

Poverty and Access to Medicine: A Medico Legal Study

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Abstract

The right to health as a basic human right- and access to medicine as a part of it- have been a matter of attention for several decades. Also the responsibilities of different parties- particularly pharmaceutical companies- in realization of this right have been emphasized by World Health Organization. This is while many companies find no incentive for research and development of medicines related to rare diseases. Also some legal structures such as “patent agreements” clearly cause huge difficulties for access to medicine in many countries. High prices of brand medicine and no legal production of generics can increase the catastrophic costs- as well as morbidity-mortality of medication in lower income countries. Here we evidently review the current challenges in access to medicine and critically assess its legal roots. How societies/governors can make the pharmaceutical companies responsible is also discussed to have a look on possible future and actions that policy makers- in local or global level- can take.

Keywords: Access to medicine, Pharmaceuticals, Pharmaceutical companies, Human rights.

Introduction

“Poverty is the parent of revolution and crime” –
Aristotle

The above quoted couplet aptly summarises the concept of Poverty. Poverty is not having enough means, resources, material possessions or income for fulfilling a person’s needs. Poverty may be social poverty, economic poverty or political poverty. Absolute poverty is the complete lack of means necessary to meet basic needs which are strictly personal such as food, clothing and shelter. The threshold of absolute poverty always remains the same independent of the person’s permanent location or other corresponding factors. On the other hand relative poverty is when a person cannot meet a minimum level of living standards, compared to others in the same time and place. Accordingly the threshold or the benchmark of relative poverty varies from one country to another or from one society to another or from one system to another and so on.

Governments and non governmental organisations try to reduce poverty. The government’s ability to deliver services and provide basic needs to people who

are unable to earn a sufficient income can be held to ransom by the major bottlenecks and speed breakers in the form of corruption, tax avoidance, debt and loan conditions and by the brain drain of health care and educational professionals . Therefore, welfare solutions, economic freedoms and providing financial services must be included in various strategies of increasing income and providing succour to poor people. In contrast to *laissezfaire* era where the functions of the government primarily involved those of protecting the community against external attacks, maintaining internal law and order and guaranteeing contracts, the welfare state concept demands a much wider and more pervasive range of government activity. Not only should the government provide social services such as social security, medical treatment, education, welfare facilities and subsidised housing but these should go beyond the provision of a bare minimum towards ensuring that all have equal opportunity, so far as the country’s resources allow. There is difference of opinion as to how this can be most effectively done and what degree of public provision it should involve, relative to private, but the principle that this is a proper public concern is generally accepted . It is also generally accepted that

the government has an obligation to steer the working of the market economy in the directions considered to be socially desirable. Fiscal policy and monetary policy should be used to combat unemployment and inflation and promote steady growth. Encouragement must be given to types of investments thought to be desirable, by means of investment allowances and grants. Help should be given in developing new industries in those areas of the country which are lagging in growth and income. The concept of welfare states thus involves much more than social services. But social services are nevertheless its most characteristic element, since they are concerned with the positive provision of service to individuals of a type and on a scale that they would not obtain through the free market. In other words, the types of services most characteristic of the welfare states are those which meet what Musgrave¹ calls 'Merit Wants'. They are not concerned with pure public wants of a kind which cannot be satisfied through the market because the benefit from them is almost entirely social and there is little or no private benefit. Defence, law and order, general administration etc. are services of this kind. On the other hand, education, medical treatment and social security are not of this type as they provide distinct benefits to individuals and are provided through the market and for a price. But an element of social benefit, from an educated and healthy community or for ensuring that all members of the community are guaranteed a minimum income in the event of inability to earn is held to arise over and above the private benefits to the individuals. As per the report of World Day Lab, the effect of various govt. initiatives will result in a level of extreme poverty in India of 50 million people today which will come down to 40 million (a poverty rate of below 3%) by end 2019.² In July 2018, World Poverty Clock, Vienna based think tank reported that a minimal of 5.3% or 70.6 million Indians are living in extreme poverty compared to 44% or 87 million Nigerians. Till 2019, Nigeria and Congo surpassed India in terms of total population earning below dollar 1.9 a day.³ Although India is expected to meet United Nations sustainable development goals on extreme poverty in due time, a very large share of its population lives on less than 3.2 dollar a day, putting country safely into category of lower middle income economies.

One third of deaths around- some 18 million people, a year or 50,000 per day are due to poverty related causes. People living in developing nations, among them women and children are over represented

among the global poor. Those living in poverty suffer disproportionately from hunger or even starvation and disease as well as lower life expectancy. According to World Health Organisation, hunger and malnutrition are the single gravest threats to the world's public health and malnutrition is by far the biggest contributor to child mortality, present in half of all cases.

Almost 90% of maternal deaths during childbirth occur in Asia and Sub-Saharan Africa, compared to less than 1% in the developed world. Those who live in poverty have also been shown to have a far greater likelihood of having or incurring a disability within their life. Infections, diseases such as malaria and tuberculosis can perpetuate poverty by diverting health and economic resources from investment and productivity; malaria decreases GDP growth by upto 1.3% in some developing nations and AIDS decreases African growth by 0.3-1.5% annually.⁴ Poverty has been shown to impede cognitive function. One way in which this may happen is that financial worries put a severe burden on one's natural resources so that they are no longer fully available for solving complicated problems. The reduced capability for problem solving can lead to sub optimal decisions and further perpetuate poverty. Many other pathway from poverty to compromised cognitive capacities have been noted, from poor nutrition and environmental toxins to the effects of stress or parenting behaviour. All of which lead to sub optimal psychological development.⁵ Neuroscientists have documented the impact of poverty on brain structure and function throughout the lifespan. Infections diseases continue to blight the lives of the poor across the world. An estimated 40 million people are living with HIV AIDS, with 3 million deaths. Every year these are 350-500 million cases of malaria, with 1 million fatalities.

India doesn't have enough hospitals doctors, nurses and health workers and since health is a state subject, disparities and inequities in the quality of care and access to health varies widely not just between states but also between urban and rural areas. As per a W.H.O. Report 2018 on India's healthcare workforce, only one in five doctors in rural India are qualified to practice medicine. This leads to widespread problem of quackery. The WHO report said that 31.4% of those calling themselves allopathic doctors were educated only up to the class 12 and 57.3% doctors did not have a medical qualification. Doctors without formal training provide up to 75% of primary care visits. The new principal of BRD medical college, Dr. P.K. Singh lamented that the

hospital gets very sick babies because most parents seek local remedies and treatment from quacks before they bring their children to hospital. He also emphasized that the hospital can't turn anyone away and therefore two to three babies on one bed or two babies in one incubator was quite common. The author of the report 'Unqualified Medical Practitioners' opined that there are no large scale surveys on quackery by national statistical agencies such as the Census of India or National Sample Survey office which could form the basis for policy making in this area⁶. She further observed that the lack of Medical qualifications was particularly high in rural areas and whereas 58% of doctors in the urban areas had a medical degree, only 19% of these in rural areas had such a qualification.

The Indian scenario represents a bleak picture as India's spending on healthcare is even less than Nepal and Sri Lanka. Further 70 percent of overall household expenditure on health in the country is on medicines. Further an estimated 469 million people in India do not have regular access to essential medicines. Moreover 63% of primary health centres did not have an operation theatre and 29% lacked a labour room. The community health centres were short of 81.5% specialists. Various studies have shown the rising out of pocket expenditures on healthcare is pushing 32.39 millions below the poverty line annually⁷. Under national health mission the government has launched several schemes some of which are enumerated below:

- (a) **Reproductive, Maternal Newborn, Child and Adolescent health**—essentially to address the major cause of mortality among women and children as well as the delays in accessing and utilising health care and services.
- (b) **Rashtriya Balswasthyakavyakaran (RBSK)**—an important initiative aimed at early identification and early intervention for children from birth till 18 years to cover 4D's viz. Defects of birth, Deficiencies, Diseases, Development delays including Disability.
- (c) **Rashtriya Keshava Swasthya Kanyakumari**—an initiative to enable all adolescents in India to realise their full potential by making informed and responsible decisions related to their health.
- (d) **Shishu Suraksha Kanyakumari**—to encourage institutional deliveries and to pre-empt communicable and non-communicable diseases.
- (e) **National AIDS control organisation**—to ensure that

every person living with HIV has access to quality care and is treated with dignity.

- (f) **Revised National TB Control Programme is a State-run tuberculosis control initiative** of the govt. providing quality tuberculosis diagnosis and treatment through the Govt. Health system to ensure a TB free India.
- (g) **National leprosy Eradication Programme**—to ensure early detection and to provide appropriate medical rehabilitation and leprosy ulcer care services.
- (h) **Mission Indra Dhanush**—to improve coverage of immunization in the country

Apart from that Ayushman Bharat Yojana or Pradhan Mantri Jan Arogya Yojana or national health protection scheme is another major initiative of the central govt. This was launched on 23rd September 2018 by Hon'ble Prime minister in Jharkhand's capital Ranchi. It is also known as PM Jan Arogya Yojna. The scheme is targeted at poor and deprived rural families and identified occupational category of urban worker's families. The scheme aims to cover around 50 crore people whereby 8.03 crore families in rural and 2.33 crore in urban areas will be covered. It will have a defined benefit cover of Rs. 5 lakh per family (on a family float basis) per year for secondary and tertiary case hospitalization and will subsume the existing Rashtriya Swasthya Bima Yojana (RSBY) launched in 2008 by the UPA government. The scheme will be cashless and paperless at public hospitals and empanelled private hospitals. Each empanelled hospital will have an Ayushman Mitra to assist patients and will co-ordinate with beneficiaries and the hospital. The benefits of the scheme are portable across the country. PM Modi has predicted it to be a game changer.

Mobile healthcare facility:

“He who has health has hope and he who has hope has everything”.

-Arabic Proverb

Access to health care in rural India and for the poor in urban slum dwellers continues to be deplorable and has got less than 4% of Govt. Primary healthcare facilities. There are two primary reasons for the adverse health conditions of the urban slum dwellers; firstly the lack of education and awareness and secondly the unwillingness and impracticability to lose a day's wage in order to reach the nearest medical facility. Thus the healthcare

which is a desperate need remains unaddressed. A two pronged approach is therefore called for. The first one is to bring quality healthcare facilities and services to the door steps of the needy and second to promote healthcare awareness and contemporary healthcare seeking behaviour amongst the underprivileged. Some of the NGOs have taken a good initiative in this direction viz. Smile Foundation, Help Age India.

Another important aspect is the mobile based Primary healthcare management system CDAC. Electronics City Bangalore has initiated the development of 'mobile based Primary healthcare' management system for development in the PHCs for betterment of management of primary healthcare specifically in rural and urban slums of India. The system will capture complete information related to an individual patient treated by a PHC.

Another initiative SehatSaathi is being developed at Media Lab Asia research hub at IIT Kanpur. It involves front-end contact through a suitably trained non medical professional; back end support from doctors, pathologists and other health professionals for diagnosis and treatment; use of digital technology to achieve objects and dissemination of information on health and disease through digital means.

Conclusions and Suggestions

The healthcare scenario in India and the access to medicine and other facilities are facing a bleak future and a catastrophe is bound to happen unless drastic measures are taken urgently. The abyss of despair through with this section is passing through requires a herculean task to bring it back on track of stability and growth with positive development. The reforms and changes required have a dual character. The initiatives are required in the medical field as well as legal field. On the legal front, it would be desirable that 'health care' is put on the concurrent list rather than on the state list. Entry 6 of the state list in schedule 7 of the Constitution provided 'Public health and sanitation; hospitals and dispensaries. This being a state subject, state govt. imposes fetters and bottlenecks on any major initiative by centre in this sector. The Ayushman Arogya Yojana initiated by PM Modi has met many such speed breakers by the hostile state govt. particularly in the national capital territory of Delhi and West Bengal albeit entirely on political factors. This has obviated a coordinated effort throughout the territory of India which could have yielded better results.

Putting it in the concurrent list will accelerate the implementation of such schemes and in cases of any contradiction in the central scheme and state scheme, the central scheme shall override. Besides it will not prevent the state government from bringing out any other beneficial health care initiative. Further the mobile health clinic facilities being undertaken at present through various NGOs and Social organisations may be developed and implemented on a large scale with prominent Public Health Care Hospitals in the Govt. Sector participating in it. This will lend credibility to the entire exercise and the faith of the public at large will be imbibed into this. The prominent hospitals in the Govt. sector in the vicinity of the area can fix a schedule and a day and time can be prefixed when the mobile health clinic shall visit the particular area. It would also be desirable that an Annual Health Appraisal of all the employees be conducted, be it in the private sector or in the public sector/Central Govt. Employees/State govt. Employees on the same lines as Annual Work and Performance appraisal. The employees be graded on both these appraisals and increments/promotions be linked to grades in these appraisals. A social audit of the same should be done annually and the report of the social audit should be part of the annual report of the organisation/company as is the corporate governance report. This is an essential requirement because it had been found that the medical facility at the workplace functions in a perfunctory manner.

These are some of the suggestions which I hope would go a long way in ensuring a better healthcare system in India and an easy access to medicine.

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