## Abortion: a fundamental right

One finds oneself agreeing with much of Dr. S.G. Kabra's views on abortion in India (1). The Indian State's interest in providing abortion services in the country, has as Dr. Kabra points out, been governed essentially by the exigencies of the family planning programme. The programme operates both from eugenic considerations - the perceived 'need' to prevent some sections of the population from reproducing themselves - and from perceived 'national' interests. He also rightly focuses on the indifference of the State in allowing illegal or badly performed abortions that can lead to a range of health problems for women, and in some cases, their deaths.

However, I take objection to the thrust of Dr Kabra's argument, which suggests that the right to abortion involves the 'fundamental rights of two individuals - the mother and the foetus'. Simultaneously, a connection is drawn between abortion and infanticide. The statement on what stage a foetus can be seen as an individual in its own right is disturbing. It tends to look at abortion at a certain stage of the pregnancy as being acceptable and unacceptable at others. The notion that the foetus is an individual in its own right infuses an emotional angle to the entire debate on abortion that in my view is unacceptable. It can, taken to its logical conclusion, lead to the perception that contraception itself is unacceptable, as it can destroy a potential life.

Abortion causes emotional turmoil for many women and their families, especially when accompanied with coercion by the state. However, it cannot be seen as anything less than an unalienable right for women. Women have a right over their bodies and their reproduction, that cannot be transferred to their families or the state. This is more relevant in this country where childbearing is modified by social mores; and women's right to decide when and if they want to bear children remains a theoretical rather than a practical right. The existing laws on abortion are inadequate and designed to serve the interests of the family planning programme, rather than to allow women to regain control over their bodies.

The Medical Termination of Pregnancy Act (henceforth MTP Act) was passed in 1971.(2). Under this act, women have a restricted right to abortion. The declared objects of the Act are to help women who become pregnant as a result of rape, married women who are pregnant due to contraceptive failure, or to reduce the 'risk' of severely handicapped children being born. As with the family planning programme, the right to contraception is seen as applicable only to married women, marital sexuality alone being seen as legitimate.

Under the MTP Act, regulations on record maintenance require the doctor performing the operation to maintain records on each abortion which include the reasons for the abortion — legally, the woman cannot avoid giving an explanation. This register is a secret document, to be destroyed by the doctor at the end of five years since the date of the last entry.

There is much scope for misuse. Many married women undergo abortions without the knowledge of their family members, including, at times, their husbands. For single women, the need for secrecy is even more pressing. Not only do they face a greater degree of social control; the abortion may well be out of the purview of the MTP Act. Given this, the register can easily become a tool for blackmail in the hands of unscrupulous medical practitioners and medical staff.

Besides, the insistence that woman explain their reasons for an abortion, and denying the clause of contraceptive failure to single women, demonstrate the not so hidden moral agenda of law makers. At a more general level, this makes a mockery of women's right to abortion, and in an extended understanding, women's rights over their bodies.

**Geetanjali Gangoli,** *Flat no. 1, Neelam, 14th B road, Khar (W), Mumbai 400 052.*

**References:**

1. Kabra SG: Abortion in India: not a right but a state-sponsored programme. *Issues in Medical Ethics* 2000 VIII (3): 70.

2. Medical Termination of Pregnancy Act, 1971. Department of Women and Child Welfare, Ministry of Human Resource Development, Government of India. 1971.

## Save public health care

The Maharashtra government is making moves to sell a newly-constructed wing of the state-run G.T. hospital in Mumbai to a private party to set up yet another private super-speciality hospital. At the same time, user charges have been introduced at all levels in municipal corporation hospitals.

These moves are part of a larger trend. Under the instructions of the International Monetary Fund and World Bank, the government has been steadily withdrawing even its minimal commitments to the poor. Even as liberalisation increases our already high unemployment levels, forcing more people into subsistence labour, ration subsidies have been reduced sharply, cooking fuel costs have shot up, and so on. Such policies have contributed to malnutrition, dangerous working conditions and the absence of clean water and sanitation — all of which make the poor even more vulnerable to disease, even as the withdrawal of public health services puts treatment further out of their reach.

Mumbai has 80 municipal and state government hospitals and nursing homes, with 20,700 beds. 235 dispensaries and clinics, and 176 health posts. The municipality and state government spend Rs 540 crore on these facilities, which provide essential care to the city's poor. These include five teaching hospitals which have trained thousands of doctors while providing essential tertiary care to the poor.

Municipal hospitals have not been "free" for many years. Poor people have had to pay for disposables, tests, and even out-of-stock drugs. Those who cannot pay are deprived of life-saving treatment.

The new user charges are levied at every stage, from case papers to diagnostic tests. People must pay Rs 10 for a new OPD case paper, and another Rs 10 for repeat visits after more than 14 days. Tests such as the stress test, and life-saving super-speciality operations, earlier done free, are now charged an astronomical Rs 500 and Rs 5,000 respectively. Existing user charges for most tests, ICU bed charges and various treatments have been

hiked by between 67 and 233 per cent, and are expected to rise further.

The government's moves are direct attacks on the right to health as a fundamental human right.

Over the years, the government's already-low commitment to public health services — only five per cent of total government expenditure in 1960 (compared to the WHO-recommended five per cent of GDP) — has declined to just 2.5 per cent today. An increasing proportion of this goes for family planning.

From the 1980s onwards, investment in health facilities has stagnated. At the same time, both OPD and in-patient use of public facilities dropped sharply, as a ratio of overall services and in absolute numbers. Dispensaries are not supplied medicines, diagnostic materials and maintenance costs, increasing pressure on tertiary care hospitals to provide primary health care. The focus of public health services has also changed from integrated, comprehensive health care to selective, target-oriented programmes.

At the same time, the private sector has grown rapidly, and without regulation. Its services are more accessible but of variable quality, and come at a price. It has come to provide the bulk of out-patient care in the cities, with over four-fifth of health care costs being borne by individual households.

Public health facilities have declined sharply in their efficiency, efficacy and availability. **Yet the public sector still provides about two-thirds of in-patient care in the city.** This includes the state government's GT hospital. **Public health services are used by the poorest of the poor. It is these poor who are worst hit by user charges and current moves to privatise existing public health institutions.**

Despite the crucial role the public sector plays in health care provision, the government has increased its efforts to weaken it:

- Inadequate budgetary allocation means medicines are not available in public dispensaries and hospitals — shifting the burden to patients.
- Patients in public institutions are forced to get tests done outside the hospital, further adding to their financial burden.
- Existing user charges for various services in public hospitals are now being hiked to virtually market levels.
- Many non-medical services in hospitals have been privatised or outsourced.
- Public institutions are being handed over to the private sector.

### What does it mean to the people?

People use government services because they have no other option. User charges are known to keep people from seeking life-saving care. People already overburdened with other expenses are forced to ignore critical health problems. When they eventually seek care, they must borrow money to pay for treatment, whether in public or private facilities. Health is the second largest cause of indebtedness in India.

We demand that the state government and the Brihan-Mumbai Municipal Corporation:

- Remove all user charges for services in dispensaries and hospitals.
- Raise medicine and maintenance budgets for existing dispensaries, and honour its commitment for one dispensary per 50,000 population.
- Rationalise hospital services through referral systems and strengthen dispensary-hospital linkages.
- Increase budgetary allocations for non-salary components like medicines, equipment, maintenance and medical records to improve efficiency, efficacy and patient satisfaction.
- Regulate the private sector and organise it under a public-private mix so that it becomes part of the public domain.

Foundation for Research into Community Health, Association for Consumer Action in Safety and Health, Indian Centre for Human Right and Law, Centre for Enquiry into Health and Allied Themes, medico friend circle, IWID, Committee for Protection of Democratic Rights, Janwadi Mahila Sanghatan, Bluestar Union and Trade Union Solidarity Committee, Municipal Mazdoor Union, Indian School of Social Sciences, Bombay Municipal Nursing and Paramedical Union, Forum for Medical Ethics Society, Lokshahi Hak Sanghatana, Centre of Indian Trade Unions, Forum for Women's Health, Vacha, Prayas

## Forcible discharge of TB patients

On August 31, 2000, the Union Health Minister announced a "fervent resolve" to reach health care to every family in the country (1). The same day, a group of Indore residents submitted a memorandum to the minister against the forcible eviction of 70 out of 75 patients in a well-attended TB sanatorium in Indore, to make the land available for an Indian Institute of Management.

The next day, the finance minister left for the US for, among other things, a "routine kidney ailment" (2). The TB patients have been less lucky following their "non-routine" discharge. At least one of them is untraceable, and one - a sputum positive, multi-drug resistant case - was last seen living (or dying) on a railway station platform.

The move to close down the sanatorium — and the agitation against this — goes back to 1998 (3). At the time, the state government gave an undertaking not to transfer the land to the IIM "without first fully establishing (the TB sanatorium) in its new premises, which will be equal to or better than the present ones". Despite this undertaking, in November 1998, the government directed sanatorium authorities to discharge all patients and vacate the land and building — without setting up any alternative facility. Its efforts were thwarted by residents of the adjoining village who later also had the support of a court order maintaining the status quo.

This year, as pressure for expediting the IIM built up, sanatorium admissions were stopped despite the stay. On August 11, ambulances arrived to remove the female patients, but they refused to leave and complained at the local police station. Still, from August 12 to 17, 51 patients were discharged - simply by declaring they were OK or writing "discharged on request" in English on their discharge slips (in a sanatorium where most patients cannot

read English) — and escorted off the premises. Even as villagers obtained another court stay and prominent citizens submitted a memorandum to the collector, police arrived at the sanatorium to "facilitate" further discharges out of the 24 remaining patients. On August 18, only 5 patients remained.

The villagers sought action against this contempt of court, and on September 8, the court ordered re-admissions. However, sanatorium authorities plead their "inability" to admit patients since they had not received official instructions following the latest court order.

On September 14 - nearly a week after the court directed re-admissions and in the midst of extensive media coverage on Vajpayee's knee and Kumaramangalam's diagnosis - 45-year-old Bhagwandas, one of the patients discharged in August, died just inside the sanatorium. He had been camping outside the gates for three days, but had been refused admission by the sanatorium management. He had been moved "just inside" the previous evening, because he was gasping for breath and crying for help. At dawn, Bhagwandas died.

The sanatorium is still in the local news. One section of the medical community is saying that TB sanatoriums are irrelevant. The administration, which is mandated to take care of public health and public health institutions, says the sanatorium is just an old building. The IIM is threatening to leave Indore if it is not quickly given its land free of "encumbrances". It promises plans for rural development and primary education but not unglamorous health care for TB patients. (4)

While much of the national media has maintained a studied silence on the matter, a leading national daily stated: "IIM Indore being killed by TB sanatorium." (5)

What, then, shall we say killed Bhagwandas? TB compounded by contempt of court and all round callousness?

*Readers are asked to register their support through letters or emails containing their name, address and occupation, at the address given below, or to purplepapaya36@hotmail.com.*

**Gita Dewan Verma**, 1356 DI Vasant Kunj, New Delhi - 110070.

**References:**

1. Menon Sreelatha: Thakur promises health care facilities to all. *Indian Express* August 2, 2000.

2. ENS Economic Bureau: FM goes to US for medical treatment. *Indian Express* August 2, 2000

3. Writ Petition no. 483/98 (filed in March 1998). Writ petition 1816/98 (November 1998), Writ petition 1040/2000 (May 2000).

4. Singh Sudhir K: IIM Indore may close shop on land issue. *The Times of India* August 14, 2000

5. The Times of India News Service: IIM Indore is being killed, says director. *The Times of India* August 17, 2000

## Correction

Regarding my case study (1), it is heartening to know there are fora that do not shy away from voicing genuine and relevant issues.

In my original article I had stated that the pregnancy that was the subject matter for the article ended in a miscarriage. A subsequent pregnancy ended with the birth of my daughter. The case study implies the pregnancy that raised the issues of the attitude problem of practioners ended happily. This was not so.

**Trivikrama Kumari Jamwal,**
Sunbeam, 129 A/D Gandhinagar, Jammu 180 004

**Reference:**

1. Jamwal, Trivikrama Kumari: Case study: a professional deficiency. *Issues in Medical Ethics* 2000; VIII (3): 91.

## Correction

The Q in *QPMPA* stands not for Quilon but for Qualified. The Qualified Private Medical Practitioners Association now has a website, www.qpmpa.com

## Not an ethical issue

In reference to Geetanjali Gangoli's report on the National Health Services (1), we should be least concerned about the problems of the NHS other than noting that such a system, like all socialistic systems, cannot survive in a demanding capitalistic environment. To expect the government to provide quality services encompassing the entire gamut of modern medicine at a disproportionate cost compared to the private sector, is absurd.

Concerning the proposal to send patients to India, we need to look at its ethical, legal and economic aspects.

Ethically, I doubt if such a transfer of patients violates any ethical principle. Legal issues may be complex and need careful evaluation. If a malpractice suit is filed while the patient has an adverse reaction during the flight, or in the parent country long after the procedure, it may be difficult to determine errors in practice, and even more to settle claims. Standards of care may vary from country to country and may need more precise definition.

As for the economic aspects, I doubt if patients arriving in India from the UK can exploit our private medical enterprise. It has never happened with patients coming from the Gulf. In fact, the reverse may be true. From past experience, patients coming from the Gulf were exploited systematically starting with taxi drivers at the airport to touts and ward boys at major hospitals. Hospital administrators, doctors, nurses and laboratory services had a hey day with each taking a slice of the Gulf pie.

I have no reason to believe that we have changed in the past decade. The state may have to enact laws to protect foreign patients against exploitation. As far as foreign patients reducing Indian patients' access to care, these numbers would be so small that the private sector easily accommodates them. They are unlikely to make a dent in our vast medical service.

**Jagdish Chinappa**, Manipal Hospital, Airport Road, Bangalore, 560 017.

**Reference:**

Gangoli G: National health services: imminent collapse. *Issues in Medical Ethics* 2000; VIII (3): 97.