UPDATE

News and Notes

Bombay's Health Priorities

A LONG-STANDING criticism of health services, curative and preventive, private and public, has been that they are heavily urban-oriented and are skewed to offer the least assistance to those who need it most, the rural poor. What is often not as well documented is that the distorted priorities also influence urban health care. The annual budget estimates of the Bombay Municipal Corporation (BMC) recently presented provide a glimpse of just how efficiently the civic body is discharging its obligations of providing health care.

The corporation spends 29 per cent of its revenue budget on public health and medical services. Expenditure on health care has been steadily increasing—there has been a 69 per cent increase in the last three years. What is important, however, is that most of this increasing expenditure has been on the curative side. The health budget comprises three components—public health, medical relief and education, and measures to control environmental pollution. The proportion spent on public health has consistently, even if marginally, decreased—from nearly 15 per cent in 1977-78 to 13.7 per cent. A grave result of this is that neither the infant mortality rate nor the overall death rate has shown an improvement in ten years. Pollution control which includes such activities as air quality monitoring, research laboratories for analysis of pollution as well as an enforcement wing for ensuring the implementation of control measures, accounts for less than one per cent of the expenditure. Admittedly, the allocations in this area have increased many times in ten years, but considering that the BMC's own health survey has shown a definite link between the prevalence of a large number of health problems and air pollution, should this area not have been considered a priority area in health?

The corporation appears to be attacking the problem of health from the wrong end—waiting for people to fall ill so that they may be taken care of, instead of eliminating the root causes of ill health. The corporation is not alone in its apparently muddled understanding of these issues—every government, state and central, has followed the same principles of neglecting preventive health care. The reasons are, of course, obvious. The creation of imposing hospitals equipped with new equipment (even if they are ever put to use) adds to the prestige of the authority even as it offers temporary 'repair facilities' for the masses. However, expanding public health measures is quite another matter. In doing so, the state will necessarily have to confront the very classes which sustain it—whether it is a matter of properly distributing clean water supplies or bringing defaulting industries to book.

Even within curative health care, the services are so created as to provide the least access to the working masses. Hospital beds, for instance, show such a skewed distribution. In 1980, 60 per cent of the hospital beds maintained by the corporation were in city wards in south Bombay comprising 35 per cent of the largely better-off population; the civic body did not maintain a single bed in the area which 'houses' a large proportion of the working class population of the city. To make matters worse 67 per cent of the government beds are also in these south Bombay wards. The rest of the population (the lower middle class and working class) is forced in the city to depend on private medicare. Although the number of hospital beds has gone up since then, the situation is hardly better. As the municipal commissioner has pointed out, "we have undertaken the construction of many skyscrapers for increasing the number of beds in our major hospitals . . . while a large suburban population is denied immediate access to primary health centres".

Quite obviously, whatever the increases in the health budget, it is unlikely to benefit the urban masses. In fact, what with the commissioner's proposal to hike hospital registration charges, "restricting use of costly medical equipment" by introducing "reasonable charges" for their use and "avoiding waste of medicines and diet", users of municipal facilities will find the services gradually moving beyond their reach.

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Ruins of War

LEBANON is constantly reported for internecine fights, the shifting loyalties of the groups involved in the fights and above all Israel's repeated invasion of that country, the latest being in 1982. In the din of all this gunfire and among the ruins of war, the condition of millions of Palestinian refugees in Lebanon and in Israeli occupied territories of West Bank and Gaza has almost been forgotten. War itself has become an epidemic in the region and its impact on people's health is of epidemic proportion.

The fighting between the Palestinians and other armed groups which are from time to time supported by Syria, Israel or Iran, has almost destroyed the whole social fabric, and as a consequence even the health care services, in the Palestinian refugee camps. Even the abysmal health services which were available to them before the 1982 Israeli invasion of that country have almost ceased to be. For the last two years the Syrian-backed Amal Shite Muslim

militia has resorted to intermittent seizure of Palestinian refugee camps and thereby cutting the residents of all civil and medical supplies.

Chatila camp has been reduced to rubble and its population have fled south in search of food and shelter. In Bourj-al-Barajneh camp 35,000 people along with the British charity, Medical Aid for Palestinians are trapped. The electricity and water supplies to the camp are cut-off by the Amal militia. Food supply is not reaching the camp people. Anybody coming out in the street to get water and food or trying to leave the camp is shot dead. All relief supplies are turned back by the militia. Much of the medical facilities established by the MAP at the cost of £ 30,000, after destruction in the 1982 war, in the Gaza hospital, are destroyed including the hospital building itself. Another remaining hospital, the Haifa hospital, has lost two of it's there floors and there even medical worker's and patients have been hit by sharpnel. Because of such attacks on all these camps, it is estimated that almost 2000 camp inhabitants are killed, 4500 wounded and 80,000 made homeless.

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Double Standards: Some Improvements

In the past dozen years, major pharmaceutical firms have made substantial improvements in the way they label and promote their products in the Third World. They are now less likely to puff up their claims to physicians and are more willing to disclose possible serious or lethal adverse reactions.

These are the findings of three researchers at the University of California School of Medicine in San Francisco (UCSF)—Milton Silverman, Philip R Lee and Mia Lydecker. This group pioneered comparative marketing studies beginning in Latin America in the early 1970s. Their latest findings were published in the October 1986 issue of the International Journal of Health Services.

Their original survey covered 147 products marketed in the United States, Mexico, Central America and South America and the results were published in 1974. In their second study, published in 1982, the UCSF group covered 515 products marketed in the United States. Latin America, Central Africa and Southern and South East Asia. Their present investigation includes 1,069 products marketed by about 300 companies in the United States, the United Kingdom and 28 developing nations.

The present study reports striking changes. Many of the firms were 'found to be showing more restraint in limiting their claims int he Third World to those which can be supported by scientific evidence and were far more willing to desclose serious hazards'.

In the case of dipyrone, a widely-used but reputedly dangerous remedy for fever and pain, itw as noted that 119 of 155 products now carry warnings of possible fatal blood damage. This represents a marked improvement over the situation in 1974 and in 1982. Most of the products still without such warnings were found to be marketed in India, Mexico and Central America, mainly by American and West German firms.

Of the 12 aminopyrine products, used for the treatment of fever and pain, seven—marketed by Polish, Spanish, Swiss and German firms—carried no adequate warnings of possible blood damage. Of the 15 phenacetin products which are used to control fever and pain, eight carried no warnings of possible kidney damage. They are marketed by American and German companies. All three of these products have long since been banned from the United States and the United Kingdom.

In the case of chloramphenicol, a valuable but potentially dangerous antibiotic used especially in the treatment of typhoid fever, 93 of 103 products now list warnings against use in trivial infections, against preventive use and against prolonged use. This too represents a remarkably improved situation. Nevertheless, some firms were found to be promoting chloramphenicol products in Indonesia, the Philippines and Thailand for such a minor illness as tonsilitis.

Similar improvement was noted in the promotion of tetracycline and other antibiotics, tranquilizers, anti-depressive agents and anti-arthritis drugs.

Silverman, Lee and Lydecker also examined the promotion of numerous 'sex-tonics' in the Third World by various American, European and Third World compaies. These are widely recommended and sold for such indications as premature aging, sexual weakness, lack of physical and mental capacity, failing memory, fatigue and 'general wearing-out phenomena'. Evidence to support such use is questionable at best. None of the products is allowed on the market in the United States or Great Britain.

Drug companies cannot explain away these differences merely by claiming that the laws of a specific developing nation dictate what may or may not be put on the label. In the same country it was obvious that some brands of a particular drug carry detailed warnings, while other brands of the identical drug carry no warnings of any kind. Among the companies whose products were examined, some were based in capitalist nations, some in Marxist-Socialist countries and some in the Communist bloc. 'Our data show no significant differences between them inthe reliability of their promotion', the USCF team said. Among the profit-making companies, some were multinational while others were domestic or national. 'Our data indicate that most cases of irrational promotion involve domestic firms in the Third World'.

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