needs. He urges her to take the children and visit her mother; she doesn't like to leave him alone, but does find this time away somewhat relieving. Shabana, her in-laws, and her mother Hina have tried all kinds of treatment to get him better, but a lot of money has been spent with little results.

Shabana's tough life worries Hina so much that she suffers from constant headaches. She said repeatedly to me, "If I think a little about my child's life and what all she has to deal with at such a young age, that's enough to send my head spinning." She consumes Calpol almost every alternate day, and has a small box of Zandu balm by her side always. She purchases a strip of ten tablets which she consumes in about eight days. She works in two people's houses in the morning, returns for lunch, and goes out at four to work in three more people's houses. When she's home for lunch she tries massaging oil on her head, eating a tablet and sleeping so that by her evening round of work the headache is gone;

this solution doesn't always work. When she has to wash a lot of dishes and clothes, it gets worse – she shivers all over, and is totally wiped out when she returns home in the evening. She tries tying her sari pallu tight around her forehead hoping for some relief. On such days she invariably gets a fever by the next day. She sees her regular doctor, who prescribes some medicines; she takes them for a day or two. This state of fatigue, and the chronic worry about her daughter causes Hina's BP to drop occasionally; she gets dizzy, weak, and isn't able to get on her feet. She then goes to the doctor and gets a bottle of glucose administered, and is back on her feet in an hour or so. She comes to the clinic by auto on such days but returns home walking.

Hina Begum is seriously unwell, severely emaciated, and is convinced her heart is weakening from the constant pill popping. This chronic unwellness is a regular state of being for Hina, but she has never taken a course of medicines for the three days for which it is prescribed; she only does so till it gets her back on her feet. When she's pushed to the edge she gets a bottle of glucose administered, which her doctor provides at a subsidized price from knowing her for so many years. Chronic emaciation and fatigue is the context in which Hina's ill health/distress occurs. An understanding of this insurmountable context is crucial for the health care system if it is to address her distress. The casual nature with which Hina and some other respondents discussed their experiences of 'glucose chadake aa gaye' stunned me. It

seemed to be the fastest way to enable them to get back to their daily life. It indicated phenomenally depleted reserves which were probably replenished by the infusion. While medicine views such kinds of treatment as irrational or illegitimate, for the ordinary person they alleviate distress and help her to get back to her demanding routine. These treatments may not be curative or improve quality of life, but they ameliorate distress. This aspect of illness treatment had slipped silently into the realm of commonplace occurrences for this segment of the population.

What transverse-section view of India's health system are we exposed to from the location of Hina's experiences? Patients are aware that symptomatic treatment is all that medicine can offer for India's poor. They treat these medicines with the amount of realism they merit in their scheme of things, as quick fixes. The picture that emerges is that symptomatic treatment is all that can be offered to them.

Excerpted from Lakshmi Kutty, "The 'Intractable Patient': Managing Context, Illness, Health Care" in Anand Zachariah, R. Srivatsan and Susie Tharu, eds. *Towards a Critical Medical Practice: Reflections on the Dilemmas of Medical Culture Today* (Hyderabad: Orient Blackswan, 2010).

*The excerpt above is from Lakshmi Kutty's essay "The Intractable Patient" which records Hina Begum's experience of ill-health as a lower middle class woman in the old city of Hyderabad. Unexpected health expenditure is often 'catastrophic' because it can drastically alter the life circumstances of families. However, there are also contexts in which the cost catastrophe has the ordinariness of an everyday rhythm. Hina, as a typical example, is not only endemically ill (poor nutrition, poverty, overwork, crowded living spaces, mental tensions, etc.) but is also staggering under the cost burden of health care and its inability to address her illness. Her response to her illness is to work out a minimalist mode of accessing, using and giving up on medicine. In medical terms, her actions are irrational, non-compliant. Yet, an interview with her showed that she has figured out ways of working from day-to-day, addressing her most pressing symptoms, of giving the slip to the prescriptive formats of medicine and of somehow making do with what she can glean from it.*