

BOOK REVIEW

## Essays by and for Amit Sengupta — A valuable commemorative volume

ANANT PHADKE

**Prabir Purkayastha, Indranil, Richa Chintan, Editors. *Political Journeys in Health, Essays by and for Amit Sengupta*. LeftWord Books, New Delhi, 2021, pages 324, Rs. 495. ISBN 978-81-947287-8-8**

This is a valuable commemorative collection of essays by the late Dr Amit Sengupta on healthcare policy issues, and by some of his colleagues in the People's Health Movement (PHM) on Amit's contribution to the PHM. A trained medical doctor, Amit was a leading political activist of the Indian and global People's Health Movement (PHM). He passed away suddenly in November 2018, at 60, leaving a huge void in the Global PHM and the Jan Swasthya Abhiyan, a broad coalition of the People's Health Movement in India, of which he was the National Convenor.

The book has four sections. The first one, "Medicines for All", consists of five articles, of which four are by Amit, where he argues that the restrictive patent regime is a ruse to "plunder" people and briefly recounts the struggle in India in 2004 to introduce a provision (section 3-d) in the modified Indian Patent Act, 1970 (IPA-1970) to offer some protection to the Indian generic pharma industry. IPA-1970 was instrumental in breaking the stranglehold of Western multinational corporations (MNCs) over the Indian generic pharma industry resulting in the emergence of India as the "pharmacy of the world". However, under the pressure of these MNCs (through their governments), there was the infamous retreat in 2005 by the Indian government, which modified the IPA-1970 to revert to the product patent regime. In his obituary piece on Mr B K Keayla, Amit shares with us how, when the stifling product patent regime was brought back in 2005, Keayla — a committed knowledgeable individual from a big pharma company — was instrumental in launching the very tough battle to partially salvage the interests of the generic pharma

manufacturers in India. This first-person account is the most interesting and valuable part of this section.

My only problem regarding this section is the title, "Medicines for All". Overcoming the product patent regime is only one of the crucial policy measures to achieve "Medicines for all". More than 90% of medicines in the Indian market are out of the patent period, i.e. they are generic, and still beyond the reach of the common people. For ordinary people to access both generic and patented medicines, four additional key policy measures are required: i) banning all irrational Fixed Dose Combinations (FDCs) — constituting 40% of the Indian market — as the majority of these are irrational when rational FDCs constitute only 7% of the World Health Organization's (WHO) Essential Medicine list; ii) instituting a cost-based price control regime, which began partially in 1979, but was later dismantled under big pharma pressure; iii) banning all brand names and instituting mandatory Standard Treatment Guidelines to curb irrational, excessive use of medicines; iv) a substantial hike in the budget for purchase and distribution of essential medicines for public health facilities and generalisation of the transparent and efficient Tamil Nadu model. Though the Indian pharma companies have benefited hugely from the Indian Patent Act, 1970, in the absence of these policy measures by the government, the majority of Indians are still deprived of essential medicines. Given this background, a title which reflected the section's main focus (the partially successful, inspiring struggle in favour of the Indian pharma companies against the product patent regime) would have been more appropriate.

The second section consists of seven articles by Amit on regulatory issues related to biosimilar medicines. Amit explains that biosimilar medicines are complex molecules produced through biological processes whereas all other medicines we use are produced through chemical processes. Some antibiotics like penicillin and traditional vaccines are examples of traditional biosimilars. But thanks to genetic engineering, a new generation of biosimilars has been produced on an increasing scale. However, their availability for ordinary people, especially in developing countries, is extremely limited, an important reason for which is the questionable regulatory norms for giving permission to non-innovator manufacturers. This regulatory issue is at the cutting edge of technology and politics of pharma regulation. Dr Rath explains how Amit marshalled his political and technical acumen to suggest modifications in the regulatory process. This section is somewhat difficult for the general reader.

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The third section titled “Health for All” consists, with one exception, of articles by Amit, on a substantive critique of the dominant neoliberal paradigm which has been adversely affecting health. He argues that the Structural Adjustment Programme (SAP) imposed at the behest of the World Bank and the International Monetary Fund (IMF) led to socio-economic changes which undermined public health. He illustrates this with an example from India which shows that there has been a resurgence of communicable diseases as well as diseases fuelled by environmental degradation, consumerist culture and unhealthy lifestyles brought about by imperialist globalisation. He argues for reclaiming public health by reversing the all-round privatisation imposed in the health sector. He then turns to privatisation of global governance which has come about through the imposition of Global Public Private Initiatives (GPPIs) and calls for a reclaiming of the role of the WHO to serve public health at the global level. At the end of this third section, Amit launches a frontal attack on the strategy of “Universal Health Coverage” (UHC) not to be confused with Universal Health Care. He points out that “the conceptual underpinning of UHC lay in ‘sustainable health financing’ and hence, its focus is not on providing adequate care for the entire population but on the financial mechanism to develop an ‘appropriate’, sustainable healthcare market. Amit does an excellent job of unravelling the differences in Universal Health Coverage and Universal Health Care and the far-reaching, practical implications for strategies that follow from these differences. It’s a nuanced argument that needs to be fully grasped by all readers and activists. It may be noted that he does not debunk the historical struggle for Universal Health Coverage in Europe. He points out that, starting from Germany and the UK, it reflected the outcome of decades of struggle between the ruling and the labouring classes in those countries. Though the Universal Health Coverage model was progressive then, it had its contradictions and the ruling class was able to push the privatisation agenda from the 1980s onwards, by using the contradictory nature of the Universal Health Coverage model. The last article in this section continues the critique of the Universal Health Coverage approach. It juxtaposes the fundamental propositions of the Alma Ata Declaration with the regressive developments resulting from the neoliberal regime from the 1980s onwards.

I am one of those who are critical of the retreat by different governments from the Alma Ata Declaration to adoption of the “Universal Health Coverage” approach. We emphasise public provisioning, which should progressively push back private provisioning. However, there are two caveats. First, the “provider–purchaser split” which Amit was staunchly opposed to, must be seen as a historical process. Historically, private practitioners were the almost exclusive providers of highly individualised medicine and they were paid by individual patients. With the development of modern medicine, all aspects of medical care—knowledge generation, production of medicines and diagnostics—have been progressively socialised. However, the social organisation of medical care

continues to be centred on private enterprise. In different countries, this obsolete social mechanism of private medical enterprise is being either undermined or promoted by different governments, depending on the degree of pressure from the labouring population and whether there is a progressive or reactionary government in power. Thus, the policy question is not whether to accept or reject the “provider-purchaser split”; but whether or not to progressively overcome this existing split. Second, in India, whatever public provisioning has been developed does not serve the public interest entirely. The Indian public health system is nominally, juridically, a public system, supposedly free of private interests; but in reality partly due to the colonial legacy, it has been partially “privatised” by bureaucrats and politicians with no accountability. Many of their decisions have served the private interests of the elites. A bureaucratic approach and disdain for the common people, servility to their political masters, incompetence of some public health officials and corruption insulated by lack of accountability to the common people — all these negative attributes have partially eroded the “public” character of the Indian public health system. Informed by the bogus, imperialist bogey of “population explosion”, the public health services have been prioritising “family planning services” (read population control) over all other health interventions in a manner that has often violated basic human rights, human dignity and safety considerations, especially those of women. The public health services continue to launch vertical health programmes (sometimes patently unscientific programmes like leprosy eradication) [1], polio eradication through vaccination alone [2] or universal vaccination with hepatitis B vaccine [3], or universal pneumococcal or rotavirus vaccination — providing huge business for some pharma companies without any rigorous cost-benefit analysis from a public health perspective. The track record of public health centres regarding human dignity and the human rights of patients or standard treatment guidelines is generally abysmal, indicating that personal or bureaucratic interests take precedence over the interests of patients, the public, and of the science of medicine and public health. Given this situation, we have to reclaim public health services from private interests — those of corrupt politicians, insensitive, pliant, incompetent public health officials and self-serving bureaucrats.

The articles in the last section convey the deep appreciation of Amit’s great contribution to the public health movement, by some of his Indian and global colleagues in PHM. These first-person accounts tell us that Amit was an all-rounder, a deft organiser, writer-advocate, alliance builder and a comrade-friend who was dear to so many colleagues in the movement, at all levels. They also reveal some of the important milestones and issues in this movement. For me, the piece by S P Shuklaji, a senior retired, progressive government officer, is the best. It is rare to read an authentic, first-person account of the complex processes of international policy level negotiations. Shuklaji tells us how

the Brazilian and Indian delegations, of which he was a part, led the fight of a group of developing countries in the General Agreement on Tariffs and Trade (GATT) negotiations to oppose the developed countries' attempts to impose a restrictive Intellectual Property Regime across the globe; and how changes at the highest political level in India in 1988 resulted in India's surrender. He also tells us how, in 2005, a group of intellectuals and activists including Keayla, Amit, himself and others, decided to try to salvage something out of the wreckage of the Indian Patent Act modified as per the World Trade Organization (WTO) terms. They drafted an amendment to the modified IPA which would partially protect the Indian generic manufacturing sector. These amendments were passed in parliament thanks to the political pressure the Left MPs were able to leverage. Shuklaji has noted his great appreciation of Amit's hard work, his skilled drafting, optimism, fighting spirit and ability to "relate technical and scientific issues to larger political questions": Such a compliment, coming from a respected senior, sums up the

dynamic force that Amit was!

To be sure, this volume is a very good collection which gives a valuable overview of some key health policy issues, including pharma patent policy and regulatory issues in India over the last 40 years. Since it is interwoven with some first-person accounts about Amit's role in the People's Health Movement and in the valiant intellectual-political struggle to save the Indian generic industry, it makes for fascinating reading.

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## BOOK REVIEW

### Healthcare workers and patients as targets and casualties in warfare

ADRIAAN VAN ES

**Leonard Rubenstein, *Perilous medicine: The struggle to protect healthcare from the violence of war*. New York: Columbia University Press, 2021, pages 416, \$35 (Hardcover), ISBN 9780231192460 (Hardcover)**

In December 2016, I witnessed the departure of the People's Convoy from the Chelsea and Westminster Hospital in London. The CanDo campaign, organised by Syrian refugee doctors in the UK, departed with a truck full of hospital equipment and supplies for a 2600-mile journey — travelling through and campaigning in France, Belgium, Holland, Germany, Austria, Hungary, Romania and Bulgaria — to the Turkish border near Aleppo. The campaign, supported by crowdfunding, managed to construct and open the Hope

Hospital in Aleppo, and was the response of Syrian doctors to the brutal targeted bombing and destruction of the children's hospital in Aleppo. The resilient and determined doctors simply did not accept the destruction of the hospital.

This initiative of hope and determination drew attention to the dreadful reality of massive and repeated attacks on hospitals and clinics in Syria, and the systematic violation of the Geneva conventions and human rights standards. A sign of hope that took shape against the background reality of continuing destructive and mortal attacks on health facilities worldwide, a reality that is described in Leonard Rubenstein's book *Perilous Medicine: the struggle to protect health care from the violence of war*. Rubenstein is a lawyer with a lifelong commitment to health and human rights. He is a former director of Physicians for Human Rights and is currently a professor at Johns Hopkins Bloomberg School of Public Health in Baltimore. In 2011, he was a founder (and is still Chair) of the Safeguarding Health in Conflict Coalition, an advocacy group that was successful in mobilising the World Health Organization (WHO) to put the issue of violence against healthcare on its agenda.

As the main theme in his book, he describes the principles designed and meant to safeguard medical practice in wartime, and the ongoing failure to respect them. Violent targeting of health workers has become a familiar fact of modern warfare, as the book documents in great detail, and

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