Reaching out for Ethical Healthcare

ADEH
Alliance of Doctors for Ethical Healthcare
ethicaldoctorsindia@gmail.com
www.ethicaldocors.org

April 18 - June18

NEWSLETTER

Editorial

1st National Conference on Ethical Healthcare 2018

We are pleased to come out with this first Newsletter on behalf of Alliance of Doctors for Ethical Healthcare (ADEH). When our book 'Dissenting Diagnosis'written by Dr Abhay Shukla and I was published by Penguin India two years back, many doctors across India approached us with their ideas; we in turn approached doctors in many cities, and so we like minded doctors (mostly engaged in private practice) kept meeting to brainstorm; out of this churning; emerged a loose network of individuals – ADEH ie Alliance of Doctors for Ethical Healthcare .

ADEH got involved mainly in advocacy. We did our bit in demanding dissolution of MCI as recommended by Joint Parliamentary committee, in capping of prices of stents; also , as ADEH we were called by parliamentary committee to present our views on National Medical Commission Bill.

We were engaged in our states, as well as across the nation. We were active in writing various articles in media, participated in many live TV discussions, and for putting forward views of the medical community to check corporatization of health care, and regulation of drug and device industry. We stood with ethical, rational doctors against high handed implementation of PCPNDT in which many honest doctors suffered; we have championed for patients' rights, and transparency regarding charges. We have been a forum for patients to address their queries. Our big dream at ADEH is to bring Universal Healthcare (UHC) in India.

This newsletter from ADEH will be covering articles from doctors on issues related to deteriorating faith in the medical profession, health advocacy, need for policy changes, position papers regarding healthcare practices. We would also like to have a bird's eye view on challenges faced for ethical practice in global context. The Newsletter will give coverage to events, workshops happening around on key issues related ethical healthcare.

Keeping the objectives laid in mind; the present issue contains an article by Dr Sanajy Nagral (Mumbai) on violence in medical field; an article by Dr Arun Mitra (Ludhiana) on the convention that ADEH (Punjab) organised to focus on the huge cost difference between MRP and purchase price by hospital in drugs and equipment.

We hope that the newsletter will help spread the message and membership of ADEH across India. We do hope and appeal that doctors should send us related articles for this quarterly Newsletter published electronically.

We are holding the unique – first ever – National conference on Ethical Healthcare (NCEH – 2018). Please join us in AIIMS – Delhi on 21st and 22nd April 2018 in this conference.

Let all of us be the change which we want to bring in!

Dr Arun Gadre

Streamlining of Drug Prices to Make Them Affordable

Dr Arun Mitra (Senior ENT Surgeon, Ex Chairperson Ethics Committee PMC and Indian Doctors for Peace and Development (IDPD), Punjab)

Since the cost on drugs comes to about 70% of the out of pocket expenditure on health, this becomes a cause for major concern. Because 80% of medical care in our country is in private sector and advanced tertiary care is mainly coming up in corporate sector, the cost concerns are increasing. As per the National Health Policy document 2017, every year 6.3 Crore people are pushed below poverty line due to out of pocket expenditure on health. It is therefore very important that prices of drugs are streamlined and made affordable. Unlike the consumer products, where the patient has a choice and can decide on what to buy, the drug is something about which patient has no choice and is dependent on medical advice. The disease is not by choice. Therefore it is all the more essential that cost of drugs is within the reach of every citizen. The government owes responsibility to bring down the cost of medicines.

There is a National List of Essential Medicines (NLEM), whose cost is to be controlled on priority basis. The essential medicines are those that satisfy the priority healthcare needs of majority of the population. The primary purpose of NLEM is to promote rational use of medicines considering the three important aspects i.e. cost, safety and efficacy. Because of their essential nature the price of these drugs needs to be fixed. Many of these drugs have been manufactured in bulk by the Indian Drug Companies mainly in the public sector and have been used in various national health programmes.

Drugs in our country are marketed in two forms, the branded medicines and the trade generics. The latter constitute about 15% of the whole pharmaceutical market. Cost of the generic ones is expected to be low so that benefit goes to the patient. Branded drugs are expensive because their marketing involves many chains and promotional activities. On the other hand approximately 50% of the trade generics are consumed by dispensing doctors. But the trade margin in several generic products is very high thus belying the very purpose of cheap drugs to the patient.

Though the issue has been highlighted after discrepancies in prices of coronary stents came up in public knowledge, these have been discussed at various levels and different forums. Exorbitant Maximum Retail Price (MRP) printed on the medicine causes distortion of price in the market. Trade margin allowed to the retailer in some cases is as high as 1800%. In the hearing of a case in the Punjab and Haryana court, the Ranbaxy Laboratories Vs. State of Haryana and another, dated 19 March 2013 noted, the Hon'ble court said: “Before parting with judgment , it has to be noted that although the petitioner is allegedly selling the drug in question to the consumers at about 900% of reasonable price of the drug, but there appears to be no legal provision in force to save the consumers from such naked fleecing of the consumer by the petitioner or other drug manufacturers by over pricing the drug to such an extent. It is surprising that no remedial or ameliorating step has been taken either by the state or by the union of India in this regard. The court hopes that now at least the concerned authorities shall wake up and also take some step to save the consumer from such fleecing”.

A committee was constituted by the ministry of Chemicals and Fertilizers Department of Pharmaceuticals on 16 September 2015 under the chairmanship of Shri Shudhansh Pant, Joint Secretary

Pharma, to compare the prices of trade generic and regular channels of marketing and give its recommendations. This committee suggested capping of trade margin as per the per unit price. Fearing that if capping of prices was done in all segments, the manufacturers would shift to the medicines with high cost for the purpose of more profit. Therefore the committee recommended to put lesser cap on the low cost medicines. It opined that there should be no cap on drugs the retail price of which is up to Rs. 2/- per unit ie per tablet/capsule/vial/tube/bottle / injection etc; For the product with per unit retail price from Rs. 2/- to Rs. 20/- trade margin to be maximum to 50%; Trade margin up to 40% on products with per unit retail price from Rs. 20 - Rs. 50/-; Above Rs.50/- trade margin recommended was maximum up to 35%.

The drug prices can be streamlined to a large extent if these recommendations are implemented. There is need for a one drug one price formula. In fact any formulation once it is labeled as medicine, becomes essential. So price of all drugs should be under check. For this purpose the National Pharmaceutical Pricing Authority (NPPA) should be strengthened. The Uniform Code of Pharmaceutical Marketing Practices (UCPMP) should be made mandatory. The PSUs which have been rendering great service to the nation in the form of supplying cheap bulk drugs at the time of national calamities and in the national health programmes should be strengthened if the dream of affordable health care is to be met.

■

Violence against doctors

Dr Sanjay Nagral (Senior Surgical Gastroenterologist, Publisher and Editorial Board Indian Journal of Medical Ethics, Mumbai)

The medical profession, as a defensive measure, demanded special legal provisions, following which the state promptly passed the Prevention of Violence and Damage of Property Act, 2010.

There has, however, been no letup in the incidents, which occur with alarming regularity.

It is tempting to dismiss the use of force as a random act by lumpen elements or instigated mobs. That is not the whole truth. Here's a scenario that I have seen unfold in Mumbai:

A young man is brought in with a serious injury to a public hospital. He needs an urgent CT scan of the brain. Since this facility is not available at that hospital the relatives are informed that the patient will need to be shifted to another centre.

The ambulance is not available immediately; one becomes available after a few hours. As the patient, accompanied by family and a junior doctor – an intern who is not trained to handle emergencies - is ferried to the new facility, his condition deteriorates and since our ambulances are often just white -coloured vans with a siren and no critical equipment, the junior doctor can do nothing. The patient dies. This sequence of events has been witnessed by friends and family, who abuse the intern and assault him.

Given such a scenario where do we locate the problem and whom do we blame? Who are the perpetrators and who are the victims?

Violence against health care workers is a complex problem with origins in a deficient health care mechanism, inadequate communication, rising costs, increased expectations and instigation by community leaders.

It is a symptom of a deeper malaise and cannot be

solved by constructs like "security" and "deterrent punishment", which dominate the discourse - increased security at work was a demand made by by resident doctors who recently struck work in the state.

Since the problem is multifaceted the resolution needs to address multiple aspects. As some of them lie in the realm of health policy they are not under the control of the usual protagonists in his conflict: the aggrieved patient's family and the junior doctor at the frontline. A few steps could, however, help.

Since a majority of such incidents occur in an emergency, an organised and prompt emergency care system is desperately needed.

For a city like Mumbai, with its claims to modernity and high technology, the nonexistence of such a system is a shame and can be easily corrected.

It is time elected representatives and community leaders take healthcare policy beyond rhetoric - it's well known that the BMC's health budget is huge but underutilised.

On the other hand health care providers should re-examine the poor communication that plagues our practice. It is my experience that a few words of explanation and reassurance even in the most adverse of situations can go a long way and pacify the angriest of mobs.

As someone who led strikes of resident doctors in the late-80s I have mixed feelings when I see young, hardworking doctors being abused and beaten up.

They are victims of a situation that is not of their making. And yet the answer does not lie in increased policing and security. That may worsen the already eroding trust that is so critical for the credibility of the medical professions ability to deliver health care.

SATHI

- Published by SATHI, Pune for Alliance of Doctors for Ethical Healthcare (ADEH)

Flat no. 3 & 4, Aman E-Terrace, Plot no. 140, Dahanukar Colony, Kothrud, Pune 411 029.
Tel. : 91-20- 25473565, 25472325, E mail : sathicehat@gmail.com, Website: www.sathicehat.org

- Printed at, Sanskruti Designers & Printers, Pune
- Published in, April 2018