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Vinod Bhanu

Dear friends,
Greetings from IMPF

We are writing on behalf of Indian Medical Parliamentarians' Forum (IMPF). It is our pleasure to share you that our IMPF Newsletter (Winter Session issue Vol. 1, No. 2) has been widely disseminated and generating good responses from Hon'ble Members of Parliament and other health sector organizations.

Union Budget 2007-08 was presented. The allocations to the Health Sector by the Central Government seem to have an increase than the previous years. Some increased plan allocations have been made in the Budget to address the problems arising out of the prevalence of TB and HIV/AIDS. The National Rural Health Mission (NRHM) has been marked with an increased amount of Rs. 9801 crore (Budget Estimate) in the Budget. While we welcome all these positive steps made in the Budget, we express our deep concerns to the myriad problems in the health sector, and emphasize the need of attention by the Government in addressing the yoke of common people on account of their health needs.

With regard to public spending on health, India is still around the 1 per cent of the GDP at the national level. While the National Common Minimum Programme (NCMP) of the UPA Government seeks to increase public spending on health to at least 2-3 per cent of GDP, it may be noted that this as against 7.5 per cent of GDP recommended by the World Health Organization (WHO). This is a point of reminder in terms of scaling up public spending on health and fulfilling the progressive promises made in the NCMP.

Once more, we express our deep gratitude and look forward to your support and involvement to carry forward our responsibilities.

R. Senthil
Convener-Secretary

M. Jagannath
Chairperson

160, South Avenue, New Delhi-110011

Tel: 91-11- 23795264; 91- 9868180617; 91- 9818111915

E-mail: impforum@gmail.com; impforum@impf.in □ Website: www.impf.in

Restructuring Medical Education: Long-term Solutions for the Healthcare Crisis

The problem of shortage of doctors in rural areas has exercised health planners for decades. In the 1940s there was a national shortage of doctors and medical colleges. Today, there is 1 doctor per 2000 population, i.e., no shortage. Yet the rural public health services face a shortage. Meanwhile high-cost, technology dependant medicine has become the accepted norm, leading to unaffordable, indebtedness-generating medical care and a flourishing urban private sector. This is not to paint doctors black, but to recognise the systemic factors forcing a large section of motivated doctors to submerge their social conscience. Dissatisfaction is high even among the doctors in the private sector. What are the possible solutions?

Drawing upon several expert analyses and committees of the 1940s to 90s, an optimal mix of three approaches appears most appropriate for the present context:

1. For services requiring lower levels of technical knowledge, enhancing clinical capacities of nurses, MPWs, ANMs, RMPs, ASHAs and creating licentiate doctors with 3 years training in the local language.

2. Attracting graduate doctors to practice in rural areas by improving infrastructure and working conditions; besides transparent transfer and placement policies; recognition of dedicated personnel; career advancement channels; preferential admission of paramedics into medical college; well-performing PHC/CHC doctors to be sent for public health specialisation; and using administrative disciplinary mechanisms for non-functioning personnel.

3. Concerted efforts for change in professional attitudes and clinical approaches. Since doctors are the leaders on health issues, their perspective will also shape how the other healthcare providers practise or what the lay public views as desirable. Therefore the long-term solution can only come by re-orienting medical education.

Earlier efforts in this had failed, so how is it possible today? Briefly presented here is a proposal that is up for discussion by the Planning Commission Task Force for Health Human Resources for the XI Plan and civil society groups such as the Medico Friend Circle.

It outlines an integrated framework for major restructuring of medical education combined with strengthening of the district health service system.

Main Points of the Proposal

Locating medical colleges for under-graduate teaching at small hospitals in small towns, e.g., at district hospitals.

Specialists and senior medical officers at district hospitals and CHCs to be the teachers. This should attract by giving added status and meaning to them.

The number of beds in these hospitals be 100-300 and the annual intake of UG medical student be 20-50. This will allow greater teacher-student interaction and opportunity for hands-on patient care so that, at the end of 5 years, the students emerge as confident doctors.

Unnecessary over-crowding at district hospitals must be eased by a l s o strengthening primary level care at village and sub-centre, PHC and CHC levels.



Source: rural-health-india.org

Impoverished areas of rural India vividly demonstrate the need for more effective health programmes and medical practitioners in India

Post-graduate education of doctors to continue at

tertiary hospitals but the PG students be posted at district and CHC levels for part of their course.

Generalist PHC doctors to form the base of an Indian Public Health Cadre, with the doctors being supported for PG degrees in Public Health and moved into positions for health data analysis and planning at district, state and national levels.

Medical colleges develop links with social science departments for interdisciplinary perspectives with sensitivity to social issues.

The AYUSH practitioners be deployed at district, CHC and PHC levels to practise their own system. Colleges of the respective streams be linked to the service delivery system at these levels.

A post of Training and Cadre Development Officer be created at the district to coordinate the required training of the various health personnel.

Thus, a sustainable system can be developed where an Indian Public Health Cadre develops through a 'bottom up' approach rather than as elite experts thrust from above.

Two processes are crucial for any such restructuring. Firstly, the national political leadership must recognize the crisis in the healthcare system and the need for drastic restructuring. Secondly, there must be wide discussion on its content and modalities, involving teachers and researchers of all medicinal systems, public health analysts and civil society.

- Dr. Ritu Priya,
Centre of Social Medicine & Community Health,
Jawaharlal Nehru University, New Delhi

HIV/AIDS, Development and Poverty

The Spread of HIV has been greater than predicted. Apart from being a medical issue, the impact of HIV is seen on social capital, population structure and economic growth. This year, as a global community we have entered the 26th year of the HIV epidemic. The impacts of HIV epidemic has grown to the extent of blotting the economy of a nation and weakening its development. Halting and reversing the spread of HIV/AIDS by 2015 is one of the Millennium Development Goals. The link between HIV and development is an important one...

HIV affects all rich and poor but we see that those who are poorest are the hardest hit by the epidemic individually and as nations and regions. So we in Asia and Africa are grappling with a growing epidemic of a disease that is not even contagious. Last year, the United Nations in its report entitled Population, Development and HIV/AIDS with Particular Emphasis on Poverty made clear this link between poverty and HIV as forming a vicious cycle...

As a doctor, it is something I have seen and experienced first hand. My patients tend to be among the poorest, those who have been left behind in our rush towards global development. They are no small minority and we must ask ourselves why after twenty years of information and awareness programmes, with treatment available, and with increased funding to deal with HIV we still cannot protect our poorest citizens. In order to effectively address the HIV epidemic we must recognize the underlying root causes and take bold steps to address them. Let me point out some of the main issues that confront us:

Poverty: We all know that HIV compromises our immune systems. In poor and developing countries poverty lends HIV a helping hand by ensuring that people's immunity is further compromised by malnutrition and other diseases. Today with treatment available and with Indian companies providing drugs at an affordable rate we must also ensure nutrition and food to see HIV-positive persons withstand treatment.

Employment: Last year the Indian Parliament passed the National Rural Employment Guarantee Act. The law aims to provide at least 100 days of work to one adult member of every rural household. Though difficult to implement, yet its vision with the assurance of work and income, the poor can start looking at their healthcare needs.

Social Security: Social security schemes are at the heart of any Government's obligation to protect the life

and health of its citizens. Social security schemes must provide a safety net for poor people and ensure their ongoing access to basic necessities.



Source: www.benettontalk.com

Access to Healthcare: In India and other developing countries healthcare expenditure imposes a significant burden on poor and even middle class households. Access to healthcare services whether they be for general illnesses, for STDs, for the prevention of HIV or for its treatment is a basic human right. Though our Constitution and international covenants recognize this, the realization of this right is a distant dream. Public healthcare systems, as in my own country and across the world, warrant immediate attention. Unless we train and recruit healthcare personnel and ensure the provision of affordable medicines, the HIV epidemic and indeed other diseases will far outpace any possible action we try and take in the future.

In India we are also considering introducing a legislation to address the HIV epidemic providing a comprehensive strategy to deal with it. The legislation intends to empower people to protect themselves from HIV and to implement a comprehensive healthcare, support and treatment programme for persons living with HIV...

Nothing less than a sustained social and political mobilization is needed to combat one of the most grave crisis facing human development. As Parliamentarians and policy makers we must take bold steps now to address the issues of poverty and development if we hope to tackle the HIV epidemic.

- Dr. M. Jagannath,
Member of Parliament

(Extract of the speech delivered on December 2006 at the Provincial Parliamentary Seminar on HIV/AIDS Policy, at Lahore, Pakistan)

The Inside Story of Medicines That Are Not Available

Nutritional anaemia is a sensitive index about the poverty in any country. After more than five decades of independence India should have got rid of poverty. But

unfortunately poverty is still abundant in India. The increasing GDP should at least be sensitive to the needs of the poor. According to a survey done by a prestigious

institution, in India, 95 per cent of adolescent girls and 92.2 per cent of children below 5 years are affected with anaemia. One would expect that there are several drugs to treat anaemia. But a small study done by Drug Action Forum-Karnataka proves on the contrary that there are no drugs to treat anaemia.

The study listed all the drugs mentioned for treating in the commercial popular publication, Current Index of Medical Specialities (CIMS). In all 338 drugs were listed in this. These were compared with a standard text book of Pharmacology, The Pharmacological Basis of Therapeutics by Goodman & Gilman and WHO's List of Essential Drugs 2005. Do the drugs in the commercial publication match (with regard to its active ingredients and their quantities) with standard text book and the WHO list? The scan of 338 drugs to treat anaemia revealed that only one drug, namely ferrous fumarate, 200 mg tablet manufactured by the drug manufacturer J & J DeChane conforms to the WHO List of Essential Drugs 2005, in terms of active ingredients and their quantities. It is also priced at Rupees 0.13 or 13 paise, the lowest priced drug to treat anaemia and a rational drug. But to our dismay the study also found that this drug, ferrous fumarate, was not available with any chemist. Price assessments of the 338 drugs also reveal that most irrational preparations were over-priced. So virtually the consumer is left with no choice but to consume drugs that are irrational and are unnecessarily costly. Few of them are even harmful.

Apart from 338 drugs to treat anaemia studied, there exist in addition several drugs in the Indian market which are not listed in CIMS. Since there is no track of the drugs registered in the country, nobody really knows the total number of formulations floating in the market to treat anaemia or even the total number of drugs in the Indian market. An approximate calculation places the total number of all formulations in the Indian market at around 80,000. Most of them being irrational combinations!

The study revealed that iron preparations combinations with vitamin C were common. Standard text book by Goodman & Gilman make it clear that "addition of ascorbic acid seems to have little advantage over increasing the amount of iron administered." Similarly, presence of copper, pyridoxine, vitamin B 12 and several other highly questionable ingredients like alcohol, liver extract, etc. Were observed by the study.

As a result there is no choice but for the government to intervene through proper legislation to protect the interest of the people, by making essential



Source: amlat.oneworld.net

drugs available to people. Countries over the world have evolved policies to tackle such similar (not same) situations. For example in USA, there is Orphan Drugs Law that makes provisions by giving tax exemptions to manufacturers involved in manufacturing drugs that are needed for few. Similarly the government should take stock of the drug situation to treat anaemia and ensure that drugs are made available through public health systems. It is further necessary to prevent the gullible public from paying unnecessarily exorbitant prices towards preparations that are not warranted in any way. The government should immediately weed out from the market all preparations that are irrational and harmful.

- Dr Gopal Dabade,

*Co-Convener, All India Drug Action Network (AIDAN),
President, Drug Action Forum Karnataka*

Does Medical Education Need a Change?

Wiping a tear off her crumpled sari, she said, "I did not go to that doctor because he will only rebuke me for not coming sooner...how to explain to him that sometimes there is money in the pocket and sometimes there isn't." She was an illiterate village woman, but her statement was a powerful reminder of the chasm that separates the medical profession in India from the health needs of her people.

Contrast this with the grumble of exasperated doctors in rural postings: "these people are completely illiterate and ignorant... it is impossible to make them understand anything..." At the core of these remarks lies a vital disconnect - social, cultural and economic. The

challenge of healthcare for rural, underprivileged populations confounds the urbane medical graduate, nurtured in elite medical schools and dedicated to Academic excellence and micro-specializations. The casualty is a social orientation in medical education.

Less than 20 per cent of our estimated seven lakh doctors - comparable to the best in the world - are available to 72 per cent of India's population, which is rural. Over 80 per cent doctors work privately and in well-to-do urban areas. Rural primary and community health centres have less than 35,000 doctors (Bulletin on Rural Health Statistics, GOI, 2005). There is an acute shortage of essential specialists gynaecologists, paediatricians and

surgeons with around 40 per cent specialists' positions lying vacant in rural areas. Only 14 per cent of PHCs have a woman doctor.

Pathetic working conditions are regarded as the main factor that keeps professionals from rural areas. But the cause is much more complex. It includes the lack of a social and public health orientation in medical education with a blind pursuit of merit as an end in itself. All of the 260 medical colleges are located in urban areas and the rigorous admissions process recruits students mainly from urban, privileged educational backgrounds. The MBBS curriculum is overloaded with theory at the cost of developing hands-on clinical skills. Teaching is rarely problem based. There is little attempt to develop communication skills, ethics, or a generic ability to deal with cultural differences and belief systems. The curriculum is disconnected from the morbidity patterns at the primary care setting. Studies report that fresh graduates have limited or no knowledge of essential procedures in ante-natal care, obstetrics, immunization, nutrition, IV Fluids, oral pills and IUDs, emergency medicine, small laboratory management and community health needs assessment. The longest internship for today's medical graduates is at the urban tertiary-care hospital with advanced diagnostic supports. They are thus better prepared for post-graduate specialization rather than for handling common primary health problems. Medical education must be synchronized with the country's public health needs, and address its social responsibility before meeting individual students' career aspirations. The MBBS curriculum must integrate subjects like Communications, Ethics, Psychology and Public Health, as well as clinical conditions of the primary care setting.



Waiting patients...

Source: www.une.edu

It should provide a longer period of guided exposure to rural practice. Didactic teaching must be replaced by innovative and evolving learning strategies, mediated by well-trained faculty. Student recruitment must expand to embrace rural students. Courses have to be redesigned; there is an urgent need for shorter courses which can develop alternative cadres of basic health care providers for rural areas, such as the Licentiate of Medical Practice (LMP) that was abolished by the Bhole Committee in 1947.

Finally the government will have to justify huge investments in new medical colleges. The naive hope that a handful of graduates will find their way into the public health system is not enough. The same resources would be better spent on attracting and supporting existing graduates with radically improved working conditions.

- Meenakshi Gautham

PhD (Public Health and Policy, LSHTM)

Urgent Need for Second-Line HIV Treatment

The Human Immunodeficiency Virus (HIV) epidemic has impacted India since 1986. Today, there are approximately 5.2 million HIV positive people in India. The Government of India's intervention in this area displays two overlapping yet disparate outcomes: India's prevention efforts, geared towards preventing HIV infection in otherwise healthy persons, are acknowledged globally as constructive; yet in the care, support and treatment of People Living with HIV (PLHIV), India is faltering, with fewer than 10 per cent of those needing treatment receiving it. This lag exists despite the introduction of a free antiretroviral (ARV) therapy programme in the public sector in 2004. Today, the Indian Network for People Living with HIV/AIDS (INP+) is urging the Government of India to introduce second-line HIV drugs alongside the first-line drugs provided in the national programme.

Today, despite ambitious targets being set, only 62,731 people are receiving first-line HIV medicines through national ART centres. For PLHIV on first-line drugs, that treatment must continue life-long or patients will face grave consequences. In December 2006, the Ministry of Health through a Parliamentary question-response announce that it was not considering



Dr. Karan Singh Yadav, M.P., Vice-Chairperson of IMPF inaugurating the Dharna of INP+ Dharna demanding second line HIV drugs at Jantar Mantar, New Delhi, December 2006

the option of providing free second-line HIV drugs as part of the treatment programme, despite the deaths of PLHIV due to lack of affordable, accessible second-line medicines. There is evidence signalling the need for

second-line treatment options: the failure of patients to respond to first-line HIV medicines (also known as “treatment failure”), the manifestation of resistant strains of HIV, and the need for different drug regimens to treat patients co-infected with tuberculosis and viral hepatitis. There is also a growing Indian civil society movement reflecting the needs of PLHIV to demand second-line ART. We set out here some of the key issues that Members of Parliament can take into consideration when forming an opinion on this critical issue.

Despite funding committed to purchasing these second-line HIV drugs from external donors, Clinton Foundation and UNITAID, for the first two years, the recalcitrance of the Government of India to provide this life-saving treatment is attracting national and international scrutiny. In addition, funding by Global Fund for AIDS, TB and Malaria (GFATM) and the proposed NACP-3 budget of Rs 1334 crores (US\$ 302.6 million) for HIV drugs should cover the cost of providing second-line medicines beyond the first two years. In fact, the total proposed NACP-3 budget for HIV for five years is US \$ 2.6 billion. Further, the number of people requiring second-line is low currently estimated below 3000 patients and the overall cost is not too high: in the first two years of second-line provision, the cost we estimate is around US\$ 1-3 million per year.

There is also good reason to believe the present costs will decline. After Indian companies drove down the price of first-line HIV drugs in 2001, prices have dropped for those First-line drugs, with an annual cost of

US \$ 130-200. The projected five-year cost of providing second-line ART is estimated as US\$ 19 million, while the draft NACP-3 budget for ART for five years is US \$ 302.6 million. NACO's effective history in negotiating lowest prices indicates that India will achieve these successes in procuring second-line HIV drugs as well.

When India has the world's largest industry of generic pharmaceutical products, then why is India one of the few countries not providing the continuum of treatment to its PLHIV? The problem lies in resource allocation. Policymakers must allocate resources differently and purchase low-cost HIV drugs from generic manufacturers, to ensure that PLHIV receive life-saving treatment.

The WHO recommends that the second-line regimen be initiated when patients start failing treatment. India's response falls short of the HIV care responses of Brazil, South Africa and Thailand, which surpass those outlined by the WHO's recommended guidelines.

INP+ and other concerned groups believe that denying treatment of the patients who currently need second-line HIV drugs is an unforgivable travesty, even when there is more donor support, generic production and growing civil society movement and involvement. We hope that the Members of Parliament will support us in advocating for these life-saving medicines.

- Priti Radhakrishnan (Initiative for Medicines, Access & Knowledge (I-MAK) & K.K. Abraham (INP+)

Knowledge Hub UN Solution Exchange; Maternal & Child Health Community

India is a vast, powerful storehouse of development knowledge. While “expert” knowledge is documented, valuable tacit knowledge gained through experience is typically lost. Development practitioners cannot always access the knowledge they need.

To harness this knowledge pool and help development practitioners avoid reinventing the wheel, the United Nations offices in India created Solution Exchange a free, impartial space where professionals are welcome to share their knowledge and experience. Members represent a wide range of perspectives from the government, NGOs, donors, private sector and academia. They are organized into Communities of Practice (CoPs) built around the framework of the globally endorsed Millennium Development Goals (MDGs). Members interact on an ongoing basis through



the three basic services ('query', 'for comments', 'e-discussion') offered by Solution Exchange. There is also a scope for 'annual face-to-face meetings' of active Community members, to strengthen their connections and build Community identity.

WHO, UNICEF and UNFPA country offices facilitate the Maternal and Child Health Community (MCH). MCH focuses on the implementation issues linked to achieving the development goals and objects set out by the Tenth Plan, National Population Policy 2000, Rural Health Mission, and Phase II of the Reproductive and Child Health Programme that correspond most closely to the MDGs relating to maternal and child health. The Community's primary focus is improving maternal and child health, and reducing maternal, infant and child mortality. The MCH Community has been active for almost two years

now, with more than 1,400 members from all over India and some other countries. Discussions have ranged from skilled birth attendants, setting up telemedicine centres, exclusive breastfeeding and complimentary feeding, operationalising urban ICDS, medical termination of pregnancies, and emergency transportation.

As of February 2007, there are ten CoPs: Health - Maternal and Child Health; Education; Poverty - Work and Employment; Poverty - Microfinance; Gender; Decentralization; AIDS; Water; Food and Nutrition

Security; and Information Communication Technology for Development. Since starting in mid-2005, membership has grown dramatically and now has over 7,300 members and 12,000 subscriptions.

For more information on MCH Community and Solution Exchange please visit <http://www.solutionexchange-un.net.in>.

- Meghendra Banerjee
Resource Person (Health),
UN Solution Exchange

TB Anywhere is TB Everywhere ! Parliamentarians call to Stop TB

A meeting between a visiting delegation of six British MPs and Members of the Indian Medical Parliamentarians' Forum (IMPF) was held on 27 March 2007, at the Rajiv Gandhi Foundation, New Delhi. The meeting was chaired by Dr. M. Jagannath, MP, Chairperson of IMPF.

India has the world's largest TB burden with about 1.6 million new cases every year and an annual death casualty of 4.17 lakh patients. The Government of India has been implementing the revised national TB control programme since 1992. Since 1997, the programme has treated just over 6 million people, averting at least 1 million deaths. The meeting of Indo-British Parliamentarians' took place in the context of the recently concluded World TB Day on the 24th of March.

"As people's representatives, it is our duty to press for action which will save 14 million lives worldwide," said Nick Herbert, MP, Co-Chair of the UK All Parliamentary Party Group on TB. Speaking at the meeting with his Indian parliamentary colleagues, he continued: "As British MPs, we are keen to work with our colleagues from other countries to help persuade our governments to step up the fight against TB. This is a global disease that does not respect borders."

The meeting between the parliamentary groups ended with both groups signing the International Call to Stop TB, urging more action on the part of all stakeholders to renew and continue the fight against TB.

Among the issues discussed, what figured prominently were improvement of the laboratory facilities and ensuring completion of treatment. The speakers on both sides were greatly concerned about the emergence of multi drug resistance and its consequences on the existing cost of the programme.



Dr. Shakeel Ahmad, Hon'ble MoS addressing the media after signing the Call to Stop TB

Speaking after the signing of the Call to Stop TB, Dr. R. Senthil, MP and Convener of the IMPF said: "We have to work on making TB control a priority in our constituencies. As leaders, it will be our responsibility to raise visibility for TB control within Parliament, and to keep a track of the programme to ensure that lives are saved."

The British Parliamentarians consisted of Mr. Tom Clarke, Ms. Ann Cryer, Mr. Nick Herbert, Mr. Jeremy Hunt, Dr. Ashok Kumar and Ms. Baroness Lindsay Northover. Their Indian counterparts were Dr. M. Jagannath, Dr. Shakeel Ahmad, Dr. Laxminarayan Pandey, Mr. Robert Kharshiing, and Dr. R. Senthil. Besides the Parliamentarians, the meeting was attended by media persons and members from Medical Sans Frontiers and Lawyers Collective.

- Shefali Gupta

Urgent need for a Public Health Act

A study of the disease burden of India reveals that about 80 per cent of the illnesses are due to 17 known diseases. These diseases include Tuberculosis, malaria,

HIV/AIDS, water borne diseases, obstetrical causes and injuries. All of them are preventable by certain measures and hence fall under the Public Health domain

as defined by the WHO. Needless to say the major brunt of the disease burden is borne by the poor and one major illness can push one to a lower level of poverty.

In democratic Governments, Public Health functions compete for scarce resources with other demands for services. Prevention of diseases is the most cost effective way of dealing with diseases. The responsibility of the state to prevent illness is as much as it is to provide curative healthcare. It is Government that possesses the sole authority to empower, regulate, or carry out activities designed to protect or promote the general health, safety and welfare of the population. The lack of a credible Public Health policy has led each of the above diseases to be dealt individually as medical problems rather than Public Health issues. The promotion of healthy life and prevention of diseases have not found its right place in the health plans despite the National Health Policy addressing this issues on several occasions.

Public health systems are conceptually distinct from medical services. They have as a key goal reducing a population's exposure to disease, for example, through assuring food safety and other health regulations, vector control, and health education. These services are largely invisible to the public. Typically, the public only becomes aware of the need for them when a problem develops (e.g., when an epidemic occurs). Yet unlike most personal medical services, these services produce "public goods", and are of high priority for assuring good health outcomes. When public health systems falter people pay a high price for illness, debility and death; and if full-fledged outbreaks occur the economic costs can be very large: for example, the WHO (1999) estimates that the 1994 plague epidemic in Surat resulted in losses totalling promotion of public health has been recognized as the responsibility of the Government. A Public Health Act would bring all concerned in providing healthy and safe living environment to come under one umbrella. This includes departments dealing with environment, water supply, sanitation and rural development. US \$ 1.7 billion.

In India we do not have a comprehensive law to fix the responsibility of preventing disease and promoting healthy living on the Government. Protection and promotion of public health has been recognized as the responsibility of the Government. A Public Health Act would bring all concerned in providing healthy and safe living environment to come under one umbrella. This



Dr. Anbumani Ramadoss, Hon'ble MoHFW and Dr. Julie L. Gerberding of the US Centers for Disease Control and Prevention, address at the meetings on Polio eradication and health policy.

includes departments dealing with environment, water supply, sanitation and rural development.

The recent epidemics of Dengue and Chikungunya again exposed the inadequate mechanisms our country has to face any spread of infectious diseases. This has to be viewed as a 'Public Health Failure'. We need a mechanism to predict, handle and prevent further spread of disease in cases of serious outbreaks of infectious diseases. This needs a team work involving trained professionals of various skills.

Wherever personal interest and liberty conflicts with the interests of the health of the community, the later needs to be given priority and this needs to be established by law. What role can legislation play in relation to non-communicable diseases and health determinants? The Public Health Bill could include a sub-purpose in these areas and, in addition, regulation-making provisions aimed at influencing factors relevant to ill health could be included. The scope of such regulation-making provisions might relate to access to products, services and facilities, constituents of those products, and the regulation of advertising. Any such regulations would require their own public health risk assessment and consultative processes before submission to Government. However, the legislation is a necessity at the earliest.

- Dr. R. Senthil,
Member of Parliament

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