Panel Discussion on
DOCTORS AND THE CONSUMER PROTECTION ACT

11th Feb 1996

Organised by :

Rotary club of Vijayanagar &
Consumer Rights, Education & Awareness Trust
(CREAT)
Vijayanagar, Bangalore - 5600 40.

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ROTARY CLUB OF VIJAYANAGAR

&

CONSUMER RIGHTS, EDUCATION AND AWARENESS TRUST (CREAT)

VIJAYANAGAR, BANGALORE - 560 040

PANEL DISCUSSION ON
DOCTORS AND CONSUMER PROTECTION ACT

NIPM Hall, Blue Cross Chambers, Bangalore

11th February 1996

P R O G R A M M E

09.30 a.m.	Invocation and Rotary Deliberations
09.45	Welcome and Programme objectives Mr.Y.G.Muralidharan, CREAT
10.00	Presentation of legal aspects Prof. M.K.Ramesh National Law School of India University
10.25	Presentation of Doctors' views Dr.Nanjundiah PRO, Indian Medical Association, Karnataka State Branch
10.50	Presentation of Consumers' views Dr. H.S.Shivanna, Mysore
11.15	COFFEE BREAK
11.30	Panel Discussion and interaction Moderator: Ms. Madhura M. Chatrapathy
12.30 p.m.	Recommendations
12.45	Vote of thanks
01.00	Lunch

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Organised by
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Sunday, 11th February 1996

A NOTE ON THE SUPREME COURT JUDGEMENT ON MEDICAL SERVICES UNDER THE CONSUMER PROTECTION ACT 1986

ON 13th November, 1995, the Supreme Court of India pronounced the landmark judgement on the Civil Appeal No.688 of 1993 filed by the Indian Medical Association. This judgement settled more than 35 Appeals and Special Leave Petitions which were pending before the apex court against divergent verdicts of High Courts and the National Consumer Disputes Redressal Commission. The disputes between the medical pofessionals and consumer activists had been raging for a couple of years with regard to the applicability of Consumer Protection Act to medical services. The SC had to say the last word in the issue.

The 65 page ruling given by a three judge bench comprising of Justices Kuldip Singh, S.C.Aggarwal and B.L.Hansaria may have some far reaching consequences on the medical services in the country and it may dedefine the future doctor-patient relationships.

The basic questions the Hon'ble judges decided upon were:

A. Whether the services rendered by a medical practitioner can be considered as 'Service' within the meaning of Section 2(10(o) of the CPA, 1986, which says 'Service' means service of any description which is made available to potential users for a 'consideration' which has been paid or promised or partly paid and partly promised, but does not include the rendering of any service free of charge or under a contract of personal service.

B. Whether the service rendered at a hospital/nursing home can also be covered under this definition.

C. Whether the people who avail of these services are 'Consumers' within the meaning of Section 2(1)(d) of the CPA which says 'consumers' means any person who buys any goods or avials of any services for a consideration which has been paid or promised or partly paid partly promised.

D. Whether the provisions of CPA are violative of Article 14 and 19 (ℓ) (g) of the Constitution, as far as the medical profession is concerned.

E. Whether the composition of the Consumer Fora with only one person as its president and other members being non-legal experts, as well as the procedure of 'summary trials' followed in these courts, ensure competency and justice in disputes relating to deficiency in medical services.

After evaluating all the arguments and earlier judgements of various High Courts and the National Consumer Disputes Redressal Commission, the Supreme Court bench has arrived at the following conclusions.

1. Service rendered to a patient by a medical practitioner by way of consultation, diagnosis and treatment, both medicinal and surgical is covered under the meaning of 'service' as defined in the CPA.

2. The fact that medical practitioners are subject to the controls of Medical Councils or any other bodies would not exclude them from the ambit of the CPA.

3. A contract OF personal service is different from a contract FOR personal service. Doctor's service to the patient is only a contract FOR service. There can be a contract OF personal service if there is a relationship of master and servant between a doctor and the person availing his services. In that case the service rendered by a medical officer to his employer will be outside the ambit of CPA.

4. The CPA will apply to cases where payment of charges is made by the Insurance Company on behalf of the insured patient to the doctor/hospital. Likewise if an employer pays for his employee's or his/her dependents medical treatment, this service also will be covered by the Law.

Doctors and hospitals (Government hospitals, nursing homes and private hospitals/nursing homes) have been classified into three categories:

a. <u>Where services are rendered FREE of charge to everybody</u>

This category is fully outside the ambit of CPA. The payment of a token amount of registration is not considered as a payment for the service. Even when the medical officer receives emoluments by way of salary for employment in the hospital, it will not be considered charged paid for the services which are free. This payment is paid by the hospital administation not on behalf of the patients and therefore the patients are not 'consumers'

Government health system is run by funds from Taxes collected from the public. But taxes paid are not considered payment made by consumers for the service.

b. Where charges are PAID for the services by everybody

This category clearly falls within the ambit of CPA because the services are 'hired' for a 'consideration' i:e payment. Consumer Fora will entertain complaints relating to deficiency in such services - cases of medical negligence - and decide upon them.

Deficiency is defined as any fault, imperfections, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained under the law by the person performing the service.

Deficiency will be established by assessing whether the provider of service has exercised the ordinary skill of an ordinary competent person doing a particular art. A medical practitioner who undertakes treatment of a patient implies that he posses enough skill and knowledge for the purpose. If there is clear negligence in applying a reasonable degree of skill and knowledge and care, the patient has a right of action against the doctor. The law requires neither the highest nor a very low degree of care and competence in the light of the particular circumstances of each case.

Profession and occupation

The Court drew a distinction between an occupation and a profession. Occupation renders service connected basically with production or sale of commodities which is very much within the scope of CPA. A profession means more of intellectual skills combined with manual skills and specialisation. Professionalism presupposes extreme commitment to moral principles, professional training and conduct besides high status in the community.

Professional liabilities also differ from other occupations as success in every case is not certain and success or failure may depend on factors beyond the professional person's control.

The Court held that the professional person should possess a certain minimum degree of competence and they should exercise reasonable care in the discharge of their duties. Thus the consumer can expect from a professional a duty in tort and a contract to exercise reasonable care in giving advice or performing services. Medical practitioners do not enjoy any immunity and they can be sued in contract or tort on the ground they have failed to exercise reasonable skill and care.

Remedies available to health consumers:

i. Return of the charges paid by the complainant
ii. Compensation for any loss or injury suffered due to negligence of the opposite party
iii. Removal of defects or deficiencies in the services

c. Where the bulk of the services ARE PAID for by those who can afford to pay but are FREE for those who cannot pay

This category where the expenses incurred for providing free service are met out of the income from the service rendered to the paying patients, will also be fully covered by the Law. This service is considered as being run on commercial lines. The SC intends to ensure uniform standard and quality of service to all patients irrespective of their paying capacity. This is very much in tune with the spirit of the CPA which is to 'encourage high levels of ethical conduct for those engaged in the production and distribution of goods and services to the consumers'. It means protection of consumers as a class.

It cannot be held that protection would be available to only those who can afford to pay and such protection would be denied to those who are poor, though they are the ones who need the protection most.

The judges observed that " the Government hospitals may not be commercial in that sense but on the overall consideration of the objectives and scheme of the Act, it would not be possible to treat the Government hospitals differently. In such situations, the persons belonging to 'poor class' who are provided seravices free of charge are the beneficiaries of the service which is hired or availed of by the "paying class"

Individual doctors employed and working in Government/non Government hospitals/nursing homes/dispensaries belonging to categories b and c would be covered by the Act along with the management of the hospital.

By holding that medical practitioners fall within the purview of the Act no change is brought about in the substantive law and principles governing claims for compensation on the ground of negligence before the Civil Court.

The judges observed that the legal system has to do justice to both patients and doctors. The fears of the medical profession should be taken into account while the legitaimate claims of the patient cannot be ignored. It would be a mistake to think of doctors and hospitals as easy targets for the dissatisfied patient. It is still very difficult to raise an action of medical negligence. A patient who has been injured by an act of medical negligence deserves compensation for loss of future earning and cost of medical treatment etc. After all there is no difference in legal theory between a person injured through medical negligence and industrial or motor accident.

As for the competence of consumer courts to decide upon medical cases the judges observed that, though the decisions at the consumer courts are taken by majority, the presence of a person well versed in law as the President will have a bearing on the deliberations. The presence of members in the

jury with ability, integrity and standing having adequate knowledge or experience in dealing with problems related to various fields, is intended to help decide cases with a sense of natural justice, without going into extreme technical details. Having limited number in the jury, it is impossible to expect specialists in every field. It will be for the parties to place the necessary materials for the members to decide upon. The consumer Fora combines the merits of lay decision making with legal competence. Further the provisions for appeals to higher courts is an added safeguard. Consumer Fora have the same powers as of the Civil Courts like summoning the defendant or witness and examining them on oath, ask for any documents or materials as evidence, reception of evidence on affidavits, ask for laboratory analysis of products etc.

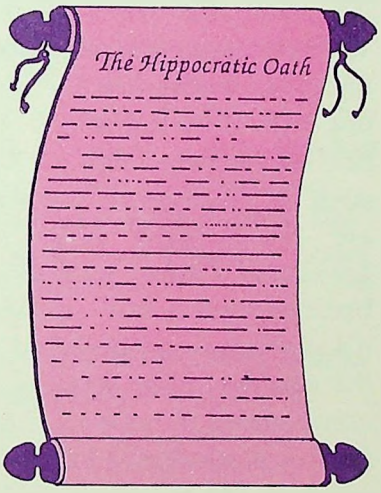
Evidence of experts may be required in deciding certain complicated medical cases. In such cases, the complainant can be asked to approach the Civil Court for appropriate relief. It may not be difficult to prove deficiency in medical services in many cases where the negligence could be easily established like removal of wrong limb, operating upon the wrong patient, giving wrong drug to the patient leading to allergic reactions, use of wrong gas for anaesthesia, leaving swabs or other operating equipments inside the patient in operation etc. Therefore, these are no reasons for exclusion of medical service from CPA.

Adapted from a paper published by Voluntary Health Association of India, New Delhi.

UPDATE
SEPTEMBER, 1993

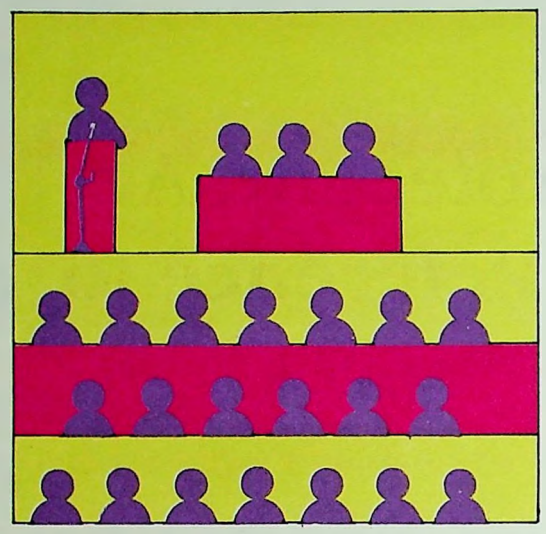
Consumer Protection Act With Special Reference to Health Services

The great Hippocrates father of modern allopathic system of medicine, enjoined upon all those in this nobel profession through an oath of first do no harm. Tragically, many in the medical profession had thrown all this to the winds. Shielded by compliant regulatory authorities and an indifferent judicial system, the health services were almost immune to charges of malpractice. Even when the problem grew to serious proportions, they failed to resort to corrective surgery.



With Consumer Protection Act (COPRA) of 1986 coming into existence, the aggrieved patients were beginning to wield the scalpel. However, due to inherent weaknesses in the Act in terms of non-inclusion of some aspects, coupled with organizational and implementational problems, diminished its efficacy. To make the seven year old statute more effective the government issued the Consumer Protection (Amendment) Ordinance which came into effect on June 18, 1993 and was passed by the Parliament on August 21, 1993. If the original act of 1986 was a landmark in consumer movement, the proposed amendment provides more teeth to the existing Act.

Extent and Coverage of Consumer Protection (Amendment) Ordinance 1993



With private doctors and hospitals now under the purview of Consumer Protection Act. More and more doctors shall find themselves in the dock over issues such as negligence, wrong diagnosis etc. But a major lacuna remains as government doctors and hospitals have been exempted. The ordinance explains if a service is provided free of cost as in the case of public services, it does not come under purview of the act. In fact there is amendment in the definition of services. The definition covers 'housing construction' in addition to services covered earlier such as banking, financing, insurance, transport, processing, supply of electricity and entertainment.

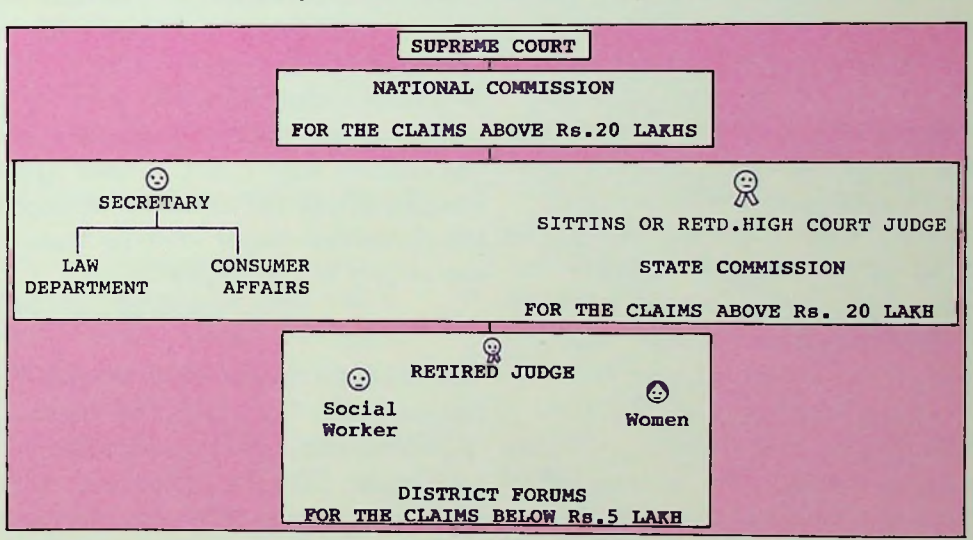
Amendments to the Act include those to its contents and its implementation. One significant change is that the loopholes of not providing for class action have been removed. Under the amended Act a group of consumers or an organisation can file a case on behalf of a class of consumers having the same interest.

There is relief for self employed persons. "A person who purchases goods for commercial purposes" was not covered by the Act and this has caused difficulties to those who buy goods for their livelihood such as a widow who buys a sewing machine. The amendment covers all such excluding, however, purchases for commercial purpose by large business houses, as in the original Act. Restrictive Trade Practices have been included as a defect, and the definition of unfair trade practice has been widened to include misleading advertisements, representation that purport to be warranties or guarantees, tall claims and price-fudging.

Another important actionable right given to consumers is with regard to information regarding hazardous goods. Legal rules require that sale of such goods should be carried out along with a display of requisite information on the contents, manner and effect of use of such goods. The consumer can now have the sale of such goods stopped in case relevant information provided by or under any law is not so provided.

A new provision, perhaps in response to the grievances of producers who become victims of false complaints, has been added. If a complaint is dismissed on the grounds of its being untrue, the complainant can be directed to pay costs up to Rs. 10,000. This will avoid misuse of the redressal forums.

The requirement of Central approval for District Forums have been done away with. State Governments can set up more than one forum in one district. There has been significant change in the procedure of selection of members to the District Forums, the State Commissions and the National Commission. They no longer have to be nominated by the state and central governments. In case of the District Forums, every appointment shall be made by the State Government on the recommendation of a committee, chaired by the State Commission President and whose other two members will be the Secretary to the law department and the Secretary to the department dealing with consumer affairs. This committee will also recommend person for the State Commission.



While the State Commission president will be appointed after consultation with the High Court Chief Justice, the President of the National Commission will be appointed after consultation with the Chief Justice of India. The tenure of these commissions will be five years. The amendment gives the National Commission administrative control over all state bodies.

However, the role of advisory body - the Central Consumer Protection Council, has been diluted. Instead of three meetings a year, it will have 'not less than one a year'.

The amendment stipulates that the National Commission, the State Commission and the district shall not admit a complaint filed beyond a year of the course of action. Many consumer activist feel that the amendment on the limitation of time to file a case is unwarranted and unduly restrictive. It would

also reduce the possibility of the compromise or a settlement. The complainant would now have to hurry to file his case before the expiry of the one year period.

A problem which remains un-rectified is - no provision for a second appeal. An appeal can be made to the State Commission, if the District Forum dismisses a case. But if the State Commission, also dismisses the case, the National Commission can not be approached for a second appeal.

A welcome feature among the procedural amendments is that the District Forums can now take up cases up to Rs.5 lakh and the State Commission upto Rs.20 lakh against Rs.1 lakh and Rs.10 lakh respectively earlier. Many consumers would benefit as they would not have to run to the State Commission or to Delhi.

The amendments in the Consumer Protection Act are definitely a step in the right direction. Hopefully, by giving additional powers to the redressal agiencies, it will go a long way in safeguarding the interests of consumers in today's vastly altered buisness environment.

Doctors Have a Social Responsibility

* A doctor comes out of the medical college spending about four lakhs of rupees from the government funds. He may spend some 40,000 rupees from his parent's purse. He is 10 times more answerable to the society. The reverse is happening now.
* The diseased people teach this doctor medicine by offering their diseased bodies in the wards/clinics/corridors.
* The unclaimed "dead" travel to anatomy theatre and teach the medicos anatomy by offering themselves after death.
* But the doctors are allowed to go for private practice and charge the people as they like neither paying back the people nor the government.
* Doctors go out of our country forgetting what this country has given to them.
* Skills are fast deteriorating; good medical teachers are disappearing.
* Between the doctor and the patient, in the place of mutual trust, money has come in a big way.

Patients Have Rights

Hence, a patient has the right to enquire several times if need be what is being done to him/her by the doctor. Doctor has the responsibility to answer and inform the patient, as accurately and completely as possible, Because

* Patient pays for consultation (it is his money)
* Patient purchases drugs (again it is his money), and
* Procedure is carried out on patient's body. If anything happens, it happens to him/her.

(Health Action, June 1993)

Physicians prescribe medicine of which they know little, to cure diseases of which they know less, of human beings of whom they know nothing.

Voltaire

At Last.....

Justice Has Prevailed For Patients

In 1989, the Consumer Protection Act (CPA) 1986, set up an apparatus which for the first time in India promised consumers speedy redressal of their grievances. As a result, consumers with complaints could approach consumer grievance redressal commission at the district, state and central level. The accused party is given five weeks to reply to the charges, failing which a hearing must be held on a daily basis, allowing for quick disposal of complaints. Though medical services are not mentioned by name in the Consumer Protection Act 1986, the commissions have handed down judgements on a number of complaints of medical negligence.

* Vasantha Nair Vs Cosmopolitan Hospital

Mr. G.P. Nair was admitted to Cosmopolitan Hospital which is a private hospital with a persistent backache. A senior consultant in orthopaedics diagnosed his ailment as tuberclosis and started treatment for it. He was later transferred to another physician for treatment of jaundice while undergoing the treatment at the hospital he died. His widow, Vasantha P Nair filed a complaint of negligence against Cosmopolitan Hospital (P) Ltd.

The Kerala State Commission awarded damages the complainants. However the cosmopolitan Hospital challeged this verdict and appealed before the National Commission. The National Commission upheld the Kerala Commission's judgement stating specifically that medical services fall under the purview of Consumer Protection Act.

* Mr. A.K Shah Vs Bombay Hospital Trust

Mr. A.K. Shah was admitted to the Bombay Hospital for the operation of his hip. After the operation, he did not regain consciousness till late in the evening. He had bled continuously after the operation till his death at 5.30 a.m. the next day. According to Mrs. Shah, the hospital did not give any treatment to stop the bleeding nor were the relatives of the patient warned in advance about the likelihood for any emergency need for blood. Relying on the code of Medical Ethics and other authorities, the Commission came to the consclusion that hospital trust was guilty of negligence and carelessness in causing the death of Mr. A.K. Shah.

The Commission directed the Bombay Hospital to pay the complainant Rs. 7 lakhs towards compensation.

(Indian Express 15 July 1992)

* Mr. B.S. Hegde Vs Dr. Sudhanshu Bhattacharya of Bombay Hospital

Dr. Bhattacharya, a leading cardiac surgeon at Bombay Hospital, charged Mr. B.S. Hegde Rs. 92,000 for cardiac by-pass surgery and post-operative care. Mr. Hegde developed complications after surgery and approached Dr. Bhattacharya for medical care. The doctor ignored patient's requests with the result that he had to undergo a second operation which was performed by another doctor.

The Maharashtra State Consumer Forum directed Dr. Bhattacharya to pay Rs. 2 lakh as compensation to the patient for not providing post operation care.

(Sunday Observer, 26 July 1992)

Mrs. Bimla Gupta Vs. Rana Nursing Home

*Mrs. Bimla Gupta, mother of a 13-year old girl got herself sterlized on August 25, 1978. Two years ago she desired to have another child. Rana Nursing Home in West Sagarpur gave her a "100 percent guarantee", and agreed to perform recanalization operation on a payment of Rs. 12,000 besides other charges. After the operation she was told that 100 percent confirmation could only be given after x-ray report which would be taken after three months. The x-ray report revealed that operation was not successful. Bimla filed a complaint in the consumer court.

She was granted a compensation of Rs. 25,000 and refund from the nursing home towards her medical expenses.

(The Pioneer, 12 March 1993)

*Mr. V. Chandrasekhar Vs. Appollo Hospital

Mr. V. Chandrasekhar, a former table tennis player went in for an operation at the Appollo Hospital for a simple cartilage tear in the right knee. Several complications developed during and after the surgery. He recovered consciousness fully nearly one month after the operation to find himself reduced to "virtually a cripple". His vision, his speech and other faculties were severely damaged. **The Madras High Court directed Appollo Hospital to pay Rs. 17 lakh as damages for the disabilities caused after he underwent the surgery at the hospital.**

(The Pioneer, 26 June 1993)

With increasing cases of doctors misusing the trust reposed in them by a patient, a new equation, which allows the patient to question a doctor's motives and actions and makes him accountable for treatment he provides, has become very necessary. The Consumer Protection Act, which has been especially enacted to provide quick relief to the consumer in any grievance, can help in establishing a more equal and satisfactory relationship. Let the doctors and the patients cooperate in using this act to restore the noble reputation, medical profession once had.

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on 03 Dec/95

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Synopsis on

CONSUMERS AND MEDICAL NEGLIGENCE

By:

Y.G.Muralidharan
C R E A T
Bangalore - 560 040

THE recent judgement of the Supreme Court bringing the medical services under the ambit of the Consumer Protection Act (CPA) has brought medical negligence into sharp focus.

Medical negligence is a response to the following types of questions:

1. What are the rights of patients vis a vis the doctors and hospitals..?
2. What if the doctor wrongly diagnoses a disease..?
3. What is the level of competence expected of a doctor.?
4. Does a doctor have to take the consent of the patient before an operation..?
5. If many doctors have handled a patient which of them is ultimately liable..?

What is negligence..?

A person is said to be negligent when he/she acts without due care in regard to the harmful consequences of his/her action. Negligence is defined as doing something that one is not supposed to do or failing to do something that one is supposed to do.

Medical negligence is absence of reasonable care and skill or wilful negligence of a patient so as to lead to his bodily injury or death. In the context of doctors, negligence has been defined thus:

" By the mere fact of undertaking the treatment of a patient, the doctor has placed himself in such a relationhip to that patient that a want of care and skill on his part will involve the risk of injury to the patient and a liability for negligence "

Medical Negligence is made up of four components.

a. Existence of a DUTY of care by the doctor
b. The failure on the part of the doctor to maintain care and skill
c. The failure to exercise a duty of care must lead to damage
d. The damage which results must be reasonably foreseable

A medical professional will be liable in following cases:

1. If there is no informed consent
2. If his negligence causes others to catch a disease from his patient
3. If he does not attend to the patient altogether or do not attend in time
4. If he fails to see the patient as frequently as required and where damages result from his absence
5. If he fails to give proper instructions
6. If he fails to examine the patient himself to find out the true facts, but relies on the diagnosis of another doctor and treats the patient
7. A wrong diagnosis
8. Premature discharge of the patient

Res Ipsa Loquitur (The thing speaks for itself)

Ordinarily, the professional negligence of a physicial must be established in court by the expert testimony of another physician. But this does not happen. No professional will speak against his colleague. However the consumer (patient) need not prove negligence in the following cases:

a. In the absence of negligence the injury would not have occurred ordinarily
b. That the doctor had exclusive control over the injury producing instrument or treatment
c. That the patient was not guilty of contributory negligence.

Medical negligence can be avoided if doctors take due precaution in discharge of their duties. Some of them are as follows:

1. Have good relationship with the patient
2. Obtain informed consent from the patient
3. Never guarantee a cure
4. Keep full, accurate and legible medical records
5. Employ ordinary skill and care at all times
6. Confirm diagnosis by laboratory tests
7. Seek consultation where necessary
8. Do not criticise another doctor
9. Check condition of equipments periodically
10. Do not experiement without the consent of the patient
11. Keep yourself abrest with medical advances
12. It is dangerous to telephone a prescription

13. Take care while appointing assistants and delegating duties to them
14. In case of death during operation infrom the police
15. Do not fail to secure the consent of both husband and the wife, if an operation is likely to result in sterility

Obligations of the consumers

Despite the fact that consumers do have a large number of rights as patients, including filing a case in the consumer fora, they should remember that they have certain obligations towards the doctors. Some of them are:

1. To give full, accurate medical history
2. Follow the instructions of the doctors in full
3. Should not refuse to take suggested treatment
4. Not to leave the hospital without doctors approval

Informed consent

One of the most rapidly growing medical malpractice litigation is in the areas of informed consent. Consent means voluntary agreement, compliance or permission. Consent may be express or implied. Express consent may be verbal or written.

Informed consent implies an understanding by the patient of the nature of his condition, proposed treatment, procedures, alternative course of action, risks involved and chances of success or failure.

Some legislations connected to medical professionals:

1. The Indian Medical Degrees Act, 1916
2. The Indian Medical Council Act, 1933
3. The Dentists Act, 1948
4. The Indian Medical Council Act, 1956
5. The Drugs and Cosmetics Act
6. The Drugs and Magical Remedies (Objectionable Advertisements) Act
7. The Homeopathy Act
8. The Indian Penal Code
9. The Constitution of India
10. The Consumer Protection Act, 1986

Bangalore
3rd December 1995

CoN 1.3

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a. In the absence of negligence the injury would not have occurred ordinarily
b. That the doctor had exclusive control over the injury producing instrument or treatment
c. That the patient was not guilty of contributory negligence.

Medical negligence can be avoided if doctors take due precaution in discharge of their duties. Some of them are as follows:

1. Have good relationship with the patient
2. Obtain informed consent from the patient
3. Never guarantee a cure
4. Keep full, accurate and legible medical records
5. Employ ordinary skill and care at all times
6. Confirm diagnosis by laboratory tests
7. Seek consultation where necessary
8. Do not criticise another doctor
9. Check condition of equipments periodically
10. Do not experiement without the consent of the patient
11. Keep yourself abrest with medical advances
12. It is dangerous to telephone a prescription

13. Take care while appointing assistants and delegating duties to them
14. In case of death during operation infrom the police
15. Do not fail to secure the consent of both husband and the wife, if an operation is likely to result in sterility

Obligations of the consumers

Despite the fact that consumers do have a large number of rights as patients, including filing a case in the consumer fora, they should remember that they have certain obligations towards the doctors. Some of them are:

1. To give full, accurate medical history
2. Follow the instructions of the doctors in full
3. Should not refuse to take suggested treatment
4. Not to leave the hospital without doctors approval

Informed consent

One of the most rapidly growing medical malpractice litigation is in the areas of informed consent. Consent means voluntary agreement, compliance or permission. Consent may be express or implied. Express consent may be verbal or written.

Informed consent implies an understanding by the patient of the nature of his condition, proposed treatment, procedures, alternative course of action, risks involved and chances of success or failure.

Some legislations connected to medical professionals:

1. The Indian Medical Degrees Act, 1916
2. The Indian Medical Council Act, 1933
3. The Dentists Act, 1948
4. The Indian Medical Council Act, 1956
5. The Drugs and Cosmetics Act
6. The Drugs and Magical Remedies (Objectionable Advertisements) Act
7. The Homeopathy Act
8. The Indian Penal Code
9. The Constitution of India
10. The Consumer Protection Act, 1986

Bangalore
3rd December 1995

CON 1.4

IN THE SUPREME COURT OF INDIA

CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO. 688 OF 1993

Indian Medical Association ... Appellant

VERSUS

V.P.Shantha & Ors. ... Respondents

[WITH C.A.NO.689/93, WP(C) NO. 16/94, C.A.NO. 4664-4665/94, C.A.NO. 254/94 AND C.A.NOS.10039,10081,10052-80/95 {Arising out of SLP(C)NOs. 18497/93, 21755/94, and 18445-73/94}, SLP(C)NOs. 6885/92, 6950/92, 351/93, 21348/93 and 21349/93]

J U D G M E N T

S.C. AGRAWAL, J. :

Leave granted in SLP(C) Nos. 18497/93 and 21755/94. Delay condoned and leave granted in SLP(C) Nos. 18445-73/94.

These appeals, special leave petitions and the Writ Petition raise a common question, viz., whether and, if so, in what circumstances, a medical practitioner can be regarded as rendering 'service' under Section 2(1)(o) of the Consumer Protection Act, 1986 (hereinafter referred to as

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'the Act']. Connected with this question is the question whether the service rendered at a hospital/nursing home can be regarded as 'service' under Section 2(1)(o) of the Act. These questions have been considered by various High Courts as well as by the National Consumer Disputes Redressal Commission [hereinafter referred to as 'the National Commission'].

In Dr. A.S.Chandra v. Union of India, (1992) 1 Andhra Law Times 713, a Division Bench of Andhra Pradesh High Court has held that service rendered for consideration by private medical practitioners, private hospitals and nursing homes must be construed as 'service' for the purpose of Section 2(1)(o) of the Act and the persons availing such services are 'consumers' within the meaning of Section 2(1)(d) of the Act.

In Dr.C.S. Subramanian v. Kumarasamy & Anr., (1994) 1 MLJ 438, a Division Bench of the Madras High Court has, however, taken a different view. It has been held that the services rendered to a patient by a medical practitioner or by a hospital by way of diagnosis and treatment, both

medicinal and surgical, would not come within the definition of 'service' under Section 2(1)(o) of the Act and a patient who undergoes treatment under a medical practitioner or a hospital by way of diagnosis and treatment, both medicinal and surgical, cannot be considered to be a 'consumer' within the meaning of Section 2(1)(d) of the Act; but the medical practitioners or hospitals undertaking and providing para-medical services of all kinds and categories cannot claim similar immunity from the provisions of the Act and that they would fall, to the extent of such para-medical services rendered by them, within the definition of 'service' and a person availing of such service would be a 'consumer' within the meaning of the Act. C.A.Nos. 4664-65/94 and Civil Appeal arising out of SLP(C) No. 21775/94 filed by the complainants and Civil Appeals arising out of SLP(C) Nos. 18445-73/94 filed by the Union of India are directed against the said judgment of the Madras High Court.

The National Commission by its judgment and order dated December 15, 1989 in First Appeal No. 2 of 1989 has held that persons who avail themselves of the facility of medical treatment in Government hospitals are not "consumers"

and the said facility offered in the Government hospitals cannot be regarded as service "hired" for "consideration". It has been held that the payment of direct or indirect taxes by the public does not constitute "consideration" paid for hiring the services rendered in the Government hospitals. It has also been held that contribution made by a Government employee in the Central Government Health Scheme or such other similar Scheme does not make him a "consumer" within the meaning of the Act. Civil Appeal arising out of SLP(C) No. 18497/93 has been filed by Consumer Unity Trust Society, a recognised consumer association, against this judgment of the National Commission.

By judgment dated April 21, 1992 in First Appeal Nos. 48 and 94 of 1991, the National Commission has held that the activity of providing medical assistance for payment carried on by hospitals and members of the medical profession falls within the scope of the expression 'service' as defined in Section 2(1)(o) of the Act and that in the event of any deficiency in the performance of such service, the aggrieved party can invoke the remedies provided under the Act by filing a complaint before the Consumer Forum having

jurisdiction. It has also been held that the legal representatives of the deceased patients who were undergoing treatment in the hospital are 'consumers' under the Act and are competent to maintain the complaint. C.A.Nos. 688/93 and 689/93 filed by the Indian Medical Association and SLP(C) Nos. 6885 and 6950/92 filed by M/s Cosmopolitan Hospital are directed against the said judgment of the National Commission. The said judgment dated April 21, 1992 was followed by the National Commission in its judgment dated November 16, 1992 in First Appeal No.97 of 1991 [Dr. Sr. Louie & Anr. v. Smt. Kannolil Pathumma & Anr.]. SLP No. 351/93 has been filed by Josgiri Hospital and Nursing Home against the said judgment of the National Commission.

By judgment dated May 3, 1993 in O.P.No. 93/92, the National Commission has held that since the treatment that was given to the complainant's deceased husband in the nursing home belonging to the opposite party was totally free of any charge, it did not constitute 'service' as defined under the Act and the complainant was not entitled to seek any relief under the Act. C.A.No. 254/94 has been filed by

the complainant against the said judgment of the National Commission.

Writ Petition No. 16 of 1994 has been filed under Article 32 of the Constitution by Cosmopolitan Hospital (P) Ltd., and Dr. K.Venogopolan Nair [petitioners in SLP(C) Nos.6885 and 6950/92] wherein the said petitioners have assailed the validity of the provisions of the Act, insofar as they are held to be applicable to the medical profession, as being violative of Articles 14 and 19(1)(g) of the Constitution.

Shri K.Parasaran, Shri Harish Salve, Shri A.M.Singhvi, Shri Krishnamani and Shri S.Balakrishnan have addressed the court on behalf of the medical profession and the hospitals and Shri Rajeev Dhavan has presented the case of the complainants. Before we proceed to deal with their contentions we would briefly take note of the background and the scheme of the Act.

On April 9, 1985, the General Assembly of the United Nations, by Consumer Protection Resolution No. 39/248,

adopted the guidelines to provide a framework for Governments, particularly those of developing countries, to use in elaborating and strengthening consumer protection policies and legislation. The objectives of the said guidelines include assisting countries in achieving or maintaining adequate protection for their population as consumers and encouraging high levels of ethical conduct for those engaged in the production and distribution of goods and services to the consumers. The legitimate needs which the guidelines are intended to meet include the protection of consumers from hazards to their health and safety and availability of effective consumer redress. Keeping in view the said guidelines, the Act was enacted by Parliament to provide for the better protection of the interests of consumers and for that purpose to make provision for the establishment of consumer councils and other authorities for the settlement of consumers' disputes and for matters connected therewith. The Act sets up a three-tier structure for the redressal of consumer grievances. At the lowest level, i.e., the District level, is the Consumer Disputes Redressal Forum known as 'the District Forum'; at the next higher level, i.e., the State level, is the Consumer Disputes Redressal Commission known as 'the

State Commission' and at the highest level is the National Commission. [Section 9]. The jurisdiction of these three Consumer Disputes Redressal Agencies is based on the pecuniary limit of the claim made by the complainant. An appeal lies to the State Commission against an order made by the District Forum [Section 15] and an appeal lies to the National Commission against an order made by the State Commission on a complaint filed before it or in an appeal against the order passed by the District Forum. [Section 19]. The State Commission can exercise revisional powers on grounds similar to those contained in Section 115 CPC in relation to a consumer dispute pending before or decided by a District Forum [Section 17(b)] and the National Commission has similar revisional jurisdiction in respect of a consumer dispute pending before or decided by a State Commission. [Section 21(b)]. Further, there is a provision for appeal to this Court from an order made by the National Commission on a complaint or on an appeal against the order of a State Commission. [Section 23]. By virtue of the definition of complainant in Section 2(1)(c), the Act affords protection to the consumer against unfair trade practice or a restrictive trade practice adopted by any trader, defect in the goods

bought or agreed to be bought by the consumer, deficiency in the service hired or availed of or agreed to be hired or availed of by the consumer, charging by a trader price in excess of the price fixed by or under any law for the time being in force or displayed on the goods or any package containing such goods and offering for sale to public, goods which will be hazardous to life and safety when used, in contravention of the provisions of any law for the time being in force requiring traders to display information in regard to the contents, manner and effect of use of such goods. The expression "complainant", as defined in Section 2(1)(b), is comprehensive to enable the consumer as well as any voluntary consumer association registered under the Companies Act, 1956 or under any other law for the time being in force, or the Central Government or any State Government or one or more consumers where there are numerous consumers having the same interest, to file a complaint before the appropriate Consumer Disputes Redressal Agency and the consumer dispute raised in such complaint is settled by the said agency in accordance with the procedure laid down in Section 13 of the Act which prescribes that the District Forum [as well as the State Commission and the National Commission]

shall have the same power as are vested in a civil court under the Code of Civil Procedure in respect of summoning and enforcing attendance of any defendant or witness and examining the witness on oath; discovery and production of any document or other material object producible as evidence; the reception of evidence on affidavits; the requisitioning of the report of the concerned analysis or test from the appropriate laboratory or from any other relevant source; issuing of any commission for the examination of any witness; and any other matter which may be prescribed. Section 14 makes provisions for the nature of reliefs that can be granted to the complainant on such a complaint. The provisions of the Act are in addition to and not in derogation of the provisions of any other law for the time being in force. [Section 3].

In this group of cases we are not concerned with goods and we are only concerned with rendering of services. Since the Act gives protection to the consumer in respect of service rendered to him, the expression "service" in the Act has to be construed keeping in view the definition of "consumer" in the Act. It is, therefore, necessary to set

out the definition of the expression 'consumer' contained in Section 2(1)(d) insofar as it relates to services and the definition of the expression 'service' contained in Section 2(1)(o) of the Act. The said provisions are as follows :

> "Section 2(1)(d) "consumer" means any person who, -
>
> (i) omitted
>
> (ii) hires [or avails of] any services for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any beneficiary of such services other than the person who hires [or avails of] the service for consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person.
>
> Explanation. - Omitted"

> "Section 2(1)(o) : "service" means service of any description which is made available to the potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, [housing construction], entertainment, amusement or the purveying of news or other information, but does not include rendering of any service free of charge or under a contract of personal service;"

The words "or avails of" after the word "hires" in Section 2(1)(d)(ii) and the words "housing construction" in

Section 2(1)(o) were inserted by the Act 50 of 1993.

The definition of 'service' in Section 2(1)(o) of the Act can be split up into three parts - the main part, the inclusionary part and the exclusionary part. The main part is explanatory in nature and defines service to mean service of any description which is made available to the potential users. The inclusionary part expressly includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy; board or lodging or both housing construction, entertainment, amusement or the purveying of news or other information. The exclusionary part excludes rendering of any service free of charge or under a contract of personal service.

The definition of 'service' as contained in Section 2(1)(o) of the Act has been construed by this Court in Lucknow Development Authority v. M.K.Gupta, 1994 (1) SCC 243. After pointing out that the said definition is in three parts, the Court has observed :

> "The main clause itself is very wide. It applies to any service made available to potential users. The words 'any' and 'potential' are significant. Both are of wide amplitude. The word 'any' dictionarily means; one or some or all'. In Black's Law Dictionary it is explained thus, "word 'any' has a diversity of meaning and may be employed to indicate 'all' or 'every' as well as 'some' or 'one' and its meaning in a given statute depends upon the context and the subject- matter of the statute". The use of the word 'any' in the context it has been used in clause (o) indicates that it has been used in wider sense extending from one to all. The other word 'potential' is again very wide. In Oxford Dictionary it is defined as 'capable of coming into being, possibility'. In Black's Law Dictionary it is defined "existing in possibility but not in act. Naturally and probably expected to come into existence at some future time, though not now existing; for example, the future product of grain or trees already planted, or the successive future instalments or payments on a contract or engagement already made." In other words service which is not only extended to actual users but those who are capable of using it are covered in the Definition. The clause is thus very wide and extends to any or all actual or potential users." [p.255]

The contention that the entire objective of the Act is to protect the consumer against malpractices in business was rejected with the observations :

> "The argument proceeded on complete misapprehension of the purpose of Act and even its explicit language. In fact the Act requires provider of service to be more objective and caretaking." (p.256)

Referring to the inclusive part of the definition it was said :

> "The inclusive clause succeeded in widening its scope but not exhausting the services which could be covered in earlier part. So any service except when it is free of charge or under a constraint of personal service is included in it." [p.257]

In that case the Court was dealing with the question whether housing construction could be regarded as service under Section 2(1)(o) of the Act. While the matter was pending in this Court, "housing construction" was inserted in the inclusive part by Ordinance No. 24 of 1993. Holding that housing activity is a service and was covered by the main part of the definition, the Court observed :

> "..... the entire purpose of widening the definition is to include in it not only day to day buying and selling activity undertaken by a common man but even such activities which are otherwise not commercial in nature yet they partake of a character in which some benefit is conferred on the consumer." [p.256]

In the present case the inclusive part of the definition of "service" is not applicable and we are required

to deal with the questions falling for consideration in the light of the main part and the exclusionary part of the definition. The exclusionary part will require consideration only if it is found that in the matter of consultation, diagnosis and treatment a medical practitioner or a hospital/nursing home renders a service falling within the main part of the definition contained in Section 2(1)(o) of the Act. We have, therefore, to determine whether medical practitioners and hospitals/nursing homes can be regarded as rendering a "service" as contemplated in the main part of Section 2(1)(o). This determination has to be made in the light of the aforementioned observations in Lucknow Development Authority (supra). We will first examine this question in relation to medical practitioners.

It has been contended that in law there is a distinction between a profession and an occupation and that while a person engaged in an occupation renders service which falls within the ambit of Section 2(1)(o) the service rendered by a person belonging to a profession does not fall within the ambit of the said provision and, therefore, medical practitioners who belong to the medical profession

are not covered by the provisions of the Act. It has been urged that medical practitioners are governed by the provisions of the Indian Medical Council Act, 1956 and the Code of Medical Ethics made by the Medical Council of India, as approved by the Government of India under Section 3 of the Indian Medical Council Act, 1956 which regulates their conduct as members of the medical profession and provides for disciplinary action by the Medical Council of India and/or State Medical Councils against a person for professional misconduct.

While expressing his reluctance to propound a comprehensive definition of a 'profession', Scrutton L.J. has said " 'profession' in the present use of language involves the idea of an occupation requiring either purely intellectual skill, or of manual skill controlled, as in painting and sculpture, or surgery, by the intellectual skill of the operator, as distinguished from an occupation which is substantially the production or sale or arrangement for the production or sale of commodities. The line of demarcation may vary from time to time. The word 'profession' used to be confined to the three learned professions, the Church,

Medicine and Law. It has now, I think, a wider meaning". [See : Commissioners of Inland Revenue v. Maxse, 1919 1 K.B. 647 at p.657].

According to Rupert M. Jackson and John L.Powell the occupations which are regarded as professions have four characteristics, viz.,

i) the nature of the work which is skilled and specialized and a substantial part is mental rather than manual;

ii) commitment to moral principles which go beyond the general duty of honesty and a wider duty to community which may transcend the duty to a particular client or patient;

iii) professional association which regulates admission and seeks to uphold the standards of the profession through professional codes on matters of conduct and ethics; and

iv) high status in the community.

The learned authors have stated that during the twentieth century an increasing number of occupations have been seeking and achieving "professional" status and that this has led inevitably to some blurring of the features which traditionally distinguish the professions from other occupations. In the context of the law relating to Professional Negligence the learned authors have accorded professional status to seven specific occupations, namely, (i) architects, engineers and quantity surveyors, (ii) surveyors, (iii) accountants, (iv) solicitors, (v) barristers, (vi) medical practitioners and (vii) insurance brokers. [See : Jackson & Powell on Professional Negligence, paras 1-01 and 1-03, 3rd Ed.n.].

In the matter of professional liability professions differ from other occupations for the reason that professions operate in spheres where success cannot be achieved in every case and very often success or failure depends upon factors beyond the professional man's control. In devising a rational approach to professional liability which must provide proper protection to the consumer while allowing for the factors mentioned above, the approach of the courts is to require that professional men should possess a certain

minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. In general, a professional man owes to his client a duty in tort as well as in contract to exercise reasonable care in giving advice or performing services. [See : Jackson & Powell (supra), paras 1-04, 1-05 and 1-56]. Immunity from suit was enjoyed by certain professions on the grounds of public interest. The trend is towards narrowing of such immunity and it is no longer available to architects in respect of certificates negligently given and to mutual valuers. Earlier, barristers were enjoying complete immunity but now even for them the field is limited to work done in court and to a small category of pre-trial work which is directly related to what transpires in court. [See : Jackson & Powell, (supra), para 1-66; Saif Ali v. Sidney Mitchell & Co., (1980) 1 A.C. 198; Rees v. Sinclair (1974) 1 N.Z.L.R. 180; Giannarelli v. Wraith (1988) 81 A.L.R. 417]. Medical practitioners do not enjoy any immunity and they can be sued in contract or tort on the ground that they have failed to exercise reasonable skill and care.

It would thus appear that medical practitioners, though belonging to the medical profession, are not immune from a claim for damages on the ground of negligence. The fact that they are governed by the Indian Medical Council Act and are subject to the disciplinary control of Medical Council of India and/or State Medical Councils is no solace to the person who has suffered due to their negligence and the right of such person to seek redress is not affected.

Referring to the changing position with regard to the relationship between the medical practitioners and the patients in the United Kingdom, it has been said :

> "Where, then, does the doctor stand today in relation to society? To some extent, he is a servant of the public, a public which is widely (though not always well) informed on medical matters. Society is conditioned to distrust paternalism and the modern medical practitioner has little wish to be paternalistic. The new talk is of 'producers and consumers' and the concept that 'he who pays the piper calls the tune' is established both within the profession and in its relationships with patients. The competent patient's inalienable rights to understand his treatment and to accept or refuse it are now well established." (pp.16-17)
>
> "Consumerism is now firmly established in medical practice - and this has been encouraged on a wide scale by government in the United Kingdom through

> the introduction of 'charters'. Complaint is central to this ethos - and the notion that blame must be attributed, and compensated, has a high priority." (p.192)
>
> [Mason & McCall Smith :Law and Medical Ethics, 4th Edn.]

In Arizona v. Maricopa County Medical Society, 457 US 332 = 73 L.Ed.(2d) 48, two Arizona county medical societies formed two foundations for medical care to promote fee-for-service medicine and to provide the community with a competitive alternative to existing health insurance plans and by agreement amongst the doctors established the schedule of maximum fees that participating doctors agreed to accept as payment in full for services performed for patients insured under plans. It was held that the maximum fee agreement, as price fixing agreements, are per se unlawful under the Sherman Act. It was observed :

> "Nor does the fact doctors - rather than non-professionals - are the parties to the price-fixing agreements support the respondents' position. ... The respondents claim for relief from the per se rule is simply that the doctors' agreement not to charge certain insureds more than a fixed price facilitates the successful marketing of an attractive insurance plan. But the claim that the price restraint will make it easier for customers to pay does not distinguish the medical profession from any other provider of goods or services." [pp. 348-49, 61-62]

We are, therefore, unable to subscribe to the view that merely because medical practitioners belong to the medical profession they are outside the purview of the provisions of the Act and the services rendered by medical practitioners are not covered by Section 2(1)(o) of the Act.

Shri Harish Salve, appearing for the Indian Medical Association, has urged that having regard to the expression 'which is made available to potential users' contained in Section 2(1)(o) of the Act, medical practitioners are not contemplated by Parliament to be covered within the provisions of the Act. He has urged that the said expression is indicative of the kind of service the law contemplates, namely, service of an institutional type which is really a commercial enterprise and open and available to all who seek to avail thereof. In this context, reliance has also been placed on the word 'hires' in sub-clause (ii) of the definition of 'consumer' contained in Section 2(1)(d) of the Act. We are unable to uphold this contention. The word 'hires' in Section 2(1)(d)(ii) has been used in the same sense as 'avails of' as would be evident from the words 'when such services are availed of' in the latter part of

Section 2(1)(d)(ii). By inserting the words 'or avails of' after the word 'hires' in Section 2(1)(d)(ii) by the Amendment Act of 1993, Parliament has clearly indicated that the word 'hires' has been used in the same sense as 'avails of'. The said amendment only clarifies what was implicit earlier. The word 'use' also means 'to avail oneself of'. [See : Black's Law Dictionary, 6th Edn., at p. 1541]. The word 'user' in the expression 'which is made available to potential users' in the definition of 'service' in Section 2(1)(o) has to be construed having regard to the definition of 'consumer' in Section 2(1)(d)(ii) and, if so construed, it means 'availing of services'. From the use of the word 'potential users' it cannot, therefore, be inferred that the services rendered by medical practitioners are not contemplated by Parliament to be covered within the expression 'service' as contained in Section 2(1)(o).

Shri Harish Salve has also placed reliance on the definition of the expression 'deficiency' as contained in Section 2(1)(g) of the Act which provides as follows :

> "Section 2(1)(g) : "deficiency" means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service;"

The submission of Shri Salve is that under the said clause the deficiency with regard to fault, imperfection, shortcoming or inadequacy in respect of a service has to be ascertained on the basis of certain norms relating to quality, nature and manner of performance and that medical services rendered by a medical practitioner cannot be judged on the basis of any fixed norms and, therefore, a medical practitioner cannot be said to have been covered by the expression "service" as defined in Section 2(1)(o). We are unable to agree. While construing the scope of the provisions of the Act in the context of deficiency in service it would be relevant to take note of the provisions contained in Section 14 of the Act which indicate the reliefs that can be granted on a complaint filed under the Act. In respect of deficiency in service, the following reliefs can be granted :

i) return of the charges paid by the complainant. [Clause c)]

ii) payment of such amount as may be awarded as compensation to the consumer for any loss or injury suffered by the consumer due to the negligence of the opposite party. [Clause (d)]

iii) removal of the defects or deficiencies in the services in question. [Clause (e)]

Section 14(1)(d) would, therefore, indicate that the compensation to be awarded is for loss or injury suffered by the consumer due to the negligence of the opposite party. A determination about deficiency in service for the purpose of Section 2(1)(g) has, therefore, to be made by applying the same test as is applied in an action for damages for negligence. The standard of care which is required from medical practitioners as laid down by McNair J. in his direction to the jury in Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582, has been accepted by the House of Lords in a number of cases. [See : Whitehouse v. Jordan, 1981 (1) WLR 246; Maynard v. West Midlands, Regional Health Authority, 1984 (1) WLR 634; Sidaway v. Governors of Bethlem Royal Hospital, 1985 AC 871]. In

Bolam (supra) McNair J has said :

> "But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art." [p.586]

In an action for negligence in tort against a surgeon this Court, in Laxman Balakrishna Joshi v. Trimbak Bapu Godbole & Anr., 1969 (1) SCR 206, has held:

> "The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz., a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law require. [p.213]

It is, therefore, not possible to hold that in view of the definition of "deficiency" as contained in Section 2(1)(g) medical practitioners must be treated to be excluded from the ambit of the Act and the service rendered by them is not covered under Section 2(1)(o).

Another contention that has been urged by learned counsel appearing for the medical professio to exclude medical practitioners from the ambit of the Act is that the composition of the District Forum, the State Commission and the National Commission is such that they cannot fully appreciate the complex issues which may arise for determination and further that the procedure that is followed by these bodies for determination of issues before them is not suitable for the determination of the complicated questions which arise in respect of claims for negligence in respect of the services rendered by medical practitioners. The provisions with regard to the composition of the District Forum are contained in Section 10 of the Act which provides that the President of the Forum shall be a person who is or who has been or is qualified to be a District Judge and the other two

members shall be persons of ability, integrity and standing, having adequate knowledge or experience or, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration and one of them shall be a woman. Similarly, with regard to the composition of the State Commission, it is provided in Section 16 of the Act that the President of the Commission shall be a person who is or who has been a Judge of a High Court appointed by the State Government in consultation with the Chief Justice of the High Court and that the other two members shall be persons of ability, integrity and standing, having adequate knowledge or experience of, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration, and one of them shall be a woman. The composition of the National Commission is governed by Section 20 of the Act which provides that the President of the Commission shall be a person who is or who has been a Judge of the Supreme Court to be appointed by the Central Government after consultation with the Chief Justice of India and four other members shall be persons of ability, integrity

and standing having adequate knowledge or experience of, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration and one of them shall be a woman. It will thus be seen that the President of the District Forum is required to be a person who is or who has been or is qualified to be a District Judge and the President of the State Commission is required to be a person who is or who has been the Judge of the High Court and the President of the National Commission is required to be a person who is or who has been a Judge of the Supreme Court, which means that all the Consumer Disputes Redressal Agencies are headed by a person who is well versed in law and has considerable judicial or legal experience. It has, however, been submitted that in case there is difference of opinion, the opinion of the majority is to prevail and, therefore, the President may be out-voted by the other members and that there is no requirement that the members should have adequate knowledge or experience in dealing with problems relating to medicine. It is no doubt true that the decisions of the District Forum as well as the State Commission and the National Commission have

to be taken by majority and it may be possible in some cases that the President may be in minority. But the presence of a person well versed in law as the President will have a bearing on the deliberations of these Agencies and their decisions. As regards the absence of a requirement about a member having adequate knowledge or experience in dealing with the problems relating to medicine it may be stated that the persons to be chosen as members are required to have knowledge and experience in dealing with problems relating to various fields connected with the object and purpose of the Act, viz., protection and interests of the consumers. The said knowledge and experience would enable them to handle the consumer disputes coming up before them for settlement in consonance with the requirement of the Act. To say that the members must have adequate knowledge or experience in the field to which the goods or services, in respect of which the complaint is made, are related would lead to impossible situations. At one time there will be two members in the District Forum and they would have knowledge or experience in two fields which would mean that complaints in respect of goods or services relating to other fields would be beyond

the purview of the District Forum. Similarly in the State Commission there may be members having knowledge or experience in fields other than the fields in which the members of the District Forum have knowledge or experience: It would mean that the goods or services in respect of which the District Forum can entertain a complaint will be outside the purview of the State Commission. Same will be the position in respect of the National Commission. Since the goods or services in respect of which complaint can be filed under the Act may relate to number of fields it cannot be expected that the members of the Consumer Disputes Redressal Agencies must have expertise in the field to which the goods or services in respect of which complaint is filed, are related. It will be for the parties to place the necessary material and the knowledge and experience which the members will have in the fields indicated in the Act would enable them to arrive at their findings on the basis of that material. It cannot, therefore, be said that since the members of the Consumer Disputes Redressal Agencies are not required to have knowledge and experience in medicine, they are not in a position to deal with issues which may arise before them in proceed-

ings arising out of complaints about the deficiency in service rendered by medical practitioners.

Discussing the role of lay persons in decision making, Prof. White has referred to two divergent views. One view holds that lay adjudicators are superior to professional judges in the application of general standards of conduct, in their notions of reasonableness, fairness and good faith and that they act as 'an antidote against excessive technicality' and 'some guarantee that the law does not diverge too far from reality'. The other view, however, is that since they are not experts, lay decision makers present a very real danger that the dispute may not be resolved in accordance with the prescribed rules of law and the adjudication of claims may be based on whether the claimant is seen as deserving rather than on the legal rules of entitlement. Prof. White has indicated his preference for a Tribunal composed of a lawyer, as Chairman, and two lay members. Such a Tribunal, according to prof. White, would present an opportunity to develop a model of adjudication that combines the merits of lay decision making with legal competence and

participation of lay members would lead to general public confidence in the fairness of the process and widen the social experience represented by the decision makers. Prof. White says that apart from their breadth of experience, the key role of lay members would be in ensuring that procedures do not become too full of mystery and ensure that litigants before them are not reduced to passive spectators in a process designed to resolve their disputes. [See : Prof. Robin C.A. White : The Administration of Justice, 2nd Edition, p. 345].

In the matter of constitution of the District Forum, the State Commission and the National Commission the Act combines with legal competence the merits of lay decision making by members having knowledge and experience in dealing with problems relating to various fields which are connected with the object and purpose of the Act, namely, protection and interests of the consumers.

Moreover, there is a further safeguard of an

appeal against the order made by the District Forum to the State Commission and against the order made by the State Commission to the National Commission and a further appeal to this Court against the order made by the National Commission. It cannot, therefore, be said that the composition of the Consumer Disputes Redressal Agencies is such as to render them unsuitable for adjudicating on issues arising in a complaint regarding deficiency in service rendered by a medical practitioner.

As regards the procedure to be followed by these agencies in the matter of determination of the issues coming up for consideration it may be stated that under Section 13(2)(b), it is provided that the District Forum shall proceed to settle the consumer disputes (i) on the basis of evidence brought to its notice by the complainant and the opposite party, where the opposite party denies or disputes the allegations contained in the complaint, or (ii) on the basis of evidence brought to its notice by the complainant where the opposite party omits or fails to take any action to represent his case within the time given by the Forum. In

Section 13(4) of the Act it is further provided that the District Forum shall have the same powers as are vested in the civil court under the Code of Civil procedure while trying a suit in respect of the following matters:

> "(i) the summoning and enforcing attendance of any defendant or witness and examining the witness on oath;
>
> (ii) the discovery and production of any document or other material object producible as evidence;
>
> (iii) the reception of evidence on affidavits;
>
> (iv) the requisitioning of the report of the concerned analysis or test from the appropriate laboratory or from any other relevant source;
>
> (v) issuing of any commission for the examination of any witness and
>
> (vi) any other matter which may be prescribed."

The same provisions apply to proceedings before the State Commission and the National Commission. It has been urged that proceedings involving negligence in the matter of rendering services by a medical practitioner would raise complicated questions requiring evidence of experts to be

recorded and that the procedure which is followed for determination of consumer disputes under the Act is summary in nature involving trial on the basis of affidavits and is not suitable for determination of complicated questions. It is no doubt true that sometimes complicated questions requiring recording of evidence of experts may arise in a complaint about deficiency in service based on the ground of negligence in rendering medical services by a medical practitioner; but this would not be so in all complaints about deficiency in rendering services by a medical practitioner. There may be cases which do not raise such complicated questions and the deficiency in service may be due to obvious faults which can be easily established such as removal of the wrong limb or the performance of an operation on the wrong patient or giving injection of a drug to which the patient is allergic without looking into the out patient card containing the warning [as in Chinkeow v. Government of Malaysia, (1967) 1 WLR 813 P.C.] or use of wrong gas during the course of an anesthetic or leaving inside the patient swabs or other items of operating equipment after surgery. One often reads about such incidents in the newspapers. The

issues arising in the complaints in such cases can be speedily disposed of by the procedure that is being followed by the Consumer Disputes Redressal Agencies and there is no reason why complaints regarding deficiency in service in such cases should not be adjudicated by the Agencies under the Act. In complaints involving complicated issues requiring recording of evidence of experts, the complainant can be asked to approach the civil court for appropriate relief. Section 3 of the Act which prescribes that the provisions of the Act shall be in addition to and not in derogation of the provisions of any other law for the time being in force, preserves the right of the consumer to approach the civil court for necessary relief. We are, therefore, unable to hold that on the ground of composition of the Consumer Disputes Redressal Agencies or on the ground of the procedure which is followed by the said Agencies for determining the issues arising before them, the service rendered by the medical practitioners are not intended to be included in the expression 'service' as defined in Section 2(1)(o) of the Act.

Keeping in view the wide amplitude of the definition of 'service' in the main part of Section 2(1)(o) as construed by this Court in Lucknow Development Authority (supra), we find no plausible reason to cut down the width of that part so as to exclude the services rendered by a medical practitioner from the ambit of the main part of Section 2(1)(o).

We may now proceed to consider the exclusionary part of the definition to see whether such service is excluded by the said part. The exclusionary part excludes from the main part service rendered (i) free of charge; or (ii) under a contract of personal service.

Shri Salve has urged that the relationship between a medical practitioner and the patient is of trust and confidence and, therefore, it is in the nature of a contract of personal service and the service rendered by the medical practitioner to the patient is not 'service' under Section 2(1)(o) of the Act. This contention of Shri Salve ignores the well recognised distinction between a 'contract of service' and a 'contract for services'. [See : Halsbury's Laws of England, 4th Edn., Vol. 16, para 501; Dharangadhara

Chemical Works Ltd. v. State of Saurashtra, 1957 SCR 152 at p. 157]. A 'contract for services' implies a contract whereby one party undertakes to render services e.g. professional or technical services, to or for another in the performance of which he is not subject to detailed direction and control but exercises professional or technical skill and uses his own knowledge and discretion. [See : Oxford Companion to Law, p. 1134]. A 'contract of service' implies relationship of master and servant and involves an obligation to obey orders in the work to be performed and as to its mode and manner of performance. [See : Stroud's Judicial Dictionary, 5th Edn., p. 540; Simmons v. Heath Laundry Co. (1910) 1 K.B. 543; and Dharangadhara Chemical Works (supra) at p. 159]. We entertain no doubt that Parliamentary draftsman was aware of this well accepted distinction between "contract of service" and "contract for services" and has deliberately chosen the expression 'contract of service' instead of the expression 'contract for services', in the exclusionary part of the definition of 'service' in Section 2(1)(o). The reason being that an employer cannot be regarded as a consumer in respect of the services rendered by his employee in pursuance of a contract of employment. By

affixing the adjective 'personal' to the word "service" the nature of the contracts which are excluded is not altered. The said adjective only emphasizes that what is sought to be excluded is personal service only. The expression "contract of personal service" in the exclusionary part of Section 2(1)(o) must, therefore, be construed as excluding the services rendered by an employee to his employer under the contract of personal service from the ambit of the expression "service".

It is no doubt true that the relationship between a medical practitioner and a patient carries within it certain degree of mutual confidence and trust and, therefore, the services rendered by the medical practitioner can be regarded as services of personal nature but since there is no relationship of master and servant between the doctor and the patient the contract between the medical practitioner and his patient cannot be treated as a contract of personal service but is a contract for services and the service rendered by the medical practitioner to his patient under such a contract is not covered by the exclusionary part of the definition of 'service' contained in Section 2(1)(o) of the Act.

Shri Rajeev Dhavan has, however, submitted that the expression 'contract of personal service' contained in Section 2(1)(o) of the Act has to be confined to employment of domestic servants only. We do not find any merit in this submission. The expression 'personal service' has a well known legal connotation and has been construed in the context of the right to seek enforcement of such a contract under the Specific Relief Act. For that purpose a contract of personal service has been held to cover a civil servant, the managing agents of a company and a professor in the University. [See : The High Commissioner for India v. I.M.Lall, (1948) L.R. 75 I.A.225; Ram Kissendas Dhanuka v. Satya Charan Law, (1949) L.R. 77 I.A.128; and Dr. S.B.Dutt v. University of Delhi, 1959 SCR 1236]. There can be a contract of personal service if there is relationship of master and servant between a doctor and the person availing his services and in that event the services rendered by the doctor to his employer would be excluded from the purview of the expression 'service' under Section 2(1)(o) of the Act by virtue of the exclusionary clause in the said definition.

The other part of exclusionary clause relates to services rendered "free of charge". The medical

practitioners, Government hospitals/nursing homes and private hospitals/nursing homes (hereinafter called "doctors and hospitals") broadly fall in three categories :-

i) where services are rendered free of charge to everybody availing the said services.

ii) where charges are required to be paid by everybody availing the services and

iii) where charges are required to be paid by persons availing services but certain categories of persons who cannot afford to pay are rendered service free of charges.

There is no difficulty in respect of first two categories. Doctors and hospitals who render service without any charge whatsoever to every person availing the service would not fall within the ambit of "service" under Section 2(1) (o) of the Act. The payment of a token amount for registration purposes only would not alter the position in respect of such doctors and hospitals. So far as the second category is concerned, since the service is rendered on payment basis to all the persons they would clearly fall within the ambit of Section 2(1) (o) of the Act. The third category of doctors and hospitals do provide free service to some of the patients belonging to the poor class but the bulk of the service is

rendered to the patients on payment basis. The expenses incurred for providing free service are met out of the income from the service rendered to the paying patients. The service rendered by such doctors and hospitals to paying patients undoubtedly fall within the ambit of Section 2(1) (o) of the Act.

The question for our consideration is whether the service rendered to patients fee of charge by the doctors and hospitals in category (iii) is excluded by virtue of the exclusionary clause in Section 2(1) (o) of the Act. In our opinion the question has to be answered in the negative. In this context it is necessary to bear in mind that the Act has been enacted "to provide for the protection of the interests of "consumers" in the background of the guidelines contained in the Consumer Protection Resolution passed by the U.N.General Assembly on April 9, 1985. These guidelines refer to "achieving or maintaining adequate protection for their population as consumers" and "encouraging high levels of ethical conduct for those engaged in the protection and distribution of goods and services to the consumers". The protection that is envisaged by the Act is, therefore, protection for consumers as a class. The word "users" (in

plural), in the phrase 'potential users' in Section 2(1) (o) of the Act also gives an indication that consumers as a class are contemplated. The definition of 'complainant' contained in Section 2(b) of the Act which includes, under clause (ii), any voluntary consumer association, and clauses (b) and (c) of Section 12 which enable a complaint to be filed by any recognised consumer association or one or more consumers where there are numerous consumers, having the same interest, on behalf of or for the benefit of all consumers so interested, also lend support to the view that the Act seeks to protect the interests of consumers as a class. To hold otherwise would mean that the protection of the Act would be available to only those who can afford to pay and such protection would be denied to those who cannot so afford, though they are the people who need the protection more. It is difficult to conceive that the legislature intended to achieve such a result. Another consequence of adopting a construction, which would restrict the protection of the Act to persons who can afford to pay for the services availed by them and deny such protection to those who are not in a position to pay for such services, would be that the standard and quality of service rendered at an establishment would

cease to be uniform. It would be of a higher standard and of better quality for persons who are in a position to pay for such service while the standard and quality of such service would be inferior for person who cannot afford to pay for such service and who avail the service without payment. Such a consequence would defeat the object of the Act. All persons who avail the services by doctors and hospitals in category (iii), are required to be treated on the same footing irrespective of the fact that some of them pay for the service and others avail the same free of charge. Most of the doctors and hospitals work on commercial lines and the expenses incurred for providing services free of charge to patients who are not in a position to bear the charges are met out of the income earned by such doctors and hospitals from services rendered to paying patients. The Government hospitals may not be commercial in that sense but on the overall consideration of the objectives and the scheme of the Act it would not be possible to treat the Government hospitals differently. We are of the view that in such a situation the persons belonging to "poor class" who are provided services free of charge are the beneficiaries of the service which is hired or availed of by the "paying class".

We are, therefore, of opinion that service rendered by the doctors and hospitals falling in category (iii) irrespective of the fact that part of the service is rendered free of charge, would nevertheless fall within the ambit of the expression "service" as defined in Section 2(1) (o) of the Act. We are further of the view that persons who are rendered free service are the "beneficiaries" and as such come within the definition of "consumer" under Section 2(1) (d) of the Act.

In respect of the hospitals/nursing homes (Government and non-Government) falling in category (i), i.e., where services are rendered free of charge to everybody availing the services, it has been urged by Shri Dhavan that even though the service rendered at the hospital, being free of charge, does not fall within the ambit of Section 2(1)(o) of the Act in so far as the hospital is concerned, the said service would fall within the ambit of Section 2(1)(o) since it is rendered by a medical officer employed in the hospital who is not rendering the service free of charge because the said medical officer receives amoluments by way of salary for employment in the hospital. There is no merit in this contention. The medical officer who is employed in the hospital

renders the service on behalf of the hospital administration and if the service, as rendered by the hospital, does not fall within the ambit of Section 2(1) (o), being free of charge, the same service cannot be treated as service under Section 2(1)(o) for the reason that it has been rendered by a medical officer in the hospital who receives salary for employment in the hospital. There is no direct nexus between the payment of the salary to the medical officer by the hospital administration and the person to whom service is rendered. The salary that is paid by the hospital administration to the employee medical officer cannot be regarded as payment made on behalf of the person availing the service or for his benefit so as to make the person availing the service a "consumer" under Section 2(1)(d) in respect of the service rendered to him. The service rendered by the employee medical officer to such a person would, therefore, continue to be service rendered free of charge and would be outside the purview of Section 2(1)(o).

A contention has also been raised that even in the Government hospitals/health centres/dispensaries where services are rendered free of charge to all the patients the provisions of the Act shall apply because the expenses of

running the said hospitals are met by appropriation from the Consolidated Fund which is raised from the taxes paid by the tax payers. We do not agree.

The essential characteristics of a tax are that (i) it is imposed under statutory power without the tax-payer's consent and the payment is enforced by law; (ii) it is an imposition made for public purpose without reference to any special benefit to be conferred on the payer of the tax' and (iii) it is part of the common burden, the quantum of imposition upon the tax payer depends generally upon his capacity to pay. [See : The Commissioner, Hindu Religious Endowments, Madras v. Sri lakshmindra Thirtha Swamiar of Sri Shirur Mutt, 1954 SCR 1005 at pp.1040-41]. The tax paid by the person availing the service at a Government hospital cannot be treated as a consideration or charge for the service rendered at the said hospital and such service though rendered free of charge does not cease to be so because the person availing the service happens to be a tax payer.

Adverting to the individual doctors employed and serving in the hospitals, we are of the view that such doctors working in the hospitals/nursing homes/dispensaries/ whether Government or private - belonging to categories (ii)

and (iii) above would be covered by the definition of "service" under the Act and as such are amenable to the provisions of the Act along with the management of the hospital, etc. jointly and severally.

There may, however, be a case where a person has taken an insurance policy for medi-care whereunder all the charges for consultation, diagnosis and medical treatment are borne by the insurance company. In such a case the person receiving the treatment is a beneficiary of the service which has been rendered to him by the medical practitioner, the payment for which would be made by the insurance company under the insurance policy. The rendering of such service by the medical practitioner cannot be said to be free of charge and would, therefore, fall within the ambit of the expression 'service' in Section 2(1) (o) of the Act. So also there may be cases where as a part of the conditions of service the employer bears the expense of medical treatment of the employee and his family members dependent on him. The service rendered to him by a medical practitioner would not be free of charge and would, therefore, constitute service under Section 2(1) (o).

Shri A.M.Singhvi has invited our attention to the

following observations of Lord Denning M.R. in Whitehouse v. Jordan & Anr., (1980) 1 All.E.R. 650 :

> "Take heed of what has happened in the United States. 'Medical malpractice' cases there are very worrying, especially as they are tried by juries who have sympathy for the patient and none for the doctor, who is insured. The damages are colossal. The doctors insure but the premiums become very high : and these have to be passed on in fees to the patients. Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved. In the interests of all, we must avoid such consequences in England. Not only must we avoid excessive damages. We must say, and say firmly, that, in a professional man, an error of judgment is not negligent." [p.658]

Relying on these observations learned counsel has painted a grim picture that if medical practitioners are brought within the purview of the Act the consequence would be huge increase in medical expenditure on account of insurance charges as well as tremendous increase in defensive medicine and that medical practitioners may refuse to attend to medical emergencies and there will be no safeguards against frivolous and vexatious complaints and consequent blackmail. We do not entertain such an apprehension. In the first place, it may be stated that the aforementioned observations of Lord Denning were made in the context of

substantive law governing actions for damages on the ground of negligence against medical practitioners. There too the last sentence in the said observations that "an error of judgment is not negligent" has not been approved, in appeal, by the House of Lords. [See : 1981 (1) All. E.R. 267]. By holding that medical practitioners fall within the purview of the Act no change is brought about in the substantive law governing claims for compensation on the ground of negligence and the principles which apply to determination of such a claim before the civil court would equally apply to consumer disputes before the Consumer Disputes Redressal Agencies under the Act. The Act only provides an inexpensive and a speedy remedy for adjudication of such claims. An analytical study of tort litigation in India during the period from 1975 to 1985 made by Prof. Galanter reveals that a total number of 416 tort cases were decided by the High Courts and this Court, as reported in the All India Reporter, out of which 360 cases related to claims under the Motor Vehicles Act and cases relating to medical malpractice were only three in number. [See : Upendra Baxi and Thomes Paul, Mass Disasters and Multinational Liability, The Bhopal Case, pp. 214-218]. One of the factors inhibiting such claims is the requirement

regarding court fee that must be paid by the plaintiff in an action for damages on the ground of negligence. Since no court fee is required to be paid on a complaint filed under the Act it would be possible for persons who have suffered injury due to deficiency in service rendered by medical practitioners or at hospitals/nursing homes to seek redress. The conditions prevailing in India cannot, therefore, be compared with those in England and in the United States.

As regards the criticism of the American malpractice litigation by the British judiciary it has been said :

> "Discussion of these important issues is sometimes clouded by an over-simplistic comparison between England and American "malpractice" litigation. Professor Miller noted in 1986 that malpractice claims were brought in the United States nearly 10 times as often as in England, and that this is due to a complex combination of factors, including cultural differences, judicial attitudes, differences in the legal system and the rules about costs. She points to the deterrent value of malpractice litigation and resent some of the criticisms of the American system expressed by the British judiciary. Interestingly, in 1989 the number of medical negligence claims and the size of medical malpractice insurance premiums started to fall in New York, California and many other states. It is thought that this is due in part to legislation in a number of states limiting medical malpractice claims, an in part to improved patient care as a result of litigation."

[Jackson & Powell on Professional Liability, 3rd Edn., para 6-25, p. 466]

Dealing with the present state of medical negligence cases in the United Kingdom it has been observed :

> "The legal system, then, is faced with the classic problem of doing justice to both parties. The fears of the medical profession must be taken into account while the legitimate claims of the patient cannot be ignored.
>
> Medical negligence apart, in practice, the courts are increasingly reluctant to interfere in clinical matters. What was once perceived as a legal threat to medicine has disappeared a decade later. While the court will accept the absolute right of a patient to refuse treatment, they will, at the same time, refuse to dictate to doctors what treatment they should give. Indeed, the fear could be that, if anything, the pendulum has swung too far in favour of therapeutic immunity."[p. 16]
>
> "It would be a mistake to think of doctors and hospitals as easy targets for the dissatisfied patient. it is still very difficult to raise an action of medical negligence in Britain; some, such as the Association of the Victims of Medical Accidents, would say that it is unacceptably difficult. Not only are there practical difficulties in linking the plaintiff's injury to medical treatment, but the standard of care in medical negligence cases is still effectively defined by the profession itself. All these factors, together with the sheer expense of bringing legal action and the denial of legal aid to all but the poorest, operate to inhibit medical litigation in a way in which the American system, with its contingency fees and its sympathetic juries, does not.

> It is difficult to single out any one cause for what increase there has been in the volume of medical negligence actions in the United Kingdom. A common explanation is that there are, quite simply, more medical accidents occurring - whether this be due to increased pressure on hospital facilities, to falling standards of professional competence or, more probably, to the ever-increasing complexity of therapeutic and diagnostic methods." [p. 191]
>
> "A patient who has been injured by an act of medical negligence has suffered in a way which is recognised by the law - and by the public at large - as deserving compensation. This loss may be continuing and what may seem like an unduly large award may be little more than that sum which is required to compensate him for such matters as loss of future earnings and the future cost of medical or nursing care. To deny a legitimate claim or to restrict arbitrarily the size of an award would amount to substantial injustice. After all, there is no difference in legal theory between the plaintiff injured through medical negligence and the plaintiff injured in an industrial or motor accident." [pp. 192-93]
>
> [Mason's Law and Medical Ethics, 4th Edn.]

We are, therefore, not persuaded to hold that in view of the consequences indicated by Lord Denning in Whitehouse v. Jorden (supra) medical practitioners should be excluded from the purview of the Act.

On the basis of the above discussion we arrive at the following conclusions:

(1) Service rendered to a patient by a medical practitioner (except where the doctor renders service free of charge to every patient or under a contract of personal service), by way of consultation, diagnosis and treatment, both medicinal and surgical, would fall within the ambit of 'service' as defined in Section 2(1)(o) of the Act.

(2) The fact that medical practitioners belong to the medical profession and are subject to the disciplinary control of the Medical Council of India and/or State Medical Councils constituted under the provisions of the Indian Medical Council Act would not exclude the services rendered by them from the ambit of the Act.

(3) A 'contract of personal service' has to be distinguished from a 'contract for personal services'. In the absence of a relationship of master and servant between the patient and medical practitioner, the service rendered by a medical practitioner to the patient cannot be regarded as service rendered under a 'contract of personal service'. Such service is service rendered under a

'contract for personal services' and is not covered by exclusionary clause of the definition of 'service' contained in Section 2(1)(o) of the Act.

(4) The expression 'contract of personal service' in Section 2(1)(o) of the Act cannot be confined to contracts for employment of domestic servants only and the said expression would include the employment of a medical officer for the purpose of rendering medical service to the employer. The service rendered by a medical officer to his employer under the contract of employment would be outside the purview of 'service' as defined in Section 2(1)(o) of the Act.

(5) Service rendered free of charge by a medical practitioner attached to a hospital/Nursing home or a medical officer employed in a hospital/Nursing home where such services are rendered free of charge to everybody, would not be "service" as defined in Section 2(1)(o) of the Act. The payment of a token amount for registration purpose only at the hospital/nursing home would not alter the position.

(6) Service rendered at a non-Government hospital/Nursing home where no charge whatsoever is made from any person availing the service and all patients (rich and poor) are given free service - is outside the purview of the expression 'service' as defined in Section 2(1)(o) of the Act. The payment of a token amount for registration purpose only at the hospital/Nursing home would not alter the position.

(7) Service rendered at a non-Government hospital/Nursing home where charges are required to be paid by the persons availing such services falls within the purview of the expression 'service' as defined in Section 2(1)(o) of the Act.

(8) Service rendered at a non-Government hospital/Nursing home where charges are required to be paid by persons who are in a position to pay and persons who cannot afford to pay are rendered service free of charge would fall within the ambit of the expression 'service' as defined in Section 2(1)(o) of the Act irrespective of the fact that the service is rendered free of charge to persons

who are not in a position to pay for such services. Free service, would also be "service" and the recipient a "consumer" under the Act.

(9) Service rendered at a Government hospital/health centre/dispensary where no charge whatsoever is made from any person availing the services and all patients (rich and poor) are given free service - is outside the purview of the expression 'service' as defined in Section 2(1)(o) of the Act. The payment of a token amount for registration purpose only at the hospital/nursing home would not alter the position.

(10) Service rendered at a Government hospital/health centre/dispensary where services are rendered on payment of charges and also rendered free of charge to other persons availing such services would fall within the ambit of the expression 'service' as defined in Section 2(1)(o) of the Act irrespective of the fact that the service is rendered free of charge to persons who do not pay for such service. Free service would also be

"service" and the recipient a "consumer" under the Act.

(11) Service rendered by a medical practitioner or hospital/nursing home cannot be regarded as service rendered free of charge, if the person availing the service has taken an insurance policy for medical care whereunder the charges for consultation, diagnosis and medical treatment are borne by the insurance company and such service would fall within the ambit of 'service' as defined in Section 2(1)(o) of the Act.

(12) Similarly, where, as a part of the conditions of service, the employer bears the expenses of medical treatment of an employee and his family members dependent on him, the service rendered to such an employee and his family members by a medical practitioner or a hospital/nursing home would not be free of charge and would constitute 'service' under Section 2(1)(o) of the Act.

In view of the conclusions aforementioned the judgment of the National Commission dated April 21, 1992 in

First Appeal No. 48 of 1991 [M/s Cosmopolitan Hospitals & Anr. v. Smt. Vasantha P.Nair] and the judgment dated November 16, 1992 in First Appeal No. 97 of 1991 [Dr. Sr. Louie & Anr. v. Smt. Kannolil Pathumma & Anr.] holding that the activity of providing medical assistance for payment carried on by hospitals and members of the medical profession falls within the scope of the expression 'service' as defined in Section 2(1)(o) of the Act and that in the event of any deficiency in the performance of such service the aggrieved party can invoke the remedies provided under the Act by filing a complaint before the Consumer Forum having jurisdiction, must be upheld and Civil Appeal Nos. 688/93 and 689/93 and S.L.P.(Civil) Nos. 6885/92, 6950/92 and 351/93 filed against the said judgment have to be dismissed. The National Commission in its judgment dated May 3, 1993 in O.P. No. 93/92 has held that since the treatment that was given to the deceased husband of the complainant in the nursing home belonging to the opposite party was totally free of any charge it does not constitute 'service' as defined in Section 2(1)(o) of the Act. The Tribunal has not considered the question whether services are rendered free of charge to all the patients availing services in the said nursing home or

such services are rendered free of charge only to some of the patients and are rendered on payment of charges to the rest of the patients. Unless it is found that the services are rendered free of charge to all the patients availing services at the nursing home, it cannot be held that the said services do not constitute 'service' as defined in Section 2(1)(o) of the Act. Civil Appeal No. 254/94 has, therefore, to be allowed and the matter has to be remitted to the National Commission for consideration in the light of this judgment. The judgment of the Madras High Court in Dr. C.S. Subramaniam v. Kumaraswamy & Anr. (supra), holding that the services rendered to a patient by a medical practitioner or a hospital by way of diagnosis and treatment, both medicinal and surgical, would not come within the definition of 'service' in Section 2(1)(o) and a patient who undergoes treatment under a medical practitioner or a hospital by way of diagnosis and treatment, both medicinal and surgical, cannot be considered to be a 'consumer' within the meaning of Section 2(1)(d) of the Act cannot be sustained and Civil Appeals Nos. 4664-65/94 as well as Civil Appeals arising out of S.L.P.(Civil) Nos. 21775/94 and 18445-73/94 have to be allowed and the said judgment of the Madras High Court has to be set aside and the

writ petitions disposed of by the said judgment have to be dismissed. The judgment of the National Commission dated December 15, 1989 in First Appeal No. 2 of 1989 holding that services rendered in Government hospitals are not covered by the expression 'service' as defined in Section 2(1)(o) of the Act cannot be upheld in its entirety but can be upheld only to the extent as indicated in conclusion No.9. Civil Appeal arising out of S.L.P.(Civil) No. 18497/93 has to be allowed and the complaint has to be remitted to the State Commission for consideration in the light of this judgment. S.L.P.(Civil) Nos. 21348-21349/93 have been filed against the judgment of the Kerala High Court dated October 6, 1993 in Writ Petitions filed on behalf of the hospitals claiming that the services rendered by the hospitals do not fall within the ambit of Section 2(1)(o) of the Act. The said Writ Petitions were dismissed by the High Court having regard to the decision of the National Commission in Cosmopolitan Hospital (supra) and the pendency of appeal against the said decision before this Court. Since the decision of the National Commission in Cosmopolitan Hospital (supra) is being upheld by us, S.L.P.(Civil) Nos. 21348-21349/93 have to be dismissed.

Writ Petition (Civil) No. 16/94 has been filed by the Cosmopolitan Hospital (P) Ltd. and Dr. K. Venugopalan Nair who have also filed S.L.P.(Civil) Nos. 6885/92 and 6950/92 against the judgment of the National Commission dated April 21, 1992. In the Writ Petition, the said writ petitioners have sought a declaration that the provisions of the Act are not applicable to alleged deficiency in medical service and that if the said provisions are held to be applicable to the medical profession and hospitals the same may be declared as unconstitutional as being violative of Articles 14 and 19(1)(g) of the Constitution. As regards the first part of the prayer regarding the applicability of the provisions of the Act to the alleged deficiency in medical service, we have already considered the matter and found that the provisions of the Act are applicable to deficiency in service rendered by medical practitioners and hospitals and for the same reason the said prayer cannot be allowed. The other prayer sought for in the Writ Petition regarding the validity of the provisions of the Act is also without any substance. The ground on which the writ petitioners are seeking to assail the validity of the provisions of the Act is that the composition of the Consumer

Disputes Redressal Agencies and the procedure to be followed by the said Agencies is such that it is not suitable for adjudication of the complex issues arising for consideration. We have already considered this grievance urged on behalf of the medical profession and have found that the composition of the Consumer Disputes Redressal Agencies as well as the procedure to be followed by them does not preclude a proper adjudication of the consumer disputes arising out of complaints relating to deficiency in service rendered by medical practitioners and hospitals. In our opinion, no case is made out that the Act suffers from the vice of arbitrariness or unreasonableness so as to be violative of Articles 14 and 19(1)(g) of the Constitution. There is, therefore, no merit in the Writ Petition and it has to be dismissed.

In the result Civil Appeals Nos. 688/93 and 689/93, and S.L.P.(Civil) Nos. 6885/92 and 6950/92 are dismissed. The State Commission will deal with the complaints in the light of this judgment. S.L.P.[Civil] Nos. 351/93 and 21348-21349/93 and Writ Petition (Civil) No. 16/94 are also dismissed. Civil Appeal No. 254/94 is allowed and the judgment of the National Commission dated May 3, 199 is

set aside and O.P.No. 93/92 is remitted to the National Commission for consideration in the light of this judgment. Civil Appeals Nos. 4664-65/94 and Civil Appeals arising out of S.L.P.(Civil) Nos. 21755/94 and 18445-73/94 are allowed and the judgment of the Madras High Court dated February 17, 1994 is set aside and the writ petitions disposed of by the said judgment of the High Court are dismissed and as a result the Consumer Disputes Redressal Agencies would deal with the complaint petitions covered by those writ petitions in the light of this judgment. Civil Appeal arising out of S.L.P.(Civil) No. 18497/93 is also allowed and Complaint Case No. 1 of 1988 is remitted to the State Commission for consideration in the light of this judgment. No order as to costs.

.....J.
[KULDIP SINGH]

.....J.
[S.C. AGRAWAL]

.....J.
[B.L. HANSARIA]

New Delhi,
November 13, 1995.

New Drug Policy

Betrayal of Consumers' Interest

The following is a statement issued by the Voluntary Health Association of India on the new drug policy. It was issued on September 16, 1994. — Editor

The Voluntary Health Association of India (VHAI), New Delhi, a federation of more than 3000 organisations involved in community health, has noted with great concern the announcement of the new drug policy. The policy was announced at a press conference on September 15, 1994. We are shocked that the policy is totally in the interest of the industry and the consumers basic needs are neglected. We are dismayed at the callous indifference of the government towards the health needs of the people. Even the way the government chose to announce the drug policy (which has far-reaching implications as far as the health and life of millions of people are concerned) through a press conference rather than after a proper discussion in Parliament itself is undemocratic.

Drug prices will shoot up because the number of drugs in the price control range has been brought down to 73 from 142. Increasing the profitability ceiling for bulk drugs will directly further worsen the situation as far as the prices are concerned.

The rationale for allowing price decontrol, can in no way be justified if the figures for the last few years are studied. There has been a steady increase in sales, profits and dividends of the drug companies. It is sad that the government has 'bought' the drug industries' argument that drug production is not profitable and drafted the policy accordingly.

The total liberalisation will further worsen the existing anarchic situation in drug production. In the absence of a mechanism to ensure the production of essential drugs, its acute shortage will hit all national health programmes. Its implications are far-reaching as it will lead to further proliferation of hazardous and irrational drugs. The argument of the industry that trade is a fundamental right should not be at the cost of the public's health and life.

The present policy as such will open the gates for the multinationals. High priced, useless and hazardous drugs will be pushed down the throat of the gullible Indian consumer. Increased dependence or imports, higher prices and proliferation will happen due to the policy which allows companies with 51 per cent equity participation to be treated on par with Indian companies. This policy will further hit the Indian industry resulting in import and increasing prices.

It is further disappointing that there has been no reference to the irrational and hazardous drugs which are still being sold.

The neglect towards such an important issue where thousands of products keep the life of the public at stake is very critical. These products will pose a continued threat as far as safety is concerned because the new drug policy does not address this critical issue.

Even in developed countries where the industry has been enjoying a "free-hand" it is under criticism of late. The spiralling costs in health care in the USA is just an example. Recent studies from different parts of the world point out that competition by market forces need not bring down prices. For example, the Office of Technology Assessment in the US was forced to study the costs and profits of pharmaceutical manufacturers because of the ever-spiralling drug costs.

The OTA report dated Februray 25, 1993 tells why drug prices in the US are high and it also shows that *competition simply does not work in the market for prescription drugs which are becoming unaffordable even in the US.* The OTA report states that to *reduce* prices there is room to reduce profits, advertising costs, unimportant research while leaving breakthrough drugs intact and leaving industry a generous profit.

These lessons of failures of such liberalisations and Structural Adjustment Programmes initiated in those countries, instead of being taken as an eye-opener, are being ignored.

The drug companies have proved in the past that

their organised sales promotion propaganda with advertising and marketing strategies will leave no chance for the medical profession to make a free decision. Furthermore, drug is not a substance which an ordinary consumer/patient can decide upon.

The government is giving a 'false hope' to the public that if required the government will bring back decontrolled drugs to the price-control category. But lessons from past experiences show that giving even a chance for overcharging for drugs by drug companies has never benefited the consumer.

The VHAI urges the government to reconsider the policy. We urge that a "rational drug policy" which will ensure the concerns of the consumers [namely, (a) availability of essential and life-saving drugs, (b) withdrawal of hazardous and irrational drugs, (c) adequate quality control and drug control, (d) technological self-reliance] is to be formulated in a democratic process by discussions at various levels, like with professional bodies, health groups, rational drug groups, consumer groups, voluntary organisations, people's organisations and in the Houses of Parliament. ■

Allround Decadence and Ray of Hope

NIKHIL CHAKRAVARTTY

While there is no doubt a lot on which to attack those in authority for their dereliction in running an orderly system of governance, one has to ask at the same time why there has been such an appalling deterioration in social conscience in most of our public activity. In other words, the corrosion of values in public life is not confined to Ministers and top bureaucrats, but has become all-pervasive, the pollution of morals seem to choke out public service.

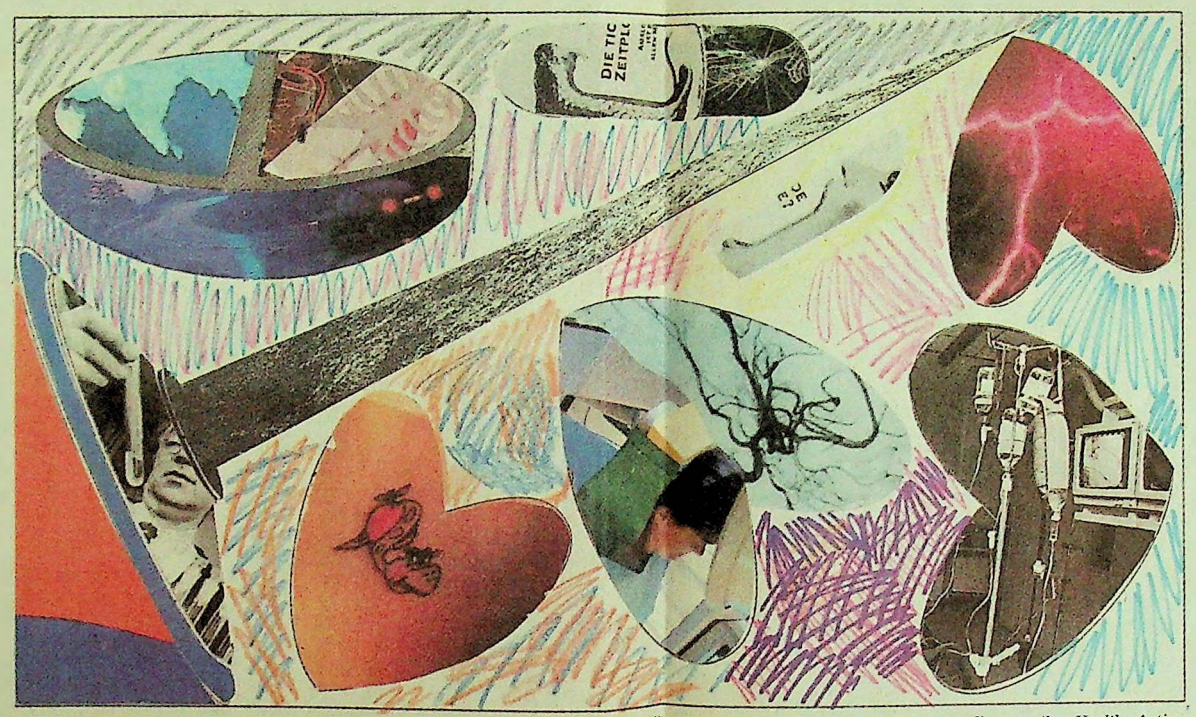
If we look around, there is undoubtedly a widespread feeling of being let-down by those in power, those who have been assigned the mandate to rule by the public that has elected them and placed them on the position of authority. It is precisely because of this reason that the Chief Election Commissioner has suddenly become a phenomenon—applauded by the public that expects him to weed out corrupt practices from the business of election, while he is the target of attack largely by those who feel that their citadel of vested interests in the business of vote-collecting is being invaded by Seshan's attempt at weeding out irregularities in the running of the election machinery. Khairnar might be reckless in his charges against Sharad Pawar, but the fact that he, a minor fry in the bureaucratic set-up, could brace up to make such charges of corruption against the Chief Minister, who is patently on the defensive, shows that in the public mind Pawar's reputation cannot smother out such a critic from inside the very government over which he presides. And quite likely there are many more Khairnars waiting to be counted in the months to come. Obviously the ministerial standing for probity has plummetted so much that it cannot make short shrift of critics from within the bureaucracy itself.

• If we look back on the immediate past, we find that in the last ten years corruption has become a by-word in our public life and is having a deleterious effect on the stability of the government. The fact that criminalisation of politics has become a serious item of concern for responsible people in politics irrespective of party labels—and not just the exaggerated outburst of some chronic critics of the establishment—shows the dangerous deterioration in our public life. All this has begun to stir the public in general. The shock of the scam, that nobody in authority is prepared to take the responsibility for, has contributed in no small measure towards the sapping of public confidence in the government.

But the government apart, the callous irresponsibility of people at different stations of public life is now becoming an issue of intense comment and concern all over the country. The scandal of the capitation fees for entry into educational institutions—and the angry objections at any ban being imposed on this vicious practice—has been widely commented upon, and one would not be surprised if this touches off violent protests. It is not merely the

New Drug Policy has many loopholes...

From the consumer point of view any drug policy should not only ensure good quality of medicines at reasonable prices but also eliminate irrational, useless and hazardous drugs. In addition, an ideal drug policy should provide a graded, essential and priority list of drugs in keeping with the actual health needs of the people. But the NDP does not seem to answer any of these requirements, writes Y G MURALIDHARAN



AFTER a long wait of eight years the New Drug Policy (NDP) has been announced, the objective of which is to create 'conditions of adequate availability of medicines of good quality at reasonable prices'.

While the objectives are laudable, one doubts whether these would be achieved in the light of the earlier experience and the contents of the NDP.

For, what we have as a drug policy is basically a pricing and production policy where the dominant force is the 'profit motive'. It is a policy which is heavily oriented towards the benefit of the multinationals. It attempts to address many of the problems facing the drug industry and not the availability of cheap and good quality medicare to the public.

From the consumers point of view any drug policy should not only ensure good quality of medicines at reasonable prices but also eliminate irrational, useless and hazardous drugs.

In addition, an ideal drug policy should provide a list of graded essential and priority list of drugs in keeping with the actual health needs of the people. But the NDP does not seem to answer to any of these requirements.

For the past many years, the objective of drug policies has been hovering around the same principles of price, quality and easy availability. For instance the S.L. Chatia Committee (1953) laid emphasis on quality and recom mended centralisation of drug regulatory set up in the country. The Borkar Committee did the same a few years later.

During 1974 the Jaisuklal Hathi Committee not only recommended strengthening quality control measures, but also nationalisation of multinational drug companies, establishment of a National Drug Authority, elimination of irrational drug combinations etc., While these recommendations were put to practice in the neighbouring Bangladesh, it was not implemented in India.

Even the successive Drug Policy statements of 1978, 1982 and 1986 had similar objectives. These statements aimed to ensure that drugs are available in abundance to meet the health needs of our people, to make drugs available at reasonable prices, to keep a careful watch on the quality and malpractice etc.,

But none of these objectives have been achieved. India is a signatory to the Alma Ata of bringing health to all by AD 2000. Only a miracle can bring about this in another five years.

One of the objectives of the NDP is to control prices. But how does it propose to do? By decontrolling more drugs! The NDP states that 'it has been decided to keep the drugs having an annual turnover of Rs. 400 lakh or more under price control'. In effect drugs, the turnover of which is below Rs. 4 crore will be out of price control.

As a result of this decision, the number of drugs under price control will get reduced to 73 from the present 142 and the span of control to about 50 per cent from the present 70 per cent.

Decontrolling half of the present drugs un der control would definitely mean rise in prices. As such it would defeat one of the objectives of the NDP. The policy further states that the government would keep a close watch on the price movement of drugs not in the list and reclamp price control, if necessary.

But the earlier efforts in this direction have not been encouraging. Drugs came under price control for the first time in 1962. The Drugs (Display of Price) Order 1962 and the Drugs (Control of Price) Order 1963 were promulgated under the Defence of India Act, freezing prices of medicines as of April 1, 1963.

The Drugs Price Control Order (DPCO) 1970 was issued under the Essential Commodities Act 1955 to bring down prices of 17 essential bulk drugs and their combinations. The DPCO 1979 and 1987 was also issued with the same objective.

Despite price control mechanism, prices of drugs have increased steadily. And many of the drug industries have been pulled up by the courts to pay back the excess amount collected on price controlled drugs.

Following the Supreme Court verdict against over-pricing by drug companies the government is to realise Rs. 270 crore from the industry. The available figures indicate that the actual recoveries is not more than Rs.13.82 crore up to 1992.

However in reality, prices of all categories of drugs have increased by almost 50 per cent. The prices of cardiac and hypertension drugs have increased by 40 per cent. Similarly, prices of anti-TB drugs like Rifampicin have gone up by 40 per cent in the last two years. Several essential drugs are not available in the market.

Even after the DPCO of 1987 was issu ed prices of drugs has shown an upward trend. Though the government intends to monitor price rise, one cannot be optimistic about it. Way back in 1978, the Lovraj Committee was set up to investigate the allegation of large profits of foreign companies, suggested that the effect of DPCO (1979) on profitability of the drug industry should be assessed periodically. So far no attempt has been made to monitor prices and profits.

The NDP states that prices would be kept in check by forces of market com petition'. One need not be an economist to understand the economics of drug industry.

The Indian drug industry has all the problems associated with an oligopolistic industry dominated by a few private firms and an industry dominated by foreign companies i.e. MNC's.

As such, market is a poor mech anism for regulation of prices of drugs. Production and price control measures are very much essential to ensure drugs at low prices.

Secondly, the market for drugs is not determined by consumers but by pharmaceutical companies, detail men (medical representatives) and doctors. Unlike all other commodities in the market, in case of drugs, the consumer has no say over the choice of the commodity he purchases. He goes entirely by the doctor's prescription.

The very fact that the concept of 'turnover' has been taken as basis to determine drugs which are to be brought under price control is itself an indication that the NDP is trade oriented.

Although medicinal products constitute essential tools for health care, it is observed that drug policies are often directed towards industrial and trade development. It is precisely for this distorted objective, that the drug policy is formulated by the Ministry of Chemicals and Fertilisers and not by the Ministry of Health.

This is the first time that we have a policy which determines the list of drugs under price control on the basis of turnover. In the DPCO 1976, essentially was the basis for categorisation of drugs. The Kelkar Committee list of drugs for DPCO 1987 also used essentiality as basis. This concept of essential drugs find no mention in the NDP.

According to the Health Action International (HAI) an essential drug is one which meet real medical needs, has sufficient therapeutic value, be acceptably safe and offer satisfactory value for tial drugs are those that satisfy the health care needs of the majority of the population.

Some efforts have been made in the past to prepare a list of essential drugs with the main objective of price control. The Committee on Essential Drugs (1967) listed 17 drugs. The Hathi Committee gave 104 drugs as essential.

The Drug Policy of 1978 prepared 37 bulk drugs grouped in Category I and II which are highly essential and life saving. The Steering Committee of NDPDC shifted from the essential drug list and prepared priority list of 95 drugs.

However, simultaneously efforts were not made to ensure production of these price-controlled essential drugs and check proliferation of non-essential drugs. The NDP states that the DPCO will be issued in "three months time". This was in September 1994. The DPCO is yet to be announced. The time lag has given enough opportunity to the interest groups to step up their lobbying efforts at New Delhi, to be out of the list.

It is fortunate that the NDP has a provision for setting up an authority for price fixation. This is a welcome move. The NDP states that the government would set up an independent body of experts to be called the Pharmaceutical Pricing Authority (NPPA) to do the work of price fixation. In addition it will also oversee the enforcement of the provisions of the DPCO. The degree of autonomy of this proposed authority is to be watched.

For the past few years drug manufacturers have been trying to pressurise the government to concede its demand for decontrol of production, and pricing. The drug industry has been claiming that its turnover and profit have suffered due to controls. And the NDP has favoured the industry. But in reality, the sales and profits of drug companies have increased over the last few years. The half yearly results (up to March 1994) of drug industry shows that sales has gone up by 32 per cent and profit by 84 per cent.

Another set back to consumers is the provision in the NDP to bring companies with foreign equity up to 51 per cent on par with wholly Indian companies. The NDP states that automatic approval would be given for foreign technology agreements, as per the Industrial Policy for all products except those produced by the use of recombinant DNA technology'. Since the government aims to revise the drug policy "so as to bring it in consonance with the Industrial Policy 1991 and the present EXIM policy" allowing foreign companies is no surprise.

Allowing foreign companies (already we have in surplus) to operate without restrictions would hit the welfare of the consumers. It is well known that MNC's are interested in the financial health of the companies and not in health of consumers. Secondly, they are not interested in producing essential bulk drugs, but in multiplying unnecessary medicines, tonics and syrups. The recommendations of the Bhore Committee, Sokhey Committee, Mudaliar Committee and the Hathi Committee have warned the exploitation of the consumers in our country by the MNC's. Again these MNC's utilise developing countries including India, as dumping grounds for substandard and discarded drugs which have been banned in the country of origin.

Due to extensive price decontrol, liberal licencing and free access to multinationals, the drug market will go unregulated. This will lead to economic drain of crores of rupees on non-essential drugs. As long as the industry is free to produce what it likes, it is almost impossible for the customers to get rational drugs. Backed by vast promotional network, the MNC's are capable of distorting the genuine marketing information and pushing the people to consumer irrational drugs. Non-essentials like tonics, vitamins, health drinks, digestive enzymes, sex stimulants and cough expectorants will increase as against essential drugs to combat TB, Malaria etc.,

A welcome feature of the NDP is that it provides for setting up of a National Drug Authority (NDA) to ensure quality control and rational use of medicines. The NDA to be set up by an Act of Parliament would also prepare and publish national formulary and also the formularies relevant to various levels (like district hospitals, community centres, PHC etc.,) for the guidance of consumers as well as doctors. One hopes that drug information, which is almost absent in the country would be soon available to consumers.

The establishment of more zonal and sub-zonal offices under the Central Drug Standards Control Organisations as well as additional regional drug testing laboratories is a welcome move. If the quality of drugs is not up to the mark, it is also because of insufficient manpower, and other facilities. The NDP needs to be reviewed before implementation so that the welfare of the consumers will get priority and not the industry as it is now.

tor is paid a salary by the hospital, the service he renders cannot be said to be free of charge. The Court rejected this ingenious interpretation, saying "there is no direct nexus between the payment of the salary to the medical officer and the person to whom service is rendered".

Dhawan, however, lauds the Court for "creatively" using his argument. It conceded his plea to discard the blanket ban imposed by the national commission in 1989 on the enforcement of the CPA in government hospitals. "The Supreme Court has removed the very foundation of the commission's verdict, the travesty that those who can't afford to pay don't get the protection of the consumer law," says Dhawan. By exempting pure welfare programmes, the Court has, in his opinion, saved primary health centres, birth-control measures, anti-malaria drive and other such vital activities from being hampered by the CPA. But, then, others argue that primary health-care and birth-control programmes, notwithstanding their "pure welfare" character, are as much known for "deficiency in service" as their now-accountable counterparts.

The judges have also turned down a more fundamental contention, that since the expenses of government hospitals are met by the public exchequer, the patients could not be said to be availing services free of charge. The reasons given inter alia: the direct and indirect taxes paid by a patient are imposed under statutory power without the taxpayer's consent, and the payment is enforced by law; and they are part of the common burden, the quantum depending generally on his capacity to pay.

Finally, was the Court right in disbelieving the doctors' grim forebodings that consumer disputes would lead to a sharp increase in insurance charges and "defensive medicine" expenses? And eventually to a situation where they may refuse to attend to emergencies? The apex court does not share these apprehensions because the CPA has not brought about any change in the substantive law governing claims for compensation. It only provides a procedural alternative, which is more attractive because of the absence of court fee and the emphasis on speed. Indeed, the whole controversy seems to be on account of the fact that the CPA is more expressly geared to enforce accountability than the general law.

a wrong organ is removed or even the wrong patient is operated upon, negligence can be inferred without expert testimony. Unfortunately, even in these cases, civil courts, with their elaborate evidentiary procedures, can take over a decade to render justice. By contrast, consumer fora are designed to provide a speedy trial, but without compromising on the fundamental principles of justice. In essence, the Supreme Court's decision to bring the medical profession under the purview of the CPA is intended to set right this anomaly.

The judgement has already had a salutary effect on doctors across the country. But the sheer scale of recklessness and disregard for human life that most Indians are compelled to suffer in the name of medical service will require a more drastic remedy. The rapid commercialisation of health services, with private practitioners accounting for over 70 per cent of out-patient care, has bred a new class of practitioners who have little knowledge to begin with, who will prescribe any combination of drugs regardless of their usefulness, who have little time for the patient, and who will do virtually anything to earn a quick buck. There is no legal recourse for the victims of such routine and widespread malpractices. Only stringent regulation governing every aspect of medical practice and its firm enforcement will make the profession accountable and restore to it the 'nobility' it could once proclaim. ■

Will greater access to consumer courts make a difference to patients?

BEFORE the Supreme Court gave its verdict, there were over 1,000 cases of medical malpractice lodged in consumer-redressal fora across the country. In 1989, the Kerala Consumer Disputes Redressal Commission held that medical services rendered for payment were 'services' within the meaning of the CPA, a view affirmed by the National Commission headed by Justice Balakrishna Eradi. But subsequently the Madras High Court ruled that they were not. Then, in 1993, the Indian Medical Association (IMA) filed an appeal before the Supreme Court against the National Commission's ruling. Now, the apex court's ruling upholding the commission's position has cleared the way for all these pending cases to go to trial.

Dr A.J. Shelat, Maharashtra state president of the IMA, fears that the ruling "will now open the floodgates for frivolous and vexatious complaints". This is a common perception among doctors, but is it necessarily true? The elimination of court fees and stamp duty certainly removes a major bar to filing complaints before the consumer forum. Also, the expedited procedure to be followed will "not be as detailed and subjected to careful cross-examination as in the case of a civil suit", says con-

The more glaring cases of neglect and callousness will be handled with a greater degree of despatch.

KAI FRIESE

CONSUMER COURTS

In State of Despair

POOR infrastructure, resource crunch, increasing backlogs: the story is the same in the three-tier—national, state and district—consumer court set-up in the country. What was seen as a means of speedy disposal (all cases under the CPA are supposed to be dispensed within 90 days), is today seen as a labyrinth of chaos in the about 450 fora at the district and state levels. The reason: the number of cases far overburden the existing facilities.

For instance, take Bihar: of the 1,000 cases registered, most are still pending. For starters, one of the two member posts in the Bihar Consumer Protection Forum has been lying vacant. The forum works out of a small room in which the court is also cramped in. West Bengal is no better. The three members in the state commission have not been paid their dues since April. The

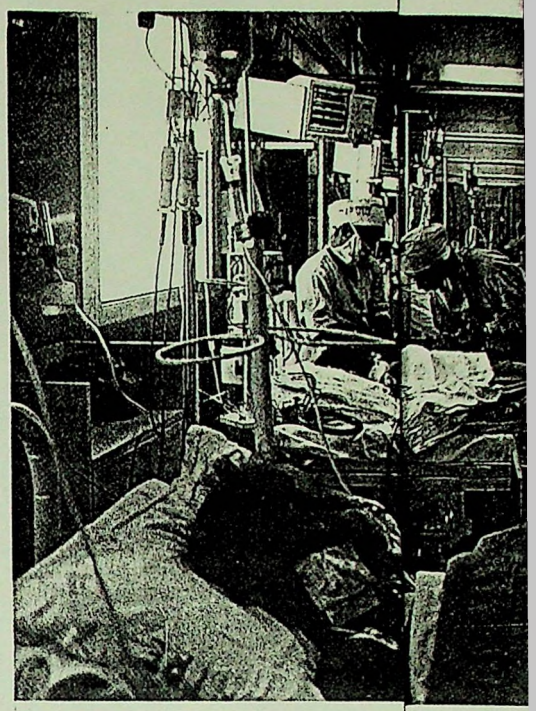
SHIVANI SHARMA

A consumer court at work in Delhi: cases far overburden facilities

court has no bench clerk, and worse, copies of notices and judgements can only be procured by greasing a palm.

In Tamil Nadu, six district foras are not even functional as the required two members have not been appointed. In another six districts, one member has not been appointed, and the required quorum for hearing cases is two. According to N.L. Rajah, a consumer-rights advocate, hardly any of the consumer courts settle disputes in the stipulated time period. Sometimes, cases take one to two years.

The National Consumer Disputes Redressal Commission in the capital fares only a shade better. Here too, the sanctioned staff strength is the same since inception in 1989. Since then, about 7,050 cases have been registered; 2,541 are still pending. Of those pending, 64 relate to medical complaints. The recent Supreme Court ruling will mean more cases for these overburdened courts. And, in that sense, just more despair for the aggrieved consumer.



A number of government

sumer lawyer Rui Rodrigues. Despite these welcome changes, there remain formidable obstacles to proving medical malpractice in consumer fora.

The most serious is the difficulty the claimant may face in getting medical opinion to support his contention. Doctors have a strong survival instinct, and if one of them were found willing to testify against a colleague, it would indeed be a rare case. Yet the president of the Maharashtra state commission has instituted a requirement that a malpractice complaint will be entertained only if the complainant's charge is backed by another doctor's opinion. This, in turn, has led lawyers appearing for the accused doctors to demand a further refinement of the procedure: how can an anaesthetist, they ask, opine on the competence of a cardiac surgeon? If the testimony is to be subjected to cross-examination, they contend, both doctors must be from the same specialisation. But considering how difficult it is to get any doctor to testify in the first place, this additional requirement is a very tall order indeed.

As in civil and criminal proceedings, the burden of proof lies squarely on the plaintiff. Doctors can employ a variety of defences: the patient had given his informed consent for the operation, death or injury was on account of wholly unrelated developments; the patient withheld crucial information (for example, a history of cardiac problems); the failure could be traced to agents beyond the doctor's control or simply that the accident was the result of an unforeseeable error that the doctor's diligence could not guard against. The Supreme Court's ruling that "deficiency of service" in the case of doctors must be "subject to the same test as is applied in an action for damages for negligence" is bound to make the standard of proof that much more rigorous. And the system that much more even-handed.

ADD to these the penalties levied to discourage frivolous litigation, the deplorable state of the consumer court infrastructure, the delays resulting from their lack of personnel and finances, the torture of participating in any sort of legal proceeding in India, not to mention the stigma of cashing in on a dear one's suffering: it would be truly surprising if anyone were to seek reparation from these fora. The fact that some intrepid souls actually do so is testimony to their grit as much as to the magnitude of the pain they have suffered at somebody else's hands.

There is little doubt, however, that the access to consumer courts granted to malpractice victims by the Supreme

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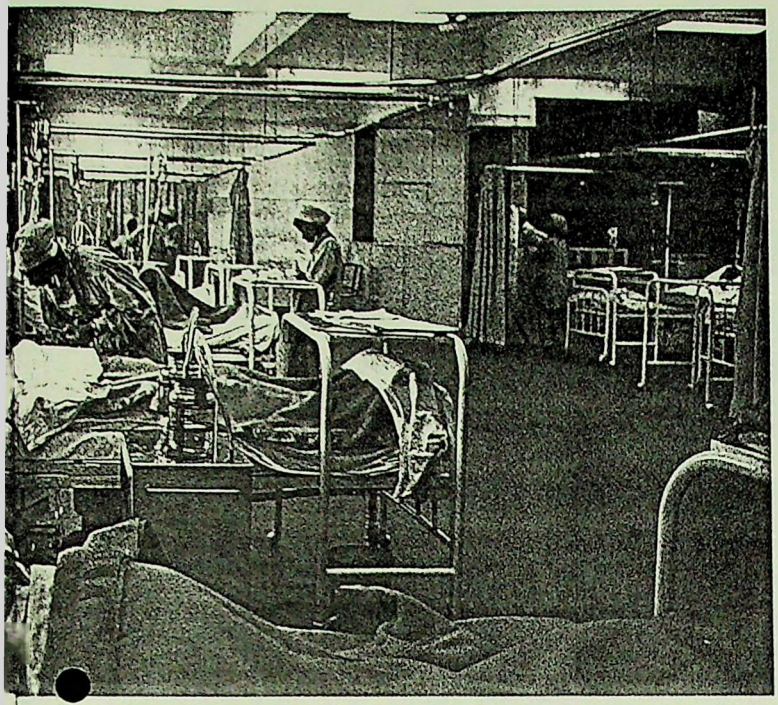


hospitals have now come into the net of the CPA.

Court will make a difference for claimants and doctors alike. The more glaring cases of neglect and callousness will be handled with a greater degree of despatch, something that will enormously increase public confidence in the possibility of legal redress. Equally important is the impact this additional liability will have on the conduct of medical practitioners. As Dr Pragnya Pai, dean of Bombay's King Edward Memorial Hospital, observes: "At the very least, it will force doctors to communicate better with their patients to help avoid any misunderstanding that might result in litigation."

Insurance Cover: What's on Offer

DOCTORS:

(Max. cover: Rs 1 crore)
For a Rs 30 lakh policy:

- GPs: Rs 1,500 p.a.
- General Practice Surgeons: Rs 6,000-10,000 p.a.
- Specialist surgeons, cosmetic surgeons and gynaecologists: Rs 18,000 p.a.

Covers all claims arising out of bodily injury or death of any patient caused by error, omission or negligence. Exclusions: Any criminal act, or any act in violation of law, or service rendered under the influence of intoxicants.

PATIENTS:

(Max. cover: Rs 1 lakh)

- Covers hospitalisation, surgery, doctor's fees, room charges, tests etc. Pre-existing diseases not covered.

Will malpractice liability insurance increase cost of health-care?

ONE of the most striking reactions to the Supreme Court judgement has been the sudden spurt of interest in doctors' and medical practitioners' 'indemnity insurance cover'. According to senior insurance officers, all four subsidiaries of General Insurance Corporation (GIC) have been receiving an unprecedented number of inquiries about these policies. But GIC General Manager M.V. Purohit maintains: "It would be an exaggeration to say that medical costs will significantly increase with wider medical insurance after the Supreme Court judgement."

Few dispute that more doctors, especially surgeons and specialists, will now seek insurance to indemnify themselves against successful claims of malpractice. At present, barely 15 per cent of the IMA's one lakh members are estimated to be insured against professional liability. Similarly, thousands of medical establishments, including large hospitals, operate without 'medical establishment cover' offered by insurance companies, despite being vicariously liable for the acts and omissions of thousands of non-medical personnel in their employ. Public hospitals have traditionally never been insured, but those that charge some of their better-off patients will have to consider doing so in the light of the judgement. So there is a huge market for medical insurance waiting to be tapped. But even if the entire cost of insurance were to be passed on to consumers, it is not clear what impact this will have on the cost of health services.

The reason is that premiums on medical indemnity insurance vary very widely. The price of a policy depends on a raft of factors which together determine the degree of risk that the insured person faces. This depends principally on the doctor's specialisation, his experience, the number of patients he sees, the quality of his equipment, his past record of malpractice claims and so on. At the top of the risk league are cosmetic surgeons, obstetricians and gynaecologists. The reason: judges tend to be very harsh when cosmetic surgery goes awry as the exercise has no medical rationale and there was nothing 'wrong' with the client in the first place. Similarly, when things go wrong with female reproductive health, the out-

ASHESH SHAH

The Court's ruling is likely to lead to a closer risk assessment of the country's medical industry.

come is usually fatal.

At the other extreme are the general practitioners (GPs) whose premium rates are a 12th of what plastic surgeons pay. The maximum that a doctor can currently insure himself for is Rs 1 crore, although rare exceptions are allowed. Usually, the premiums work out to less than 1 per cent of the amount insured for and payments are restricted to four claims a year. Claims arising from a criminal act or any violation of law are disallowed as are those arising from "services rendered under the effect of intoxicants and narcotics". Premium rates were last revised in 1989 and the Finance Ministry is now considering another revision. With the sudden surge in demand from both ends of the spectrum, GPs' rates are likely to be increased while those paid by specialists could be reduced. Moreover, a number of foreign insurers have approached the IMA with a range of policies. So, despite the increased demand for medical insurance, its cost could go down in the short run.

According to Purohit, the positive fallout of the judgement is that "it will compel doctors to put their houses in order, improve the quality of their record keeping and force them to keep the patient better informed". The real increase in medical costs, he feels, will come from additional tests that physicians might now insist upon to reduce their chances of error. Agrees Dr B.K. Sharma, director, Post-Graduate Institute of Medical Education and Research, Chandigarh: "Escalation in the cost of medicare out of overabundant precaution by the doctors would be the immediate fallout," he says.

On the other hand, the apprehension of an overall increase in healthcare costs could expand the market for medical insurance among patients. The present mediclaim policies that the industry offers have a limit of Rs 1 lakh. And despite numerous complaints of non-payment of claims by the companies, following abuse of the systems by patients and hospitals, these policies too are becoming increasingly popular. In effect, the judgement is likely to lead to a closer risk assessment of the medical industry in an effort to spread the risk of failure as wide as possible. ■

CPA: Who's Liable and Who's Not

Those Subject to the Consumer Law...

- Doctors with independent practice, unless rendering only free service.
- Private hospitals charging all.
- All hospitals having free as well as paying patients. They are liable to both.
- Doctors/hospitals paid by an insurance firm for treatment of a client, or an employer for that of an employee.

...and Those Exempt from its Ambit

- Doctors in hospitals which do not charge any of their patients.
- Hospitals offering free service to all patients.

Will the judgement curb unethical and reckless medical practices?

IN 1986, India had 7.6 lakh registered doctors practising a variety of systems of medicine. About 3.2 lakh of them, or 42 per cent, were allopaths, the majority of whom were concentrated in the cities. It is estimated that just over a quarter of all allopathic doctors are employed in government services, the rest being either self-employed or working in private hospitals and clinics. The concentration of the profession in urban areas has led to intense competition and, consequently, to dubious practices to earn a living. As Sunil Nandraj, a Bombay-based health researcher, observes: "The doctor-doctor relationship is characterised by what is known in medical parlance as 'cut practice'—the doctor gets a cut of the fees charged by the consultant, laboratory or nursing home that he refers the patient to."

In Bombay, the cut could be as high as 30-40 per cent of the fees charged. The system is pervasive and the nexus extends even to beauty parlours who supply a steady stream of clients to the booming cosmetic-surgery business. As Nandraj points out, the practice thus inevitably leads to "unethical and unnecessary investigations, referrals, hospitalisation"—in short, to the sys-

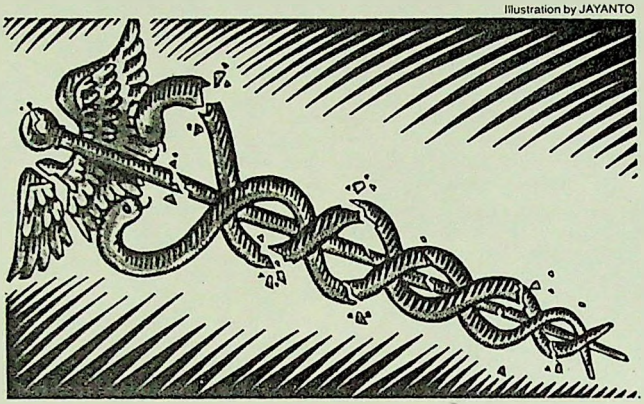
MEDICAL COUNCILS

Discredited Cabal

IF the case for self-regulation by the medical profession has been so thoroughly discredited, the blame rests with the medical councils. Almost everybody who has ever had occasion to approach a state council to seek redressal against professional misconduct of doctors has come away with the distinct impression that it is nothing more than a cabal created to shield doctors against criticism.

The Medical Council of India (MCI), constituted under the Central statute in 1956, is entrusted with the task of regulating medical education and maintaining academic standards in the country. The state medical councils, created under state legislation, are entrusted with registering qualified medical practitioners and providing a disciplinary forum for public grievances against doctors. Those found guilty of misconduct can be deregistered, which amounts to a denial of the right to practise. Of course, deregistration in one state does not mean the doctor can't practise elsewhere in the country.

Illustration by JAYANTO



A state medical council has 22 members, five of whom are nominated by the state government. The council, however, meets extremely infrequently, as a result of which complaints take years to be dealt with. Proceedings before the council are in two stages. In the crucial first stage, a prima facie case has to be made out against the doctor but the complainant is not allowed to be represented by a lawyer. It's a rare case that makes it to the second stage of inquiry. But even here, the case is held in-camera. Descriptions of proceedings border on the absurd, with a continuous stream of members wandering in and out, asking the president which case was being heard while others spend the time reading newspapers.

According to consumer-activist Vijay Jathanna, in its three decades of existence, the Maharashtra Medical Council has deregistered just three doctors: one for having been convicted of murdering his wife and two for violating the council's sacrosanct bar on advertising. Over this period, Bombay has witnessed hundreds medical-malpractice cases ending in death and disability, but in not one has the council thought it necessary to do anything more than issue a stern warning.

—ARUN SUBRAMANIAM

Liability under CPA : The Debate

DOCTORS

- Medical service not a commodity.
- Judge competence and timeliness, not result.
- Judges can't grasp the technical nature of medical cases.
- No court fee and stamp duty means frivolous suits.
- Consumer fora are kangaroo courts.
- Costs will rise as doctors turn to 'defensive' medicine.
- Doctors would withhold services in critical cases.
- A USA-like situation of huge awards will be created.

CONSUMER ACTIVISTS

- It is like any other professional service.
- Needed to do only what's professionally possible.
- Civil and criminal courts have been judging with the help of expert testimony.
- The CPA being amended to deter such cases.
- All civil-court procedures followed.
- Already do so to recover investment in equipment.
- Already do so for fear of medico-legal complications.
- India's limited insurance market will prevent that.

tematic plunder of the patient. So doctors who have warned that the Supreme Court judgement will encourage "defensive medicine", or a basic conservatism that relies on more investigations to avoid the risk of misdiagnosis, forget to mention that such practices are already an industry standard.

Doctors treat disease with a degree of casualness that can at times be breathtaking. A much-cited study of TB treatment by 100 private practitioners in Bombay discovered no less than 80 different treatment regimens, most of which were both expensive and ineffective. For supplies, doctors often rely on free samples from medical representatives and routinely dispense the medicines loose in paper packets without identifying the contents. Many do not consider it necessary to even provide the patient any information regarding the diagnosis or the line of treatment being prescribed. Nor are fees charged by doctors standardised. By making them accountable under the CPA, feel many, could see that change. Says K. Sudhakaran,

former Kerala advocate-general: "It will improve the quality of treatment."

The state of health infrastructure in the private sector, however, is just as alarming. Barring a few large corporate hospitals, the vast majority of private nursing homes are badly constructed, with poor ventilation, lighting, water and sanitation. A recent study in Bombay found that 62 per cent of private hospitals were located in residential premises. The operating theatres and labour rooms would typically be located in the kitchen. Many of them were congested, with insufficient space to move a trolley or stretcher. They had few emergency-support services like an ambulance, blood, oxygen cylinders or electricity generators. Worse, all the hospitals studied disposed of their waste in open garbage dumps, thereby endangering public health.

All this is widely known, but little seems to be done about it. The medical councils (*see box*)—which are entrusted with registering practitioners, setting standards of practice and disciplining the profession—have collapsed into disrepute. More scandalous, a 1992 nationwide survey of state regulations governing the establishment and operation of private hospitals and nursing homes revealed that only Maharashtra and Delhi have enacted laws to govern this vital sector. The acts of both states stipulate that all nursing homes must renew their registration every year by submitting detailed information regarding their staff strength and qualifications, equipment, accommodation and sanitary conditions, with penalties for non-compliance. Yet the Delhi administration readily admitted that only 134 out of 545 nursing homes in the state were registered while the Bombay Municipal Corporation admitted, for its part, that for the past two to three years, officials had not visited the hospitals in several city wards.

As Nandraj observes: "Despite having one of the largest private health sectors in the world, providing 70 per cent of the country's healthcare, the fact that it functions practically unregulated is a matter of grave concern." Such a callous attitude towards health regulation on the part of the Government encourages the private health sector to behave recklessly. Consumer courts are now empowered to compensate those who are injured by the gross negligence of medical practitioners, but sadly they are helpless to prevent it. ■

Is tougher regulation the only way to ensure accountability?

THE Supreme Court has sent a strong signal to doctors that it is no longer willing to sit by and watch as they run roughshod over patients' rights. But in the absence of punitive damages, even a responsive consumer court cannot deter rash and negligent behaviour. And if the medical profession cannot regulate itself, it is inevitable that the state will be called upon to do so.

It is obvious that the medical councils will first have to be revamped to restore their credibility. Their members have to be fairly elected and must include a larger proportion of non-medical personnel. Those doctors who choose to serve on the council should be required to sacrifice their private practice for the duration of their tenure if the council is to function on a regular basis. The register of medical practitioners should be scrutinised and brought up to date. And all proceedings before the council should be public: perhaps like their US and UK counterparts, they could provide for a preliminary screening process by the president. But the trial of all charges of misconduct must be held in public.

"The argument that this could compromise the reputations of prominent doctors is disingenuous," says advocate Colin Gonsalves. "After all, anybody charged with a criminal offence is forced to testify in an open court. The presumption of innocence till he's proven guilty is the only protection the law affords to his reputation." Why indeed should doctors be treated any differently? In fact, as Gonsalves adds, "It is the preoccupation with secrecy that has raised suspicions about their intentions and undermined the council's status of an

Continued on page 195

The Government must establish clear standards for the regulation of the health sector as a whole.

BHAWAN SINGH

What Can be Done

Medical Councils can:

- Stop government appointments
- Take full-time members
- Update registers
- Make proceedings public
- Make continuous education compulsory
- Arrange for imposing fines on erring doctors

The Government can:

- Set clear standards for health institutions
- Standardise fees
- Invest in health sector

SINGHI CASE

Waiting for Justice

IT is one of the most intriguing medical malpractice cases ever to have been fought in India. Retired IAS officer P.C. Singhi has spent the best part of the past eight years seeking both to prosecute and claim damages for the suffering his wife had to endure at the hands of one of the country's most eminent oncologists, Dr Praful Desai, the director of Tata Memorial Hospital (TMH), Bombay.

Singhi's wife Leela had been suffering from cancer for over a decade when in 1987 she complained of acute pain in the abdomen. She had been under the treatment of Dr J.C. Paymaster and his assistant, Dr A.K. Mukherjee, at TMH, Bombay. Paymaster advised her to seek the advice of doctors at New York's Sloan Kettering Memorial Hospital to see if her uterus could be removed. However, Sloan doctors determined that the cancer had spread too far for an operation, and recommended chemotherapy.

But soon after the couple returned, Leela started bleeding excessively and was admitted to TMH. Dr Desai, who had succeeded Paymaster as the head of oncology, examined Leela, and recommended immediate operation, to be conducted by him. On the appointed day, however, Desai asked Mukherjee to operate on Leela. When Mukherjee opened her up and confirmed that the cancer had indeed spread all over, Desai told him to sew Leela up, not once having looked at her.

P.C. Singhi and wife Leela: their case highlights the need for tougher regulation

The operation aggravated Leela's condition and exactly 14 months later, she died painfully. When Singhi complained to TMH, he found that Desai had completely disowned the case, claiming that Leela had all along been Mukherjee's patient. Yet Singhi was presented a Rs 5,000 bill as Desai's fees. He filed a complaint before the medical council, and Mukherjee testified in his support. In a move to exonerate himself, Desai produced what he claimed was the hospital register showing Leela as Mukherjee's patient. Singhi, in turn, produced a xerox copy of the original proving quite the contrary.

On January 13, 1990, the medical council found Desai guilty of "professional misconduct" and issued him "a very strict warning". In civil proceedings before the Bombay High Court, Singhi sued Desai for Rs 25 lakh. He was offered Rs 5 lakh to settle the case. The police have also charge-sheeted the director on the strength of the medical council's finding. Desai tried to quash proceedings three times by filing writ petitions before the high court but failed. Now that Justice P.D. Upasani of the sessions court has held that a prima facie case of rash and negligent behaviour has been made out against Desai and ordered him to appear before the metropolitan magistrate on December 12, 1995, the case is finally going to trial.

It would have been inconceivable earlier that a doctor of Desai's standing could ever be indicted by the medical council, which operates more often as a doctor's counsel. The charges of fabricating evidence to evade responsibility might have helped. But if Mukherjee had not testified in Singhi's favour, the latter would have had virtually no chance at all. Mukherjee proved a man of enormous courage to publicly denounce his superior. Desai, on the other hand, appears to have underestimated Singhi's shrewdness and tenacity. But even with this formidable combination, Singhi is still waiting for justice.

—ARUN SUBRAMANIAM

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independent watchdog."

Another major responsibility of the council is to ensure that those registered for practice undergo continuous medical education to ensure that they stay abreast of developments in their field, so as to provide patients the best available medical care. In the US, every licensed medical practitioner must devote 50 hours a year to attending medical school as a condition for retaining his licence to practise. It has also been suggested time and again that the medical councils be empowered to levy punitive fines in addition to their powers to suspend and deregister offenders.

But equally important, the Government must establish clear standards for the regulation of the health sector as a whole. These include minimum standards for hospitals and clinics, whether in the public or private sector; standardising fees charged by practitioners for specified services; ensuring patients have a right to their medical records; and so on. It must, moreover, compel everybody to adhere to them, including institutions under its control. The exclusion of services rendered free of charge from the ambit of the CPA has widely been seen to reflect the Government's inability to maintain standards in public hospitals. While the Government might have other considerations, as the Supreme Court has clearly recognised, the deplorable state of public-health services may make it difficult for it to enforce the law against the private sector without attracting the charge of double standards. The judgement thus could provide the first step in treating the consumer as a class. ■

From India Today. Dec 15-1995

ON.

Consumer Protection Act and The Doctors

CON 1.7

BY ARUN SUBRAMANIAM

"NO greater opportunity, no greater responsibility, no greater obligation fall to the lot of the human being than to become a medical doctor. In the care of the suffering, he/she needs scientific knowledge, technical skill and human understanding. And those who use these with courage, with humility and with wisdom, will provide a unique service to their fellowmen and women and will build an enduring edifice of character within themselves. It is this nature of human service that gives medicine its unique status of being a noble profession."
—Dr R.D. Lele, former director, Jaslok Hospital, Bombay.

Sadly, countless patients who have had first-hand experience of the Indian medical profession do not share Lele's exalted notion of his calling. Not even the judiciary. Last fortnight, a three-judge bench of the Supreme Court ruled that doctors were like any other provider of services under contract and, therefore, are under the same obligation to compensate the purchaser for any deficiency in the quality of their wares. The apex court decreed that medical practitioners, like other professionals, were indeed liable under the Consumer Protection Act (CPA), 1986.

Doctors are already liable under civil and criminal law for acts of negligence. A doctor who fails to do what is required of him in his professional capacity, or who does something that a reasonable person under the circumstances would not do, is said to have acted negligently. Of course, in diagnosing or treating a patient, no doctor guarantees perfect judgement, let alone a cure. The inexactness of biological science precludes such certainty. But by undertaking to render medical service, a doctor is "understood to hold himself out to possess the standard professional skill and knowledge", as advocate Mihir Desai puts it. In determining what this "standard" of skill is, courts rely not on the average ability that a member of the profession possesses, but the minimum common skill that is required to belong to that profession.

Proving medical negligence is not easy. In order to pass judgement on matters of medical science or technique, judges typically rely on expert testimony. But where the issues in contention can be said to lie within common sense or common knowledge, as in cases where

Negligence: Court's Definition

"A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person, when consulted by a patient, owes him certain duties, namely a duty of care in deciding whether to take the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient."

SAIBAL DAS

SUPREME COURT RULING

Speeding up Redressal

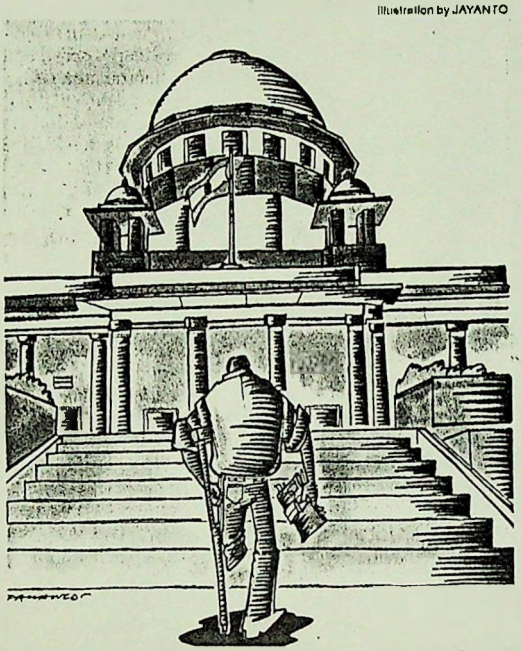
BY MANOJ MITTA

IN what circumstances can a doctor be sued under the Consumer Protection Act (CPA)? This question arose for the first time about seven years ago when a Rajasthan villager, Sushila Devi, became an invalid after undergoing a tubectomy operation as part of the family-planning programme. In December 1989, the National Consumer Disputes Redressal Commission ruled that she was technically not a consumer as she had undergone the surgery at a government hospital. But last fortnight, the Supreme Court made it possible for victims like Sushila Devi to get the benefit of the CPA.

Last fortnight, while deciding a bunch of medical-malpractice cases, including an appeal filed on behalf of Sushila Devi, the Court held that the only precondition for applying the CPA to a government hospital was that there should be some paying patients as well. The non-paying patients can also then take recourse to the CPA because "consumers as a class" are envisaged to be protected. Otherwise, those who cannot afford to pay would be denied access to the CPA "even though they are the people who need the protection more". As the Court pointed out: "It is difficult to conceive that the legislature intended to achieve such a result." Thus, a number of big government hospitals have now come into the net of the CPA, which provides a speedy and inexpensive remedy to aggrieved consumers.

In an equally significant development, the Supreme Court has put its stamp of approval on the peculiar composition of consumer commissions which are dominated by laypersons. The CPA stipulates a judicial background for only the president of a commission, while the members could be from any field. This is unlike the other tribunals, such as administrative and income tax, which have judicial and non-judicial members in equal strength. Doctors' organisations had argued that the president could thus be overruled by the lay members of a commission. This, they claimed, would be prejudicial to them and therefore was a ground for exempting doctors from the purview of the CPA. But the apex court asserted that the CPA actually combined legal competence with "the merits of lay decision making".

Illustration by JAYANTO



The ruling clarifies that "deficiency in service" will mean only negligence.

At the same time, the judgement has strengthened the position of the doctors and hospitals by clarifying that, in their case, the statutory expression "deficiency in service" would mean only negligence. This is how the Court met the contention of the Indian Medical Association (IMA) that doctors should be exempted from the CPA because there were no fixed norms for ascertaining any deficiency in medical service. Which means that deficiency would be determined under the CPA "by applying the same test as is applied in an action for damages for negligence" in a civil court. Negligence implies a gross failure to take reasonable care as, for instance, amputation of the wrong limb or performance of an operation on the wrong patient. IMA's counsel Harish Salve, therefore, welcomes the judgement despite his client's reservations. "The IMA does not seem to have understood how the situation has improved. Doctors cannot be hauled up anymore by a commission on a vague charge like substandard service," he says.

Another major gain for the medical side has been the Court's guideline that "in complaints involving complicated issues requiring recording of evidence by experts, the complainant can be asked to approach the civil court" instead of pursuing the matter before the commission. The Supreme Court conceded IMA's point that the summary procedure prescribed by the CPA would suit only glaring cases of negligence. But, as senior advocate C.S. Vaidyanathan points out, most of the medical complaints that have so far come before the various commissions were found to be amenable to a summary trial. And yet, a lot of those complaints were dismissed. "This shows that the commissions have erred in favour of the doctors," he says.

While the consumer lobby has succeeded in maintaining the CPA's jurisdiction over medical malpractices, it has failed in its bid to expand the ambit to include those hospitals that render only free service. This is because of an express bar in the CPA, stating that the law will not apply to a service rendered "free of charge". The advocate representing the consumers, Rajeev Dhawan, sought to overcome this hurdle by arguing that when the doc-

CON 1.8

After six-year battle, consumer court tells doctor to carry on

Meera John Chakraberty

BANGALORE: Unarguably, the recent decision to bring the medical profession under the purview of the Consumer Protection Act pinches practising doctors the most. Reason: the slightest complication in a medical case and inevitably, the needle of suspicion points to the doctor first. But the case of 68-year-old Dr N.P. Mookherjee of Bangalore, who has with 43 years of service behind him in obstetrics and gynaecology, might hearten conscientious doctors who might have feared victimisation, post-CPA.

In an agonisingly long and sapping battle, spanning nearly six years in the Karnataka consumer court, Dr Mookherjee fought valiantly to the finish to "save his honour". On November 18, 1996, he created history of sorts, when the Justice D.R. Vithal Rao, president of the Karnataka State Consumer Disputes Redressal Forum (State Commission) pronounced a verdict, negating all charges levelled against him.

Dr Mookherjee's patient, Uma Pingle, had dragged him to court on January 11, 1991, slapping charges of "sheer negligence and mishandling her case, causing untold suffering" on him. She claimed Rs 6.8 lakh by way of damages.

After subjecting a long line of deposers, including the complainant and the accused, through gruelling cross-examination, the judge concluded that: "...given the facts and circumstances of the case, we find Dr Mookherjee has attended the patient with care, skill and diligence. No material has been placed on record to attribute negligence in operation and subsequent management. This complaint fails and is dismissed. The parties are directed to pay and bear their own costs."

In delivering its judgement, the State Commission harked back to the Supreme Court verdict in the *Achutrao Haribhau Khodwa and others vs. State of Maharashtra and others* case reported in 1996 which read: "...the skill of medical practitioners differs from doctor to doctor. Courts should be slow in attributing negligence on the doctor's part if he has performed his duties to the best of his ability and with due care and caution..."

Unspool to the year 1980, when Uma Pingle, wife of an army major, approached Dr Mookherjee, then senior adviser (obstetrics and gynaecology) at the Command Hospital Air Force in Bangalore, with a problem of excessive vaginal bleeding and pain in the abdomen. The doctor diagnosed it as extra-uterine endometriosis at the vault of the vagina.

The options before Dr Mookherjee at that time were to perform surgery or to put his patient on drugs. He decided on the latter. "In 1982, another gynaecologist at the military hospital in Udhampur bungled up the case by performing a total hysterectomy on her, removing her uterus and cervix but leaving behind the ovaries and fallopian tubes from which she continued to bleed," said Dr Mookherjee.

In late 1989, a frustrated and anaemic Ms Pingle reapproached Dr Mookherjee in Bangalore. After a thorough examination Dr Mookherjee suggested surgery to remove both her ovaries for permanent cure. She requested Dr Mookherjee (now retired from the Services), to conduct the operation in a private nursing home of her choice.

Dr Mookherjee operated on her at the Ashok Nursing Home in the city on July 23, 1990 and the doctors were satisfied with her post-operative recovery. On July 26, 1990, however, she developed swelling of the abdomen, fever and irregular bowel sounds. "We diagnosed it as 'paralytic ileus', a reversible complication that crops up in abdominal surgeries. It is only if spontaneous correction fails that we resort to laporotomy (a re-operation of the abdomen)," Dr Mookherjee pointed out.

Dr Mookherjee decided to open her up again to get to the root of the problem. On Ms Pingle and her husband's insistence, she was shifted to the Command Hospital for re-surgery.

The patient's case-sheet at the Command Hospital has recorded that both the duty doctor on admission and the senior surgeon who operated on Ms Pingle diagnosed her case as 'paralytic ileus'.

The re-surgery was successful and after recouping in the hospital for close to a month, the patient was discharged.

However things took a nasty turn, when close on the heels of her discharge, Ms Pingle, who till then had expressed no complaints about Dr Mookherjee's line of treatment, sued him for "mishandling her case". Her evidence stated: "The doctors who treated me in Command Hospital convinced me that all this was due to the negligence of Dr Mookherjee at the nursing home."

Dr Mookherjee further disclosed before the State Commission that in a deaprture from convention, Ms Pingle's case-sheet was not destroyed 48 hours after her discharge from hospital but was recorded in the statistics section, to be followed up as a medico-legal case. "The doctors had planned to frame a case against me."

Shattered though he was by the six-year-long nightmare, Dr Mookherjee has come out trumps. His victory, like that of the eminent Bombay-based cardiac surgeon, Dr S. Bhattacharyya, should reassure his medical colleagues that the Consumer Protection Act cannot be used cavalierly as an instrument of harassment.

M.D. Asad

Seeing your doctor? Do you know about your rights?

CONSUMER RIGHTS

Y.G. Muralidharan

The enactment of the Consumer Protection Act (CPA) in 1986 and the Supreme Court's judgement in 1995 setting at rest the controversy over CPA's applicability to doctors, coupled with increasing instances of medical negligence has brought into focus the right of patients.

Patients can expect and get the best healthcare only when they know their rights and aren't afraid to assert them. Many countries have already adopted a charter of patients' rights, though in many cases it is yet to receive legal sanction. In Indonesia, a health law adopted in 1992 sets out provision for these rights, like information and informed consent. The Australian Consumers Council is developing a charter for all recipients of healthcare in public and private hospitals. A country like Vietnam has a law on this subject. Malaysia, where consumer awareness is quite high, has a charter of patients rights.

In India, in response to an increasing number of complaints about deterioration of health service, the ministry for food and civil supplies and consumer affairs, set up a workgroup to identify possible improvements. As a result, a voluntary scheme sets out the basic standards for health facilities in both the public and private sector.

The Consumers International, an organisation having more than 200 member organisations in over 80 countries has recently launched a campaign at the international level for patients rights.

The first right of the patients relates to reasonable and acceptable standards of healthcare. It is the responsibility of the government to ensure that optimal healthcare services are provided to all citizens without discrimination on the basis of age, sex, ethnic origin, religious affiliations etc.

According to the World Health Organisation (WHO), minimum healthcare includes safe water in homes or within 15 minutes walking distance, adequate sanitary facilities and immunisation against certain diseases. Health workers say that if good drinking water is made available, one-third of diseases can be eliminated.

A patient's second right is access to information. The charter says that access to information is essential for a patient to play an active role in his/her health care. The WHO feels that an informed patient responds more effectively to treatment.

The right to information includes information about cost of treatment, side-effects, various alternatives to treatment, right to view their own medical records etc. Recently, the Bombay high court held that the hospital is bound to furnish medical records if a patient asks for it.

A patient should have the right to information not only about the disease but also drugs and medicines. Almost all patients blindly follow doctors' instructions. They do not dare to ask questions lest the doctor be annoyed.

For instance, a study conducted by a doctor at the University of California showed that only 2 out of 23 manufacturers were consistent in what they told Indian and Latin American customers about their products.

Also, in Third World countries, it has become increasingly common to sell drugs in foil strips without cardboard packs or package inserts. Foil strips have the advantage of protecting drugs from humidity. but they have little space for vital information on dosage and precautions for use.

Patients should also have the right to choose their health care. Choice implies consent. Patients have the right to refuse treatment, provided they are well informed. The right to choice includes changing doctors, confidentiality of their ailment etc. The healthcare system should be flexible enough to enable patients to choose their own doctor, healthcare provider and healthcare establishment.

The right to participation ensures that healthcare consumers receive adequate representation in policymaking bodies and decisionmaking processes. Right to participation not only enhances quality of healthcare service but also encourages allocation of resources necessary for maintaining adequate healthcare systems.

Another important right of patients is the right to complain in case of injury, suffering or loss of life due to medical negligence. In the event of negligence, the patient should have the right to recover damages even if he/she has not been caused any harm.

Fortunately in India, the CPA has given opportunity for patients to sue doctors in case of negligence. At present, government-run hospitals are not covered under the CPA. Since most Indians depend on public health service, there is a need to bring government hospitals with the CPA net.

The author is executive trustee, CREAT (Consumer Rights Education and Awareness Trust)

CLARIFICATION

While discussing courier services in these columns (3.1.97) a case relating to **Sudhir Deshpande vs Elbee Services** *was quoted and it was said that the National Commission had ordered Elbee Services to pay compensation of Rs 1,29,992 to Mr Deshpande.*

Attorneys representing Elbee Services have informed us that the company went in appeal to the Supreme Court against the National Commission's order. Meanwhile, a settlement was reached between the parties under which Mr Deshpande agreed for compensation of Rs 25,000.

The Supreme Court also directed Mr Deshpande to pay back the amount to Elbee Services after deducting Rs 25,000. Since Mr Deshpande is yet to refund the amount, Elbee Services have filed a complaint in the National Commission.

This clarification has been issued at the request of Elbee Services' attorneys.

Write In

Send in your queries and concerns to: ***The Resident Editor, Times of India, 40/1 M.G. Road, Bangalore — 560001.***

PHA – 10

THE TIMES OF INDIA, BANGALORE 26/6/2000

Consumer charter for health

BANGALORE: Come December, more than 600 members of the civil society from all over the world will be converging at Dacca to re-establish health and equitable development as items of priority in local, national and international policy making. To ensure this, a People's Charter for Health has been formulated.

In an effort to find a solution to the current global health crisis characterised by growing inequities within and between countries a People's Health Assembly (PHA) has been planned. The assembly aims to draw on and support people's involvement in their struggle to build long term and sustainable solutions to health problems.

Twenty years ago the world community adopted a resolution to provide Health For All by 2000. It meant that national governments should provide primary healthcare for everyone, irrespective of the ability to pay for it. It laid emphasis on primary health centre including health education, promotion of food supply, proper nutrition, equitable supply of safe drinking water and control of endemic diseases. More importantly it accepted health as a fundamental right.

Unfortunately today the health scenario is highly disturbing. Despite medical advances and increasing average life expectancy, there is evidence of rising disparities in health status. Enduring poverty with all its facets and in addition epidemics like HIV/AIDS are leading to reversals of previous health gains. Last year the World Health Organisation (WHO) reported that certain diseases like TB and Malaria which was thought to be eradicated are back with a vengeance. In India every year 5 lakh die of TB and over 9 million cases of Malaria are reported.

Part of this gloomy situation is because of faulty planning and administrative distortions. The available statistics is an indication. It is estimated that of every 1000 children born, 70 die before the age of one and another 50 die before they reach the age of five. This is 12 times the rate for UK and about 5 times that of Sri Lanka. In every one lakh birth about 510 women die. That is every year about 1,48,000 women die in childbirth.

— CONSUMER RIGHTS —

Y.G. Muralidharan

The global health crisis is due to several factors. For example health and drug issues has never been considered as part of an overall social policy. Secondly people's involvement in their own health development is not encouraged or promoted. There is reduced state responsibility at all levels as a consequence of widespread privatisation process.

In this background the civil society groups meeting at Dacca has formulated a People's (consumers) Health Charter which addresses several consumer related issues like the ongoing deterioration of the health situation, particularly of the poor, lack of participation of most people in decision that effects their lives at levels and lack of access to quality, affordable and universal primary health care.

The charter says that the present state of health affairs is due to prevailing dominant world economic order which is creating greater inequalities and poverty despite growing world wealth. Secondly, governments have failed to confront transnational companies which are the main driving force behind many of the health related problems. The charter says that the role in world governance played by a few advanced industrial countries, few hundred multinational companies supported by World Bank, the International Monetary Fund and the World Trade Organisation is a major cause of worry for world health situation.

A large number of voluntary health and consumer organisations in India have taken up the issue seriously. Associations like the Catholic Health Association of India, Drug Action Forum, Karnataka Rajya Vignana Parishat, Voluntary Health Association of India, the Vivekananda Foundation etc have started a series of activities to promote people's health charter. Keeping in mind the peculiar situation in India, a draft charter has been prepared whichcalls for a thorough look at the primary health centres and its working, it calls for immediate action to upgrade these PHCs and be run with people's monitoring and involvement.

Most importantly the Indian charter demands a rational and people oriented drug policy with a ban on irrational, hazardous and redundant formulations. Other points of action include production quotas and price ceiling for essential drugs, compulsory use of generic names, repeal of the new Patent Act and control over the multinational drug companies. The charter wants the government to support traditional healing systems.

However, none of these charters mention anything about quacks who are playing with the lives of consumers, particularly in rural India. Though government may enact legislations to ban quackery, but ultimately it is the people and the community which can really put an end to this unhealthy system. How people can do this needs to be highlighted in these charters.

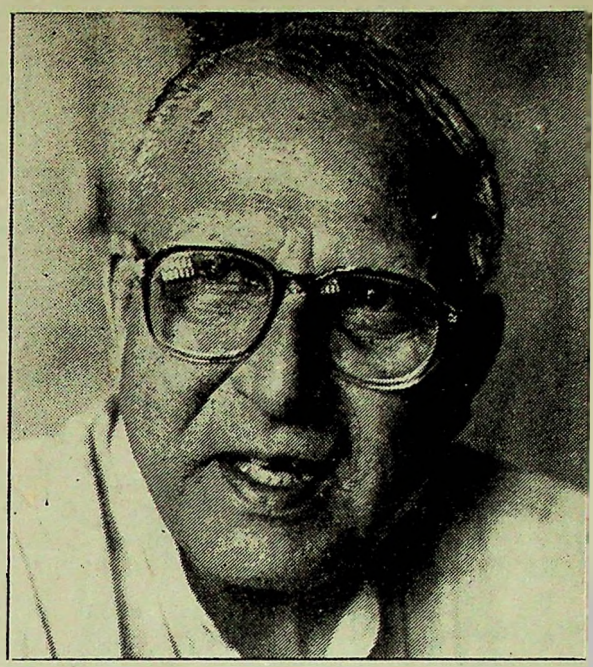
Those interested in PHA activities may email: sochara@vsnl.com

Con - 1.

THE TIMES OF INDIA, BANGALORE

'Doctors can't expect to loot & scoot forever'

***Kalpana Jain** speaks to Dr N.H. Antia about the Supreme Court judgement which brings doctors under the purview of the CPA*



The recent Supreme Court decision to bring doctors under the purview of the Consumer Protection Act has worried the medical fraternity. However, Dr N.H. Antia, an acclaimed community health expert, feels this was necessary to check malpractices that have come into the profession.

Dr Antia is a plastic surgeon and has done extensive work with leprosy patients. He is director of the Foundation for Medical Research and the Foundation for Research in Community Health in Bombay. A recipient of the Padma Shri and the Gandhi Award for International Understanding, he is evolving models to take health care to the masses.

Excerpts from the interview:

Do you think the Consumer Protection Act will be able to help patients?

It is true that insurance premia will go up and medical costs will increase. But it had to come. The policy of loot and scoot cannot work for a long time. Ten years ago doctors paid Rs 100 as malpractice insurance. That means virtually no one sued. Now, the insurance premium is running into thousands.

All this is bound to happen if you lose your moral and ethical basis of life. All prophets have said: subdue greed. Are they outdated? The medical profession has converted health into illness and illness into industry. A person from the middle class is willing to sell his house to get his father treatment for heart disease.

It is also a fact that you cannot run the world on a legal basis. When everyone becomes immoral, you cannot legislate. Therefore, we have to support a new wave, it will come.

What has brought health care to this state?

My main criticism is that we depended on the medical profession to provide leadership in taking health care to the people. We depended on medical colleges and expected doctors to go to rural areas. Both had their own problems, which we could not foresee.

The medical profession thought that Western science will solve all our problems. The trouble with Western science and technology was that it was a result of revolt against Christian church dogma. They didn't realise that it was the ritual in dogma that was disturbing. They threw out the religion. What resulted was a dissective kind of science. It was discovery of the method of discovery.

The problem was while science found the atom and the gene, it threw out religion, which has morals and ethics. Powerful knowledge without the wisdom to use it, resulted in its misuse. Western science does not even understand the mind, it understands the brain — which is a machine.

What is responsible for the decline of values at prestigious institutions like the All India Institute of Medical Sciences?

We have to take a look a the overall picture. Anything that becomes too large is difficult to tackle. We have to see why we are in this situation. We had a blueprint for developing health care in the form of the Bhore committee and Sokhey committee reports, which talked about decentralised health care.

We had four major problems when we attained independence: small pox, cholera, malaria and plague. With simple technology and masses of workers, small pox was eliminated. There was no political interference and no unions to check us from enforcing work culture. Malaria cases came down to 65,000 in 1965 and cholera was controlled to some extent. It proved that people can do lots even with limited resources.

But soon the few elite monopolised technology. Self-interest was important. There was no interest in educating people. They saw medicine as a good way of making money. In fact, the best way, as there was no consumer resistance. The United States, too, has shown that it is the fastest-growing industry.

The Westernised medical profession has denigrated all our own systems of medicine. While the West has evaluated technology, we have just borrowed Western technology. The West has shown that general development is important to control communicable disease. But we have done the opposite. The medical profession has failed the country in its greed.

What has led to a failure of major national disease control programmes?

We have taken up vertical programmes without any knowledge of sociology. The primary health centre has nothing to do with people. People go to private practitioners and take a vitamin injection. An intravenous drip is given in which the needle is taken out from the arm of one, wiped and pushed into another. It gives them some energy and they feel better.

If the village woman is educated, she will be able to handle health care needs better as she is interested in looking after the village. Instead, the medical profession is buying so-called high technology for what — for few more months of life for a cancer patient. We don't look at our own systems which are very good for non-communicable diseases. The classical instance is family planning.

Now we have these advisers come and tell us how to handle tuberculosis. They tell us to try DOTS, where a health worker opens the mouth of each patient and pops the drug in. It has been tried on a few thousand patients in New York, they say.

My view is that people in India love suffering from TB; they love passing it one to their wives; they love passing it on to their children and they love dying of it. Hence they do not take the medicines.

The health minister has already said that India will not be able to meet its commitment towards Health for All by 2000. How do you feel it can be achieved even a few decades later?

Health has to viewed in its overall context. It cannot be separated from other development indicators. And this can be done through panchayat raj. The village can be made a nice self-sustaining unit with lots of cultural activity. How can you talk of health without nutrition, education, water supply and sanitation.

Kerala has shown that we need not be very wealthy to be healthy. The US has achieved an infant mortality rate of 10 after spending $ 3,500 per capita per annum. Kerala has achieved an infant mortality rate which is close enough., 17, after spending $ 20 per capita per annum.

You should reach the best of all systems to the people. Use the Western system for communicable diseases. Also use the best of Indian systems.

THE CUTS newsletter

14th World Consumer Congress, Sept '94

Consumers in the Global Market

IOCU

14th World Congress

Montpellier

26-30 September 1994

FRANCE

CONTENTS

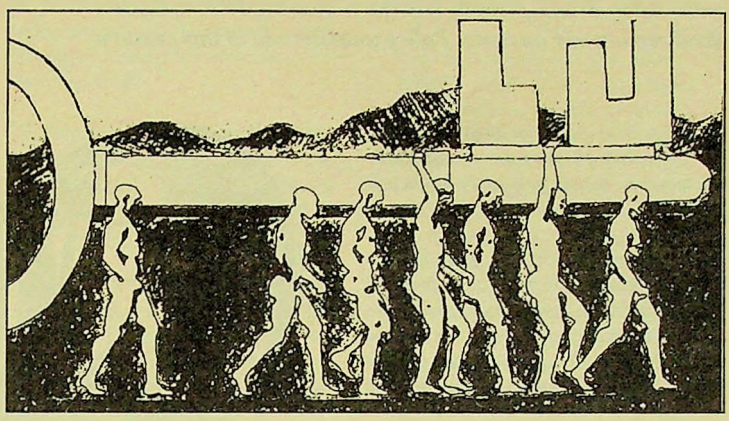
We present herewith a collection of articles specially written for the 14th World Consumer Congress and commend them for your kind perusal. Given below are the names and a small summary of each of the pieces:

■ LEADER

CONSUMERS OF THE WORLD UNITE

PRADEEP S. MEHTA & UDAYAN NAMBOODIRI

The North-South divide in the consumer movement must end



The integration of the world into one composite trade block bound by common rules makes the world consumer movement an extremely important instrument to articulate the economic and environmental concerns of human beings globally. Therefore "Consumers of the World Unite " should be the logical message to ring from the 14th IOCU World Congress.

Sadly, those of us who have given our lives nursing this movement from its early stages, are already discerning a schism growing in the movement. The northern consumer is speaking in one voice, the southerners in another. The former thinks goods made with child labour should be boycotted. The latter says this is a ruse to protect the high-cost industries of the north. On the other hand the northern businesses unload unsafe medicines, pesticides etc on the unsuspecting south, which many of us in the south would like to be boycotted.

This is not only unfortunate but also dangerous. With the the all-round withdrawal of government from the economic process, the cry "Workers of the World Unite" needs to inspire the consumer movement as well. The only positive checks and balances that can be offered to big business is a globally united consumer movement. And they should not get the slightest opening to infiltrate into our struggle.

ROLE OF IOCU AND CONGRESS

Today the IOCU is doubtless doing commendable work in binding the disparate cultures that make up the movement with common concerns. Thanks to its inititatives and interventions, the consumer movement's concerns were advocated before GATT, including opposing the much abhorred patents regime which has caused serious concern in many developing nations including India.

This Congress should critically evaluate IOCU's role, not just praise it. What, for instance, is the IOCU? Is it us, the men and women working in cities, villages and deserts awakening people about their rights? Or a mere postal address to which we seek network support and funding?

CONSUMER MANIFESTO 2000?

The road before us is very hard. So we must tone up the organisation. The Consumers' Manifesto is a forgotten document today. We must look into it afresh and revivify it. Members must use IOCU more frequently as a forum than a mere address to write for information for several things. The infrastructure of IOCU is perfectly suited to bind us all together into a common body so we can fight for our basic goal of Value for People.

That the consumer movement is like a phoenix rising from oblivion need not be overemphasised. In our country for instance, there were barely a couple of dozen voluntary groups at the turn of the 1980s. Today there are over a thousand. The government of India takes the movement very seriously and these organisations are seen forcing its various arms to prove this through action. We feel proud not only for CUTS, but for India too, that the first ever NGO initiative to press for the UN guidelines on TNCs was held here (CUTS-IOCU Conference on Fairplay in Global Business, New Delhi, Feb.14 & 15,1994) and led to the adoption of the Delhi Declaration (Pg. 20). We would have liked the event to be a bigger one, but still it was an important beginning. We would like to follow it up with a similar conference next year on the need for adoption of an universal competition policy and thus seek members' support.

Like in previous years CUTS has taken out a special IOCU World Congress number of its newsletter. We decided to attract the members' attention to the real issues in India, the country of 900 million consumers or roughly one-sixth of humanity. We hope it serves as a show window of the problems that result from following an open door policy with TNCs.

GLIMPSES OF CONCERNS

There is no doubt that developing countries need to shed their old fears about the North. But the opening up process must be cautious, never hasty. At stake are the interests of the consumers who have been used to certain traditions.

That the market is never perfect and needs constant correction is best illustrated by the widespread damage to the social, economic and political scene by unchecked FDI. We are afraid that for constraints of space we can offer only glimpses. Members are welcome to visit our ancient land to study its modern problems first hand. We promise it will be a rewarding experience and shake us all out of our complacence. ■

■ DOCUMENT

CONSUMER MANIFESTO 2000

This Manifesto was adopted by IOCU members who had gathered in Bronx, New York in the summer of 1986 to discuss the direction of Consumer Policy until the end of this century.

The modern consumer movement, born more than 50 years ago, has become an important means to achieve a just and fair society.

As we move towards the year 2000 it remains committed to this aim. Its theme is that the conditions in which consumers have to live must become better and more equitable. It applauds economic growth only when this leads to well-being and happiness.

By careful research and concerted action, it sets out to redress the imbalance in knowledge and power between suppliers and consumers. It has concrete economic and social ills to challenge, specific market abuses to change, and shortsighted exploitative and destructive use of resources to expose. It draws attention to the need to change bad systems, as well as to deal with their unpleasant symptoms.

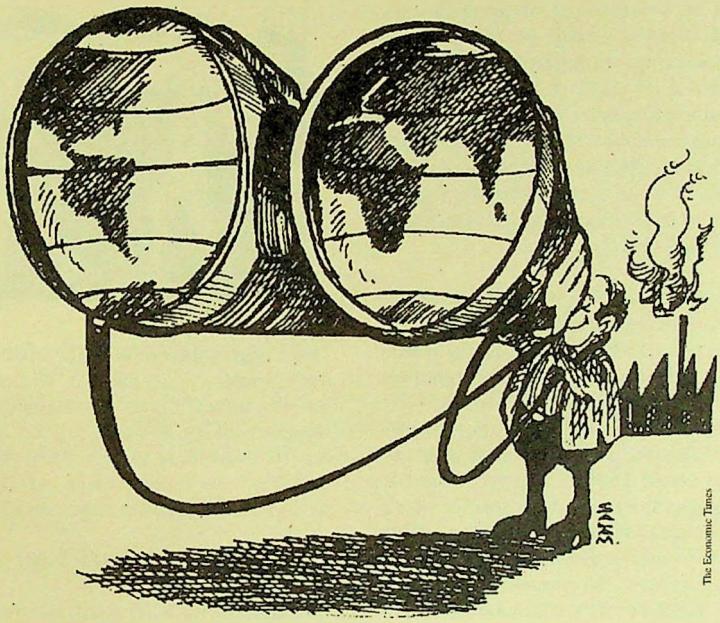
The principal needs of the consumer — access to essential goods and services and fair choice, safety, information, representation, redress, consumer education and a healthy environment — form the agenda of the consumer movement. The market place and public authorities alike should become more responsive to those needs.

Such responsiveness includes :

* participation by consumer organizations, on an equal footing with other corporate groups in society, in the formation of policies that affect those they represent;

* ensuring that the basic needs of all consumers are met : adequate food, clothing, shelter, health care, sanitation and education;

* measures to enhance fair competition and to control harmful business and professional practices; for example, to oppose practices that mislead, restrict choice, or erect barriers to trade so as to "protect" business and state enterprises at the expense of the private individual;



* laws and standards that safeguard consumers from hazardous goods and services, as well as from the social costs of environmental pollution;

* procedures, formal and informal, to provide effective redress to aggrieved consumers at all income levels;

* accurate and adequate information to help consumers choose, an example of the consumer movement's own contribution being the publication by IOCU's affiliates of comparative test and survey results;

* consumer education to ensure that all people may acquire the knowledge and skills necessary to be informed and active consumers exercising their rights and fulfilling their economic role; special attention must be given to the needs of vulnerable groups such as children, handicapped and the elderly.

We assert the right of organized consumers to be represented, heard and heeded — nationally, regionally, and internationally.

Through IOCU, consumer representatives have successfuly called these needs and interests to the attention of the United Nations. The Guidelines for Consumer Protection, adopted by Resolution of the General Assembly, map out a future that it is our duty to advocate and realize for all consumers. By "all", we mean five billion consumers, organized and unorganized, in richer countries and poorer, whose wish is to dwell in peace and safety, enjoying goods and services that are a fair reward for honest work.

The following are among the goals we aim at before this century is over:

1. Full implementation in all countries of the United Nations Guideliens for Consumer Protection and the establishment within the United Nations of a monitoring and assistance system for such implementation.

2. Adoption by the United Nations and full implementation by governments of a Code of Conduct on Transnational Corporations.

3. Promoting the fulfillment of basic needs of all consumers, in particular of the poor, low income and disadvantaged groups.

4. Establishment of national and international laws that prohibit trade in hazardous products and eliminate double standards in international trade.

5. Establishment of stringent international guidelines on the siting and operations of potentially hazardous industrial and agricultural plants, processes and practices, including the right to full information by the local community and the workers.

6. Elimination of economic practices which inhibit the equitable distribution of food and the encouragement of national and international food policies aimed at meeting people's need for safe and nutritious food.

7. Implementation of policies on new information technology which ensure on the one hand the fair protection of consumers and on the other that they can make full use of the technology for their own benefit.

8. Development of testing and research with particular reference to the needs of Third World countries, building on the experience, skills and resources of IOCU's testing organizations.

9. The reduction and finally dismantling of trade barriers which have a negative impact on consumers and the establishment of national bodies with consumer representation to analyse and publish the relevant information concerning the costs and benefits of proposed and existing trade controls.

10. Ensuring responsiveness of monopolies providing services to consumers, including ways to measure their performance in relation to meeting the needs of consumers and to ensure accountability.

Looking towards the year 2000, IOCU and its member organizations reaffirm their commitment to produce social change. We shall do so by striving to attain the goals set out above. We shall vigorously continue to work within and strengthen the networks and programmes already established to fight hazardous commercial practices. We shall intensify our efforts to seek fair protection of consumers and representation of their interests in the economic field. In all this our aim will be to further a society responsive to the consumers interest. ■

UN Guidelines for Consumer Protection

As we enter 1995 there is a cause for celebration as it will witness 10 years since the UN Guidelines for Consumer Protection were adopted by the United Nations in 1985. In the Asian region there was a kind of stock taking on this during 1990, when the Economic and Social Commission for Asia and the Pacific organised a regional seminar at Bangkok during 19-22, June, 1990.

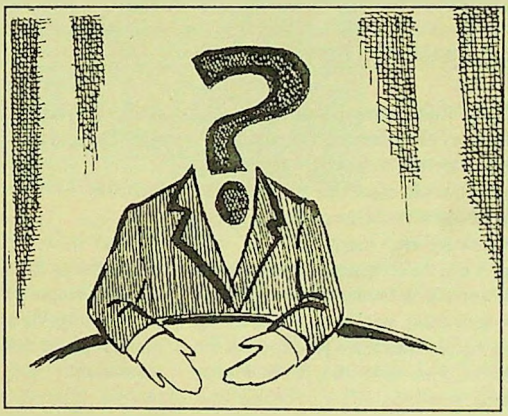
The following resolution was adopted at this seminar, which we think important to reproduce here for the benefit of consumer activists and for follow up towards fruition.

The Economic and Social Commission for Asia and the Pacific.

Recalling General Assembly resolution 39/248 of 9 April 1985, in which the Assembly adopted guidelines for consumer protection,

Noting with satisfaction the recommendations of the United Nations Regional Seminar of Consumer Protection for Asia and the Pacific, held at ESCAP from 19 to 20 June 1990,

Noting also Economic and Social Council resolution 1990/85 of 27 July 1990 on consumer protection, in which the Secretary-General was requested in cooperation with, *inter alia*, the regional commissions of the United Nations to continue to provide assistance to Governments, in particular to those of developing countries and other interested countries in implementing the guidelines for consumer protection, and to develop a programme for action for the next five years on the implementation of the guidelines.



1. *Commends* the Executive Secretary on the efforts currently being undertaken by ESCAP to promote the implementation of the guidelines for consumer protection;

2. *Requests* the Executive Secretary, for cooperation with non-governmental organisations, development funds and programmes of the United Nations, and other relevant bodies and agencies in the United Nations system, to promote the implementation of the United Nations guidelines for consumer protection, initiate specific activities to follow up the recommendations of the Regional Seminar on Consumer Protection for Asia and the Pacific and to seek such extrabudgetary contributions as may be necessary for that purpose.

739th meeting, 23 April 1992

■ YOUNG CONSUMER ACTIVISTS

TRAINING A TRIBE

SHIVANI PRASAD

In association with IOCU, CUTS takes up an exciting programme in India to create a breed of young consumer leaders to meet the challenges of the 21st century

Shanti Ramanathan of IOCU addressing participants at the first workshop on "Skills in Consumer Campaigning" organised by CUTS and IOCU at Calcutta, January 1994.

When Karl Marx propounded his theory of 'Economic Determinism', neither he nor anybody had realised that very soon it would come true and the world would became a large market place dominated by two major groups - the producers and the consumers. However this market was not in favour of the consumer despite their being more in number and was strongly tilted towards the producers or the providers who held the reins of the economy.

Yet, as it is truly said, no condition can remain constant forever, now we can feel clearly the blowing of the winds of change. A slow and silent movement - the consumer movement - is sweeping across the world today. The most important aspects of this movement are - it is democratic in nature, it speaks of the urges and the aspirations of the people and it has unified the people irrespective of age, sex, caste, colour and creed.

Consumers are now awakening from their 'great sleep', asserting their rights and are putting pressure on those elements who took them for granted.

ROOTS

It was in the USA, that the consumer movement has its roots, when in 1900, the American Consumer League was formed to tackle an increasingly complex market place following the industrial revolution.

"If the consumer's interest suffers, the national interest suffers", said the illustrious US President John F. Kennedy, while advocating the famous Bill of Rights for Consumers before the US Congress on March 15, 1962.

Ten years later the International Organisation of Consumer Unions (IOCU) adopted March 15 as the World Consumer Rights Day to be celebrated from 1983. In 1985, the efforts of IOCU suceeded in the United Nations adopting the UN Guidelines for Consumer Protection - a tool for nations to adopt measures for protection of consumers, and for consumer activists to demand better legislation from their governments. Since then the consumer movement has never looked back.

ROOTS IN INDIA

Though laws for protecting consumer's interests existed as long ago as 400 B.C., the roots of the modern consumer movement in India can be traced to 1913, when in Bombay, citizens formed the Passengers and Traffic Relief Association and in 1949 when the Madras Provincial Consumers Association came into being.

In the sixties, some voluntary consumer bodies were formed, notably the Consumer Guidance Society of India in Bombay. However it is during the late seventies and early eighties that the consumer movement gathered momentum.

In India liberalisation began in the mid-eighties, when the late Prime Minister Rajiv Gandhi launched the process of reforms. He was farsighted enough to realise that consumers need protection not only against unscrupulous traders and manufacturers, but also against the monopolistic public utilities which are inherently anti-consumer.

His observations and thoughts finally culminated in an omnibus Consumer Protection Act in 1986, which for the first time recognised six rights of consumers:

1. Safety,
2. Information,
3. Choice,
4. Representation,
5. Redress, and
6. Consumer Education.

The only law of its type in the world, exclusive courts for consumer disputes have been set up at district, state and national levels to provide simple, inexpensive and timebound adjudication.

The courts are empowered to give various reliefs:

1. Removal of defect,
2. Refund of price,
3. Replacement of goods,
4. Withdrawal of and ban on marketing of hazardous goods,
5. Removal of unfair and restrictive trade practices,
6. Compensation due to negligence, and
7. Costs of litigation.

The law also spurred the development and growth of several consumer groups. Launched in 1983, today CUTS is the second largest consumer group in India and at the forefront of several happenings in the history of the Indian consumer movement.

LAUNCH OF TRAININGS

In today's age the world is becoming increasingly complex, as the borders are crumbling in the wake of globalisation and marketisation of several protected economics, including that of India. Liberalisation of economy has heralded newer forms of marketing and products, and a very complex market leaving consumers confused and bewildered.

A participant, Raghav Narsalay at the workshop on " Skills in Consumer Campaigning".

Over a period of time, CUTS realised that the present consumer movement, dominated by a handful of consumer activists, is incapable of tackling the new challenges. An urgent need was felt to scientifically promote a generation of young consumer leaders who can carry the flag into the 21st century. The regional office of the IOCU saw reason in this viewpoint.

As a part of its programme to strengthen the consumer movement in India, the IOCU selected CUTS to organise a training workshop to impart leadership traits among the young leaders.

About 25 activists in the country between the ages of 25 and 35, both staff and volunteers were identified.Those cleared, were invited to participate in the first ever training programme on Skills in Consumer Campaigning, with priority to members of IOCU affiliated organisations in the sub-continent..

"The success of this workshop can only be measured in what you young leaders do with the newly acquired knowledge in the months to come. It should be your commitment that your knowledge should enrich your organisation and they be better equipped to conduct consumer campaigns", thus spake Shanthi Ramanathan, Project Officer of IOCU, Penang, at the inaugural session of the Training Workshop for Young Consumer Leaders at Calcutta on January 22,1994.

One key feature of the programme was to enable the trainees to interact with current consumer leaders in India. Realising the fact that the best learning can be done through actual examples, CUTS selected three successes and three failures of consumer campaigns at three levels: local, provincial and national. The participants analysed the causes for failure and success of a campaign. The rest of the event dealt with the know-how and do-how of designing and implementation of a campaign - advocacy, communicating and dealing with the government and courts.

The process was extremely interactive with trainees divided into four working groups to ensure maximal participation and interaction. Said a trainee Sonal Mehta: "The workshop was indeed exhilarating, excellent combinations of theoretical framework and practical experience with actual examples of successes and failures. It gave a lot of intellectual excitement and emotional triggering. We look forward to the next one."

SERIES LAUNCHED

The workshop programme was such a huge sucess that both the participants and the organisers felt that one workshop is not enough for imparting the multifarious skills of consumer activism. And thus the idea of second workshop came into being. The second on Skills in Advocacy and Media: "Reaching Out" was held at New Delhi during 14-18, August,1994.

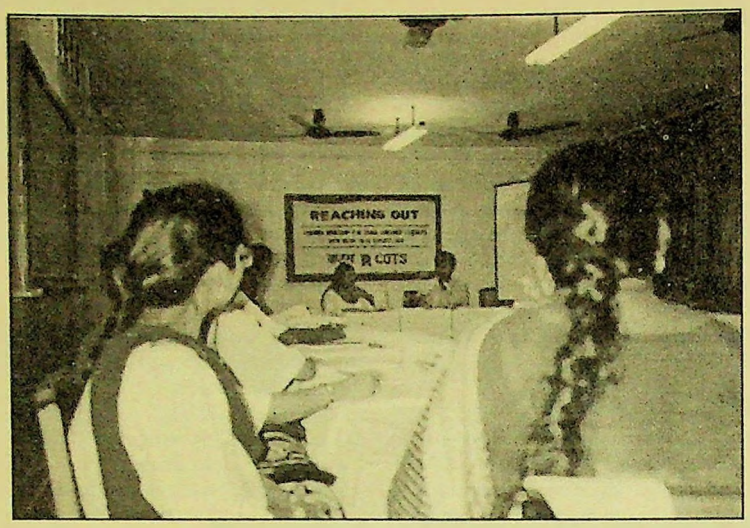
Instead of lectures in the abstract, the workshop was woven around four current issues of social concern:

1. Legal redress, innovations and delays.
2. Pollution in cities, quality of life.
3. Safe drinking water, elusive goals
4. Irrational and sub-standard drugs and prices.

The structure of the second workshop involved the impartation of skills in both advocacy and media with real persons.

The success story of first workshop was repeated in the second one also. The participants were divided into four groups and were asked to draw up workable plans on the four issues. The response of the participants was quite enthusiastic and they came out with many innovative ideas.

The most interesting and exciting part of the workshop was the participation of the youngsters on the 'Question Forum' - a popular national TV programme. The young activists threw a number of questions to a distinguished panel of persons like Dr. G. Sundaram, Secretary in the Consumer Affairs department of the Govt of India. Justice V. B. Eradi, President of the National Consumer Disputes Redressal Commission. Ms. Pushpa Girimaji, a popular consumer columnist, Mr. S. P. Virmani, a businessman and past President, Council for Indian Food Trade & Industry, and Mr. Pradeep S Mehta, a noted consumer activist. The programme was an eye-opener for all the participants, as they got a hands-on exposure in using the electronic media for lobbying.



Umesh Anand, a journalist, speaking to the participants at the second training workshop: " Reaching Out" held at New Delhi, August 1994.

CAMPAIGN ON DRUGS & MEDICINES

At the concluding session, it was decided unanimously that one single issue should be selected for evolving a workable action plan. The issue selected was drugs and medicines - a very timely and important issue, thus a campaign was revitalised.

Stressing on the importance of a rational drug policy, the All India Drug Action Network coordinator, Dr. Mira Shiva, as one of the key resource persons at the workshop, said: " If we do not immediately gather a mass base for a rational drug policy, essential drugs required by 80 percent of our population will be beyond their reach in terms of prices."

A four point action plan was proposed by the participants to work on the drug issue:

1. A mass signature campaign on a memorandum demanding a rational drug policy be launched, so that while people are educated a pressure is also created on the government.

2. Many banned drugs are still sold in the local markets. Consumer groups should buy them and file cases in district forums under the Consumer Protection Act, so that there is a local media interaction leading to higher awareness.

3. A writ petition on banned and bannable drugs is already pending in the Supreme Court. Consumer and health groups should intervene in the same to pressure the court and build up solidarity.

4. In view of attractive incentives, doctors often over-prescribe unnecessarily. Consumer and health groups should conduct test checks at major pharmacists' shops, obtain copies of prescriptions and expose such doctors.

A MILESTONE

Thus the final outcome of the second workshop was concrete and on a timely issue in India. This outcome charged the participants, as succinctly observed by one of the young activists Yogini Acharya of ACASH, Bombay: "It's good to be back with our respective organisations armed with the strong knowledge base and skills acquired at the workshop."

Others were overwhelmimg in their feedback. Said Parag Redkar of Mumbai Grahak Panchayat. Bombay: "CUTS have foresighted the need of Indian activists and organised such a unique programme for constructing a movement, itself a milestone in the consumer movement." His colleague, Raghav Narsalay acknowledged the values learnt: " The workshops are among the few instances in my life that have taught me what hard work is. Most of the resource persons were outstanding."

A third workshop scheduled at Ahmedabad in February, 1995 will impart training in strategic planning and capacity building again to be woven around the one issue of rational drugs. The fourth and conclusive workshop will be held at Bangalore to cover uncovered issues, take stock of the whole excercise and the campaign on rational drugs. Donor agencies would also be invited to send their representatives to this culminating event.

The logical end envisaged is the building of a second line of leadership in the Indian consumer movement. One that is alert to the fast developments in the world of communications and conscious of the need to build bridges with the community. The questioning society thus developed will make a positive contibution to the growth and progress of the nation. ■

Working groups at the second workshop seen absorbed drafting press releases.

■ RURAL CONSUMERS

HELPING THE POOR, AND WOMEN

PRADEEP S. MEHTA

Nearly 300 rural consumer activists have been trained by CUTS in Rajasthan, a state in north-west of India, and they are tackling a range of citizen abuses.

It is indeed a fallacy to continue to believe that the consumer movement exists only in the cities of India. Today it is not only helping the well-to-do but a large section of poor and illiterate brethren in villages also. Thanks to the Consumer Protection Act of 1986 (COPRA) and a growing army of dedicated and trained activists in India's rural areas.

The need for such activism is directly proportional to the increasing consumer abuses in our society. Many continue to make a fast buck by cheating helpless consumers, as if it is a normal thing. The outdated anti-consumer clause : 'Goods once sold will not be taken back' continues unbridled.

WIDOW'S WOES

In Rashmi, a small tehsil/taluqa headquarters of the Chittorgarh district in south west Rajasthan, there are two photographic studios. Amar Art Studio owned by Bhanwar Lal Sharma and the Mateswari Photo Studio owned by Shankerlal Prajapat. Considering the need for photographs by consumers for a thousand and one reason, they are doing a fairly good business. Though the population of Rashmi is only 10,000, the town serves a rural hinterland of nearly 50,000 people.

Farmers who have to obtain a loan under the Integrated Rural Development Project or similar scheme from the local co-operative bank need to apply with three copies of passport size photographs. The pictures are affixed to the loan papers for proper identification, especially for the illiterates.

Rural women at CUTS Centre for Human Development, Chittorgarh at the first training programme for women, December 1991.

One such illiterate widow, Sunder Bai Orh of village Lasadiya Khurd applied for a short term crop loan of Rs.2000 to the Chittorgarh Central Co-operative Bank's branch in Rashmi on 28th February 1991. She went to Amar Art Studio for the necessary pictures and paid Rs.15 for 3 copies of her P.P. photo. Since she cannot read she did not see the condition on the bill, that she should have paid only half the price as advance.

She and her son went to Amar Art five times but was handed out one or the other excuse. Her loan was stuck and she had to borrow from a moneylender at usurious interest to finance the sowing of pulses etc. in her tiny 8-bigha (2.5 acres) land-holding.

In one of her visits to the local marketing co-operative society to buy fertilizers etc., she narrated her woes to the assistant manager : Goverdhan Lal Sharma, who also happens to be the founder secretary of the Rashmi Tehsil Upbhokta Sangrakshan Samiti, a local consumer group.

Women protesting for closure of an arrack shop.

Sharma took up the matter with Amar Art Studio but he only received threats and abuses. Undeterred, he asked Sunder Bai to put her left thumb impression on a complaint to the Chittorgarh district forum and a letter authorising him to appear on her behalf.

Unlike the city district forums, the Chittorgarh Distt Forum sends notices through the Tehsildar (the lowest revenue official) instead of postal deptt. It does not have a budget for such valid expenses. Well, as soon as Amar Art received the notice, the proprietor quietly approached friends in the bank and affixed the pictures in Sunder Bai's file.

Close on the heels of this complaint, Goverdhanlal was deluged by similar grouses against both the studios. Dhukal Chamar had asked for Rs.2000 loan for purchase of goats, Mohan Chamar had wanted Rs.800 for a crop loan, and Janakilal Sharma Rs.1000 for a similar purpose. All were in the same boat.

Both the studios, working in cahoots, were piled with a barrage of complaints in the

consumer court for delivery of pictures, return of money and damages as well. While they unsuccessfully contested these cases, they stopped cheating other innocent, illiterate and poor consumers.

It was not a case of few rupees for the non-delivery of pictures - but its multiplier effect on the economy as a whole. The mischief of a small neglect, immortalised by Benjamin Franklin in his famous poem :" For want of a nail, the shoe was lost ... the horse was lost ... the battle was lost .. the country was lost ".

ADVOCACY PAYS

This is not a story of nails but that of stone dust in 'atta' (wheat flour used to make local bread). Since the arrival of electricity power in many of our villages, local entrepreneurs have set up atta chakkis or electrically driven flour mills. This has reduced the drudgery of village women-folk to a large extent, if at all.

Three consumers namely Gyarsiram, Ramesh and Ram Sahay of village Khan Satal Khedi in Kota district had got their wheat ground at a local chakki owned by Hanuman and Sheodayal. Their atta was spoiled due to dust from bad millstones. They then complained to a local consumer group,the Kota Zilla Gramin Upbhokta Sangrakshan Samiti, village Luhawad, whose secretary, Fazr Mohammed sent a notice of the complaint to the chakki owners.

Rather than face protracted legal proceedings, the chakki-owners surrendered to the group and paid Rs. 68 to Gyarsiram for spoiling 13.5 Kg. wheat, Rs. 150 to Ram Sahay for 30 kgs and Rs. 50 to Ramesh for 10 Kgs. In this case the threat of COPRA worked with the chakki owners.

In another instance, a similar threat worked with a prospective chakki owner. Prakash Chand of Hingora village in Chittorgarh district had applied for a new electricity connection to the Rajasthan State Electricity Board, but nothing happened for over six months. He filed a complaint before the Chittorgarh distt forum. Just on reciept of the forum's notice, RSEB delivered the connection.

Another Chittorgarh based group in village Upreda, once hauled up the fair price shop when caught selling under weighed kerosene. The group, headed by Ramlal Kalal, complained to the area weights & measures inspector and the shop owner was fined Rs. 300. Similarly, Kalal also stopped corruption by the village council head who religiously collected Rs. 100 to 150 from farmers for issuing revenue certificates, while the official fees was only Rs.20. Now farmers of Upreda pay just the official charges.

POSTCARD - A POTENT WEAPON

Jaswant Singh, an agricultural teacher in Masuda, District Ajmer, has been associated with CUTS since its inception. In 1985 he set up the Ajmer Distt. Rural Consumers Organisation. By the simple use of a 15 paise post card the group has been able to resolve hundreds of complaints. For instance, widow Hiradevi was unable to recover Rs. 55,000 from the Life Insurance Corpn. of India against her late husband, Badri Prasad's policy. The group sent a postcard to LIC which promptly settled the matter.

It has also resolved many non-consumer disputes by using the same humble weapon. Balchand Sain of village Juni Kekri in the same district could not get a rightful job in the govt. deptt. that his father had worked in and died while in harness. On this group's intervention he was called to join.

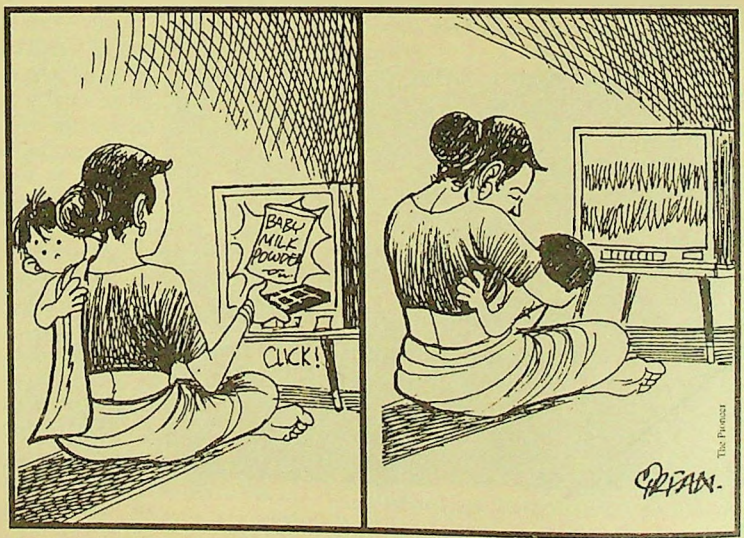
Earlier, through a novel postcard campaign, a group in Mithariya village of the Bikaner distt. had got an electric transformer installed. It was an interesting story. The state legislator from the constituency was annoyed with the village as it had not voted for him, so he got the installation blocked. As a result there was no electric power in the village.

Several efforts by the villagers proved futile, until one youth, Mahendra Singh Sekhawat appealed to CUTS. On advice from CUTS, he organised the villagers to write five postcards a day to the chairman of the utility: Rajasthan State Electricity Board. Presto, the transformer was installed in no time. Now the village is booming with economic activity, and Sekhawat has formed a consumer group with branches all over the district.

Rauf Ahmed, a teacher in a village school of Ramsar in Ajmer district, was inspired by Jaswant Singh to set up a local consumer group. He swung into action by writing to the distt. medical officer about doctors and nurses not attending to patients at the local primary health centre. Rauf was soon pleasantly surprised to see the medicos changing their ways.

Similarly his advocacy paid off with nearly every local problem, and he proved that the pen is mightier than the sword. In another instance he was able to get a widow's pension regularised.

Goverdhanlal Sharma, Fazr Mohammed, Prakash Hingora, Jaswant Singh, Rauf Ahmed, Mahendra Singh have only qualified at school. They have never been to a college or a university. They among several others underwent training as para legals with 'CUTS', where it is our mission to train barefoot lawyers. Activists who will question every injustice, and will protest each such action, so that our moot brethren in villages can demand their rightful due. And in turn create a questioning society, which will make every small and large enterprise accountable to poor consumers. ■



■ INDIA

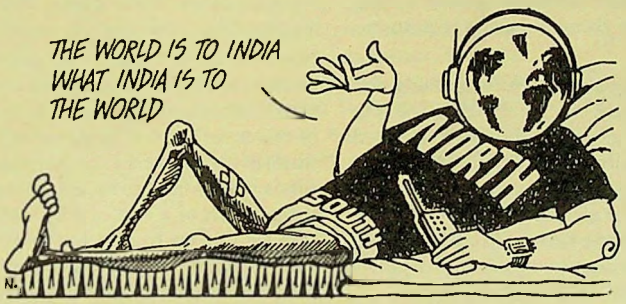
A PLANET IN THE TNC UNIVERSE

UDAYAN NAMBOODIRI

Traditional priorities go haywire as TNCs force pace of liberalisation.

India, a nation of 900 million, is growing in the focus of transnational corporations (TNCs). The nation's leadership, brushing its age old social problems under the carpet, is increasingly packaging it as a corporate entity ripe for TNC takeover. This is not parotting the line often taken by the country opposition programmes left and right of the political spectrum, but an easily distinguishable characteristic iterating through all the new policies announced by the federal government since July 1991.

The traditional reason extended for Indian prime ministers and lesser mandarins' frequent foreign jaunts had been either " to develop bilateral ties ", or to " study how system X works". No longer. Today, the Indian prime minister travels abroad to 'sell' India as an investment proposition. The usual retinue of bureaucrats, journalists apart, a large number of indegenous businessmen accompany him these days. And each time he returns with promises of huge investment. Even those Foreign Direct Investment (FDI) proposals which materialise, make India, according to the 1994 World Investment Report, the fastest growing destination of FDI. It is estimated that at this rate, India will surpass China's record by the turn of the century.



Down To Earth

This is the same nation which felt the brunt of the East India Company, the empire building corporate to which the history of the multilnational form of doing business can be traced. With the memory of two centuries of political subservience to a foreign power fresh, the first few governments of independent India adopted a policy to keep TNCs in check. The route to nation building, according to the Gandhian ideal, was to empower the state with the levers of the economy and till 1991, successive governments did just that. While doing this they also steered clear of communism, subscribing to this was a juicy proposition for many countries in India's neighbourhood. The state allowed private enterprise to thrive in limited areas, promoted research to develop indigenous technology so as to lessen dependence.

Exactly when this path was abandoned is difficult to say. Certainly before July 1991 when the newly elected Narasimha Rao government discovered that the foreign exchange situation was hopeless and the global stock of India quite low. Since at least a decade before that TNC lobbies were very active in New Delhi, using every mechanism available to ensure that the country abandon its chosen path in favour of easy imports. TNCs were thrusting obsolete technology undermining domestic research, by paying hefty kickbacks to ministers and bureaucrats. Consumers in the country were fed up with the shoddy quality of goods and services that the domestic state and private sector churned out insulated from competition. The economic outlook was characterised by langour. Clearly a break had to be made from the past if India had to survive. Her neighbours to the east had made tremendous strides forward by liberalising and opening their doors to foreign investment. India now decided to emulate them.

THE REFORMS

Far reaching corrections were demanded by the vocal section of urbans. But bowing to political expediency,the government decided to use the medicine with restraint. After three years, reaction to the progress of the 'reform'effected in the name of liberalisation. Some agree that India launched the programme much after China and so must hurry up. Others feel the government is yet to take the crucial decisions, like what to do with the cash strapped public sector, how to make the transition from the welfare state to capitalist, etc. At the same time it is solemnly declaring that the public sector will not be privatised and the small scale industries using much labour will be protected. Sceptics think the government will unravel the inhuman face of liberalisation only after the 1996 elections. Till then, India's ability to increase the inflow of FDI is all that matters. Many are rejoicing that the foreign exchange situation is much better, so the reforms must be working.

To the consumer liberalisation must be good. The dismantling of barriers against imports means lower prices. More players in the market means competition. The entry of TNCs means better standards in products and services. Indian consumers have a very useful law they can use against recalcitrant agents of production :The Consumer Protection Act,1986 (COPRA). It is very comprehensive, aimed to protect the poorest of the poor against a wide variety of quarters, including doctors.

What are these reforms ? Today, a TNC can not only pick up the controlling stake in their companies, they can float 100 per cent subsidiaries. They can operate in the financial markets. They can import raw material for their production lines by paying less and less import duty. They can influence the government to give to them wide preferences which were hitherto denied to even domestic businessmen. As one economist puts it :

"I see the transition happening too fast.

Under the Nehruvian model, the official policy was to regard the private sector as pure profiteers, interested in nothing else. So they were kept at arms length. An industrialist may be a billionaire, but he had to stand before the door of a petty official and cajole him into giving him one of the hundreds of licenses necessary to start a factory. But overnight, the government is going overboard in trying to please not only domestic, but even transnationals."

THE LEVEL PLAYING FIELD

If you spend a week in India you cannot miss this phrase. Everybody is demanding it today without grasping its full import. It was first heard from the so called "Bombay Club", a body of industrialists who, in late 1993, issued, after a meeting in the financial capital of India, a statement integrating this demand. Domestic industries, so long kept under 'harness' must be allowed to flourish, not be swamped by competition from international giants. In other words they must be protected by exclusive rights over certain sectors in which TNCs must not be allowed. That was the sum and substance of their demand.

They paid for it. Countless words in condemnation of this attitude, the Indian businessmen' inability to perform without protection, were churned out all over the world. Their ulterior motive, as pointed out, was that they should not lose control over their companies which they treated as their fiefdoms. The professional classes were particularly angered. TNCs operating in their country meant fatter salaries, better work environment and choice of jobs. Quickly the Bombay Club, in the interest of public relations was forced to backtrack from the statement.

But few in India failed to see an important parallel. India's small scale industries often raise the demand for greater offtake of their

ENRON DEAL : SCANDALOUS !

The west coast is India's most industrially prosperous, contributing more than 24 per cent of her net produce. Because of its relative infrastructural superiority , this region is the destination of more than half the country's total FDI projects. The Indian government hopes to generate 16,000 megawatts of electric power in this region alone to match the rising demands of industry over the next few years.

Power projects imply huge investment, something that the government cannot fork out. So allowing TNCs to operate in this capital intensive industry required fundamental change in the official outlook towards their entry into a sector so long considered 'core' and therefore out of bounds for private foreign investment. This was managed when the Finance Ministry argued that inviting private/foreign investors in the power sector would garner 'additionality of resources'.

The Dabhol Power Corporation, in which the state - owned electricity company, MSEB and the Houston based, Enron Corp, tied up with General Electric and Bechtel, and some Indian companies to build a 2015 megawatt project in Dabhol, Maharashtra. How the deal was struck and the manner in which money was raised for it, bears out two typical modern TNC traits. First : the whole affair was conducted in secret. Second, the TNC demanded, and got, special privileges which led to it sinking less money than the Indian government.

The fallout of the first game affects consumers directly. There was complete lack of transparency in the dealings between the government and the investor. There had been no attempt to invite offers from other suitors to rate the Enron offer. The lack of competitive bidding is undoubtedly going to make the project cost astronomical and then this will logically be passed on to the consumer. "The people who will pay for the project are totally in the dark," says G. V. Ramakrishna, a member of the government's Planning Commission. Besides, the TNC has also extracted an agreement from the government on the price per unit at which it proposes to sell the generated power."The consumer in this country is entitled to the supply of electricity on a least cost basis and the scheme of private sector participation should subserve this primary objective — something that is clearly missing from the implementation of the power policy and definitely in the awarding of the project to Enron", Ramakrishna adds.

Now, the second part : The raison d'etre of inviting private/foreign investors in the power sector according to the Indian finance ministry, is to garner "additionality of resources". But a fundamental departure has been made in the case of the Dabhol project. Indian investible funds will be used to set up the entire first phase of the project. Out of a cost of $ 910 million, more than half will be put up by the government owned financial institution, the Industrial Development Bank of India in terms of loans and counter guarantees. Other loans too are being guaranteed by the government and as if this was not enough, a bond issue of $ 300 million issued by the Dabhol Power Corporation and lead managed by Lehman Brothers, will now be guaranteed by the government of India.

Then comes the revelation that Enron was allowed to raise $ 650 million outside India at 12 per cent interest. Indian financial institutions have been stopped from raising funds at less than 7 per cent. This, when the 12 - year bond already carries the government's counter-guarantee. The high cost of money raised is bound to be passed on to the consumer.

Besides, the project will be using imported natural gas, a big drain on India's foreign exchange reserves. But this is only the beginning. Everything that Enron does will, and has to be, followed in toto by six other projects involving TNC gas and power giants in the south — western part of India. A senior government official says:"Now that Enron has managed to get the Government of India's ascent on a 12 - year paper, six other projects waiting in the queue will follow suit and probably raise money at even higher rates of interest. This is scandalous."

produce by the government's procuring agencies. But here was the creme de la creme of Indian business raising an identical outcry!

In their own clumsy way, the Bombay Club had driven home a valid point. Vital sectors of the economy — telecommunications, power generation to name a few —were hitherto closed to them. Instead of allowing them time and space to operate with indigenously available technology developed through institutions into which considerable public money had been sunk, here was India throwing open its doors in one shot to TNCs. How were they to compete? The impatient editorials only demanded that if the domestic sector cannot compete, they can fold up. If the public sector is to perish, so be it. An Unilever director on visit to India scornfully said : "Those who wait for a level playing field will end up never playing."

The transnational form of business is not bound by any rules. The international forum to develop a Code of Conduct for TNCs is a sad story. TNCs do not respect governments or social mores. The developing world in the eighties were seen bending or discarding laws originally designed to protect consumers from TNCs. India too decided likewise. The consensus was the country is essentially stronger today than in the 18th century. There can be no repeat of the East India Company syndrome, they say.

But they fail to grasp the fact that there is no longer one East India Company. There are some 37,000 of them, multiplying constantly all over the world. Today the governments backing them don't need to send armies to conquer. They do it through intricate little games of mergers, acquisitions and cartels. Operations that Indians, like their counterparts elsewhere in the developing world, will take years to understand. More than protection they wanted policing of the visitors. But they lacked communication skills. History will condemn them for this.

INDIA, THE OPPORTUNITIES :

What does India offer to the TNC ? If taken as part of the developing world, it offers a tremendous opportunity for the developed nations to come out of their recession. The share of the developing countries in world FDI flows, according to the 1994 UNCTAD World Investment Report, reached about 40 per cent.

The most important factors making developing countries attractive to TNCs were rapid economic growth, privatisation programmes open to foreign investors and the liberalisation of the FDI regulatory framework. Taken individually, India is a sound investment proposition.

Today China, thanks to its early liberalisation, is the largest host country with annual inflows totaling $ 26 billion. India, with only three years, has crossed the $ 4 billion mark. But before the decade is out, India is expected to catch up, thanks to the following favourable factors :

1. Her vast population of 900 million includes a middle class of some 200 million. This segment is concentrated in a few urban areas making the distribution of products more cost effective. They are also educated, skilled in various ways and quite 'global' in the sense they adapt quite fast to foreigners.

2. A democratic political system which is gradually maturing makes India far more attractive than China. "Unlike China where you never know when hardliners will re-emerge,India is basically liberal," a foreign company head says.

3. Cheap, easily motivated labour is India's trump card. One only needs an efficient, technically sound professional class. India has this too in plenty, thanks to four generations of subsidy in higher education.

4. Basic infrastructure exists in India. The country has a well spread railway network, airports, shipping, enough power near the cities and above all, vast mineral and forest wealth. The best part, in the view of TNCs, is that there is immense scope for improvement, hence business opportunities.

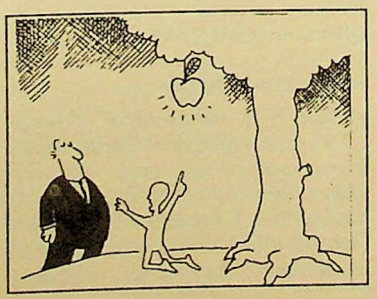
5. A sound, westernised judicial system exists in India which is highly respected. Industrial disputes can be settled in courts which still use English as the official language.

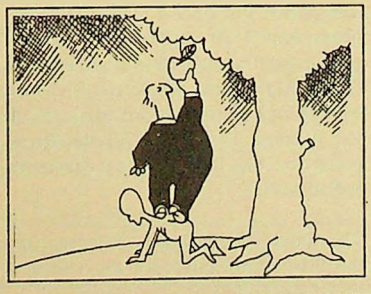
There is also a crude underbelly about India which the TNCs are cynically addressing. Its highlights are :

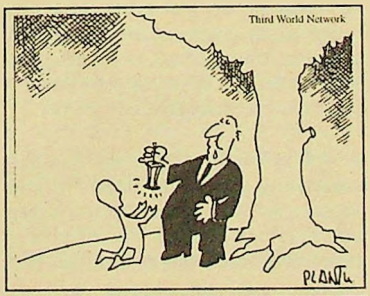
1. A thoroughly corrupt polity aided and advised by a bureaucracy made up of well heeled rogues, is still calling the shots.The red tape can thus easily be cut through using familiar means. In China, corruption can lead its perpetrators to jail, even the firing squad. Not so in India. The judicial system can very easily protect the wrong-doer as it can the wronged. On paper, it may be difficult to exploit the Indian consumer, but with a little intelligence and greasing of palms its a cakewalk.

2. The capital market is nebulous, suspiciously operated and certainly imperfect. Transnational mutual funds and fund managers are already reaping the bounty. Foreign banks have been manipulating the bourses with their depositors' money for long time. Facing slow growth back home, some fund managers have started shifting their 'emerging market funds' to India and their presence has quite threatened the indigenous broking community.

3. A huge market of 200 million suckers is waiting here to be dazed by the flow of 'phoren' goods. Environment standards are very weak here and so a number of polluting industries — aluminium, steel, textile dyestuff to name a few — can be transferred here without much difficulty, so long as they earn foreign exchange. Consumers are protected very well on







MORE JOBS?

Job generation is an important impulse behind opening the floodgates to FDI. India, with a registered unemployed population of 12 million, hopes to generate 8.5 million jobs in the Eighth Plan (1992-97) period. But after three years of economic liberalisation, which has led to over $ 4 billion in FDI, planners are worried that far from generating fresh jobs, liberalisation is creating 1.5 million more jobless every year. This, even before the process of restructuring has started in the state-owned industries. The highlights :

★ Planning Commision adviser, Jairam Ramesh, says the liberalisation is going to cost 1.2 million jobs as companies undergo restructure and state owned units are privatised. More than 70 per cent of these losses are to take place in the country's eastern region alone. And this region is least attractive to investors, both domestic and foreign for its poor infrastructure.

★ The actual employment generation picture is skewed. Openings are created in the services — financial, computer software, etc — and only for the western educated, highly skilled. Doors are in fact closing for the poor. Companies are no longer employing errand boys, gate men, drivers, etc. For these personnel, they ring up service companies who supply men and women hired at atrocious terms. Even TNCs are not above giving job contracts to these labour contractors.

★ The employment growth during the first two years of the Eighth Plan, coinciding with the liberalisation period, has been lower than the modest target of 8.5 million new jobs per year. According to official estimates, employment had achieved an estimated growth of 2.1 per cent in 1992-93 and 1.8 per cent in 1993-94 against an average annual growth rate of 2.6 per cent.

Most Indians however believe this is just a manifestation of the difficult transition that the nation is undergoing. But a government official says : "This rise in unemployment is due to slow economic growth. The average annual economic growth rate for the first two years of the plan is 3.9 per cent against the target of 5.6 per cent for the entire period".

paper. Ignorance about the very existence of COPRA is rampant. This is but a small reflection of the general feeling of welcome towards TNCs. Most Indians are quite convinced that a few small sacrifices have to be made if the nation is to 'globalise'.To be honest, the entry of TNCs has at least improved the quality of the packaging of consumer items. Besides, a lot of things like fountain Pepsi, Camay soap and Lacoste T-shirts have put smugglers out of work.

4. An indolent indigenous business community is only too eager for joint ventures and play a subordinate role in them too. They are entering into all sorts of technical and marketing tieups to gain from the obsolete plants and the practically saturated markets of the west. At the same time, they offer excellent hands-on experience about Indian conditions to the TNCs who are, at this stage, content at prospecting. Some Indians have already sold their businesses lock stock and barrel to TNCs. Parle, the largest beverage maker, sold off four of its leading brands to Coke fearing a swamp when the Atlanta-based cola giant announced plans of a return to India. The soaps giant, Tomco, sold off its 50 per cent marketshare and merged it with Hindustan Lever, thereby handing over a total 77 per cent share of the soaps market to the TNC. Levers even got a notable Indian NGO to act as its in-house set-up to deal with any consumer with a grouse in a market where it has no rival. The TNC has thought it out carefully indeed. Better to preempt oppostion by having a pet opposition !

THE FLIP SIDE

There is a flip side to this, of course. Memories of the humiliation of foreign dominance still persist. There is a vast groundswell of opposition against globalisation in general and institutions like GATT, World Bank — IMF and TNCs, just waiting for a charismatic political leader to tap. A recent Wall Street Journal article pointed out that TNC bashing is a favourite Indian pastime.

The consumer movement, encompassing the environment protection movement, is steadily growing. All it needs is a strong orientation to the larger issues threatening the consumer. For the moment these groups are middle class outfits visible mostly in urban and semi-urban parts. But movements like CUTS' in the rural areas are growing. Every district in the country is entitled to a consumer protection group. Once active, they can stretch the top managements of even TNCs quite thin by forcing them to travel endlessly from one corner of the country to another.

The 200 million strong market may prove a myth. It is assumed that this group, large enough to fill many European countries, have enough liquidity to keep the cash registers active. But then, it took 12 years for Suzuki-Maruti, India's most popular car, to sell its first million cars. Only 32 Indians in thousand own a television set. On examination of the consumption pattern of almost every product of industry, it is seen that India ranks lower than even Thailand. To sustain a consumer boom one needs an educated, well employed population constantly on the move upwards. The opposite is happening. Most professional Indians in the 25-45 age group are right now stashing away their excess cash in pursuit of their biggest obsession, which is, owning a house.

As production shifts from high-cost Europe to cheaper Asia, the impoverishment of the working class will only increase. In India, wages are not just low, but in fact ridiculously low. A World Bank study last year identified India as one the biggest computer software developers of the future because not only are skilled engineers and technically qualified people available here, but they can be had real cheap. At the lowest level is the man keying in data. After slogging monotonously, straining his eyes from the glare of the computer screen six days a week, he takes home less than Rs 800 ($ 25). This, and a lot of other examples suggest that the ever widening consumer base in India may be a myth. Moreover, all but one Indian state (West Bengal) is seeing agriculture's former dominance in the GDP fast go down. And agriculture is the biggest employer in India!

JOINT VENTURING

Since 1991, the queue of corporate houses seeking qualification to enter the primary market to raise money is growing. Their prospectuses tell the same story. "So many millions of rupees needed to fund expansion and meet working capital requirements". Replace the "expansion"

Level playing what ... ?

When, in late 1993, a group of prominent industry captains issued a statement demanding 'level playing field' against TNCs, they were quickly dubbed 'the Bombay Club', retrogressive for wanting insulation from competition. Actually their concerns are quite valid but owing to lack of articulation, the wrong signal was conveyed to the public. It was not so much the technological might of the TNCs that they feared, because ultimately the large markets in India always has special niches for both TNCs and indigenous businesmen. Perhaps what scared them most was the complicated strategies that TNCs are constantly formulating all over the world which is too confusing for even seasoned businessmen like them to grasp fully. But they bungled the whole thing. The term stuck, however. Hardly a week passes in India newspapers reporting one new economic group or the other demanding it.

In the first four decades, newly independent India's attitude towards TNCs suited indigenous industry. They were allowed to invest only in earmarked areas, mainly consumer goods manufacture, and that too with less than 51 per cent control of their companies. In fact, the domestic private sector was also manacled. The state owned companies controlled vital — called 'core' — industries like power, coal, metal mining, telecommunications, railways, etc.Protecting economic sovereignty of the nation was high priority, consumer rights not. The largest number of cases filed in the nationwide consumer courts set up under the Consumer Protection Act since 1987 was against the stated owned public utilities.

TNCs, since the government began the economic and industrial liberalisation process, are now welcome anywhere. They may even increase their stake in formerly widely held companies. Or, like Sony, may even float 100 per cent subsidiaries. What is worrying big domestic industrialists most is that TNCs, with their brute money power, may even raid their companies, and by buying out key officials in the government, even succeed. Reason : government owned financial institutions are stakeholders in virtually all companies deemed public. The rest of the stock can be picked up from the market with the help of the operators specialising in the task.

Some of their worries should be shared by consumers. Indian manufacturers were notorious for their shoddy quality. But at least they kept the price line down. For instance, an everyday product like soaps and detergents used to be manufactured by over 250 small shops, some of who never even used electricity in the process. The big companies' products were for the rich, the poor were content with inexpensive soaps.

Today however the picture is changing. The soap TNCs are operating at the upper end of the market, pushing international brands with multi-million dollar advertising campaigns. Anticipating a rout, a leading Indian manufacturer, Tomco, sold out to Hindustan Lever, the subsidiary of the Unilever group resulting in a 77 per market share for the TNC in most segments.The price advantage that the small-scale producers formerly enjoyed is now fast eroding because TNCs are using their clout to get excise and customs cuts for themselves. Advertising is alluring the consumer to pay just two-three rupees more for an 'international choice'.

TNCs are also seen disrupting the economic life of poor fishing communities along India's coastline. Some 10 million fishermen used primitive craft for their catch all these years. But enticed by TNC hype about increasing India's share in the international marine product market, the government threw this sector open to them. Addressing the UN Conference on Negotiating the Future of World Fisheries at New York in August 1994, Harekrishna Debnath, general secretary of the National Fishworkers' Forum, said : " ... an armada of foreign, hi-tech fishing fleets is poised to invade India, armed with the most predatory and destructive technologies on earth... our future is at stake". TNC entry implies unsustainable development.

once in a while with "diversification" or "new project". But invariably, there will be some joint venture, either for technology or access to markets abroad.

"Joint ventures are very necessary because though Indian goods are widely sold abroad, they carry foreign brandnames because not a single Indian brandname , with some notable exceptions like 'Bajaj' scooters and a few brands of tea and basmati rice, is known in the developed markets," says an underwriter of primary issues.

The Indian facility will forever be used with the Indian partner getting only thin margins in spite of his investment in the project being larger. A few foreign partners are not only picking up hefty stakes in the joint ventures, but also making the Indian partner pay for using his technology.

Solemn promises are made at the time of the tie-up that the foreign collaborator will

always pay prevailing international prices for offtake. But actually quite the opposite happens in reality. "What ensues is plain blackmail. The TNC collaborator lifts the offtake paying ridiculously low prices. If the Indian partner protests, the TNC threatens to cut off his links with the world outside, or, walk out with his money, plants, and leave the Indian high and dry," an Indian economist says.

The 1993 World Investment Report described the "growing complexity of TNC operations as they pursue strategies of integrated production ". The examples are so bizarre, they defy classification. An Italian company growing crystals exports a certain quantity of crystals at prevailing international rates to a company in India in which it has a 50 per cent stake. This Indo-Italian venture, after importing the ingots, slices them with Italian technology and much cheap labour into wafers. Now, this product is used to make photovoltaic cells. Luckily, one company manufacturing photovoltaic cells exists on the other side of the boundary wall to which it can easily sell the wafers. And what coincidence, the Italian has 25 per cent stake in its three-way stakeholding. Now, the prospectus of this third entity which entered the capital market recently, claimed "technology has been supplied (sic) by a leading Italian company which has also guaranteed 100 per cent buyback." No prizes for guessing which one.

Every few months, a high-powered committee clears applications for setting up FDI fuelled projects. The vast majority will serve no real good to the Indian economy in the long run. Domestic companies, in the thick of working capital shortages, can never plough back their sales turnovers into research aimed at technological self-reliance. Eventually a large number of them will be forced to close down, paving the way for monopolies or oligopolies in the marketplace. The dream of employment generation will also remain unfulfilled. In many instances, employment opportunities may be created, but scenarios full of low human resource utilisation will result. Sony, for instance, has been given permission to set up a 100 per cent owned unit where 180 qualified Indian technicians and engineers will use screw-drivers to assemble 300,000 color TV sets from imported kits annually. Other Indian manufacturers are naturally peeved. They employ 300 to turn out 100,000.

Lastly, the flow of FDI has made no difference to India's improved export performance. At best liberalisation has saved a lot of precious dollars by compressing imports for indegenous industries. Exports have risen, but of the same old basket of products from agriculture, hand cut and polished gemstones and computer software. Joint ventures with TNCs have often led to highly import based industries. This is reflected in the latest statistics. The rate of growth of imports is larger (9.9 per cent) than the same for exports (8.3 per cent). The trade deficit for the April to July 1994 period is $ 594.73 million compared to $ 437.99 million in the same period last year.

AGENTS OF RECOLONISATION

It is a truism about colonialism that divide and rule is the best policy if you are to enjoy the fruits sitting at home. Just develop a sub-nation of obedient natives and they will do the dirty work for you. In the nineteenth century, the East India Company ruled India with just 5,000 European army officers (a motley crowd of Europeans of different nationalities) and some three to four thousand businessmen, clergymen and other professionals. The day to day business of running the Empire was carried out by the new class of Indians who carried out their orders with unqualified zeal

Foreign Shylocks

Foreign banks were allowed to operate in India even after the bank nationalisation in 1969. The nationalised banks totted up huge losses over the years because the government forced them to lend money to the 'priority sector' (like creating assets in poor farming communities) and opening banks in remote areas where people have practically no savings.. But the foreign banks made money. Their clientele was small and rich. But no one minded them, because of their miniscule role in the nation's economy.

Since 1991 however, the foreign banks have become more dominating. The cash strapped domestic banks are less forthcoming with loans. So industries are quickly getting trapped by the foreign bank consortium. Though foreign banks' combined contribution to the debts of companies is yet small, they call the shots now. Their executives demand, and get, special treatment. Many companies allege unfair practices by the foreign Shylocks'. Meanwhile domestic banks are still forced by the political godfathers to continue funding operations which the foreigners will not touch with a bargepole. The less said about the poor units and agriculture the better.

Direct interface between consumers and foreign banks is growing. Seduced by advertisements to buy high priced products, middle class consumers are incresingly sucked into their orbit. The huge burden subsequently borne can be imagined from this example. Say, an Indian takes a loan to buy a car costing over Rs 200,000. Apart from the compounded interest of between 18.5 and 19.57 per cent, the foreign banks charge upto Rs 450 for 'documentation'.The visit to the bank must be made with securities worth at least Rs 450,000 in hand. Next, an account has to be opened with the branch. The loan will be given as an overdraft with the interest debited quarterly to his account. That works out to Rs 9,500 debited every three months taking the interest to be 18.5 per cent until the principal is paid off. And don't forget, the 'out of pocket expenses' which work out to about 1.5 per cent per annum. Says the newspaper Business Standard : " If you think this is astronomical you are right."

I hope foreign competition is not allowed to enter our business too !

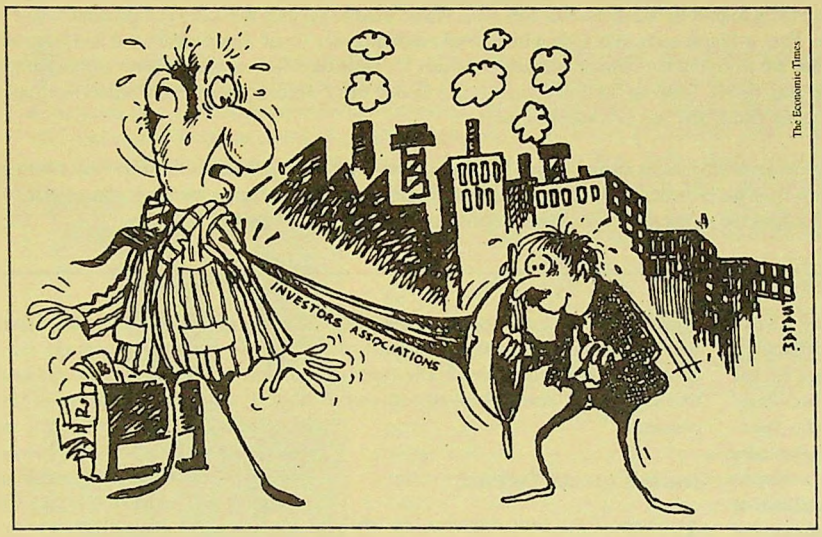
and loyalty. More than monetary compensation, what thrilled them most was proximity to the white man. It was Thomas Babbington Macaulay, a great Empirist, who first hit upon the idea of developing the millions whom we govern — a class of Indian in blood and colour, but English in taste, in opinions, in moral and intellect....to render them by degrees fit vehicles for conveying knowledge to the great mass of the population."

In today's multinational way of doing business, such a race of Indians is very important. Highly paid young men and women, drawing monthly salaries equivalent to what their parents could accumulate as a lifetime's savings, are today ruling the roost in the TNCs' Indian operations. In their arrogance, their impatience and irreverence to everything traditional, not to mention corruption, they better their counterparts of the last century. A young MBA with a foreign bank or TNC, is also the model before every young Indian. A decade ago, the same status was accorded to the youth qualified in the cheapest high such an auxiliary race and the best way to do it was instilling a sense of awe in Occidental civilisation through the medium of western education. He wrote, in his famous Minute on Education (circa 1835): "... (is to be) interpreters between us and

Investment blues

The capital markets in India, thanks to the recession in the west, are booming. In 1993, companies raised more than Rs 200 million (more than $ 6.5 million), an Indian record which will easily be surpassed this year. Investor abuse has also grown. Some examples :

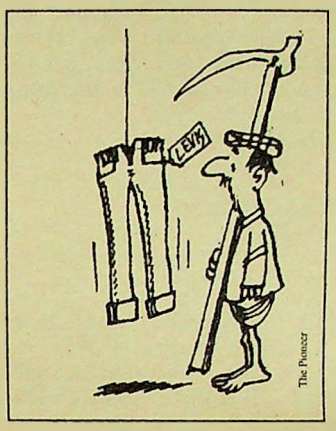
- Morgan Stanley, the US Mutual Fund, raised Rs 20 million ($ 650,000) by misleading investors on two counts.The common investor was quite in awe of their product. But they misled on two counts. One, they announced allocation of units on a first-come-first-serve basis, where no scientific system existed to determine this. Second, they concealed important facts. Today the units are quoting below par.



- The Indian bourses run on primitive lines. TNC mutual funds and emerging market funds were at first sceptical, but now they have struck strategic alliances with the local broking community and are merrily manipulating prices. As S S Nadkarni, chairman of the official monitoring agency,SEBI, points out : " there is no link between the performance of a company and the price of its scrip. A few big brokers are manipulating prices."
- The middle class, chasing the big Indian dream are not satisfied with low-interest yielding bank fixed deposits. They are applying for primary market scrips buy enclosing the full amount in cheque. These are immediately debited from their accounts. In the mad rush, most issues are oversubscribed many times over. So most applicants get their refunds three months later without interest. But they consider themselves lucky. Because half of them never hear from the company again.
- As a matter of irony, investors' associations, formed over the past few decades, are now winding up. Reason : lack of funds and manipulation by the big brokers. Sebi, which professes to guard the investors' interest, is largely ineffective. Nadkarni now wants investors to be redefined consumers, and their complaints dealt with by the Consumer courts where justice is speedier.
- Mutual funds are the biggest frauds. Most of the schemes are quoting below par even when the market is booming. But the fund managers add insult to injury by issuing newsletters claiming credit for the high net asset value(NAV) The simple investor is confused. What is the good in an investment that gives no liquidity ? "All this talk about NAV is hoax. They said Mutual Funds are quick return yielding. Now we have been thoroughly suckered," says an investor.

An Indian Story

"The changing lifestyle in India is a great business opportunity " — C.Boonstra, head of operations (Asia), NV Philips.



Pravin Desai, a 49-year-old computer engineer in Delhi, is reasonably well placed in life. But nine years to go before retirement, he is a worried man. He just cannot save enough money for sending his son to the US for higher education.This is very important in middle class India today. He sometimes wishes he had been a civil engineer, for he could have raised enough money 'under the table' against contracts. Plus he could have built a house. The one he lives in is a company flat.

One of the reasons he cannot stash much away is his son. The college going fellow wants new clothes every month. When Pravin was his son's age, he just wore his father's old clothes to college. But his son will have none of that. He wants Benetton T-Shirts, Levis jeans and Adidas sneakers. These are the 'casual wear' now promoted heavily by TNC lifestyle advertisements. Most urban Indians believe they are now catching up with the West.

The 19-year -old also wants Pravin to pick up his motorbike fuel bills. Pravin used to get only bus fare. The generation gap is getting very expensive. *Bhel Puri*, a simple and cheap Indian traditional roadside snack is out. Hamburgers and footlongs are in. Two other things about this are worrying him. Motor bike ads on Indian TV these days feature male models zipping at top speed, performing death defying deeds. Suppose his son emulates that in real life ? Second, those Hamburgers are "non-vegetarian " ! And nobody in his family tree has ever touched meat.

Last year the financial papers were singing paens about Morgan Stanley and predicted overnight riches for subscribers to their scheme. Pravin foolishly drew from his provident fund to buy hundreds of units. Nowadays he just scans the stocks page in his newspaper. He will sell of his units the moment Morgan Stanley quotes at par (Rs. 10 or 30 cents).

education available in the world (it is a fact that no country subsidises its technology, management and generally higher studies better than India) who made his money in the west. But now, the Indian who makes six figure salaries a month sitting in India is the prince charming. He is worshipped by advertising copy and the journalism of the day makes his PET bottle marketing feel like commanding the Bismarck.

Within this tribe too, there are individuals who keep their conscience intact by questioning, even if to themselves, the justification in all this. A young executive with Citibank, who keeps in touch with CUTS in his spare time, reflected one day :

" I sometimes hate myself to be part of that scene. I mean, I hear my own boss sometimes sardonically remark 'we are agents of Uncle Sam.' Its treacherous.... the things we do to our own companies. On some mornings, a few of my colleagues just decide to f**k Company X. Just makes a few calls and soon he has five executives on the other end eating out of his hand. The other day, one chap in the office actually chartered a helicopter to fly to a company's factory in the suburbs because the client will pay for it....."

These reflections convince us, somewhere time bombs must be ticking. The spirit of questioning is not quite dead. The repetitive saga that is history, will take its own course.

Indian versus Indian

For the first four decades, federal governments swore by a policy of uniform industrial development. Special packages were given to private investors who set up factories in uneconomical areas. Because this rarely happened, government distributed its own investment widely. There were aberrations of course. Industrialist R P Goenka recalls that under the *license raj* ministers promoted only their constituencies. But generally uniform development guided the industrial policy.

Not any more. Today, with sudden government withdrawal from industry, people in states far from raw material sources and markets, with poor infrastructure, are only reading in newspapers as the maximum concentration of new investment takes place in the south west.The north and the east get the crumbs.

India has 25 states, and keeping the nation together amidst more than 80 language and three big religious groupings is a basic problem for the federal government. But now, a new nuisance is emerging.The prosperous states are inviting envy, and their governments are even conducting roadshows abroad and in other state capitals laying out special incentives like sales tax holidays and cheap power to woo investment. "An unhealthy competition has started which will lead to national disintegration", says Jyoti Basu, octogenarian chief minister of West Bengal. "Unless the federal government intervenes, uniform national development will be impossible".

There is a point here. The east and north-east are the most mineral rich and populous rts. But it lacks roads, sufficient electricity and is dotted with cities bursting with people living under poor sanitary conditions. In the fifties and sixties, the federal government pumped a lot of money into these states but most of these were aimed at exploiting its huge reserves of petroleum, iron ore, copper, coal, manganese,tea, etc. Its lush forests were felled to supply the nation's paper, coal burnt to run the aluminium and steel plants. But little was invested in people's education

and sustainable economic planning. " In the liberalised scenario, industries are to come up where markets exist. So the east is a lost case and the west is the hope", says J.J.Irani, head of India's largest privately owned steel plant, Tisco.

As India discovers capitalism, the dominant middle class feeling is "market forces must lead". But this perception is not shared lower down. Militant groups have sprung up in the north-east demanding secession from India. Meanwhile, the rich of Bombay and New Delhi enjoy themselves like never before. They are blissfully ignorant about the wider implications of this boom on their society, their concept of nation.
The consumer in India is facing a peculiar dilemma. The reforms have certainly given him greater say in the market place. Hitherto arrogant government owned utilities are now about to be gobbled up by TNCs through their Indian operations. Prices of everyday goods and services are crashing. He never had it so good.

But this is an illusion as he is fast realising. Liberalisation is making him bear the burden of the subsidies that are no longer absorbed by the producers. At the behest of the World Bank and other funders, the state is no longer is withdrawing support everywhere. The sceptre of paying at every step as is commonplace in the north is looming large before him. "The World Bank will demand an interest which the government will pass on to us. Next, the private party executing the contract will make us pay. Third, the local government will demand its own share. We are to be squeezed", is a common consumer complaint.

The consumer movement in the subcontinent had for long been working on specific issues. For want of funds and committed people, its scope has generally been restricted to representing consumers with their grievances before the telephone department or the railways. The real issue which is dominating his purchasing ability is lost on the movement.

Clearly, the time has come for the consumers to assert themselves as an important factor in the economy. They have totake the immediate advantages of liberalisation with a pinch of salt and reflect on the ramifications of the rapid industrialisation on the country's environment, its politics and society.

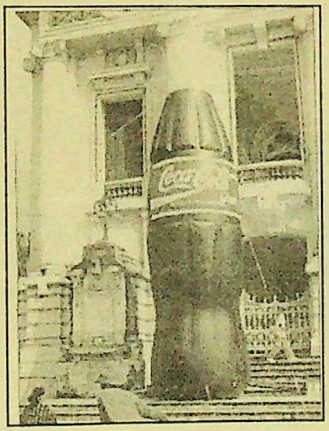
There is another area requiring immediate addressing. The country's consumer movement must quickly identify the areas in which it can build bridges with the factors directly affecting the economy. Indian indusry, or instance, needs a friend. which can bring it up to date with the modern ideas on environment and consumerism dominating the counties where it seeks its markets.Besides, only a neutral NGO network can provide it with reliable information, a tool which is vital if the onslaught of the TNCs has to be resisted.

Indian PrimeMinister P V Narasimha Rao told businessmen in Singapore : " We cannot wish away multinationals anymore. In these times `multinational' is no longer a dirty word.". TNCs today are an essential factor in a nation's growth.

Liberalisation has empowered the consumer movement with greater responsibilities. In the absence of other forms of resistance it is the consumers' lone battle ahead . ■

A 'Socialist' Cola

The socialist politician, George Fernandes, as federal industries minister in 1977, ordered Coca Cola to close down its Indian operations. The TBC had refused to dilute its holding in the Indian company as was the rule those days. Moreover it refused to disclose its special formula which was also a must.



Third World Resurgence

So for a few years, India was without a Cola drink. But the nation then placed a greater premium on the spirit of self reliance. So, within months, Parle developed a Cola drink, it named it 'Thums Up'. The accompanying sign suggested " yes, we too can do it".

Pepsi was allowed to enter India against several conditions in 1989. But by then Thums Up was a market leader and this TBC was content with niches. In the wake of liberalisation, there was talk of Coke being allowed to reenter. Parle's Ramesh Chauhan, fearing a wipeout, went to Atlanta and sold the product to Coke for a reported $ 60 million. Today Thums Up is just another Coke brand. Symbolic of the great spirit of self reliance.
Fernandes is angry again.As the two rival TBCs fight increasingly dirty battles in the marketplace, he announced last month his plans for a 'Socialist Cola'. His party is to take on the TBCs in two months time by raising capital for the venture literally on the streets of Indian towns. The appeal to Indian self respect, he believes, will be enough. The cola will be bottled in the plants of the numerous former small operators who are on the brink of a wipeout.

A side show : Formerly, only foreign tourists drank water from PET bottles. Now 'increased consumer awareness'among India's rich, is supposedly behind the boom in PET bottled water sales. To meet the rising demand for this new status symbol, Pepsico, says *Multinational Monitor*, is collecting discarded PET bottles in the US, and exporting them to its Indian operations, who in turn sells them to the dozens of bottlers across the country. Last month, the US Embassy's lab in New Delhi found traces of human excreta in one unopened PET bottle of mineral water and banned all local bottlers.

TOO BIG FOR RULES

PRADEEP S. MEHTA

Corrupt practices, abuse of environment, consumers, labour and sovereignty have a bright future indeed.

Trade is the new geopolitik affecting every aspect of human life anywhere, facilitating an expanding 'universe' of Transnational Corporations(TNCs) with increasing rights but reducing obligations. More than 37,000 TNCs with 170,000 foreign affiliates control 70 p.c. of the world trade, sales of $5.5 trillion, 90 p.c. of all technology patents and account for 25 p.c. of the world's gross national product. If guided properly, they can play a pivotal role in achieving sustainable development, or otherwise, serve as major impediments in the transition process.

After GATT'94, which will encompass every possible socio-economic activity, there is every reason to believe that TNCs' role will increase in the coming years, as developing countries pursue growth through structural adjustment programmes, market reforms and liberalisation of foreign direct investment regimes.

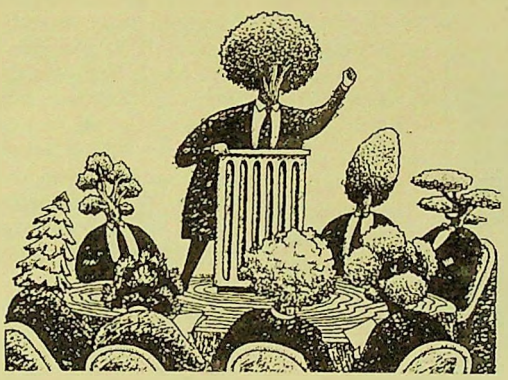
According to a 1992 report of the UN Centre for TNCs (UNCTC), more than 50 p.c. of the world's greenhouse gas emissions is generated by TNCs. Notwithstanding the fallout of the Bhopal gas disaster,industrial chemical production, including that of highly toxic substances, is dominated by TNCs - 94 p.c. of world agro-chemical sales in 1990 was in the realm of 20 transnational pesticide manufacturers.

Over half of the world's mining, refining and smelting capacity in the energy-intensive aluminum industry is in the hand of TNCs. The list is endless. TNCs are ubiquitous in all areas of economic activity raising serious concerns on the sustainable use of renewable and non-renewable natural resources, sustainable consumption, disposal of hazardous waste, new biotechnolgical interventions, occupational and consumer health and safety et al.

These questions were raised at the UNCED prepcoms, but the developed nations managed to obfuscate the issues. Without any reference to TNCs, the Agenda 21 has some 65 statements in two sections on what business should do for environmental protection, but there is no recommendation for legislation to regulate TNC environmental behaviour.

The NGO treaty prepared after Rio rightly concluded : " UNCED has abdicated responsibility to take measures to control TNC activities, instead promoting TNCs ... willingness to regulate themselves. The UN has given up trying to develop a code for TNCs and the UNCTC has been weakened."

In fact the UNCTC met with its demise shortly thereafter when all its functions and staff in New York were transferred to Geneva as a programme on TNCs under the UNCTAD.



HISTORY

When sovereignty was more important than environment, the fiasco over the political 'interference' of International Telephones & Telegraph (ITT) in Chile, in the 1960s, led to the setting up of the UNCTC alongwith a UN Commission on TNCs in 1974. Their agenda: to address issues and problems arising out of the global operations and behaviour of TNCs and develop a Code of Conduct to govern the same.

Negotiations on the Code which began in 1976, culminated in an omnibus document in 1990 covering the entire gamut of TNC operations impacting environment, consumers, culture, human rights, labour, corruption, competition etc. Cheesed with UNCTC's sterling work on several exposures of global business and faced with the alarming prospect of a millstone around their necks, international business (read International Chamber of Commerce) was in no mood to accept the Code. It bickered and scowled, and in the same year, plead the US congress to pre-emptorily reject it.

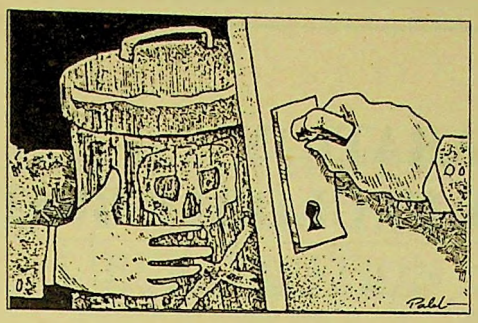
In March 1991, the USA killed the Code by scaring developing nations that any support would send wrong signals to TNCs whose money they were wooing to buttress their impoverished economies. It further advised them and fellow rich nations, 'that it maybe best to postpone indefinitely negotiations on the Code. We can accept a voluntary code as part of an appropriate investment regime, as witnessed by the fact that since 1975, we have supported the OECD Guidelines for Multinational Enterprises.'

Evidently the North propelled by its business was never interested in having any kind of document under the UN which could in anyway bring any kind of curbs on their operations. It suited them to see various other 'codes and guidelines' which would have no bite. The ICC guidelines had existed since 1974, the OECD principles revised in 1991, and as viewed by this writer, the next pre-emptory step was the World Bank guideline of 1992.

The proliferation of such FDI instruments including several bilateral and regional treaties only confused the scenario. In the words of a noted scholar of these developments, Prof. John Kline of Georgetown University, Washington : "These threaten to become a morass of binding and non-binding partial instruments that overlap on some issues while leaving broad areas of FDI policy and transnational business activity uncovered by effective regulations."

In the UNCTAD World Investment Report 1993 : TNCs and Integrated International Production, Secretary General, Kenneth Dadzie, says in the preface : "... policy and regulatory frameworks need to adapt to the emerging integrated production system, if the benefits of regionalisation and globalisation are to be spread as widely as possible."

But there is another side to this. Keeping in mind the Bhopal gas tragedy, TNCs today still take unfair advantage of their elite status and exploit national laws and economic policies tailored to attract them - often with serious consequences for people and the environment. This is particularly true when countries are competing to get FDI. The UNCTAD report also points out that in 1991-92, 35 countries introduced 82 policy changes specifically to attract FDI.



For instance, the Namibian ambassador to the UN, Dr Tunguru Huaraka told this writer that in the special economic zones of his newly liberated country, the laws were diluted and the local people left at the mercy of business. For example, the labour has no right to organise. The list is endless. Another area of concern is the transfer of polluting industries from the North to the South, because they would be happy to be rid of dirty factories which cannot comply with their stiffer environment protection laws.

Simultaneously developing countries are expected to incur enormous costs in balancing development with environment protection. The World Bank estimates that such a full scale effort could require anywhere between $75 and 125 billion annually in extra aid. Its 1992 World Development Report cautioned: "Industrial countries must bear most of the costs of addressing global problems, especially when the required investments are not in the narrow interests of developing countries ... such arrangements have the potential to make all countries better off if the world's willingness to pay for policy changes exceeds the cost of the changes."

RECENT HAPPENINGS

At the 19th meeting of the UN Commission on TNCs in April,1993 the issue was kept barely alive due to herculean efforts made by a long time advocate of the code, Allan Asher of Australia. After diluting a G-77 resolution, the meeting agreed that an oral presentation could be made at the next meeting by the secretariat on guidelines, while institutions like the World Bank and the OECD would make presentations on guidelines for FDI developed by them.

Just a few months before, at a conference in New Delhi, February 14-15, organised by the International Organisation of Consumer Unions (IOCU) and Consumer Unity & Trust Society (CUTS), the first ever to take stock of the work on the guidelines, Asher made a strong pitch : "Some guidelines (under the UN umbrella) to regulate the conduct of TNCs should be evolved. With the demise of the Code, the fire among the proponents has died down, but the embers are still there. Let's rekindle them."

But rekindling was not possible. As a last effort the IOCU, which had been campaigning for the Code since beginning, in the 20th meeting of the Commission held in Geneva in May, 1994, cautioned the assembly:

"Faced with the globalisation of the world economy, most people feel powerlessness, mistrust and concern. Approval by the UN of a single set of Guidelines for the behaviour of global business on aspects such as safety, information, good labour practices, environmental protection, commercial policies including competition, relations with host governments, good business practices and others, would help dispel those fears. Such guidelines would also give citizens a concrete tool for monitoring the activities of TNCs and give companies greater investment confidence and clear goals."

While recalling the unsuccessful debate on the code since long last, the statement, endorsed by the International Council of Voluntary Agencies, the Netherlands Committee of the IUCN and the International Youth and Student Movement for the United Nations, further noted :

"IOCU supports proposals for a single international instrument based on voluntary codes and guidelines, such as OECD's and the International Chamber of Commerce's guidelines for multinational enterprises, the Agenda 21 and the UN Guidelines for Consumer Protection, among others.These and other existing instruments have a particular objective and focus but none of them cover all aspects concerning the activities of TNCs. Hence the need for the proposed UN Guidelines for TNCs."

'YEARS OF DEBATE'

This initiative flopped when the US delegate 'ruled' : " There had been years and years of debate on this issue. The debate was closed in the past and for the future. A Code of Conduct for TNCs was irrelevant and should not be considered." There was not a whimper of protest in a lackadaisical assembly, provoking the IOCU to observe: " No government nor any UN official wants to antagonise TNCs these days."

Only Pakistan intervened with the warning that producers often abuse economic freedom, therefore globalisation of economy needs regulatory frameworks which are global in scope. The G-77, according to its Chairman's statement, was happy to explore other initiatives that are taking place in other institutions.

The only 'achievement' of this meeting was to rename the body, as the UN Commission on International Investment and Transnational Corporations. The new agenda, for whatever it means, will 'promote the exchange of views and experiences among ... on issues relating to international investment and transnational corporations.'

Views and experiences known so far will not encourage the promotion of any globally recognised code or guidelines for TNC conduct. Corrupt practices, abuse of environment, consumers, labour and sovereignty have a bright future, indeed ■

■ CAMPAIGN

DELHI DECLARATION ON FAIRPLAY IN GLOBAL BUSINESS

The following declaration presents principal issues discussed and general consensus emerging from the International Conference on Fairplay in Global Business, New Delhi, 14-15, February.1994, although not every participant necessarily supports every word in this statement.

The global economy has fundamentally changed in the last half century with the emergence of Trans National Corporations as major actors, the largest of which are larger than many nation states. Yet even the minimal efforts by the international community to monitor, let alone regulate, these global giants have been all but abandoned.

ON TNCs/MNCs

Those of us associated with consumer, environment, labour, human rights and other citizens groups and movements around the world will work together to create a new, dynamic system for monitoring the performance of TNCs while simultaneously urging the United Nations to resume and strengthen its monitoring role.

Meaningful standards for the behaviour of TNCs as they impact on consumer, environment, labour and human rights are critical tools for citizen organising and mobilising to protect and assert these rights. We therefore urge that a fresh attempt be made through the United Nations Commission on Trans-national Corporations (meeting in May,1994) and other appropriate intergovernmental forums to formulate the Guidelines for Global Business, which will ensure fairplay for all concerned.

We also propose that as a parallel effort, concerned citizens groups should join together in constructing performance standards for TNCs, drawing on existing guidelines and conventions, including those of the International Chamber of Commerce, the OECD, the Caux Principles etc., which have already achieved widespread acceptance in the international community.

ON GATT

We furthermore recognise the opportunity presented by the forthcoming meeting of GATT ministers in April in Marrakesh, which will be settling the GATT's future work programme. It is essential that this programme lays the foundations for future GATT accords on trade and the environment, and on the inter-relation between trade and competition policy - an issue of the first importance if abuses of market power by TNCs are to be checked.

In both these areas, there must be full consultation with consumer and other public interest groups as the research and debate proceeds. And the GATT's work programme must not shrink from evaluating and correcting the effects on competition of the Uruguay Round package itself, especially in the context of the TRIPS agreement.

Many of us are concerned that the Uruguay Round accord will strengthen the role of TNCs in the global political economy and lead to extensive violations of consumer, labour, human rights and abuse of the environment.

We therefore declare our commitment to work in different ways to counter these effects of the trade agreement, particularly of the most objectionable features such as intellectual property rights provisions, some of us through non-violent direct action and others through legal and other channels.

We furthermore recognise the opportunity presented by the forthcoming GATT Ministerial meeting this April to lay the groundwork for further stages of GATT negotiations and we urge that all further negotiations include active participation of citizens groups and movements, greater transparency in the negotiations and changes in those elements in the Agreement that foster monopolies and restrict competition. ■

15 February, 1994
New Delhi, India

Ambassador Farooq Sobhan speaking at the closing of the CUTS - IOCU International Conference on TNC guidelines, New Delhi, February 15 '94

A report of the conference in English, French and Spanish: " Too Big for Rules/Trop Grands Pour des Lois/Demasiado Grande para Reglas", is available for US$ 10. Orders to be sent to CUTS, 3-B, Camac Street, Calcutta-700 016, India.

INTERNATIONAL CONFERENCE ON COMPETITION POLICY IN THE CONTEXT OF LIBERALISATION

New Delhi, India, January 20-21,1995
Theme: Liberalisation and Market Intervention

OBJECTIVES

1. To assert consumers' demand for a just marketplace where true competition and fair business practice prevails.
2. To identify and collate information on anti-consumer practices of global business such as cartels, mergers and acquisitions.
3. To identify linkages of the impact of competition on the environment.
4. To adopt recommendations for the World Trade Organisation to incorporate in their policies on environment and trade, and competition and investment.

WHO SHOULD ATTEND

International and national organisations concerned with the issues.

Interested participants are encouraged to send reports on the existing situation in their region with emphasis on how these issues are being tackled and specific problems associated with implementation and/or policy.

For further information please contact:
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RESOURCE PERSONS *

Mr Allan Asher, Commissioner, Australian Trade Practices Commission

Mr Phillipe Brusick, Chief, Restrictive Business Practices Unit, UNCTAD, Geneva

Dr. S.Sothi Rachagan, Dean, Faculty of Law, University of Malaya, Kuala Lumpur.

Mr Stephen Locke, Director, Policy, Consumers Assen., London, U.K.

Mr H.H. da Silva, Secretary General, Fair Trading Commission, Colombo, Sri Lanka

Mr Kyu, Uck Lee, Vice President, Korea Development Institute and Commissioner, Fair Trade Commission, Seoul

Mr David Harland, Challis Professor of Law, University of Sydney, Australia

Dr. Rajiv Dhawan, Sr. Advocate, Supreme Court of India and Director, Public Interest Litigation Support & Research Centre, New Delhi

** Those who have confirmed till date.*

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PRODUCING HEALTH, CONSUMING HEALTH CARE

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INTRODUCTION

People care about their health, for good reasons; and they try in a number of ways to maintain or improve it. Individually and in groups at various levels—families, associations, work groups, communities and nations—they engage in a wide range of activities which they believe will contribute to their health. People also attempt to avoid activities or circumstances which they see as potentially harmful. Implicit in such behaviour are theories, or more accurately loosely associated and often inconsistent collections of causal hypotheses, as to the determinants of health.

In particular, but only as a sub-set of these health-oriented activities, modern societies devote a very large proportion of their economic resources to the production and distribution of 'health care', a particular collection of commodities which are perceived as bearing a special relationship to health. The 'health care industry' which assembles these resources and converts them into various health-related goods and services is one of the largest clusters of economic activity in all modern states [1, 2]. Such massive efforts reflect a widespread belief that the availability and use of health care is central to the health of both individuals and populations.

This concentration of economic effort has meant that public or collective health policy has been predominantly health *care* policy. The provision of care not only absorbs the lion's share of the physical and intellectual resources which are specifically identified as health-related, it also occupies the centre of the stage when the rest of the community considers what to do about its health.

Health care, in turn, is overwhelmingly *reactive* in nature, responding to perceived departures from health, and identifying those departures in terms of clinical concepts and categories—diseases, professionally defined. The definition of health implicit in (most of) the behaviour of the health care system, the collection of people and institutions involved in the provision of care, is a negative concept, the absence of disease or injury. The system is in consequence often labelled, usually by its critics but not unjustly, as a "sickness care system".*

Yet this definition of health was specifically rejected by the World Health Organization (WHO) more than 40 years ago. Its classic statement, "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or injury" expressed a general perception that there is much more to health than simply a collection of negatives—a state of *not* suffering from any designated undesirable condition.

Such a comprehensive concept of health, however, risks becoming the proper objective for, and is certainly affected by, *all* human activity. There is no room for a separately identifiable realm of specifically health-oriented activity. The WHO definition is thus difficult to use as the basis for health policy, because implicitly it includes *all* policy as health policy. It has accordingly been honoured in repetition, but rarely in application.

Moreover, the WHO statement appears to offer only polar alternatives for the definition of health. Common usage, however, suggests a continuum of meanings. At one end of that continuum is well-being in the broadest sense, the all-encompassing definition of the WHO, almost a Platonic ideal of 'The Good'. At the other end is the simple absence of negative biological circumstances—disease, disability or death.†

But the biological circumstances identified and classified by the health care disciplines as diseases are then experienced by individuals and their families or social groups as illnesses—distressing symptoms. The correspondence between medical disease and personal illness is by no means exact. Thus the patient's concept of health as absence of illness need not match the clinician's absence of disease. Further, the functional capacity of the individual will be influenced but not wholly determined by the perception of illness, and that capacity too will be an aspect, but not the totality, of well-being.

There are no sharply drawn boundaries between the various concepts of health in such a continuum; but that does not prevent us from recognizing their

*The rhetoric of 'prevention' has penetrated the health care system to a significant degree; reactive responses to identified departures from health may be labelled secondary or tertiary prevention insofar as they prevent further deterioration of an adverse condition. But even when components of the health care system move from a reactive to a promotive strategy—screening for cholesterol, for example, or hypertension—the interventions still consist of identifying departures from clinically determined norms for particular biological measurements, and initiating therapeutic interventions. Elevated blood pressure or serum cholesterol measurements become themselves identified as 'diseases', to be 'cured'.

†The representation of mental illness is always troublesome—where is the borderline between clinical depression, and the 'normal' human portion of unhappiness? The difficulty of definition persists, however, across the whole continuum; the WHO definition of health does not imply perpetual bliss.

differences. Different concepts are neither right nor wrong, they simply have different purposes and fields of application. Whatever the level of *definition* of health being employed, however, it is important to distinguish this from the question of the *determinants* of (that definition of) health [3].

Here too there exists a broad range of candidates, from particular targeted health care services, through genetic endowments of individuals, environmental sanitation, adequacy and quality of nutrition and shelter, stress and the supportiveness of the social environment, to self-esteem and sense of personal adequacy or control. It appears, on the basis of both long-established wisdom and considerable more recent research, that the factors which affect health at all levels of definition include but go well beyond health care *per se* [4–9].

Attempts to advance our understanding of this broad range of determinants through research have, like the health care system itself, tended to focus their attention on the narrower concept of health—absence of disease or injury. This concept has the significant advantage that it can be represented through quantifiable and measurable phenomena—death or survival, the incidence or prevalence of particular morbid conditions. The influence of a wide range of determinants, in and beyond the health care system, has in fact been observed in these most basic—negative—measures.

Precision is gained at a cost. Narrow definitions leave out less specific dimensions of health which many people would judge to be important to their evaluation of their own circumstances, or those of their associates. On the other hand, it seems at least plausible that the broad range of determinants of health whose effects are reflected in the 'mere absence of disease or injury', or simple survival, are also relevant to more comprehensive definitions of health.

The current resurgence of interest in the determinants of health, as well as in its broader conceptualization, represents a return to a very old historical tradition, as old as medicine itself. The dialogue between Asclepios, the god of medicine, and Hygieia, the goddess of health—the external intervention and the well-lived life—goes back to the beginning. Only in the twentieth century did the triumph of 'scientific' modes of inquiry in medicine (as in most walks of life) result in the eclipse of Hygieia. Knowledge has increasingly become defined in terms of that (and only that) which emerges from the application of reductionist methods of investigation, applied to the fullest extent possible in a 'Newtonian' frame of reference [10].

The health care system has then become the conventional vehicle for the translation of such knowledge into the improvement of health—more, and more powerful, interventions, guided by better and better science. Nor have its achievements been negligible in enhanced ability to prevent some diseases, cure others and alleviate the symptoms or slow the progress of many more. Thus by mid-century the providers of health care had gained an extraordinary institutional and even more an intellectual dominance, defining both what counted as health, and how it was to be pursued. The WHO was a voice in the wilderness.

But the intellectual currents have now begun to flow in the other direction. There has been a continuing unease about the exclusive authority of classically 'scientific', positivist methods, both to define the knowable and to determine how it may come to be known [11, 12], an unease which has drawn new strength from developments in sub-atomic physics and more recently in artificial intelligence and mathematics.* In addition, the application of those methods themselves to the exploration of the determinants of health is generating increasing evidence—in the most restricted scientific sense—of the powerful role of contributing factors outside the health care system [16–20].

Simultaneously, the more rigorous evaluation of the health care system itself has demonstrated that its practices are much more loosely connected with scientific or any other form of knowledge, than the official rhetoric would suggest [21–24]. And finally, the very success of that system in occupying the centre of the intellectual and policy stage, and in drawing in resources, has been built upon an extraordinarily heightened set of social expectations as to its potential contributions. Some degree of disappointment and disillusion is an inevitable consequence, with corresponding concern about the justification for the scale of effort involved—the rhetoric of 'cost explosions'.

There is thus a growing gap between our understanding of the determinants of health, and the primary focus of health policy on the provision of health care. This increasing disjunction may be partly a consequence of the persistence, in the policy arena, of incomplete and obsolete models, or intellectual frames of reference, for conceptualizing the determinants of health. How a problem is framed will determine which kinds of evidence are given weight, and which are disregarded. Perfectly valid data—hard observations bearing directly on important questions—simply drop out of consideration, as if they did not exist, when the implicit model of entities and inter-relationships in people's minds provides no set of categories in which to put them.

There is, for example, considerable evidence linking mortality to the (non)availability of social support mechanisms, evidence of a strength which House [16] describes as now equivalent to that in the mid-1950s on the effects of tobacco smoking. Retirement, or the death of a spouse, are documented as important risk factors. Similarly some correlate or combination of social class, level of income or education, and position in a social hierarchy is clearly associated with mortality [4, 6]. None of this is denied, yet no account is taken of such relationships in the formulation of health (care) policy.

*This does not represent a rejection of rational modes of enquiry; the universe is still seen as, on some levels, a comprehensible and orderly place. But there appear to be fundamental limits on its comprehensibility—not just on our ability to comprehend it—and the relevant concepts of order may also be less complete than was once hoped. Whether or not Nietzsche turns out to be right about the death of God [13], Laplace's Demon appears definitely defunct [12, 14, 15]. (But has he met his maker?)

Such policy is, by contrast, acutely sensitive to even the possibility that some new drug, piece of equipment, or diagnostic or therapeutic manoeuvre may contribute to health. That someone's health may perhaps be at risk for lack of such intervention, is *prima facie* grounds for close policy attention, and at least a strong argument for provision. Meanwhile the egregious fact that people are suffering, and in some cases dying, as a consequence of processes not directly connected to health care, elicits neither rebuttal nor response.

The explanation cannot be that there is superior evidence for the effectiveness, still less the cost-effectiveness, of health care interventions. It is notorious that new interventions are introduced, and particularly disseminated, in the absence of such evidence [21–23]. If (some) clinicians find it plausible that a manoeuvre might be beneficial in particular circumstances, it is likely to be used. The growing concern for 'technological assessment' or careful evaluation *before* dissemination, is a response to this well-established pattern. But those who might wish to restrain application, fearing lack of effect or even harm, find themselves bearing the burden of rigorous proof. If the evidence is incomplete or ambiguous, the bias is toward intervention.

This heavy concentration of attention and effort on a sub-set of health-related activities, and *de facto* dismissal of others, may be a product of the conceptual framework within which we think about the determinants of health. A simple mechanical model captures the causal relationships from sickness, to care, to cure. The machine (us) is damaged or breaks, and the broken part is repaired (or perhaps replaced). Although this mental picture may be a gross oversimplification of reality, it is easy to hold in mind.

By contrast, it is not at all obvious how one should even think about the causal connections between 'stress' or 'low self-esteem', and illness or death—much less what would be appropriate policy responses. The whole subject has a somewhat mysterious air, with overtones of the occult, in contrast to the (apparently) transparent and scientific process of health care.* There being no set of intellectual categories in which to assemble such data, they are ignored.

In this paper, therefore, we propose a somewhat more complex framework, which we believe is sufficiently comprehensive and flexible to represent a wider range of relationships among the determinants of health. The test of such a framework is its ability to provide meaningful categories in which to insert the various sorts of evidence which are now emerging as to the diverse determinants of health, as well as to permit a definition of health broad enough to encompass the dimensions which people—providers of care, policy makers and particularly ordinary individuals—feel to be important.

*The actual interventions themselves may be very far from transparent; 'medical miracles' are an everyday occurrence, and the processes are presented as beyond the capacity or ken of ordinary mortals. But the application of a high degree of science and skill is still within the conceptually simple framework of a mechanical model—fixing the damaged part.

Our purpose is *not* to try to present a comprehensive, or even a sketchy, survey of the current evidence on the determinants of health. Even a taxonomy for that evidence, a suggested classification and enumeration of the main heads, would now be a major research task. Rather, we are trying to construct an analytic framework within which such evidence can be fitted, and which will highlight the ways in which different types of factors and forces can interact to bear on different conceptualizations of health. Our model or precedent is the federal government's White Paper, *A New Perspective on the Health of Canadians* [25], which likewise presented very little of the actual evidence on the determinants of health, but offered a very powerful and compelling framework for assembling it.

We will also follow the *White Paper* in offering no more than the most cursory indication of what the implications of such evidence might be for health policy, public or private. Policy implications will arise from the actual evidence on the determinants of health, not from the framework *per se*. If the framework is useful it should facilitate the presentation of evidence in such a way as to make its implications more apparent. But there is of course much more to policy than evidence; 'the art of the possible' includes most importantly one's perceptions of who the key actors are and what their objectives might be. We will be addressing these issues in subsequent work, but not here.

Finally, we must emphasize that the entities which form the components of our framework are themselves categories, with a rich internal structure. Each box and label could be expanded to show its complex contents. One must therefore be very careful about, and usually avoid, treating such categories as if they could be adequately represented by some single homogeneous variable, much less subjected to mathematical or statistical manipulations like a variable. Single variables may capture some aspect of a particular category, but they are not the same as that category. Moreover, in specific contexts it may be the *interactions* between factors from different categories of determinants that are critical to the health of individuals and populations.

DISEASE AND HEALTH CARE: A (TOO) SIMPLE FOUNDATION

We build up our framework component by component, progressively adding complexity both in response to the demonstrable inadequacies of the preceding stage, and in rough correspondence to (our interpretation of) the historical evolution of the conceptual basis of health policy over the last half century. The first and simplest stage defines health as absence of disease or injury and takes as central the relation between health and health care. The former is represented in terms of the categories and capacities of the latter. The relationship can be represented in a simple feed-back model, as presented in Fig. 1, exactly analogous to a heating system governed by a thermostat.

In this framework, people 'get sick' or 'get hurt' for a variety of unspecified reasons represented by the unlabelled arrows entering on the left hand side. They

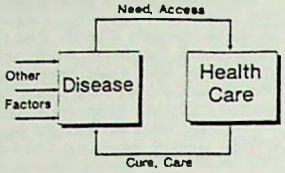

Fig. 1

may then respond by presenting themselves to the health care system, where the resulting diseases and injuries are defined and interpreted as giving rise to 'needs' for particular forms of health care. This interpretive role is critical, because the definition of 'need' depends on the state of medical technology. Conditions for which (it is believed that) nothing can be done may be regrettable, and very distressing, but do not represent 'needs' for care. The patient feels the distress, but the health care system defines the need.

Potential 'needs' for health care are, however, pre-filtered before they reach the care system, an important process which is reflected explicitly neither in Fig. 1 nor in most of health policy.* Whether or not people respond to adverse circumstances by contacting the health care system, seeking 'patient' status, will depend on their perceptions of their own coping capacities, and their informal support systems, relative to their expectations of the formal system. These expectations and reactions are thus included among the 'other factors' that determine the environment to which the health care system responds.

The health care system then combines the functions of thermostat and furnace, interpreting its environment, defining the appropriate response and responding. The level of response is determined by the 'access' to care which a particular society has provided for its members. This access depends both on the combination of human and physical resources available—doctors, nurses, hospitals, diagnostic equipment, drugs, etc.—and also on the administrative and financial systems in place which determine whether particular individuals will receive the services of these resources, and under what conditions.†

The top arrow in Fig. 1 thus reflects the positive response of the health care system to disease—the provision of care. But the form and scale of this response is influenced, through a sort of 'two-key' system, both by the professional definition of needs—what should be done to or for people in particular circumstances, suffering particular departures from health—and by the whole collection of institutions which in any particular society mobilize the resources to meet the needs, and ensure access to care.

Those organizing and financing institutions have very different structures from one society to another, but their tasks are essentially similar, as are the problems and conflicts they face. The actual technologies, and the institutional and professional roles, in health care also show a remarkable similarity across modern societies, suggesting that those societies share a common intellectual framework for thinking about the relationship between health and health care.

The feed-back loop is completed by the lower arrow, reflecting the presumption that the provision of care reduces the level of disease, thereby improving health. The strength of this negative relationship represents the effectiveness of care. These effects include: the restoration and maintenance of health (providing 'cures'); preventing further deterioration; relieving symptoms, particularly pain; offering assistance in coping with the inevitable; and providing reassurance through authoritative interpretation.

The important role of health care in providing comfort to the afflicted fits somewhat ambiguously into this framework, since services which can clearly be identified as making people feel good, but having no present or future influence on their health status however defined, can readily be seen to include a very wide range of activities, most of which are not usually included as health care [26].

The provision of services which *are* generally recognized as health care should obviously take place in a context that preserves a decent consideration for the comfort of those served. There is no excuse for the gratuitous infliction of discomfort, and patients should not be made any more miserable than they have to be. But for those services which represent *only* comfort, it is important to ask both: Why should they be professionalized, by assigning 'official' providers of health care a privileged right to serve? and Why should the clients of the health care system be awarded privileged access to such services? There are many people, not by any sensible definition ill, who might nevertheless have their lives considerably brightened by comforting services at collective expense.‡

*To the extent that overt policy does recognize this process, it tends to respond with marketing activities encouraging people to seek care. A surprising proportion of so-called 'health promotion' includes various forms of 'see your doctor' messages, and might more accurately be called 'disease promotion'. Measures to encourage 'informal' coping should *inter alia* include recommendations *not* to contact the health care system in particular circumstances; the latter are virtually unheard of.

†The experience of the United States is a clear demonstration of the distinction between the resource and administrative/financial dimensions of access. The United States devotes a much larger share of its national resources to producing health care than does any other nation, and spends much more per capita [1, 2]. Yet the peculiarities of its financing system result in severely restricted (or no) access for a substantial minority of its citizens. On the other hand, nominally universal 'access' to a system with grossly inadequate resources would be equally misleading.

‡Providers of care, particularly nurses, often emphasize their 'caring' functions. The point here is not at all that caring is without importance or value, but rather that it is by no means the exclusive preserve of providers of health care. Furthermore, the 'social contract' by which members of a particular community undertake collective (financial) responsibility for each other's health narrowly defined, does not necessarily extend to responsibility for their happiness. 'Caring' independently of any contemplated 'curing', or at least prevention of deterioration, represents an extension of the 'product line'—and sales revenue—of the health care system. If collective buyers of these services, public or private, have never in fact agreed to this extension, its ethical basis is rather shaky.

In this conceptual framework, the level of health of a population is the negative or inverse of the burden of disease. This burden of disease in Fig. 1 is analogous to the temperature of the air in a house in a model of a heating system. The health care system diagnoses that disease and responds with treatment; the thermostat detects a fall in air temperature and turns on the furnace. The result is a reduction in disease/increase in room temperature. The external factors—pathogens, accidents—which 'cause' disease are analogous to the temperature outside the house; a very cold night is equivalent to an epidemic. But the consequences of such external events are moderated by the response of the heating/health care systems.

The thermostat can, of course, be set at different target temperatures, and the control system of the furnace can be more or less sophisticated depending on the extent and duration of permissible departures from the target temperature. Similarly access to care can be provided at different levels, to meet different degrees of 'need' and with tighter or looser tolerances for over- or under-servicing.

The systems do differ, insofar as the house temperature can be increased more or less indefinitely by putting more fuel through the furnace (or adding more furnaces). In principle the expansion of the health care system is bounded by the burden of remediable disease. When each individual has received all the health care which might conceivably be of benefit, then all needs have been met, and 'health' in the narrow sense of absence of (remediable) disease or injury has been attained. Health is bounded from above; air temperature is not. The occupants of the house do not of course *want* an ever-increasing temperature, whether or not it is possible. Too much is as bad as too little. Yet no obvious meaning attaches to the words 'too healthy'. More is always better, a closer approximation to the ideal of perfect, or at least best attainable, health.*

The differences are more apparent than real, however, since in practice the professionally defined needs for care are themselves adjusted according to the capacity of the health care system, and the pressures on it. The objective of health, René Dubos' mirage [27], ever recedes as more resources are devoted to health care. As old forms of disease or injury threaten to disappear, new ones are defined. There are always 'unmet needs'.†

Furthermore, obvious meanings *do* attach to the words 'too much health care', on at least three levels. First, too much care may result in harm to health in the narrow sense—iatrogenic disease—because potent interventions are always potentially harmful. But even if care contributes to health in the narrow sense—keeping the patient alive, for example—it may still be 'too much'. Painful interventions which prolong not life but dying are generally recognized as harmful to those who are forced to undergo them. More generally, the side effects of 'successful' therapy may in some cases be, for the patient, worse than the disease.

Second, even if the care *is* beneficial in terms of both health and well-being of the recipient, it may still represent 'too much' if the benefits are very small relative to the costs, the other opportunities foregone by the patient or others. If health is an important, but not the only, goal in life, it follows that there can be 'too much' even of effective health care [28].

And finally, an important component of health is the individual's *perception* of his or her own state. An exaggerated sense of fragility is not health but hypochondria. Too much emphasis on the number of things than can go wrong, even presented under the banner of 'health promotion', can lead to excessive anxiety and a sense of dependence on health care—from annual check-up to continuous monitoring. This is very advantageous economically for the 'health care industry',‡ and *perhaps* may contribute in some degree to a reduction in disease, but does not correspond to any more general concept of health [29–31].

Unlike a heating system, however, health care systems do not settle down to a stable equilibrium of temperature maintenance and fuel use. The combination of the 'ethical' claim that all needs must be met, and the empirical regularity that, as one need is met, another is discovered, apparently *ad infinitum*, leads to a progressive pressure for expansion in the health care systems of all developed societies. It is as if no temperature level were ever high enough, more and more fuel must always be added to the furnace(s).§

CONCERNS ABOUT COST, EFFECTIVENESS AND THE MARGINAL CONTRIBUTION OF HEALTH CARE

The result is shown in Fig. 2, in which the top arrow, access to health care, has been dramatically

*Best attainable health begs the question of by which *means* health may be attained. A hypothetical situation in which the members of a population had each received all the health *care* which might benefit them, might nevertheless be one in which the population fell well short of attainable health because other measures outside the health care system were neglected.

†A classic example has been provided by the response of paediatrics to the collapse of the baby boom in the mid-1960s. The 'New Paediatrics'—social and emotional problems of adolescents—was discovered just in time to prevent underemployment. At the other end of the paediatric age range, progress in neonatology will ensure a growing supply of very low birthweight babies surviving into childhood, with a complex array of medical problems requiring intervention. We do not suggest that these system responses are the result of conscious and deliberate self-seeking by providers; such is almost certainly not the case. But the outcome is what it is.

‡The quotes are needed because the health care system, and the people in it, are not simply an 'industry' in the sense of a set of activities and actors motivated solely by economic considerations. But to the extent that they are—and it is undeniable that economic considerations *do* matter, even if they are not the exclusive motivations—then this observation holds.

§If building environmental standards were set by fuel supply companies, would we have similar problems with the regulation of thermostats?

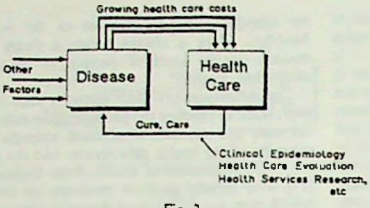

Fig. 2

expanded to reflect a 'health care cost crisis.'* A comparison of international experience demonstrates that the *perception* of such a crisis is virtually universal, at least in Western Europe and North America. It is interesting to note, however, that the countries which perceive such a crisis actually spend widely differing amounts on health care, either absolutely or as a proportion of their national incomes [1, 2].

Nevertheless, whether they spend a little or a lot, in all such countries there is an expressed tension between ever-increasing needs, and increasingly restrained resources. Even in the United States, one finds providers of care claiming that they face more and more serious restrictions on the resources available to them [32], despite the egregious observation that the resources devoted to health care in that country are greater, and growing faster, than anywhere else in the world.

We interpret this observation as implying that perceptions of 'crises' in health care finance arise from conflicts over the level of expenditure on health care (and thus by definition also over the levels of incomes earned from its provision). Such conflicts develop whenever paying agencies attempt to limit the rate of increase of resources flowing to the health care system. They are independent of the actual level of provision of health care to a population, or of its expense, let alone of the level of health, however defined, of that population. They also appear to develop independently of the particular form taken by the payment system in a country.

Nor, as the American example shows, does it matter whether the attempts to limit cost escalation are successful. Perceptions of crisis emerge from the attempt, not the result. Accordingly one should not expect to find any connection between the health of a population, and allegations of 'crisis' in the funding of its health care—or at least not among the countries of Western Europe and North America.

On the lower arrow, and intimately connected with the perceptions of 'cost crisis', we find increasing concern for the effectiveness with which health care services respond to needs. The development and rapid expansion of clinical epidemiology, for example, reflects a concern that the scientific basis underlying much of health care is weak to non-existent. More generally, the growing field of health services research has accumulated extensive evidence inconsistent with the assumption that the provision of health care is connected in any systematic or scientifically grounded way with patient 'needs' or demonstrable outcomes [21–24, 33, 34]. Accordingly, the greatly increased flow of resources into health care is perceived as not having a commensurate, or in some cases any, impact on health status. Nor is there any demonstrable connection between international variations in health status, and variations in health spending [35].

If there were a commensurate impact, then presumably efforts to control costs would be less intense (and perhaps more focussed on relative incomes). As Culyer [36] emphasizes, "... cost containment in itself is not a sensible objective." The rapid increase in spending on computers has not generated calls for cost caps. A care system which could 'cure' upper respiratory infections, colds and flu, for example, would have an enormous positive impact on both economic productivity and human happiness, and would be well worth considerable extra expense. So would a 'cure' for arthritis. Offered such benefits, we suspect that few societies would begrudge the extra resources needed to produce them; indeed these resources would to a considerable extent pay for themselves in higher productivity.†

The combination of virtually universal concern over cost escalation, among payers for care, with steadily increasing evidence from the international research community that a significant proportion of health care activity is ineffective, inefficient, inexplicable, or simply unevaluated, constitutes an implicit judgement that the 'expanding needs' to which expanding health care systems respond are either not of high enough priority to justify the expense, or simply not being met at all.

It is not that no 'needs' remain, that the populations of modern societies have reached a state of optimum health—that is obviously not the case. Nor is it claimed that medicine has had no effect on health—that too is clearly false. The concern is rather that the remaining shortfalls, the continuing burden

*The rhetoric of 'cost crises' rarely if ever recognizes an extremely important distinction between expenditures or outlays, and the economist's concept of resource or opportunity costs. Expenditures on health care may rise (fall) either because more (fewer) resources of human time, effort, and skills, capital equipment and raw materials, are being used in its production, or because the owners of such resources are receiving larger (smaller) payments for them—higher (lower) salaries, fees, or prices. The arrow from health care to disease represents a response in the form of actual goods and services provided—real resources. But much of the public debate over 'underfunding' and 'cost crises' is really about the relative incomes of providers of care, not about the amount and type of care provided. For obvious political reasons, income claims are frequently presented as if they were assertions about levels of care [26, 32].

†There might still, however, be quite justifiable interest in the patterns of prices and incomes generated by such care (see § on p. 1351). A competitive marketplace can generate intense pressures which automatically control prices and incomes, as the computer example has demonstrated. Health care, however, is nowhere provided through such a market (not even in the United States), and has not been for at least a hundred years. There are excellent reasons for this [e.g. 26, 37], and the situation is not in fact going to change in the foreseeable future. It follows that other mechanisms, with associated controversy, will remain necessary to address issues of income distribution.

of illness, disability, distress, and premature death, are less and less sensitive to further extensions in health care—we are reaching the limits of medicine. At the same time the evidence is growing in both quantity and quality that this burden may be quite sensitive to interventions and structural changes outside the health care system.

These concerns and this evidence are by no means new—they go back at least two decades. Yet most of the public and political debate over health policy continues to be carried on in the rhetoric of 'unmet needs' for *health care*. There is a curious disjunction in both the popular and the professional 'conventional wisdom', in that widespread concerns about the effectiveness of the health care system, and acceptance of the significance of factors outside that system, co-exist quite comfortably with continuing worries about shortages and 'underfunding'.

The current 'shortage of nurses' in Canada and indeed in much of the industrialized world, provides a good example. Nursing 'shortages' have been cause for periodic concern in Canada for more than a quarter century. Yet throughout that period, there has been virtually uniform agreement among informed observers that utilization of in-patient beds in Canada is substantially higher than 'needed', and efforts have been on-going to reduce such use. Taking both positions together, this suggests that there is a 'shortage' of nurses to provide 'unnecessary' care!

The significant point is not the validity or otherwise of either perception, but the fact that they do not confront one another. In terms of the thermostatic model, public discussion still consists almost entirely of claims by providers (with considerable public support) that the room temperature is not high enough, or is in danger of falling, or that a severe cold spell is on the way . . . but in any case it is imperative that we install more and bigger furnaces immediately, and buy more fuel. Meanwhile payers—in Canada provincial governments—wring their hands over the size of the fuel bill and seek, with very little external support, ways of making the existing heating system more efficient.

A more efficient heating system is indeed a laudable objective, although it is understandable that the providers of health care, as the owners of the fuel supply companies, may give it a lower priority than do those who are responsible for paying the bills. But there is a much more fundamental question. The people who live in the building are primarily concerned about the level and stability of the room temperature, not the heating system *per se*. They become drawn into an exclusive focus on the heating system, if they perceive that this is the only way to control the room temperature. But as was (re)learned in North America after the oil shock of 1974, this is not so.

Similarly the health care system is not, for the general population, an end in itself. It is a means to an end, maintenance and improvement of health [26]. And while few have followed Ivan Illich [29] in arguing that the health care system has no positive—and indeed net negative—effects on the health of those it serves, nevertheless as noted above, the evidence for the importance of health-enhancing factors outside the health care system is growing rapidly in both quantity and quality.

But the intellectual framework reflected in Figs 1 and 2 pushes these other, and perhaps more powerful, determinants of health off the stage and into the amorphous cluster of arrows entering from the left hand side of the diagram. By implication they are unpredictable, or at least uncontrollable, so there is no point in spending a great deal of intellectual energy or policy attention on identifying or trying to influence them. For most of the twentieth century, rapid advances in the scientific, organizational and financial bases of health care have encouraged, and been encouraged by, this dismissal. We have given almost all our attention to the heating contractor and the fuel salesman, and have had no time or interest to consider how the house is insulated.

By the early 1970s, however, all developed nations had in place extensive and expensive systems of health care, underpinned by collective funding mechanisms, which provided access for all (or in the United States, most) of their citizens. Yet the resulting health gains seemed more modest than some had anticipated, while the 'unmet needs', or at least the pressures for system expansion, refused to diminish.

Simple trend projections indicated that, within a relatively short span of decades, the health care systems of modern societies would take over their entire economies. As public concerns shifted from expansion to evaluation and control, the alternative tradition began to reassert itself. In such an environment, a growing interest in alternative, perhaps more effective, hopefully less expensive, ways of promoting health was a natural response.

The resurgence of interest in ways of enhancing the health of populations, other than by further expansion of health care systems, was thus rooted both in the observation of the stubborn persistence of ill-health, and in the concern over growing costs. The latter development has been particularly important in 'recruiting new constituencies' for the broader view of the determinants of health. Financial bureaucrats, both public and private, have become (often rather suspect) allies of more traditional advocates [38, 39].

THE HEALTH FIELD CONCEPT: A NEW PERSPECTIVE

The broader view was given particularly compact and articulate expression in the famous Canadian *White Paper* referred to above which came out, presumably by complete coincidence, in the same year as the first 'energy crisis'. Its 'Four Field' framework for categorizing the determinants of health was broad enough to express a number of the concerns of those trying to shift the focus of health policy from an exclusive concern with health care. In Fig. 3 this framework is superimposed upon the earlier 'thermostat/furnace' model of health care and health.

The *New Perspective* proposed that the determinants of health status could be categorized under the headings of Lifestyles, Environment, Human Biology and Health Care Organization. As can be seen in Fig. 3, the first three of these categories provided specific identification for some of the 'other and unspecified' factors entering on the left hand side of

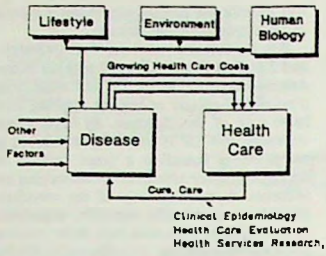

Fig. 3

Figs 1 and 2. By labelling and categorizing these factors, the *White Paper* drew attention to them and suggested the possibility that their control might contribute more to the improvement of human health than further expansions in the health care system. At the very least, the health field framework emphasized the centrality of the objective of *health*, and the fact that health care was only one among several forms of public policy which might lead towards this objective.

The *White Paper* was received very positively; no one seriously challenged its basic message that who we are, how we live and where we live are powerful influences on our health status. But the appropriate policy response was less clear, because the document could be read in several different ways. At one end of the ideological spectrum, it was seen as a call for a much more interventionist set of social policies, going well beyond the public provision of health care *per se* in the effort to improve the health of the Canadian population and relieve the burden of morbidity and mortality.

At the other end, however, the assumption that lifestyles and to a lesser extent living environments are *chosen* by the persons concerned could be combined with the *White Paper* framework to argue that people are largely responsible for their own health status—have in fact chosen it. If so, then the justification for collective intervention, even in the provision of health care, becomes less clear.* This appears to have been far from the intention of the authors of the paper, but the framework in Fig. 3 lends itself to 'victim-blaming' as well as to arguments for more comprehensive social reform [38].

Whatever the original intent, however, the *White Paper* led into a period of detailed analysis of *individual* risk factors, i.e. both individual hazards and individual persons, as contributors to 'disease' in the traditional sense.† The potential significance of processes operating on health at the level of groups and populations was obscured, if not lost [41]. Smoking, for example, was viewed as an individual act predisposing to specific diseases. Specific atmospheric pollution contributes to lung disease. Genetic defects result in well-defined genetic diseases. The central thermostatic relationship is preserved, with health as absence of disease, and health care as response to disease in order to provide 'cures' or relieve symptoms, individual by individual.

To illustrate the distinction, one can formulate health policy to address cancer across a spectrum from the individual to the collective. One can increase facilities for the treatment of cancer patients, a wholly individualized, reactive response. One can increase research on cancer treatment, an activity with a 'collective' focus only insofar as the specific recipients of new treatments may not be known in advance. One can launch anti-smoking campaigns, trying to induce certain individuals whose *characteristics* are known—they smoke—to change their behaviour voluntarily. These campaigns may in turn be wholly individualized—paying or otherwise encouraging physicians to provide counselling, for example—or advertising campaigns aimed at the general population. Or one can try to limit involuntary exposures by regulating the presence of carcinogens in the environment, establishing mandatory smoke-free zones (hospitals, restaurants, aircraft, workplaces ..) or regulating industrial processes.

The focus on individual risk factors and specific diseases has tended to lead, not away from but back to the health care system itself. Interventions, particularly those addressing personal lifestyles, are offered in the form of 'provider counselling' for smoking cessation, seat-belt use or dietary modification [42, 43]. These in turn are subsumed under a more general and rapidly growing set of interventions attempting to modify risk factors through transactions between clinicians and individual patients.

The 'product line' of the health care system is thus extended to deal with a more broadly defined set of 'diseases'—unhealthy behaviours. The boundary becomes blurred between, e.g. heart disease as manifest in symptoms, or in elevated serum cholesterol measurements, or in excessive consumption of fats. All are 'diseases' and represent a 'need' for health care intervention. Through this process of disease redefinition, the conventional health care system has been able to justify extending outreach and screening programmes, and placing increased numbers of people on continuing regimens of drug therapy and regular monitoring.

The emphasis on individual risk factors and particular diseases has thus served to maintain and protect existing institutions and ways of thinking about health. The 'broader determinants of health' were matters for the attention of individuals, perhaps in consultation with their personal physicians, supported by poster campaigns from the local public health unit. The behaviour of large and powerful organizations, or the effects of economic and social policies, public and private, were not brought under scrutiny. This interpretation of the *White Paper* thus not only fitted in with the increasingly conservative

*Not nonexistent. There is no basis in ethical theory or institutional practice for the proposition which creeps into so much of normative economics, that individual choice is the ultimate and even the only ground of obligation [40].

†We do not mean to imply that the authors of the *White Paper* had the relatively limited view which we present below, still less that all of their subsequent interpreters have been so intellectually constrained. But it is our perception that the principal impact of the *White Paper* framework on debates about, and the development of, health policy, *has* been limited in the way we describe.

zeitgeist of the late 1970s and early 1980s, but protected and even enhanced the economic position of providers of care, while restricting sharply the range of determinants, and associated policies, considered. Established economic interests were not threatened—with the limited exception of the tobacco industry.

This tendency was reinforced by attempts to estimate the relative contribution of the four different fields or sets of factors to ill-health. As Gunning-Schepers and Hagen [44] have pointed out, a simple partitioning of sources of mortality, morbidity or care utilization into four discrete 'boxes' is fundamentally misguided. Nevertheless, 'expert opinion' suggested that, of the three fields external to the health care system, 'Lifestyles' had the largest and most unambiguously measurable effect on health. 'Lifestyles'—diet, exercise, substance use—were also the factors most readily portrayed as under the control of the individual. They thus lent themselves to the politically innocuous, inexpensive, highly visible and relatively ineffective intervention of health education campaigns—carried on through the public health arm of the health care system.

Smoking cessation provides a partial counter-example, which illustrates the difficulty of breaking out of the disease–health care intellectual framework. Tobacco is not only toxic, but addictive, and addiction most commonly commences in childhood. Consequently the presumption that users rationally and voluntarily 'choose' smoking as a 'lifestyle' is particularly inappropriate. Furthermore, the observation that smoking behaviour is very sharply graded by socioeconomic class undercuts the argument that it represents an individual choice, and indicates instead a powerful form of social conditioning.*

Partly for these reasons, Canadian health policy has gone beyond educational campaigns to spread information about the ill effects of smoking and includes limitations on the advertising and marketing of tobacco products. The political resistance to these limitations has been much more intense, suggesting *prima facie* that the marketers of such products fear that they might be effective. But the broader question, of the social determinants of tobacco use, is still left open.†

The intellectual framework of the *White Paper*, at least as it has been applied and as represented in Fig. 3, has thus supplemented the thermostatic model of health as absence of disease, and health care as response, but has failed to move beyond the core relationship. Since as noted above, 'disease' is defined through the interpretation of individual experience by the providers of health care, it is perhaps not surprising that the Health Care Organization field tended to take over large parts of the other three, when they were presented as determinants of disease.

EXTENDING THE FRAMEWORK: HEALTH AND ITS BIOLOGICAL AND BEHAVIOURAL DETERMINANTS

Yet in the years since the publication of the *White Paper*, a great deal of evidence has accumulated, from many different sources, which is difficult or impossible to represent within this framework. The very broad set of relationships encompassed under the label of 'stress', for example, and factors protective against 'stress' [17, 20], have directed attention to the importance of social relationships, or their absence, as correlates of disease and mortality. Feelings of self-esteem and self-worth, or hierarchical position and control, or conversely powerlessness, similarly appear to have health implications quite independent of the conventional risk factors [4, 6, 16, 20].

These sorts of factors suggest explanations for the universal finding, across all nations, that mortality and (when measurable) morbidity follow a gradient across socioeconomic classes. Lower income and/or lower social status are associated with poorer health.‡

This relationship is not, however, an indication of deprivation at the lower end of the scale, although it is frequently misinterpreted in that way. In the first place, the socioeconomic gradient in health status has been relatively stable over time [9], although average income levels have risen markedly in all developed societies. The proportion of persons who are deprived of the necessities of life in a biological sense has clearly declined. But even more important, the relationship is a *gradient*, not a step function. Top people appear to be healthier than those on the second rung, even though the latter are above the population averages for income, status or whatever the critical factors are [6].

It follows that the variously interpreted determinants of health which lie outside the health care system are not just a problem of some poor, deprived minority whose situation can be deplored and ignored by the rest of us. *De te fabula narratur*, we are all (or most of us) affected. And that in turn implies that the effects of such factors may be quantitatively very significant for the overall health status of modern populations. The issues involved are not trivial, second- or third-order effects.

Moreover, the fact that gradients in mortality and morbidity across socioeconomic classes appear to be relatively stable over long periods of time, even though the principal causes of death have changed considerably, implies that the underlying factors influence susceptibility to a whole range of diseases. They are general rather than specific risk factors. Whatever is going round, people in lower social positions tend to get more of it, and to die earlier—even after adjustment for the effects of specific individual or environmental hazards [47].

This suggests that an understanding of the relationship between social position, or 'stress', and health, will require investigation at a more general level than the aetiology of specific diseases. It also raises the possibility that disease-specific policy responses—through health care or otherwise—may not reach deeply enough to have much effect. Even if one 'disease' is 'cured', another will take its place.

*None of which is news to tobacco marketers.

†One should note, however, that the very limited experience in the early 1970s with *anti-smoking* advertising on television appeared to be sufficiently successful that tobacco companies were willing voluntarily to abandon this medium in order to get the 'opposition' off the air.

‡Wilkins [45] and Wolfson [46] provide recent Canadian data.

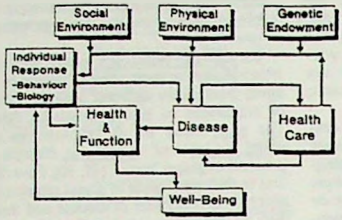

Fig. 4

An attempt to provide a further extension to our intellectual framework, to encompass these new forms of evidence, is laid out in Fig. 4.

In Fig. 4, two major structural changes are introduced. First, a distinction is drawn between disease, as recognized and responded to by the health care system, and health and function as experienced by the individual person. Such a distinction permits us to consider, within this framework, the common observation that illness experienced by individuals (and their families or other relevant social groups) does not necessarily correspond to disease as understood by the providers of care. Persons with 'the same' disease, from the point of view of the health care system—similar biological parameters, prognoses and implications for treatment—may experience very different levels of symptoms and distress, and very different effects on their ability to function in their various social roles. Arthritis, and musculo-skeletal problems more generally, are leading examples of conditions for which the patient's sense of 'illness' bears no very close relationship to the clinician's interpretation of 'disease'.

This is not to say that one perspective is 'right' and the other 'wrong'; the two modes of interpretation simply have different purposes. The clinician's concept of disease is intended to guide the appropriate application of available medical knowledge and technology, so is formulated in terms of that knowledge and technology. The patient, on the other hand, is ultimately concerned with the impact of the illness on his/her own life. The clinician's disease may be an important part of that impact but is by no means the only relevant factor.

Moreover, from the point of view of the individual's well-being and social performance—including economic productivity—it is the individual's sense of health and functional capacity which is determinative—as shown in Fig. 4. The 'diseases' diagnosed and treated by the health care system are important only insofar as they affect that sense of health and capacity—which of course they do. But health, even as interpreted by the individual, is not the only thing in life which matters. Figure 4 introduces the category of 'well-being', the sense of life satisfaction of the individual, which is or should be (we postulate) the ultimate objective of health policy. The ultimate test of such policy is whether or not it adds to the well-being of the population served.

Going back to the original WHO definition of health, we are relabelling that broad definition as well-being. Our concept of health is defined, in narrow terms but from the patient's perspective, as the absence of *illness* or injury, of distressing symptoms or impaired capacity. Disease, as a medical construct or concept, will usually have a significant bearing on illness, and thus on health, but is not the same thing. Illness, in turn, is a very important (negative) influence on well-being—but not the only one. The WHO broad definition of 'health' is, as noted above, so broad as to become the objective, not only of health policy, but of all human activity.

Hypertension screening and treatment gives a clear and concrete example of this distinction, as well as bringing out the limitations of the static framework expressed in all the accompanying figures. It is sometimes said that hypertension does not hurt you, it only kills you. Target organ damage proceeds silently and without symptoms; a sudden and possibly fatal stroke announces both the presence of the long-term condition, and its consequences. Until that point the individual concerned may have no illness, although a clinician who took his/her blood pressure might identify a disease.

Studies of the impact of hypertension screening and treatment programmes, however, have made it clear that the fact of *diagnosis*, 'labelling', makes the patient ill, in ways which are unambiguous and objectively measureable [30]. Treatment exacerbates the illness, through drug side effects, although those who comply with treatment may suffer less severe labelling effects. Screening and treatment of hypertension thus spread illness among the beneficiaries and reduce their functional capacity, in a real and literal sense, even as their disease is alleviated.

Of course such screening is not carried out from clinical malice! The long-term consequences of hypertension as a disease may be expressed in definite forms of illness, including death. The immediate consequences of discovery and treatment of disease may be increased illness; the longer term consequences are reduction in illness, and very severe illness at that, for some of those under care. There is substantial evidence that screening and treatment of moderate to severe hypertension have very significantly reduced both morbidity and mortality from stroke; this is widely regarded as one of the leading 'success stories' in clinical prevention [48]. But regardless of their relative strength, the static framework of Fig. 4 does not reflect this pattern of off-setting movements in different time periods.

Indeed there is an implicit time structure to all of the figures. 'Cures' are rarely instantaneous, so health care has its negative effect on disease only with a time lag of variable length. The lifestyle and environmental factors displayed in Figs 3 and 4 have long-term and cumulative effects on health/disease. But the extra problem in Fig. 4 arises because the relationship being displayed may reverse itself over time. Health care can have a negative

effect on health in the short term, and a positive one in the longer term.*

The possibility of 'long-term gain' may, but does not necessarily, justify the 'short-term pain', and analysts and evaluators of preventive programmes are acutely aware of the necessity of weighing the health benefits and health costs against each other. Over-zealous intervention can do significant harm to the health of those treated, even if at some later date it can be shown to have 'saved lives', or more accurately postponed some deaths.

The debate over cholesterol screening, and the contradictory recommendations arising from 'experts' in different jurisdictions is a current case in point [31, 50, 51]. At issue are not merely differing interpretations of the epidemiological evidence, or different weightings of 'lives and dollars'—programme resource costs versus mortality outcomes. The prospect of converting a quarter of the adult population of North America into 'patients' with chronic illness requiring continuous drug therapy gives at least some clinicians (and others!) pause.

The framework of Fig. 4 enables, indeed encourages, one to consider this distinction. Large-scale cholesterol screening and drug therapy, in this framework, would represent an epidemic of new illness, with negative impacts on health and function from both labelling effects and drug side effects. As the hypertension studies remind us, these negative effects are real and concrete, measurable in people's lives. Against this, there would be a reduction in disease, as measured first in serum cholesterol, and subsequently in heart disease. The latter would then contribute positively to health, but the conflicting health effects of disease reduction, i.e. deterioration in health now, improvement later, must be weighed against each other in assessing their net impact on well-being.

In addition to distinguishing explicitly 'disease' from 'illness', Fig. 4 extends the categorization of the determinants of health provided in the *White Paper* framework. This permits us to incorporate within the framework the diverse and rapidly-growing body of research literature on the determinants of health which does not fit at all comfortably within the *White Paper* categories.

The key addition is the concept of the individual 'host response', which includes but goes beyond the usual epidemiological sense of the term. The range of circumstances to which the organism/individual may respond is also wider than is usually encompassed within epidemiology [52]. This 'host response' now includes some factors or processes which were previously assembled under the labels of 'Lifestyle' and 'Human Biology'.

The implications of this change can be seen when one considers (yet again) smoking behaviour. In the *White Paper* framework, tobacco use is labelled as a 'Lifestyle', from which one can draw the implication that its use is an 'individual choice'. That in turn leads not only to victim-blaming, but also to an emphasis on informational and educational strategies for control, which are notoriously ineffective. The powerful ethical overtones of 'choice', with its connections to 'freedom' and 'individual self-expression', introduce not only political but also intellectual confusions into the process of control of an addictive and toxic substance.

Yet it is widely observed that tobacco use is powerfully socially conditioned. Income, status and prestige rankings in modern societies have become strongly negatively correlated with smoking, such that differential smoking behaviour is now a significant factor in the social gradient in mortality. This was not always so: prior to the widespread dissemination of information about its health effects, smoking was positively correlated with status. It seems clear that, far from being simply an 'individual' choice, smoking is an activity engaged in—or not—by groups of people in particular circumstances. Understanding why some people smoke, and others do not, and *a fortiori* developing successful strategies to discourage this self-destructive behaviour, requires that one explore these group processes, and their conditioning circumstances. To treat smoking as 'individual choice' is simply to throw away the information contained in the clustering of behaviour.

This is not to reduce the individual to an automaton, or deny any role for individual choice. Nor is smoking the only activity which is socially conditioned—far from it. But the well-defined clustering of smoking and non-smoking behaviour within the population suggests that such behaviour is also a form of 'host' (the smoker) response to a social environment which does or does not promote smoking. Heavy tobacco advertising promotes, for example, while legislated smoke-free environments discourage, quite separately from the 'individual choice'.

The psychological dynamics of status and class may have even more powerful, if subtler, effects. The sense of personal efficacy associated with higher social position encourages beliefs both in one's ability to break addictions, and in the positive consequences of doing so. Beliefs in the effectiveness (or lack of it) of one's own actions are both learned, and reinforced by one's social position.

The distinction between social environment and host response also permits us to incorporate conceptually factors which influence health in much less direct and obvious ways than smoking. It has been observed that the death of a spouse places an

*One might point out that this is true of much therapy. Surgery, for example, typically has a very powerful negative effect on health and function in the immediate intervention and recovery phase, while (when successful) yielding later improvements. In the hypertension case, however, healthy individuals are introduced to prolonged low-level illness, in order to receive large but uncertain benefits in the farther future. Such a difference of degree becomes one of kind.

For people with short time horizons, painful or disabling interventions with longer term payoffs may not be justified. Elderly people, in particular, will quite rationally discount future benefits more heavily. The finding that elderly cancer patients are more likely to choose radiation treatment over surgery, even if the latter has a greater five-year survival rate [49] illustrates the point. The enthusiasm among dentists to provide 'optimum' oral health to residents of nursing homes, raises similar concerns. Would you want to spend a day in a dentist's chair if you expected to die tomorrow? Next week? Next month? . . .

individual at increased risk of illness, or even death. This may be due to a reduction in the competence of the immune system, although the causal pathways are by no means wholly clear. Evidence is accumulating rapidly, however, that the nervous and immune systems communicate with each other, each synthesizing hormones that are 'read' by the other, so that the social environment can, in principle, influence biological responses through its input to the nervous system. Data from animal experiments have shown the power of these effects [17].

Biological responses by the organism to its social environment are not restricted to the immune system. Forms of stress which one feels powerless to control—associated with hierarchical position, for example—may be correlated with differences in the plasma levels of reactive proteins such as fibrinogen [53], or with the efficiency of the hormonal responses to stress [20]. The adequacy or inadequacy of nutrition in early infancy may 'programme' the processing of dietary fats in ways which have consequences much later in life [54, 55]. The range of possible biological pathways is only beginning to emerge, and is at present still quite contentious, but it seems clear that the sharp separation between 'Human Biology' and 'other things' is crumbling.

Accordingly we have in Fig. 4 unbundled that field, and restricted it to the genetic endowment. This endowment then interacts with the influences of the social and physical environments, to determine both the biological and the behavioural responses of the individual [56]. Some of these responses will be predominantly unconscious—few of us are aware of how our immune systems are performing (unless they are overwhelmed), much less can deliberately affect them. Other responses will be behavioural—smoking, for example, or buckling seatbelts. Both forms of response, or rather the continuum of such responses, will influence the ability of the individual to deal with external challenges, either to resist illness or to maintain function in spite of it. They will also affect the burden of disease, separately from illness, insofar as the decision to seek care, compliance with therapy, and response to therapy (or to self-care) are also part of the host response.

An example of the significance of changes in such host responses may be given by the decline in tuberculosis in the United Kingdom over the last century. This dramatic change in mortality patterns occurred prior to the development of any effective responses from either public health measures or medical therapy [7]. Sagan [57] notes that the decline was apparently *not* due to a reduced rate of exposure to the bacillus, as the majority of the population continued to test positive for the TB antibody as late as 1940. The resistance of the population simply increased. McKeown offers improved nutrition as an explanation, but the issue still seems to be open [7, 57].* The point for our purposes is that the *biological* response of the organism is malleable.

Indeed, progress in genetics is also extending the older picture of a fixed genetic endowment, in which well-defined genetic diseases follow from single-gene defects. It now appears that particular combinations of genes may lead to predispositions, or resistances, to a wide variety of diseases, not themselves normally thought of as 'genetic'. Whether these predispositions actually become expressed as disease, will depend *inter alia* on various environmental factors, physical and social [56].

The insertion of the host response between environmental factors, and both the expression of disease and the level of health and function, provides a set of categories sufficiently flexible to encompass the growing but rather complex evidence on the connections between social environment and illness. Unemployment, for example, may lead to illness (quite apart from its correlation with economic deprivation) if the unemployed individual becomes socially isolated and stigmatized. On the other hand, if support networks are in place to maintain social contacts, and if self-esteem is not undermined, then the health consequences may be minimal.

The correlation of longevity with hierarchical status may be an example of reverse causality—the physically fitter rise to the top. But it is also possible that the self-esteem and sense of coping ability induced by success and the respect of others results in a 'host response' of enhanced immune function or other physiological strengthening. The biological vulnerability or resilience of the individual, in response to external shocks, is dependent on the social and physical environment in interaction with the genetic endowment. While as noted the biological pathways for this process are only beginning to be traced out, the observed correlations continue to accumulate. Figure 4 provides a conceptual framework within which to express such a pattern of relationships.

In this extended framework, the relationship between the health care system and the health of the population becomes even more complex. The sense of self-esteem, coping ability, powerfulness, may conceivably be either reinforced or undermined by health care interventions. Labelling effects may create a greater sense of vulnerability in the labelled, which itself influences physiological function. Such a process was an important part of Ivan Illich's message. Yet the initiation of preventive behaviour, or, of therapy, may also result in positive 'placebo' effects, perhaps reflecting an increased sense of coping or control, independently of any 'objective' assessment of the effectiveness of such changes.

The possibility that medical interventions may have unintended effects is inevitable. Our framework includes both placebo and iatrogenic effects in the causal arrow from care to disease. But there is also a potential effect, of ambiguous sign, from care to host response.

At yet another level, the protective sense of self-esteem or coping ability seems to be a collective as well as an individual possession. Being a 'winner', being on a 'winning team', or simply being associated with a winning team—a resident of a town whose

* 'Improved' nutrition is ambiguous. For impoverished and deprived populations better is simply more, and more nutritious. But for a high proportion of modern populations better is probably less, and particularly less fats. It is not clear when in the historical record 'better' shifted from more to less, for the majority of industrialized populations, such that (from a health perspective) nutrition may have begun to deteriorate.

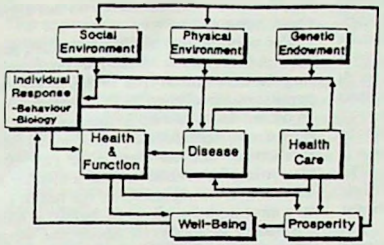

Fig. 5

team has won a championship—all seem to provide considerable satisfaction, and may have more objectively measurable influences on health.

A FURTHER EXTENSION: ECONOMIC TRADE-OFFS AND WELL-BEING

But there is still another feed-back loop to be considered. Health care, and health policy generally, have economic costs which also affect well-being. Once we extend the framework, as in Fig. 4, to reflect the fact that the ultimate objective of health-related activity is not the reduction of disease, as defined by the health care system, or even the promotion of human health and function, but the enhancement of human well-being, then we face a further set of trade-offs which are introduced in Fig. 5.

Health care is not 'free'; as noted above the provision of such services is now the largest single industry or cluster of economic activities in all modern societies. This represents a major commitment of resources—human time, energy, and skills, raw materials and capital services—which are therefore unavailable for other forms of production. To the extent that health care makes a positive contribution to health, it thereby contributes to human happiness both directly and through the economic benefits of enhanced human function and productivity.

The latter effect is frequently referred to as an 'investment in health'; spending on health care may even pay for itself through increased capacity of the population to work and produce wealth. The increasing concentration of health care on those outside the labour force, the very elderly or chronically ill, has however severely weakened this form of linkage. For most health care now provided, the benefits must be found in the value of the resulting improvements in health, not in some further productivity gains.

Whatever the form of the pay-off to health care, the resources used in its provision are inevitably a net drain on the wealth of the community. The well-being and economic progress of the larger society are thus affected *negatively* by the extension of the health care system *per se*. The fallacious argument frequently put forward by the economically naive, that health care, or any other industry, yields economic benefits through the creation of jobs, rests on a confusion between the job itself—a resource-using activity or cost—and the product of the job, the output. It is in fact an extension into the general economic realm of a common confusion in health care, between the process of care and its outcome.*

Yet 'job-creation' is very easy; one can always hire people to dig holes in the ground and fill them in again. (Keynes suggested burying bottles filled with banknotes, thereby creating opportunities for profitable self-employment.) The creation of wealth, however, depends upon the creation of jobs whose *product* is valued by the recipient. This understanding is implicit in references to 'real jobs', as distinct from make-work, or employment purely for the sake of keeping people busy—and remunerated. In a complex modern economy, large numbers of people can be kept busy, apparently gainfully employed, and yet adding little or nothing to the wealth of the population as a whole.†

This distinction between the cost of an activity, its net absorption of productive resources, and the benefits which flow from it in the form of valued goods and services, is not unique to health care. It applies to any economic activity, as reflected in the generality of the techniques of cost–benefit analysis. The situation of health care is different, however, for a variety of complex and interrelated reasons which are implicit in the chain of effects from health care, to disease reduction, to improved health and function, to well-being.

As a commodity, health care has characteristics which make it intrinsically different from 'normal' commodities traded through private markets, and this is reflected in the peculiar and complex collection of institutional arrangements which surround its provision. As a consequence both of these intrinsic peculiarities, and of the institutional responses to them, the mechanisms which for most commodities maintain some linkage between the resource costs of a commodity and its value to users are lacking.

These problems are discussed in detail in the literature on the economics of health care [e.g. 26, Chap. 1–5]. For our purposes, however, the important point is that over-expansion of the health *care* system can in principle have negative effects not only on the well-being of the population, but even on its *health*. These dual effects are shown in Fig. 5.

The possible negative impact of over-provision on well-being is straightforward. As emphasized, the

*The operation was a success, but the patient died.

†The common identification between private sector jobs as by definition 'real', and public sector ones as 'unreal' is however simply ideological nonsense—'real' and unreal' exist in both sectors, wherever activity is being carried on with no output, or none of any value. It includes, but is not restricted to, the caricature of the lazy or obstructionist bureaucrat.

A strong argument can be made, for example, that most of the jobs in the private health insurance sector in the United States—complex, demanding and highly paid—are not 'real jobs', because they actually yield nothing of value and in all other health care funding systems are dispensed with. That is, of course, another story, but one which emphasizes the invalidity of an equation between 'unreal jobs' and 'lazy public servants'. One can work quite hard and conscientiously, both individually and as a group, and yet be completely useless or even get in the way. Parallels with public bureaucracies in centrally planned economies are not inapt.

provision of health care uses up economic resources which could be used for other valued purposes. Canadians spend nearly 9% of their national income on health care—1 dollar in 12—and these resources are thus unavailable for producing consumer goods like clothing or furniture, or building rapid transit systems, or improving the educational system, etc. (expanding the capacity of the Toronto airport!). In the United States, nearly 12% of national income is spent on health care; in Japan, about 6%. The Japanese correspondingly have a larger share of their income available for other purposes, the Americans a smaller proportion.

Less obviously, but implicit in Fig. 5, the expansion of health care draws resources away from other uses which may also have health effects. In public budgets, for example, rising health care costs for the elderly draw funds which are then unavailable for increased pensions; rising deficits may even lead to pension reductions. Increased taxes or private health insurance premiums lower the disposable income of the working population. Environmental clean-up programmes also compete for scarce resources with the provision of health care.

Once we recognize the importance and potential controllability of factors other than health care in both the limitation of disease and the promotion of health, we simultaneously open for explicit consideration the possibility that the direct positive effects of health care on health may be outweighed by its negative effects through its competition for resources with other health-enhancing activities. A society which spends so much on health care that it cannot or will not spend adequately on other health-enhancing activities may actually be *reducing* the health of its population through increased health spending.

Two points of clarification may be helpful here, along with one of qualification.

First, we are *not* referring to iatrogenesis, the direct negative effects of health care on health. Powerful interventions have powerful side effects; the growing reach of medical technology often brings with it increased potential for harm.* Clinical judgement includes the balancing of probabilities for benefit and harm, the best care will sometimes work out badly. Moreover, all human systems involve some degree of error—inappropriate and incompetent care, or simply bad luck. Expansion of the health care system thus carries with it a greater potential for harm as well as good, as a direct result of care, but that is not the point here.

Second, the potential effects we are postulating are the economist's *marginal* effects. The global impact of health care, on either health or resource availability, is not addressed. Perhaps Ivan Illich is right, and the health care system as a whole has a net negative impact on the health of the population it serves. But we do not know that, and we do not know how one could come to know it.

The point we are making is a much more limited one, and one which within the framework of Fig. 5 may be self-evident. The health of individuals and populations is affected by their health care, but also by other factors as well. Expansion of the health care system uses up resources which would otherwise be available to address those other factors. (Whether they would be so used or not, is another matter.) It follows that an expansion of the health care system may have negative effects on health. A *health* policy, as opposed to policies for *health care*, would have to take account of this balance.

The qualification, however, arises from the fact that when we speak of the health of a population, we are aggregating across all the individuals in it. Different policies benefit different individuals. A decision to reallocate resources from health care to other health-enhancing or productivity-enhancing activities might indeed result in a population which was in aggregate both healthier and wealthier, but particular individuals in it will be worse off. Most clearly, of course, these will include persons who either make or intended to make their living from the provision of health care. But in addition, health care services respond to the circumstances of identified individuals, in the present. A more limited commitment of resources to health care might leave such persons worse off, even though in future there might be fewer people in their position.

Such trade-offs, between the interests of those who are now ill, and those who may become so, may be inevitable. In any case it is important to note their possibility, because they are hidden from view in the aggregate framework. But conversely, it should also be noted that there is no obvious ethical, much less prudential, basis for resolving this trade-off in favour of more health care. We need to be clear as to whether we have, as a community, undertaken a collective obligation of concern, and support, for each other's *health*, or only for those aspects of health which can be enhanced through *health care*. If the latter, we may find that we are as a society both poorer, and less healthy, than we could otherwise be, and we may want to re-think the details of our (self-imposed) ethical obligation.

In this context, as in so many others, the Japanese experience is startling, and may provide an illustration of the feed-back loop from prosperity to health included in Fig. 5. The extraordinary economic performance of Japanese society is not a new observation; the phenomenon goes back 40 years, and indeed a similar period of extraordinary modernization and growth began after the Meiji restoration in 1868. What is new, is that within the last decade Japan has begun to shift from the very successful copying of innovations elsewhere in the world, to being increasingly on the leading edge of both economic growth and technological change.

Over the same period there has been a remarkable growth in Japanese life expectancy, which in the 1980s has caught up with and then surpassed that of the rest of the developed world [58]. Like the Japanese economy and per capita wealth, average life expectancy is continuing to rise on a significantly

*Often, but not always. Improvements in the techniques of diagnostic imaging, for example, have reduced the degree of risk and distress associated with earlier forms of diagnostic imaging; and the substitution of lithotripsy for kidney surgery has yielded similar benefits. On the other hand, less risky or uncomfortable procedures tend to be offered to many more patients.

faster trend than in other industrialized countries. This experience is now setting new standards for the possible in human populations.

On the other hand, the Japanese health care system absorbs one of the lowest shares of national income in the industrialized world, and has been described by a recent American observer as 'an anachronism' in the context of modern Japanese society [59]. And the popular external image is that life in Japan is very crowded, highly stressful and quite polluted. How then does one explain the extraordinary trends in life expectancy?

One causal pattern suggested in Fig. 5 would lead from outstanding economic performance, to rapid growth in personal incomes and in the scope and variety of life, to the greatly enhanced sense of individual and collective self-esteem and hope for the future. A number of observers, concerned not with comparative health status but with international economic competitiveness, have noted the extraordinary Japanese sense of self-confidence and pride arising from their rapid progress toward world economic leadership. Individually and as a nation the Japanese are seeing themselves as harder-working, brighter, richer and just plain better than the rest of the world; could this attitude be yielding health benefits as well?

Conversely the centrally planned economies of Eastern Europe and the Soviet Union have on most measures of economic success performed dismally for many years, to the extent that their rulers as well as their populations have been willing to undertake a massive and indeed revolutionary political restructuring. Corresponding to this extended period of economic decline, measures of life expectancy in those nations have been stagnant or even falling, in marked contrast to the universal improvements in Western Europe [60].

Uncontrolled environmental pollution and unhealthy lifestyles are commonly cited explanations, but the observation is at least consistent with the hypothesis of a relationship between collective self-esteem and health—a relationship which could be expressed in part through unhealthy lifestyles.

The factors underlying the shift in world economic leadership are no doubt complex and diverse. One of several recurring explanatory themes, however, is the Japanese advantage in access to low-cost long term capital, which is channelled into both research and development, and plant and equipment investment embodying the latest technology. This low-cost capital is generated by the very high savings rates of the Japanese people. The United States, by contrast, reports a savings rate close to zero, and now relies heavily on savings borrowed from the rest of the world—particularly Japan.

To maintain a high savings rate, one must limit the growth of other claims on social resources—such as health care.* The difference between Japanese and United States rates of spending on health care amounts to over 5% of national income, and could account for a significant proportion of the large difference between Japanese and American aggregate savings rates. (The difference in military spending accounts for another large share.)

Very speculatively, then, one can suggest that by limiting the growth of their health care sector, the Japanese have freed up resources which were devoted to capital investment both physical and intellectual. The consequent rapid growth in prosperity, particularly relative to their leading competitors, has greatly enhanced (already well developed) national and individual self-esteem, which has in turn contributed to a remarkable improvement in health.

It must be emphasized that this is a rough sketch of a possible argument, not a well developed case, much less a 'proof'. There are other candidate explanations for Japanese longevity—diet, for example, or the peculiar characteristics of Japanese society which may be protective against the ill effects of stress. (On the other hand, there are different forms of stress, and the stress of success is much less threatening to health than the stress of frustration and failure.)

Equally problematic, there is good evidence that environmental effects on morbidity and mortality may operate with very long lags, so that present Japanese life expectancies may reflect factors at work over the past 50 years. And in any case, what has been observed is that the Japanese live a long time, whether they are relatively healthy in any more comprehensive sense is another matter. On the other hand, the Japanese gains in life expectancy are occurring across the age spectrum, with both the world's lowest infant mortality, and extended lives among the elderly, consistent both with some contemporaneous effects, and with more general increases in health.

Whatever the explanation, it is clear that something very significant is happening (or has happened) in Japan—something reflected in trends in life expectancy which are remarkable relative to any other world experience. These observations are at least consistent with the rough sketch above. A good deal of closer investigation would seem warranted.

It is not our intent in this paper to lay 'The Decline of the West' at the feet of the health care system of the United States, or even those of North America and Western Europe combined. Rather our point is to show that the framework laid out in Fig. 5 is capable of permitting such a relationship to be raised for consideration. Its network of linkages between

*It would, of course, be quite possible for a nation to maintain both high savings rates, and high spending on health care—or the military—simply by cutting back on consumption. But there is strong resistance at both bargaining table and ballot box to a reduction in current consumption through higher taxes or lower wages. Citizens do not want to accept a reduction in present living standards to pay for more health care.

A neo-classical economist might argue that the living standard is *not* reduced; what is given up in smaller houses, poorer roads or fewer electronic gadgets is gained in more cardiac bypass grafts, laboratory tests, MRI procedures and months in nursing homes. But the average individual is, quite rightly, unconvinced. Health care, like military spending, is not valued for its own sake. What, after all, are the direct satisfactions from a tonsillectomy, or a tank? Each is simply a regrettable use of resources, a service for which in a better world one would have no need. Hence the tendency for health spending increases to be drawn from savings, whether through government budget deficits or reduced corporate retained earnings.

health, health care, the production of wealth and the well-being of the population is sufficiently developed to encompass the question, without overwhelming and paralyzing one in the 'dependence of everything upon everything'.

FRAMEWORKS IN PRINCIPLE AND IN PRACTICE

As noted above, the test of such a framework will be the extent to which others find it useful as a set of categories for assembling data and approximating complex causal patterns. The understanding of the determinants of population health, and the discussion and formulation of health policy, have been seriously impeded by the perpetuation of the incomplete, obsolete and misleading framework of Fig. 1. There is a bigger picture, but clearer understanding, and particularly a more sensible and constructive public discussion, of it requires the development of a more adequate intellectual framework. The progression to Fig. 5 is offered as a possible step along the way.

In this paper we have suggested several important features of such a framework. It should accommodate distinctions among disease, as defined and treated by the health care system, health and function, as perceived and experienced by individuals, and well-being, a still broader concept to which health is an important, but not the only, contributor. It should build on the Lalonde health field framework to permit and encourage a more subtle and more complex consideration of both behavioural and biological responses to social and physical environments. Finally, it should recognize and foster explicit identification of the economic trade-offs involved in the allocation of scarce resources to health care instead of other activities of value to individuals and societies, activities which may themselves contribute to health and well-being.

To date, health care policy has in most societies dominated health policy, because of its greater immediacy and apparently more secure scientific base. One may concede in principle the picture in Fig. 5, then convert all the lines of causality into 'disease' and 'health and function' into thin dotted ones, except for a fat black one from 'health care'. That is the picture implicit in the current emphasis in health policy, despite the increasing concern among health researchers as to the reliability and primacy of the connection from health care to health.

One lesson from international experience in the post-Lalonde era is that appropriate conceptualization of the determinants of health is a necessary, but not a sufficient, condition for serious reform of health policy. Intellectual frameworks, including the one offered here, are only a beginning. Simply put, to be useful, they must be used.

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John Libbey, Montrouge, France et Les Presses de l'Université de Montréal, Montréal, Québec.

Subject: Press Release from Consumer Education and Research Society
Date: Sat, 15 Dec 2001 15:04:53 +0530
From: cerc@wilnetonline.net
To: Darlena David <cd.cmai@vsnl.com>, Madan Kataria <laugh@vsnl.com>, Mathew Nampudakam <vhai@vsnl.com>, Naresh Agarwal <saveraindia@rediffmail.com>, Nina Shah <inika@icenet.net>, Phalgun Patel <sandesh@ad1.vsnl.net.in>, Praviena Sharma <pravi_s@yahoo.com>, Ravi Narayan <sochara@vsnl.com>, World Consumer <consint@entelchile.net>

PRESS RELEASE

Ref:E&R/37/Legal/An/2001

CDRF rejects Oriental Insurance stand, orders payment of Mediclaim

The Consumer Disputes Redressal Forum, Ahmedabad City has upheld the Consumer Education and Research Society (CERS) claim that Oriental Insurance Co. Ltd., should reimburse its member, Dr. Rohitkumar R. Shah, medical expenses he incurred for undergoing surgery for an ear ailment under the Mediclaim policy.

Oriental Insurance had declined to pay for the surgery under the policy saying that Dr. Shah's ailment was "pre-existing" and therefore he was not entitled to reimbursement. It referred to the findings of its panel doctor, Dr. Pravin N. Patel, who averred that based on x-ray and other case papers Dr. Shah's disease had existed since childhood. The insurance company in support of its stand further stated that Dr. Shah had renewed the Mediclaim policy after a gap of 13 months and, within two months of the renewal, had undergone the operation.

In his rejoinder, Dr. Shah said he had undergone the operation for discharge in his right ear and that he had suffered the ailment for two months and not from childhood. He produced a certificate in this regard from Dr. Mahendra Naik, a city ENT surgeon. He also said that it was a "misconceived idea" to diagnose ear diseases by mastoid x-ray, which the insurance doctor had done.

The Forum while rejecting the insurance company's charge of pre-existing disease, came down heavily on Dr. Patel, the panel doctor, saying that he had "failed to discharge his legal and moral duty" and had "simply" given his opinion from the file given by the insurance company."

It held that the repudiation of the claims of the medical policy-holder by Oriental Insurance Co. was "illegal, void and without application of mind" and ordered payment of Rs. 8,738 with 12 per cent interest and Rs. 3000 compensation for causing mental agony and harassment to Dr. Shah. It also awarded Rs. 1000 as cost.

The Forum was headed by its President Mr. K.D. Desai and attended by Ms. Leenaben Desai and Mr. Malaybhai Kantharia, both members.

Advocate Mr. John Pinto appeared for the complainants and Mr.

HB 18/12

H.J.Bhatt for Oriental Insurance Co. Ltd.

Date : 15-12-2001 Lalita Meduri
Place: Ahmedabad Consumer Relations Officer

Opinions, test results and research findings issued through this Press Release cannot be used in any form directly or indirectly for advertising, promotional or commercial purpose.

CONSUMER EDUCATION AND RESEARCH SOCIETY
"Suraksha Sankool", Thaltej, Ahmedabad-Gandhinagar Highway, Ahmedabad- 380 054 (INDIA) Phone: 079-7489945-46, Fax: 079-7489947, E-mail: cerc@wilnetonline.net

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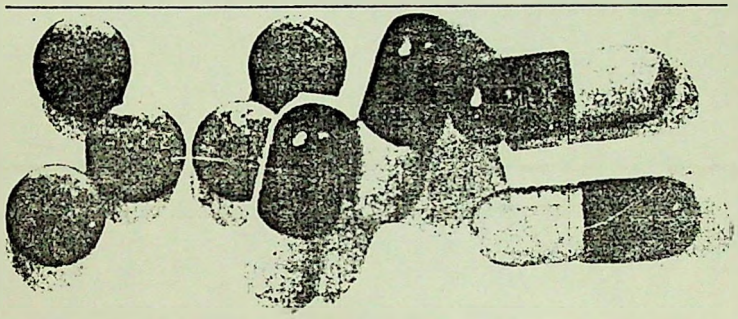
SPURIOUS AND SUBSTANDARD DRUGS

BEWARE OF THE



SILENT KILLERS

By Anju D. Aggarwal

It is commonly known that the manufacture of spurious and substandard drugs has now assumed alarming and gigantic proportions in India, with parallel institutions manufacturing such items, with ramifications in every state. A catalogue of spurious and sub-standard drugs being manufactured in India today would require several volumes.

Substandard drugs are those drugs which do not conform to the standards as specified by the Drugs and Cosmetics Act, 1940. Spurious drugs, on the other hand, are essentially a clandestine operation which unlicensed manufacturers or dealers indulge in. Substandard drugs, on the other hand, can be manufactured by licensed producers as well.

Quality assurance is important for drugs and pharmaceuticals especially where the hazards to life and health are high. In India, nigh quality standards are being maintained by very few national and international companies. Inadequate machinery and infrastructure in various states to enforce the requisite standards have resulted in the proliferation of several tiny and small units in the country. These unit, however, have no quality control or testing facility.

CALLOUS NEGLECT OF QUALITY

Preferential treatment being given to certain drug firms for medical supply to Government hospitals within the states, especially Maharashtra, is also coming to light. The status of the firms is ignored, the quality control discipline exercised by them is poor while in certain other states, reportedly, there are firms which wrest orders for their clients from hospitals.

As the Hathi Committee way back in 1975 observed, "Such parochial tendencies in matters relating to purchasers of drugs are fraught with dangerous consequences to the health of the people and tend to make the public believe — and rightly so in many cases — that the quality of drugs purchased and used by the hospitals is poor."

Mr. K. Jayaraman (Member Indian Economic Service; Member Tariff Commission; Consultant Indian Drug Manufacturer's Association; Consultant, Organisation of Pharmaceutical Producers of India, etc.) maintains," the menace of spurious and substandard drugs has reached alarming proportions in the country and this has frequently drawn attention and debate in the media as well as in Parliament."

Even the Drug Controller of India, in his presidential address at the 31st Indian Pharmaceutical Congress held on December 27, 1979, expressed his opinion on the subject as follows: "Even after thirty years, only in a few states the Drug control administration is headed by qualified pharmacists.... The main reason for the ineffective enforcement of the law is that in many states the drug control machinery has not been organised on proper lines.... It has been our experience that anti-social elements dealing in spurious drugs concentrate their activities in states where drug control is lax...."

On March 30 1982, there was discussion in the Lok Sabha on spurious drugs. Members of Parliament from almost all political parties expressed their anguish to the Health Minister over "inaction and lack of seriousness in dealing with the manufacturers of spurious drugs." Evocative epithets like "merchants of death", "killers" etc., were reportedly used to describe such illicit drugs. The Lok Sabha speaker had also called them "murderers". It was even suggested that the National Security Act, which is a far-reaching punitive law and used only in extreme cases of national danger, be used now. Some instances of spurious drug manufacture cited during the Lok Sabha debate were:

i) Fungus-infested glucose used in a Kanpur hospital, and at the All-India Institute of Medical Sciences (AIMS) in New Delhi;

ii) A black-listed firm was allowed

to continue to supply glucose to the AIIMS;

iii) How did hospitals run by the government and the Central Government Health Scheme get spurious drugs remains a mystery;

iv) In a raid in Delhi on March 23, 1982, the police had discovered a "factory" where life-saving drugs were being manufactured without a licence. Thirty different types of labels of popular medicines of reputed companies, along with the raw materials were seized;

v) Not long ago, in Calcutta, when a woman was operated upon for severe abdominal pain, more than 100 undissolved tablets were found in the intestines. Obviously, the quality was substandard.

The spurious drug menace has been growing unabatedly. Consider the following cases which reveal the glaring iniquity in the health care system in India today.

The hearings by the Lentin Commission into the deaths of 14 patients last year in Bombay's J.J. Hospital run by the State Government, as a result of chemical contamination of the administered drug. There was also a close unhealthy nexus between unscrupulous manufacturers of drugs and corrupt politicians as well as bureaucrats. The adulterated glycerol is not an isolated case. Reportedly, today in India, nearly 15 per cent of the drugs marketed are substandard or spurious.

On June 8 a 27-year-old woman, Mahananda Bhalchandra, a class IV employee of the hospital at Tiwasa in Amravati district, died at the same hospital after being injected intravenously with substandard xylocaine (an anaesthetic injection of two per cent strength and one cc). This, despite the fact that after the Food and Drugs Administration (FDA) had certified the tested xylocaine to be sub-standard. The complete batch (No. 101 delivered in January 1987) was seized. And the supply of this drug by the particular firm had been only restricted to Amravati district.

A family friend who suffered from 'tennis elbow' was injected unknowingly with a spurious injection but his gangrenous arm was saved in the nick of time from an amputation. Such an accident is possible if the drugs have passed their expiry dates, or are poorly stored.

APPALLING INDIFFERENCE BY AUTHORITIES

A news item in an eveninger dated June 15, reveals that at a medico-legal seminar, organised by the Bombay Council of Academicians and Professionals on June 14, a startling case of how matters relating to drugs, suspected to be adulterated, are being handled by the concerned authorities was mentioned.

Dr. S.N. Deshmukh, Dean of the faculty of medicine, Bombay University, pointed out that following the J.J.Hospital tragedy last year, the civic authorities had issued a circular to all it s hospitals, including the one at Sion, where he is an honorary physician, that if they came across any substandard drug, the authorities should immediately be informed about it.

Dr. Deshmukh came across a case in the hospital where the patient, suffering from fever, was treated with all the precautions but did not respond to treatment, even after seven days. As he suspected the drug to be substandard, the vial was handed over to the hospital dean who sent a drug sample for analysis.

After some days, a letter was received by the Dean wherein it was stated that Rs. 500 should be sent with the application for the analysis of the drug. However, the dean found that he had no power to send the amount in such matters.

Thereafter all the relevant papers were sent to the concerned Deputy Municipal Commissioner by Dr. Deshmukh. However, no reply has been received by him as yet.

This reveals that the present drug control infrastructure is inadequate to weed out these unlicensed units and also to inspect and control the manufacture and distribution of drugs. For an effective campaign against spurious drugs, drug inspectors should be made fully conversant with the ins and outs of the manufacture of drugs and with the procedure of testing. It is for the government to educate the inspectors about these. The Govt. should also educate inspectors in Acts allied to the Drugs and Cosmetics Act, 1940, such as the Drug (Control) Act, 1950, the Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954, and the Indian Penal Code, the Evidence Act, and the Criminal Procedure Code etc.

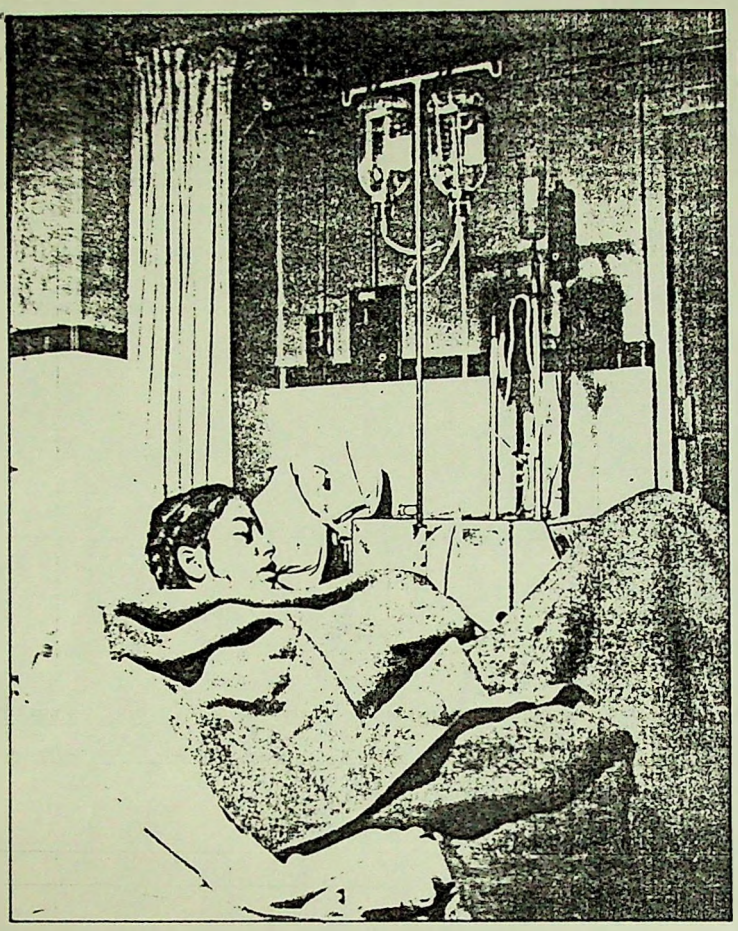
THE DRUGS & COSMETICS ACT

Also, the authorities should enforce all the provisions of the Drugs and Cosmetics Act, 1940, a consumer protection legislation, which is mainly concerned with the standards and purity of the drugs manufactured in this country and with the control of the manufacture, sale and drug distribution. Thus the main object is to prevent sub-standard drugs so that high standards of medicines and drugs can be maintained.

This Act prohibits the manufacture and/or import, sale or exhibit for sale, distribution of any cosmetic or drug which is either substandard or misbranded or may be injurious to health or any patent/ medicine which is not dispensed in a prescribed manner and does not contain a proper list of ingredients.

Drugs and cosmetics cannot be manufactured, sold, and distributed, without a proper license for the purpose. This license is granted usually by the Drug Technical Advisory Board and a Drugs Control Committee or any similarly constituted board by the Central Government to determine the quality standard of the drug or cosmetic.

A person who contravenes any of the provisions of the Act relating to drug import can be punished with two years' imprisonment and/or fine, and if he or she does



not act in accordance with provisions relating to the manufacture and sale of drugs, he may be punished with ten years' imprisonment and/or fine.

The Government appoints inspectors to search any premises where any kind of manufacturing activity regarding any drug or cosmetic is going on or such drugs and cosmetics are stocked or exhibited for sale and if he finds or has doubts about the offence having been commented them either the premises, or the drug/cosmetic and/or the vessel or vehicle carrying such drugs can be confiscated.

A licence is required for the manufacture of ayurvedic or unani medicines also which has to be manufactured under the prescribed conditions with proper and genuine raw materials. Imprisonment and/ or fine for the non-compliance of the above is prescribed by the Act.

On notification, the Drugs and Cosmetics (Amendment) Act, 1986, will suitably amend Section 26 and Section 32 of the Drugs and Cosmetics 1940 Act so that consumer associations as defined under the Act are conferred with the powers to draw samples legally and launch prosecution.

THE DRUG (CONTROL) ACT

The Drug (Control) Act, 1950, controls the distribution of drugs. The chief commissioner decides the maximum price of any drug which is to be charged, the maximum quantity that a dealer can possess and the maximum quantity that can be sold to a person at a time.

Thus, any drug beyond the prescribed limit cannot be possessed by a dealer. This prescribed limit can, however, be altered by the chief commissioner in certain special cases.

As per the provisions of the Act, a cash memo with all the details must be given to the consumer who makes purchases, so that the dealer only supplies genuine medicine to the consumer.

A detailed price list also has to be maintained by each person manufacturing every drug he sells. With all the drugs that he keeps for sales there also has to be maintained list of sale price for the consumer's benefit.

For the contravention of the provisions, imprisonment and/or fine is the punishment.

The Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954, controls the advertisement of drugs in an objectionable manner. Misleading advertisements giving a false impression to a consumer et al and many other such examples (with exceptions) are also quoted in the Act. Punishment by way of imprisonment or fine is laid down for contravention.

It is now for the Food and Drug Administration authority or any similar authority enforcing the above laws in each state to enforce the provisions of the Acts mentioned above. They should also educate the drug inspectors and encourage them to maintain close liaison with the public health department authorities and hospitals etc.

"Intelligence-cum-legal unit" is necessary in each state. However, expecting for a few states like Maharashtra, Gujarat, West Bengal and Union territory of Delhi, other states have not made a conscientious effort to organise cells for counteracting fake drugs. Even in states where the cell had been set up, drug fakers have hardly been effectively bought to book as is apparent from the probe being carried on now-a-days by the Lentin Commission. Many spurious drugs are being successfully marketed even today.

HOW TO BUY A DRUG

How then can you guard against being palmed off a spurious drug? While buying any drug, shop only at reputable chemists, one to whom you can get back to in case of a complaint. The label should be examined carefully and care should be taken to see that it is well within the expiry date. A drug should have the manufacturer's name and address on it and also the manufacturing license number.

Many times, consumers just pop in a medicine given to them by an allopath without knowing what it really is. Sometimes general practitioners give unlabelled medicines.

Why do general practioners give unlabelled drugs? One, either he is afraid that revealing the medicine name may lead the patient to question the rationale behind the drug administered and the treatment. Two, the doctor feels he might lose a patient if he discloses the drug's name and also other practitioners might get to know he treats a particular ailment. Three, the practitioner must be overcharging and thus making a huge profit on the medicine; obviously the practitioner would not like the patient to know this. Four, cheap generic substitutes available at half price or even less may be administered and price for the original charged.

Sometimes practitioners do not even wait to diagnose the cause. In case of complaints of fever, pain, etc., they administer a fever reducing drug, an antibiotic, a pain killer, an antihistamine or a sleeping combination gives instantaneous relief without the doctor having bothered to go to the root of the problem. The patient, meanwhile, gets hooked onto the drug and the doctor.

Amongst branded drugs in the market, it is very few drug manufacturers operating in the organised sector who bother to market safe and reliable drugs. Sometimes new drugs discovered abroad are introduced in the Indian market. This has led to some kind of a controversy over the brand names versus generics.

In any kind of drug therapy, however, one cannot do without brand names as they afford the greatest assurance in both reliability and the course of treatment an illness can take. Brand identification is a responsibilty on the manufacturer to market his product and help him achieve a high excellence level on the total performance.

If the brand name is abolished, it will encourage even more spurious and substandard drugs especially in the Indian market. The need of the hour is a strong, qualitatively efficient and vigilant drug control administration, which sadly is lacking in many Indian states.

Even in the United States, reportedly the FDA — 'the largest and the most professionally organized regulatory agency in the world' — has not been able to police the entire drug industry in the country.' Also, there "generics equivalence" has been difficult to attain. In the U.S.A., Pakistan, Soviet Union and other European countries "generics" have been experimented within varying degrees of failure and they have had to go back to "brands" finally.

One argument set forth by many who are in favour of the introduction of generics is that the drugs will be available at a cheaper price as a consequence of the abolition of the brand name. This, anti-generics feel, is misplaced. Drug prices and profits of drug companies in India are already controlled whether the drug is sold under the brand or the generic name. On the other hand, those anti-generic feel that one consequence of the brand yielding to generics, will cost the nation dearly in terms of both standards and quality of drugs, for which the nation might have to pay dearly.'

The government should especially step up checks in hospitals to avert fatal drugs being administered in future. The need of the hour is also to set up a large number of testing labs at district levels and locally so that tests on more and more drugs can be carried out immediately and quickly before the drugs are marketed. In the past, many meaningful legislations like the Drug and Cosmetics Act, 1940, and the Prevention of Food Adulteration Act, 1954, have been unsuccessful mainly because of inadequate lab facilities.

The Delhi administration's drug control department either sends product samples to the Ghaziabad's central laboratory or the State laboratory at Bangalore in Karnataka. Even otherwise, labs take a long time over analysis as they are overburdened with work and the concerned departments sometimes receive the test reports after two months.

Though consumers have legal recourse, the courts have to be moved, thus involving a lot of expenditure and time. In the near future, you could perhaps have an inexpensive recourse in the Consumer Protection Councils to be set up in each state and the Consumer Disputes Redressal agencies to be set up soon at the national, state and district level under the Consumer Protection Act.

But whatever it may be, it is time for the Government to streamline the functioning of its drug enforcing authorities and take harsh steps to enforce rigorous standards in the industry. Officials should be recruited on merits and no favour shown on sectoral consideration. To check such cases in future there should be wide publicity of cases unearthed. Where the manufacturer and the dealer have been indulging in the sale of either substandard or spurious drugs, even deterrent punishment meted out should be widely publicised. It would be unfair for the government to jeopardise the nation's health or for it to compromise on extraneous or chauvinistic consideration!

Next: After sales service or disservice?

THE TIMES OF INDIA, BANGALORE

July 5

Unsafe intravenous fluids

—CONSUMER RIGHTS—

Y.G. Muralidharan

BANGALORE: Reports of innocent patients (consumers) paying with their lives due to unsafe and adulterated drugs are not uncommon.

Sometime back it was reported that several hundred patients had to lose their eyesight as they were treated with a particular batch of eye solution which was later found to be contaminated. Complaints against transfusion of infected blood have also come to light.

Thirteen years ago when the glycerine tragedy took its tool of 14 patients at J.J. Hospital, Mumbai, it was felt that things would improve. The Lentin Commission which went into the details made several revelations.

Yet unsafe drugs and medicines continue to be on the shelves of the pharmacists as been proved by the tests of intravenous (IV) fluids conducted by Consumer Education Research Society (CERS), Ahmedabad.

When a patient visits a private nursing home or hospital the first thing that is done is to administer IV fluids, irrespective of the need. The use of IV fluids is estimated to be 320 million units, which was 150 million units ten years ago.

Intravenous (IV) fluids includes any fluid or drug whose delivery does not utilise the normal digestive route. It is to be used in emergencies where normal oral intake of food or medication becomes difficult like in case of accidents, burns, kidney failures, the patient need IV fluids.

Considering the fact that IV fluids serve as the only way to rehydrate and provide life-saving nutrition, as well as to introduce different drugs for treatment into the patients body, its quality and safety needs priority.

But out of 41 brands of IV fluids tested for various parameters, fourteen have found to be unsafe. Of about 20 products marketed under the IV fluids category, only four - Normal Saline (NS), Dextrose Injection (DI) Dextrose and Normal Saline (DNS) and Renger Lactate Injection (RLI) have a major share. Hence they were tested.

Normal saline injection is a sterile solution of sodium chloride. It contains no added substance. Dextrose injection is a sterile solution of dextrose.

This is the most extensively used injection in hospitals. Dextrose and Normal Saline is a sterile solution of dextrose and sodium chloride given to patients with a low sodium level. Ringer Lactate injection contains potassium chloride, sodium chloride and sodium lactate. It is used to cure dehydration.

The Sterility test is conducted to find the presence of micro organisms. Microbial contamination of intravenous systems may occur at several points from the time of manufacture till its use in hospitals.

Administering such contaminated fluids may result in blood poisoning, causing fever, headache, nausea or diarrhoea. The samples from the DNS category of M/s Kokad Pharmaceuticals was found to be contaminated by bacteria.

The presence of foreign particles, although minute, may cause serious consequences.

The report says that this may result in loss of blood supply to certain vital tissues. The test for Particulate Matter (presence of foreign materials) has revealed that 14 brands of IV fluids did contain foreign materials above the permissible limits. The rest report published in the recent issue of the society's magazine INSIGHT, says that quite a few brands had particles visible to the naked eye.

The quality of glucose used in Dextrose injection decides the stability and shelf life of the fluid. To test the quality of glucose and its decomposition, the brands were put through a test (5-HMF). Except two brands all others fell within the maximum absorbance limit of 0.25 specified in the Indian Pharmacopea.

The brands which passed the basic tests have been rated. In the normal Saline, six out of seven brands have been rated.

Denis Chem with 90 per cent tops the chart followed by Core Healthcare (87%), Albert David (86%), Wokhardt (84%) and Shree Krishna Keshav (81%). In the case of 5 per cent dextrose only 6 out of 10 brands passed in all the parameters.

The test has revealed that only brands with glass containers carried particles. All the brands in plastic containers met the specification set by Indian Pharmacopea.

For a copy of the detailed report write to CERS, Thaltej, Ahmedabad-Gandhinagar Highway, Ahmedabad 380 054 or visit http://www.indiatrade.com.cerc.

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The above publications may be obtained in person or by sending the amount through DD/ Cheques drawn in favour of CREAT, Bangalore. Please add Rs. 10/- for outsation cheques.

PREFACE

The Consumer Rights, Education and Awarness Trust (CREAT) has launched a programme "Consumer Awarness Series" under which it is planned to publish a series of leaflets, booklets and guides on various subject of interest to consumers. The objective of this series is to educate consumers, provide them with information and to create an awarness about their rights and responsibilites.

CREAT belives that providing information to consumers is one way of creating a responsible citizen who can always guard his rights and take remedial measures in case they are violated.

So far five leaflets and two booklets have been published in this series. Subjects for few more booklets have been identified and CREAT hopes that the same will be made available at the earliest.

Our thanks to Mr. Vijay Vikram, Joint Commissioner (Transport/Admn.) for having gone through the booklet and giving suggestions in preparing this booklet.

Bangalore
April, 1995

Executive Trustee
(CREAT)

GUIDELINES TO R.T.O. PROCEDURES

It is everybodys experience that information about the procedures to be followed and documents to be furnished for various works at the RTO is not known well although the details are made known over display boards. An effort has been made in the following lines, to help the public by providing broad guidelines to be followed for obtaining the services of RTO.

Every Regional Transport Office deals with all transactions relating to Drivers, Conductors, TravelAgents as well as Transport Vehicles. The important works in which common man is interested are:

A. Learners driving licence
B. Permanent driving licence
C. Renewal of driving licence
D. Registration of vehicles

A - LEARNER'S LICENCE

Every person who wants to drive a vehicle should possess a valid learners or permanent driving licence. At the first instance, a person should obtain a learners licence. The eligibility conditions for obtaining a learners licence is as follows:

AGE LIMIT

1. Should not be less than 18 years for all Motor Vehicles other than transport vehicles.
2. Should have attained 16 years for Motor Cycles without gears. A consent of the parent or guardian should be obtained and produced.
3. Should not beless then 20 years for transport vehicles

APPLICATION

An application for grant of learners licence is to be made in Form 2 to the RTO/ARTO having jurisdiction in the area in which the candidate ordinarily resides or carries on business or the school in which he is receiving or has received instruction is situated.

DOCUMENTS TO BE ANNEXED

The following documents should be annexed along with the application for grant of learners licence.

1. A medical certificate in Form IA, issued by a Registered Medical Practitioner. This is only for transport vehicles
2. Three copies of recent photographs of size 3 cm X 6 cm. Photographs may be black and white or colour
3. A fee of Rs. 15 (Rupees fifteen only) is to be remitted in the Treasury Counter in the RTO and the challan is to be submitted along with the application.

   (Note down the number and date of the challan or take a xerox and keep for your records)
4. Any document mentioned below, as proof of your age and bonafide residential address
   a) Ration card wherein your name is included
   b) Electrol Roll slip or Voters Identity card
   c) LIC policy with your address mentioned therin
   d) Electricity or Telephone Bill
   e) Pay Slip/Salary packet issued by your employer, in case of State or Central Government employees
   f) House Tax receipt
   g) Birth certificate issued by Corporation.
   h) School certificate (S.S.L.C marks card)

Original marks card of SSLC should be produced and taken back before leaving the RTO. Better you have two xerox copies of the marks card duly attested by a Gazetted Officer.

To have a driving licence you should not be suffering form any disease or disability likely to cause your driving of a motor vehicle a source of danger to the public or passenger.

If the application is proper in all respects and if all the documents are submitted, you will be called for a simple test. Users have the right to ask the concerned officer to send the intimation regarding the date and time of the test by post.

CONTENTS OF THE TEST

Granting of the learners licence involves passing of a simple test in which you will be tested whether you possess adequate knowledge and understanding on the following matters:

a. Traffic signs, traffic signals, rules and regulations of the road

b. Duties of driver when the vehicle is involved in an accident causing, death, injury of a person or damage to property or party

c. Precautions to be taken while passing unmanned railway crossing

d. Documents the driver should carry while driving a motor vehicle

The test will be conducted by the licencing authority or Inspector of Motor Vehicles or through a computer.

Learners licence will be issued subject to pass in the test. Vehicle users should follow the instructions to avoid penalty or confiscation of the licence.

B - GRANTING OF PERMANENT LICENCE

1. A permanent licence will be issued to persons who have a valid learners licence, subject to other conditions. Eligibility conditions as far as age in case of getting learners licence is valid for getting a permanent licence also.

2. An application for a permanent driving licence should be made in Form No.4 to the RTO/ARTO in whose jurisdiction the applicant resides or carries on business or the school where he is receiving or has received instructions is situated after the candidate has held a learners licence for a period of atleast thirty days

3. The application should be accompanied by the following documents.

   a. Challans for remittence of the Test fee of Rs. 15/- (Fifteen only) and
   b. Driving licence fee of Rs. 20 (Twenty only)
   c. Valid learners driving licence in original
   d. Three copies of the applicant's recent photographs of size 5 cms X 6 cms
   e. Driving certificate in Form 5 issued by the school where the applicant received the instructions, if any. This is not applicable in case the user has learnt driving on his own

4. If the application and documents are proper in all respects, the concerned RTO/ARTO will call the user to appear for a test of competence to drive. You should be ready to appear for the test with a serviceable vehicle of the class for which you have applied for licence. It is not necessary that you should be the owner of the vehicle

5. If you pass the test you will be granted with a permanent driving licence which will be valid for a period of 20 years or till you attain the age of 50 years whichever is earlier in case of non- transport vehicles and three years in respect of transport vehicles.

6. In case you fail in the test you will have to reappear after seven days upto three attempts. Thereafter it is after 60 days. In such a case you will have to remit the test fees once again. It is better you appear for the test after you have acquired adequate proficience and competence in driving.

C - RENEWAL OF DRIVING LICENCE

As a user of the vehicle you should remember that a driver is expected to carry with him/her a valid driving licence. The word 'valid' indicates that it is not expired. Driving with an outdated licence attracts all penalties as if driving without a licence . So watch the date of expiry and apply for renewal without waiting for the last day. The procedure for renewal is an follows:

1. Application for renewal of driving licence should be made in Form No. 9.

2. If the application for renewal is made within thrity days from the date of expiry of the licence, the licence will be renewed from the date of expiry. For example if your licence expires on 1st March, your licence will be renewed from 1st March if you apply within 30 March.

3. If the application is made after thirty days of the date of expiry of the licence, renewal will be made from the date of renewal. If appication is made after five years of the date of expiry the applicant will have to appear for a re-test.

4. Fees for Renewal

   a. If renewal of licence is made within thirty days of the date of expiry Rs. 15/- (Fifteen only)
   b. If renewal of licence is made thirty days after the date of expiry Rs. 15/- (Fifteen only) plus Rs. 10/- (Rupees ten only) will have to be paid for dalay of one year or part thereof, reckoned from the date of expiry
   c. If you hold a licence for both Non-transport and transport vehicles, separate fees is to be paid for each category.

5. The application for renewal of licence should be accompanied by the following:

   a. Challan of fees paid
   b. Three copies of recent photograph of size 5 X 6 cms
   c. The Driving licence
   d. Medical Certificate in Form 1A

6. In case of Non-transport vehicles the licence will be renewed:

   i. For a period of 20 years or till the applicant attains the age of 50 years
   ii. If the applicant has attained the age of 50 years, for a period of five years.

7. In case of Transport vehicles licences will be renewed for three years only. If the applicant is a holder of a licence issued outside the region, such licences will be renewed after receipt of antecedent from O.L.A. or after fifteen days after the date of application.

D - REGISTRATION OF VEHICLES

Every vehicle purchased, either new or old, has to be registered and an R.C. book obtained.

Application for registration of a motor vehicle should be made in Form 20 to the Registering Authoring in whose jurisdiction the applicant thas the residence or place of business or where the vehicle is normally kept.

Application should be submitted within seven days from the date on which the vehicle was purchased or taking delivery of the vehicle.

The present fee for registration of a motor vehicle is as follows:-

	Rs.
Invalid carriage	10/-
Motor Cycle	30/-
Light Motor vehicle	100/-
Medium Goods/passenger vehicle	200/-
Heavy goods/Passenger vehicle	300/-
Imported vehicle	100/-
Imported motor vehicle	100/-
Any other vehicle	150/-

In addition to registration fee, taxes at the rates specified in part A of the schedule to Karnataka Motor Vehicles Tax Act 1957 will have to be remitted.

The life time tax for motor cycles is as follows:

a. Below 75 cc Rs. 1000/-
b. Between 75 and 300 cc Rs. 2000/-
c. Above 300 cc Rs. 3000/-

The taxes in respect of motor cars other than imported cars or cars owned by.companies is as follows:

a. Vehicle upto 800 cc Rs. 10.000/- (Life Time Tax).

b. Vehicle of 800cc to 1500cc Rs. 15,000/- (Life Time Tax)

c. Above 1500 cc Rs. 20,000 (Life Time Tax)

DOCUMENTS TO BE FURNISHED ALONG WITH APPLICATION

1. Sale certificate in Form 21
2. Valid Insurance Certificate
3. Proof of address by producing any one of the following:
   a. Ration card
   b. Electrol roll or identity card
   c. Life Insurance policy
   d. Passport
   e. Electricity or telephone Bill
   f. Pay slip issued by State or Central Govt. offices
   g. House tax receipt
   h. School certificate
   i. Birth certificate
4. Temporary registration if any, or extract of From 19 if the vehicle is covered by trade certificate
5. Roadworthiness certificate issued by the Manufacturer in Form 22
6. Receipt for having paid Registration fee and tax

After filing the application along with the documents detailed above, the vehicle should be produced for inspection so that the Registering authority will satisfy that the particulars contained in the application are true and that the vehicle compleies with the requirements of M.V. Act 1988 and rules made thereunder.

After satisfying that the particulars contained in the appplication are true and the vehicle complies with the requirements of the Act, the RTO will register the vehicle, assign a registration mark and will issue registration certificate (RC book)

The applicant/owner should exhibit the registration mark assigned on the vehicle in the manner prescribed on black background with white letter in repect of Non Transport vehicles and white background and black letters in respect of Transport vehicles.

If the vehicle is covered by Hirepurchase/hypothecation/lease agreement the signature of the other party to such agreement shall be obtained in the application in the column provided for the purpose and additional fee of Rs. 50/- (Fifty only) shall be remitted for recording such agreement.

If the vehicle is to be registered as a Transport vehicle a separate application in the prescribed form, with prescribed fee should be filed for grant of fitness certificate and permit

The certificate of registration of a motor vehicle other than a transport vehicle will be valid for fifteen years and is renewable.

GENERAL GUIDELINES

A driver of a vehicle should carry with him/her the following documents in original or xerox copies duly attested by a State Government Gazetted Officer

1. Registration Certificate (RC Book)
2. Valid driving licence
3. Valid Insurance Policy or receipt of premium

The Traffic police can ask the driver to produce the following documents within Corporation or Municipal limits:

1. Valid driving licence

The Regional Transport Officials can ask the driver to produce the following document for verification:

1. Registration Certificate
2. Any other documents pertaining to he vehicle

LOCAL R.T.O. ADDRESSES

Bangalore City has five Regional Transport Offices, the details of which are as follows:

Division	Address	Phone No.
North	Corporation Complex Yeshwanthpur BANGALORE-560 022	3376039
South	Shopping Complex Jayanagar IV Block BANGALORE-560 011	6630989
East	BDA Shopping Complex Indiranagar BANGALORE-560 038	562726
West	BDA Shopping Complex Rajajinagar II block BANGALORE-560 010	3324288
Central	BDA Complex Koramangala BANGALORE-560 035	5533525

Office of the Transport Commissioner
4th Floor, Multistoreyed Buildings
Dr. Ambedkar Veedhi
BANGLORE - 560 001
Phone No: 2253717

TRAFFIC CONTROL DEVICES

Traffic signs, signals and markings are designed to regulate, warn and guide the flow of traffic. These devices are standardised so they have the same meaning in every State.

Traffic signs are used to convey specific information.Theytellyouaboutregulations,warnyouofhazardsorpotentialhazardsand helpyoufind your way.

Signs are divided into four basic categories:

Regulatory
Warning
Construction
Guide

Regulatory signs tell you what you can or cannot do. They advice you on the regulations concerning speed, the direction of traffic, turning restrictions and parking.

Warning signs tell you what you expect ahead. They warn you about existing or potential hazards on or near the roadway and are posted before the hazard so you can be prepared.

Constructions signs indicate that some repair, construction or maintenance work is in progress

Guide signs tell you shere you are going and how to get there. They provide information on intersecting roads, help direct you to cities and towns and note points of interest along the highway. Guide signs also help you find hospitals, service stations, restaurants etc.

SEEING WELL AT NIGHT

It's harder to see things at night than during the daytime. Here are some things you can do to help you see better.

Use your high beams whenever there are no oncoming vehicles. You can see twice as far with high beams than with low beams. It's particularly important to use your high beams when driving on unfamiliar roads, in construction areas or where there may be people along the roadside.

Dim your lights when following another car or when car coming toward you.

Use low beams when driving in fog, snow or heavy rain. Light from high beams will reflect and cause glare.

COMMUNICATING

Accidents often happen because one drived doesn't see another driver, or one driver does something the other driver doesn't expect. It's important that drivers COMMUNICATE.

Communicating means letting others know where you ar and what you plan to do:

By using yours lights
By using your horn
By making sure your vehicle is seen
By using emergency signals
By positioning your vehicle
By signaling when changing directions
By signaling when slow or stopping

USING HORN

Your horn can get the attention of other drivers. Use it whenever you suspect another driver or a pedestrain doesn't see you, but don't abuse it.

If there is a real danger, don't be afraid to sound a SHARP BLAST on your horn. For example use your horn

a. When a child is about to run into the street
b. When another vehicle is in danger of hitting you
c. When you have lost control of your vehicle

DRIVING ON A WET ROAD

While driing on a wet or slippery road be careful. If the road is slippery, your tyres have less traction. Drive slower on wet roads then you would on dry droads. Exercise special caution on roads posted with warning signals.

At speeds upto 35 mph most tyres will wipe water from the road surface similarly to the way a sindshield wiper cleans water off the window. As you go faster, your tyres cannot wipe the road as well. They start to ride on a film of water like water skis. This is called Hydroplaning.

In a heavy rain your tyres can lose all contact with the road at higher speeds. Bald tyres lose contact more readily. A slight change in direction or a gust of wind could throw you vehicle into a skid. The best way to prevent hydroplaning is to keep your speed down.

ALCOHAL AND DRIVING IMPAIRMENT

It is highly dangerous and illegal to drive when you are under the influence of alcohal and drugs. No one can drive safely no matter how long he or she has been driving.

Alcohal is a depressant. It affects all the cells of the body, especially the main and central nervous system. As a resul, alcohol dulls your memory, concentration, insight, perception and judgement

When high levels of alchol are absorbed into your blood stream, it affects your ability to distinguish different light intensities. This may be particularly dangerous when driving. Your eyes taken longer to read just when exposed to glare from bringt lights. It also impairs your eyes sensitivlty to certain colours, especially red.

As the alcohol concentration increases in your blood, so will you driving errors. You will reach slower and fluctuate between driving fast and driving slow. Your ability to brake and drive will be impaired so that your vehicle swerves and stalls. In general, your driving will become careless after drinking.

You don't have to drink much to be affected by alcohol. Studies indicate that driving skills begin to deteriorate at blood- alcohol levels below 0.05 per cent.

Finally, it's important to remember that alcohol gives a driver a false sense of security. The driver thinks that he or she is driving well. In reality the driver is endangering himself and others on the roads.

Alchohol is not the only drug that can adversely influence your driving performance. Many other drugs either used alone or in combination with alcohol, increase your risk of having an accident.

Every drug has some effect on the person using it. Befoer taking a drug, find out from your doctor how the particular drug might affect your sight, coordination, timing and general ability to drive.

HEALTH

Some of the diseases or ailments may be dangerous for driving. Persons with the following health problems should be careful while driving. Better they do not drive alone.

Epilepsy - As long as it is under medical control, epilepsy is not dangerous. Persons with known instances of epilepsy should not drive alone

Diabetes - Diabetics on insulin should not drive when there is any danger of going into shock. This danger could result from skipping a meal or snack or from taking amount of insulin. It is better, a friend or a relative drive you. Diabetics should also have their eyes checked for possible night blindness.

Heart condition - People with heart disease, high blood pressure or circulation problems should be aware of the impact of these conditions on ther driving ability. There is danger of a black out, fainting spell or heart attack.

GOOD DRIVING HABITS

1. Drive slow and steady
2. Keep your engine healthy
3. Use brakes sparingly
4. Let go of your clutch
5. Clean air filter regularly
6. Watch your tyre pressure
7. Stop fuel leaks
8. Stop the engine if you stop for more than 2 minutes
9. Use the right lubrication.

The information is based on the leaflets issued by the Department of Transport, Government of Karnataka and Pennsylvania manual for drivers published by Department of Transportation, Commonwealth of Pennsylvania.

CREAT

Established in December 1993, CREAT is a non political, non-profit, voluntary organisation devoted to the cuase of consumer protection and welfare.

The objective of CREAT is to act as a platform for consumers to raise their grievance on issues relating to consumer protection, environment, health, public issues etc. To achieve its objectives CREAT has chalked out the following programmes:

1. To set up a consumer information centre
2. To publish books, leaflets and other literature
3. To bring out a periodical
4. To set up a food testing laboratory
5. To arrange lectures, demonstrations, exhibitions, seminars and workshops
6. To arrange programmes to train consumer activists
7. To take up individual/class cases for redressal
8. To provide faculty, trainig material etc, for consumer groups
9. To conduct surveys, product evaluation studies and print reports

CREAT is an organisation depending entirely on contributions from the general public, philonthropists and social organisations. While the trust welcomes donations, interested persons can join CREAT as donor members on payment of Rs. 50/- (fifty only) per annum. For details contact:

Consumer Rights, Education and Awareness Trust (CREAT)
239, 5th C Main, Remco Layout,
Vijayanagar, BANGALORE - 560 040

Con-t.

IN THE SUPREME COURT OF INDIA

CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO. 688 OF 1993

Indian Medical Association ... Appellant

VERSUS

V.P.Shantha & Ors. ... Respondents

[WITH C.A.NO.689/93, WP(C) NO. 16/94, C.A.NO. 4664-4665/94, C.A.NO. 254/94 AND C.A.NOS.10039,10081,10052-80/95 {Arising out of SLP(C)NOs. 18497/93, 21755/94, and 18445-73/94}, SLP(C)NOs. 6885/92, 6950/92, 351/93, 21348/93 and 21349/93]

J U D G M E N T

S.C. AGRAWAL, J. :

Leave granted in SLP(C) Nos. 18497/93 and 21755/94. Delay condoned and leave granted in SLP(C) Nos. 18445-73/94.

These appeals, special leave petitions and the Writ Petition raise a common question, viz., whether and, if so, in what circumstances, a medical practitioner can be regarded as rendering 'service' under Section 2(1)(o) of the Consumer Protection Act, 1986 (hereinafter referred to as

Received from vidhi on 12/12/95

To Dr CMF for information and perusal RN 12/12

Consumer Protection Act

'the Act']. Connected with this question is the question whether the service rendered at a hospital/nursing home can be regarded as 'service' under Section 2(1)(o) of the Act. These questions have been considered by various High Courts as well as by the National Consumer Disputes Redressal Commission [hereinafter referred to as 'the National Commission'].

In Dr. A.S.Chandra v. Union of India, (1992) 1 Andhra Law Times 713, a Division Bench of Andhra Pradesh High Court has held that service rendered for consideration by private medical practitioners, private hospitals and nursing homes must be construed as 'service' for the purpose of Section 2(1)(o) of the Act and the persons availing such services are 'consumers' within the meaning of Section 2(1)(d) of the Act.

In Dr.C.S. Subramanian v. Kumarasamy & Anr., (1994) 1 MLJ 438, a Division Bench of the Madras High Court has, however, taken a different view. It has been held that the services rendered to a patient by a medical practitioner or by a hospital by way of diagnosis and treatment, both

medicinal and surgical, would not come within the definition of 'service' under Section 2(1)(o) of the Act and a patient who undergoes treatment under a medical practitioner or a hospital by way of diagnosis and treatment, both medicinal and surgical, cannot be considered to be a 'consumer' within the meaning of Section 2(1)(d) of the Act; but the medical practitioners or hospitals undertaking and providing para-medical services of all kinds and categories cannot claim similar immunity from the provisions of the Act and that they would fall, to the extent of such para-medical services rendered by them, within the definition of 'service' and a person availing of such service would be a 'consumer' within the meaning of the Act. C.A.Nos. 4664-65/94 and Civil Appeal arising out of SLP(C) No. 21775/94 filed by the complainants and Civil Appeals arising out of SLP(C) Nos. 18445-73/94 filed by the Union of India are directed against the said judgment of the Madras High Court.

The National Commission by its judgment and order dated December 15, 1989 in First Appeal No. 2 of 1989 has held that persons who avail themselves of the facility of medical treatment in Government hospitals are not "consumers"

and the said facility offered in the Government hospitals cannot be regarded as service "hired" for "consideration". It has been held that the payment of direct or indirect taxes by the public does not constitute "consideration" paid for hiring the services rendered in the Government hospitals. It has also been held that contribution made by a Government employee in the Central Government Health Scheme or such other similar Scheme does not make him a "consumer" within the meaning of the Act. Civil Appeal arising out of SLP(C) No. 18497/93 has been filed by Consumer Unity Trust Society, a recognised consumer association, against this judgment of the National Commission.

By judgment dated April 21, 1992 in First Appeal Nos. 48 and 94 of 1991, the National Commission has held that the activity of providing medical assistance for payment carried on by hospitals and members of the medical profession falls within the scope of the expression 'service' as defined in Section 2(1)(o) of the Act and that in the event of any deficiency in the performance of such service, the aggrieved party can invoke the remedies provided under the Act by filing a complaint before the Consumer Forum having

jurisdiction. It has also been held that the legal representatives of the deceased patients who were undergoing treatment in the hospital are 'consumers' under the Act and are competent to maintain the complaint. C.A.Nos. 688/93 and 689/93 filed by the Indian Medical Association and SLP(C) Nos. 6885 and 6950/92 filed by M/s Cosmopolitan Hospital are directed against the said judgment of the National Commission. The said judgment dated April 21, 1992 was followed by the National Commission in its judgment dated November 16, 1992 in First Appeal No.97 of 1991 [Dr. Sr. Louie & Anr. v. Smt. Kannolil Pathumma & Anr.]. SLP No. 351/93 has been filed by Josgiri Hospital and Nursing Home against the said judgment of the National Commission.

By judgment dated May 3, 1993 in O.P.No. 93/92, the National Commission has held that since the treatment that was given to the complainant's deceased husband in the nursing home belonging to the opposite party was totally free of any charge, it did not constitute 'service' as defined under the Act and the complainant was not entitled to seek any relief under the Act. C.A.No. 254/94 has been filed by

the complainant against the said judgment of the National Commission.

Writ Petition No. 16 of 1994 has been filed under Article 32 of the Constitution by Cosmopolitan Hospital (P) Ltd., and Dr. K.Venogopolan Nair [petitioners in SLP(C) Nos.6885 and 6950/92] wherein the said petitioners have assailed the validity of the provisions of the Act, insofar as they are held to be applicable to the medical profession, as being violative of Articles 14 and 19(1)(g) of the Constitution.

Shri K.Parasaran, Shri Harish Salve, Shri A.M.Singhvi, Shri Krishnamani and Shri S.Balakrishnan have addressed the court on behalf of the medical profession and the hospitals and Shri Rajeev Dhavan has presented the case of the complainants. Before we proceed to deal with their contentions we would briefly take note of the background and the scheme of the Act.

On April 9, 1985, the General Assembly of the United Nations, by Consumer Protection Resolution No. 39/248,

adopted the guidelines to provide a framework for Governments, particularly those of developing countries, to use in elaborating and strengthening consumer protection policies and legislation. The objectives of the said guidelines include assisting countries in achieving or maintaining adequate protection for their population as consumers and encouraging high levels of ethical conduct for those engaged in the production and distribution of goods and services to the consumers. The legitimate needs which the guidelines are intended to meet include the protection of consumers from hazards to their health and safety and availability of effective consumer redress. Keeping in view the said guidelines, the Act was enacted by Parliament to provide for the better protection of the interests of consumers and for that purpose to make provision for the establishment of consumer councils and other authorities for the settlement of consumers' disputes and for matters connected therewith. The Act sets up a three-tier structure for the redressal of consumer grievances. At the lowest level, i.e., the District level, is the Consumer Disputes Redressal Forum known as 'the District Forum'; at the next higher level, i.e., the State level, is the Consumer Disputes Redressal Commission known as 'the

State Commission' and at the highest level is the National Commission. [Section 9]. The jurisdiction of these three Consumer Disputes Redressal Agencies is based on the pecuniary limit of the claim made by the complainant. An appeal lies to the State Commission against an order made by the District Forum [Section 15] and an appeal lies to the National Commission against an order made by the State Commission on a complaint filed before it or in an appeal against the order passed by the District Forum. [Section 19]. The State Commission can exercise revisional powers on grounds similar to those contained in Section 115 CPC in relation to a consumer dispute pending before or decided by a District Forum [Section 17(b)] and the National Commission has similar revisional jurisdiction in respect of a consumer dispute pending before or decided by a State Commission. [Section 21(b)]. Further, there is a provision for appeal to this Court from an order made by the National Commission on a complaint or on an appeal against the order of a State Commission. [Section 23]. By virtue of the definition of complainant in Section 2(1)(c), the Act affords protection to the consumer against unfair trade practice or a restrictive trade practice adopted by any trader, defect in the goods

bought or agreed to be bought by the consumer, deficiency in the service hired or availed of or agreed to be hired or availed of by the consumer, charging by a trader price in excess of the price fixed by or under any law for the time being in force or displayed on the goods or any package containing such goods and offering for sale to public, goods which will be hazardous to life and safety when used, in contravention of the provisions of any law for the time being in force requiring traders to display information in regard to the contents, manner and effect of use of such goods. The expression "complainant", as defined in Section 2(1)(b), is comprehensive to enable the consumer as well as any voluntary consumer association registered under the Companies Act, 1956 or under any other law for the time being in force, or the Central Government or any State Government or one or more consumers where there are numerous consumers having the same interest, to file a complaint before the appropriate Consumer Disputes Redressal Agency and the consumer dispute raised in such complaint is settled by the said agency in accordance with the procedure laid down in Section 13 of the Act which prescribes that the District Forum [as well as the State Commission and the National Commission]

shall have the same power as are vested in a civil court under the Code of Civil Procedure in respect of summoning and enforcing attendance of any defendant or witness and examining the witness on oath; discovery and production of any document or other material object producible as evidence; the reception of evidence on affidavits; the requisitioning of the report of the concerned analysis or test from the appropriate laboratory or from any other relevant source; issuing of any commission for the examination of any witness; and any other matter which may be prescribed. Section 14 makes provisions for the nature of reliefs that can be granted to the complainant on such a complaint. The provisions of the Act are in addition to and not in derogation of the provisions of any other law for the time being in force. [Section 3].

In this group of cases we are not concerned with goods and we are only concerned with rendering of services. Since the Act gives protection to the consumer in respect of service rendered to him, the expression "service" in the Act has to be construed keeping in view the definition of "consumer" in the Act. It is, therefore, necessary to set

out the definition of the expression 'consumer' contained in Section 2(1)(d) insofar as it relates to services and the definition of the expression 'service' contained in Section 2(1)(o) of the Act. The said provisions are as follows :

> "Section 2(1)(d) "consumer" means any person who, -
>
> (i) omitted
>
> (ii) hires [or avails of] any services for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any beneficiary of such services other than the person who hires [or avails of] the service for consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person.
>
> Explanation. - Omitted"

> "Section 2(1)(o) : "service" means service of any description which is made available to the potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, [housing construction], entertainment, amusement or the purveying of news or other information, but does not include rendering of any service free of charge or under a contract of personal service;"

The words "or avails of" after the word "hires" in Section 2(1)(d)(ii) and the words "housing construction" in

Section 2(1)(o) were inserted by the Act 50 of 1993.

The definition of 'service' in Section 2(1)(o) of the Act can be split up into three parts - the main part, the inclusionary part and the exclusionary part. The main part is explanatory in nature and defines service to mean service of any description which is made available to the potential users. The inclusionary part expressly includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy; board or lodging or both housing construction, entertainment, amusement or the purveying of news or other information. The exclusionary part excludes rendering of any service free of charge or under a contract of personal service.

The definition of 'service' as contained in Section 2(1)(o) of the Act has been construed by this Court in Lucknow Development Authority v. M.K.Gupta, 1994 (1) SCC 243. After pointing out that the said definition is in three parts, the Court has observed :

"The main clause itself is very wide. It applies to any service made available to potential users. The words 'any' and 'potential' are significant. Both are of wide amplitude. The word 'any' dictionarily means; one or some or all'. In Black's Law Dictionary it is explained thus, "word 'any' has a diversity of meaning and may be employed to indicate 'all' or 'every' as well as 'some' or 'one' and its meaning in a given statute depends upon the context and the subject- matter of the statute". The use of the word 'any' in the context it has been used in clause (o) indicates that it has been used in wider sense extending from one to all. The other word 'potential' is again very wide. In Oxford Dictionary it is defined as 'capable of coming into being, possibility'. In Black's Law Dictionary it is defined "existing in possibility but not in act. Naturally and probably expected to come into existence at some future time, though not now existing; for example, the future product of grain or trees already planted, or the successive future instalments or payments on a contract or engagement already made." In other words service which is not only extended to actual users but those who are capable of using it are covered in the Definition. The clause is thus very wide and extends to any or all actual or potential users." [p.255]

The contention that the entire objective of the Act is to protect the consumer against malpractices in business was rejected with the observations :

"The argument proceeded on complete misapprehension of the purpose of Act and even its explicit language. In fact the Act requires provider of service to be more objective and caretaking." (p.256)

Referring to the inclusive part of the definition it was said :

> "The inclusive clause succeeded in widening its scope but not exhausting the services which could be covered in earlier part. So any service except when it is free of charge or under a constraint of personal service is included in it." [p.257]

In that case the Court was dealing with the question whether housing construction could be regarded as service under Section 2(1)(o) of the Act. While the matter was pending in this Court, "housing construction" was inserted in the inclusive part by Ordinance No. 24 of 1993. Holding that housing activity is a service and was covered by the main part of the definition, the Court observed :

> "..... the entire purpose of widening the definition is to include in it not only day to day buying and selling activity undertaken by a common man but even such activities which are otherwise not commercial in nature yet they partake of a character in which some benefit is conferred on the consumer." [p.256]

In the present case the inclusive part of the definition of "service" is not applicable and we are required

to deal with the questions falling for consideration in the light of the main part and the exclusionary part of the definition. The exclusionary part will require consideration only if it is found that in the matter of consultation, diagnosis and treatment a medical practitioner or a hospital/nursing home renders a service falling within the main part of the definition contained in Section 2(1)(o) of the Act. We have, therefore, to determine whether medical practitioners and hospitals/nursing homes can be regarded as rendering a "service" as contemplated in the main part of Section 2(1)(o). This determination has to be made in the light of the aforementioned observations in Lucknow Development Authority (supra). We will first examine this question in relation to medical practitioners.

It has been contended that in law there is a distinction between a profession and an occupation and that while a person engaged in an occupation renders service which falls within the ambit of Section 2(1)(o) the service rendered by a person belonging to a profession does not fall within the ambit of the said provision and, therefore, medical practitioners who belong to the medical profession

are not covered by the provisions of the Act. It has been urged that medical practitioners are governed by the provisions of the Indian Medical Council Act, 1956 and the Code of Medical Ethics made by the Medical Council of India, as approved by the Government of India under Section 3 of the Indian Medical Council Act, 1956 which regulates their conduct as members of the medical profession and provides for disciplinary action by the Medical Council of India and/or State Medical Councils against a person for professional misconduct.

While expressing his reluctance to propound a comprehensive definition of a 'profession', Scrutton L.J. has said " 'profession' in the present use of language involves the idea of an occupation requiring either purely intellectual skill, or of manual skill controlled, as in painting and sculpture, or surgery, by the intellectual skill of the operator, as distinguished from an occupation which is substantially the production or sale or arrangement for the production or sale of commodities. The line of demarcation may vary from time to time. The word 'profession' used to be confined to the three learned professions, the Church,

Medicine and Law. It has now, I think, a wider meaning". [See : Commissioners of Inland Revenue v. Maxse, 1919 1 K.B. 647 at p.657].

According to Rupert M. Jackson and John L.Powell the occupations which are regarded as professions have four characteristics, viz.,

i) the nature of the work which is skilled and specialized and a substantial part is mental rather than manual;

ii) commitment to moral principles which go beyond the general duty of honesty and a wider duty to community which may transcend the duty to a particular client or patient;

iii) professional association which regulates admission and seeks to uphold the standards of the profession through professional codes on matters of conduct and ethics; and

iv) high status in the community.

The learned authors have stated that during the twentieth century an increasing number of occupations have been seeking and achieving "professional" status and that this has led inevitably to some blurring of the features which traditionally distinguish the professions from other occupations. In the context of the law relating to Professional Negligence the learned authors have accorded professional status to seven specific occupations, namely, (i) architects, engineers and quantity surveyors, (ii) surveyors, (iii) accountants, (iv) solicitors, (v) barristers, (vi) medical practitioners and (vii) insurance brokers. [See : Jackson & Powell on Professional Negligence, paras 1-01 and 1-03, 3rd Ed.n.].

In the matter of professional liability professions differ from other occupations for the reason that professions operate in spheres where success cannot be achieved in every case and very often success or failure depends upon factors beyond the professional man's control. In devising a rational approach to professional liability which must provide proper protection to the consumer while allowing for the factors mentioned above, the approach of the courts is to require that professional men should possess a certain

minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. In general, a professional man owes to his client a duty in tort as well as in contract to exercise reasonable care in giving advice or performing services. [See : Jackson & Powell (supra), paras 1-04, 1-05 and 1-56]. Immunity from suit was enjoyed by certain professions on the grounds of public interest. The trend is towards narrowing of such immunity and it is no longer available to architects in respect of certificates negligently given and to mutual valuers. Earlier, barristers were enjoying complete immunity but now even for them the field is limited to work done in court and to a small category of pre-trial work which is directly related to what transpires in court. [See : Jackson & Powell, (supra), para 1-66; Saif Ali v. Sidney Mitchell & Co., (1980) 1 A.C. 198; Rees v. Sinclair (1974) 1 N.Z.L.R. 180; Giannarelli v. Wraith (1988) 81 A.L.R. 417]. Medical practitioners do not enjoy any immunity and they can be sued in contract or tort on the ground that they have failed to exercise reasonable skill and care.

It would thus appear that medical practitioners, though belonging to the medical profession, are not immune from a claim for damages on the ground of negligence. The fact that they are governed by the Indian Medical Council Act and are subject to the disciplinary control of Medical Council of India and/or State Medical Councils is no solace to the person who has suffered due to their negligence and the right of such person to seek redress is not affected.

Referring to the changing position with regard to the relationship between the medical practitioners and the patients in the United Kingdom, it has been said :

> "Where, then, does the doctor stand today in relation to society? To some extent, he is a servant of the public, a public which is widely (though not always well) informed on medical matters. Society is conditioned to distrust paternalism and the modern medical practitioner has little wish to be paternalistic. The new talk is of 'producers and consumers' and the concept that 'he who pays the piper calls the tune' is established both within the profession and in its relationships with patients. The competent patient's inalienable rights to understand his treatment and to accept or refuse it are now well established." (pp.16-17)

> "Consumerism is now firmly established in medical practice - and this has been encouraged on a wide scale by government in the United Kingdom through

> the introduction of 'charters'. Complaint is central to this ethos - and the notion that blame must be attributed, and compensated, has a high priority." (p.192)
>
> [Mason & McCall Smith :Law and Medical Ethics, 4th Edn.]

In Arizona v. Maricopa County Medical Society, 457 US 332 = 73 L.Ed.(2d) 48, two Arizona county medical societies formed two foundations for medical care to promote fee-for-service medicine and to provide the community with a competitive alternative to existing health insurance plans and by agreement amongst the doctors established the schedule of maximum fees that participating doctors agreed to accept as payment in full for services performed for patients insured under plans. It was held that the maximum fee agreement, as price fixing agreements, are per se unlawful under the Sherman Act. It was observed :

> "Nor does the fact doctors - rather than non-professionals - are the parties to the price-fixing agreements support the respondents' position. ... The respondents claim for relief from the per se rule is simply that the doctors' agreement not to charge certain insureds more than a fixed price facilitates the successful marketing of an attractive insurance plan. But the claim that the price restraint will make it easier for customers to pay does not distinguish the medical profession from any other provider of goods or services." [pp. 348-49, 61-62]

We are, therefore, unable to subscribe to the view that merely because medical practitioners belong to the medical profession they are outside the purview of the provisions of the Act and the services rendered by medical practitioners are not covered by Section 2(1)(o) of the Act.

Shri Harish Salve, appearing for the Indian Medical Association, has urged that having regard to the expression 'which is made available to potential users' contained in Section 2(1)(o) of the Act, medical practitioners are not contemplated by Parliament to be covered within the provisions of the Act. He has urged that the said expression is indicative of the kind of service the law contemplates, namely, service of an institutional type which is really a commercial enterprise and open and available to all who seek to avail thereof. In this context, reliance has also been placed on the word 'hires' in sub-clause (ii) of the definition of 'consumer' contained in Section 2(1)(d) of the Act. We are unable to uphold this contention. The word 'hires' in Section 2(1)(d)(ii) has been used in the same sense as 'avails of' as would be evident from the words 'when such services are availed of' in the latter part of

Section 2(1)(d)(ii). By inserting the words 'or avails of' after the word 'hires' in Section 2(1)(d)(ii) by the Amendment Act of 1993, Parliament has clearly indicated that the word 'hires' has been used in the same sense as 'avails of'. The said amendment only clarifies what was implicit earlier. The word 'use' also means 'to avail oneself of'. [See : Black's Law Dictionary, 6th Edn., at p. 1541]. The word 'user' in the expression 'which is made available to potential users' in the definition of 'service' in Section 2(1)(o) has to be construed having regard to the definition of 'consumer' in Section 2(1)(d)(ii) and, if so construed, it means 'availing of services'. From the use of the word 'potential users' it cannot, therefore, be inferred that the services rendered by medical practitioners are not contemplated by Parliament to be covered within the expression 'service' as contained in Section 2(1)(o).

Shri Harish Salve has also placed reliance on the definition of the expression 'deficiency' as contained in Section 2(1)(g) of the Act which provides as follows :

"Section 2(1)(g) : "deficiency" means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service;"

The submission of Shri Salve is that under the said clause the deficiency with regard to fault, imperfection, shortcoming or inadequacy in respect of a service has to be ascertained on the basis of certain norms relating to quality, nature and manner of performance and that medical services rendered by a medical practitioner cannot be judged on the basis of any fixed norms and, therefore, a medical practitioner cannot be said to have been covered by the expression "service" as defined in Section 2(1)(o). We are unable to agree. While construing the scope of the provisions of the Act in the context of deficiency in service it would be relevant to take note of the provisions contained in Section 14 of the Act which indicate the reliefs that can be granted on a complaint filed under the Act. In respect of deficiency in service, the following reliefs can be granted :

i) return of the charges paid by the complainant. [Clause c)]

ii) payment of such amount as may be awarded as compensation to the consumer for any loss or injury suffered by the consumer due to the negligence of the opposite party. [Clause (d)]

iii) removal of the defects or deficiencies in the services in question. [Clause (e)]

Section 14(1)(d) would, therefore, indicate that the compensation to be awarded is for loss or injury suffered by the consumer due to the negligence of the opposite party. A determination about deficiency in service for the purpose of Section 2(1)(g) has, therefore, to be made by applying the same test as is applied in an action for damages for negligence. The standard of care which is required from medical practitioners as laid down by McNair J. in his direction to the jury in Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582, has been accepted by the House of Lords in a number of cases. [See : Whitehouse v. Jordan, 1981 (1) WLR 246; Maynard v. West Midlands, Regional Health Authority, 1984 (1) WLR 634; Sidaway v. Governors of Bethlem Royal Hospital, 1985 AC 871]. In

Bolam (supra) McNair J has said :

> "But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art." [p.586]

In an action for negligence in tort against a surgeon this Court, in Laxman Balakrishna Joshi v. Trimbak Bapu Godbole & Anr., 1969 (1) SCR 206, has held:

> "The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz., a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law require. [p.213]

It is, therefore, not possible to hold that in view of the definition of "deficiency" as contained in Section 2(1)(g) medical practitioners must be treated to be excluded from the ambit of the Act and the service rendered by them is not covered under Section 2(1)(o).

Another contention that has been urged by learned counsel appearing for the medical professio to exclude medical practitioners from the ambit of the Act is that the composition of the District Forum, the State Commission and the National Commission is such that they cannot fully appreciate the complex issues which may arise for determination and further that the procedure that is followed by these bodies for determination of issues before them is not suitable for the determination of the complicated questions which arise in respect of claims for negligence in respect of the services rendered by medical practitioners. The provisions with regard to the composition of the District Forum are contained in Section 10 of the Act which provides that the President of the Forum shall be a person who is or who has been or is qualified to be a District Judge and the other two

members shall be persons of ability, integrity and standing, having adequate knowledge or experience or, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration and one of them shall be a woman. Similarly, with regard to the composition of the State Commission, it is provided in Section 16 of the Act that the President of the Commission shall be a person who is or who has been a Judge of a High Court appointed by the State Government in consultation with the Chief Justice of the High Court and that the other two members shall be persons of ability, integrity and standing, having adequate knowledge or experience of, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration, and one of them shall be a woman. The composition of the National Commission is governed by Section 20 of the Act which provides that the President of the Commission shall be a person who is or who has been a Judge of the Supreme Court to be appointed by the Central Government after consultation with the Chief Justice of India and four other members shall be persons of ability, integrity

and standing having adequate knowledge or experience of, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration and one of them shall be a woman. It will thus be seen that the President of the District Forum is required to be a person who is or who has been or is qualified to be a District Judge and the President of the State Commission is required to be a person who is or who has been the Judge of the High Court and the President of the National Commission is required to be a person who is or who has been a Judge of the Supreme Court, which means that all the Consumer Disputes Redressal Agencies are headed by a person who is well versed in law and has considerable judicial or legal experience. It has, however, been submitted that in case there is difference of opinion, the opinion of the majority is to prevail and, therefore, the President may be out-voted by the other members and that there is no requirement that the members should have adequate knowledge or experience in dealing with problems relating to medicine. It is no doubt true that the decisions of the District Forum as well as the State Commission and the National Commission have

to be taken by majority and it may be possible in some cases that the President may be in minority. But the presence of a person well versed in law as the President will have a bearing on the deliberations of these Agencies and their decisions. As regards the absence of a requirement about a member having adequate knowledge or experience in dealing with the problems relating to medicine it may be stated that the persons to be chosen as members are required to have knowledge and experience in dealing with problems relating to various fields connected with the object and purpose of the Act, viz., protection and interests of the consumers. The said knowledge and experience would enable them to handle the consumer disputes coming up before them for settlement in consonance with the requirement of the Act. To say that the members must have adequate knowledge or experience in the field to which the goods or services, in respect of which the complaint is made, are related would lead to impossible situations. At one time there will be two members in the District Forum and they would have knowledge or experience in two fields which would mean that complaints in respect of goods or services relating to other fields would be beyond

the purview of the District Forum. Similarly in the State Commission there may be members having knowledge or experience in fields other than the fields in which the members of the District Forum have knowledge or experience. It would mean that the goods or services in respect of which the District Forum can entertain a complaint will be outside the purview of the State Commission. Same will be the position in respect of the National Commission. Since the goods or services in respect of which complaint can be filed under the Act may relate to number of fields it cannot be expected that the members of the Consumer Disputes Redressal Agencies must have expertise in the field to which the goods or services in respect of which complaint is filed, are related. It will be for the parties to place the necessary material and the knowledge and experience which the members will have in the fields indicated in the Act would enable them to arrive at their findings on the basis of that material. It cannot, therefore, be said that since the members of the Consumer Disputes Redressal Agencies are not required to have knowledge and experience in medicine, they are not in a position to deal with issues which may arise before them in proceed-

ings arising out of complaints about the deficiency in service rendered by medical practitioners.

Discussing the role of lay persons in decision making, Prof. White has referred to two divergent views. One view holds that lay adjudicators are superior to professional judges in the application of general standards of conduct, in their notions of reasonableness, fairness and good faith and that they act as 'an antidote against excessive technicality' and 'some guarantee that the law does not diverge too far from reality'. The other view, however, is that since they are not experts, lay decision makers present a very real danger that the dispute may not be resolved in accordance with the prescribed rules of law and the adjudication of claims may be based on whether the claimant is seen as deserving rather than on the legal rules of entitlement. Prof. White has indicated his preference for a Tribunal composed of a lawyer, as Chairman, and two lay members. Such a Tribunal, according to prof. White, would present an opportunity to develop a model of adjudication that combines the merits of lay decision making with legal competence and

participation of lay members would lead to general public confidence in the fairness of the process and widen the social experience represented by the decision makers. Prof. White says that apart from their breadth of experience, the key role of lay members would be in ensuring that procedures do not become too full of mystery and ensure that litigants before them are not reduced to passive spectators in a process designed to resolve their disputes. [See : Prof. Robin C.A. White : The Administration of Justice, 2nd Edition, p. 345].

In the matter of constitution of the District Forum, the State Commission and the National Commission the Act combines with legal competence the merits of lay decision making by members having knowledge and experience in dealing with problems relating to various fields which are connected with the object and purpose of the Act, namely, protection and interests of the consumers.

Moreover, there is a further safeguard of an

appeal against the order made by the District Forum to the State Commission and against the order made by the State Commission to the National Commission and a further appeal to this Court against the order made by the National Commission. It cannot, therefore, be said that the composition of the Consumer Disputes Redressal Agencies is such as to render them unsuitable for adjudicating on issues arising in a complaint regarding deficiency in service rendered by a medical practitioner.

As regards the procedure to be followed by these agencies in the matter of determination of the issues coming up for consideration it may be stated that under Section 13(2)(b), it is provided that the District Forum shall proceed to settle the consumer disputes (i) on the basis of evidence brought to its notice by the complainant and the opposite party, where the opposite party denies or disputes the allegations contained in the complaint, or (ii) on the basis of evidence brought to its notice by the complainant where the opposite party omits or fails to take any action to represent his case within the time given by the Forum. In

Section 13(4) of the Act it is further provided that the District Forum shall have the same powers as are vested in the civil court under the Code of Civil procedure while trying a suit in respect of the following matters:

> "(i) the summoning and enforcing attendance of any defendant or witness and examining the witness on oath;
>
> (ii) the discovery and production of any document or other material object producible as evidence;
>
> (iii) the reception of evidence on affidavits;
>
> (iv) the requisitioning of the report of the concerned analysis or test from the appropriate laboratory or from any other relevant source;
>
> (v) issuing of any commission for the examination of any witness and
>
> (vi) any other matter which may be prescribed."

The same provisions apply to proceedings before the State Commission and the National Commission. It has been urged that proceedings involving negligence in the matter of rendering services by a medical practitioner would raise complicated questions requiring evidence of experts to be

recorded and that the procedure which is followed for determination of consumer disputes under the Act is summary in nature involving trial on the basis of affidavits and is not suitable for determination of complicated questions. It is no doubt true that sometimes complicated questions requiring recording of evidence of experts may arise in a complaint about deficiency in service based on the ground of negligence in rendering medical services by a medical practitioner; but this would not be so in all complaints about deficiency in rendering services by a medical practitioner. There may be cases which do not raise such complicated questions and the deficiency in service may be due to obvious faults which can be easily established such as removal of the wrong limb or the performance of an operation on the wrong patient or giving injection of a drug to which the patient is allergic without looking into the out patient card containing the warning [as in Chinkeow v. Government of Malaysia, (1967) 1 WLR 813 P.C.] or use of wrong gas during the course of an anesthetic or leaving inside the patient swabs or other items of operating equipment after surgery. One often reads about such Encidents in the newspapers. The

issues arising in the complaints in such cases can be speedily disposed of by the procedure that is being followed by the Consumer Disputes Redressal Agencies and there is no reason why complaints regarding deficiency in service in such cases should not be adjudicated by the Agencies under the Act. In complaints involving complicated issues requiring recording of evidence of experts, the complainant can be asked to approach the civil court for appropriate relief. Section 3 of the Act which prescribes that the provisions of the Act shall be in addition to and not in derogation of the provisions of any other law for the time being in force, preserves the right of the consumer to approach the civil court for necessary relief. We are, therefore, unable to hold that on the ground of composition of the Consumer Disputes Redressal Agencies or on the ground of the procedure which is followed by the said Agencies for determining the issues arising before them, the service rendered by the medical practitioners are not intended to be included in the expression 'service' as defined in Section 2(1)(o) of the Act.

Keeping in view the wide amplitude of the definition of 'service' in the main part of Section 2(1)(o) as construed by this Court in Lucknow Development Authority (supra), we find no plausible reason to cut down the width of that part so as to exclude the services rendered by a medical practitioner from the ambit of the main part of Section 2(1)(o).

We may now proceed to consider the exclusionary part of the definition to see whether such service is excluded by the said part. The exclusionary part excludes from the main part service rendered (i) free of charge; or (ii) under a contract of personal service.

Shri Salve has urged that the relationship between a medical practitioner and the patient is of trust and confidence and, therefore, it is in the nature of a contract of personal service and the service rendered by the medical practitioner to the patient is not 'service' under Section 2(1)(o) of the Act. This contention of Shri Salve ignores the well recognised distinction between a 'contract of service' and a 'contract for services'. [See : Halsbury's Laws of England, 4th Edn., Vol. 16, para 501; Dharangadhara

Chemical Works Ltd. v. State of Saurashtra, 1957 SCR 152 at p. 157]. A 'contract for services' implies a contract whereby one party undertakes to render services e.g. professional or technical services, to or for another in the performance of which he is not subject to detailed direction and control but exercises professional or technical skill and uses his own knowledge and discretion. [See : Oxford Companion to Law, p. 1134]. A 'contract of service' implies relationship of master and servant and involves an obligation to obey orders in the work to be performed and as to its mode and manner of performance. [See : Stroud's Judicial Dictionary, 5th Edn., p. 540; Simmons v. Heath Laundry Co. (1910) 1 K.B. 543; and Dharangadhara Chemical Works (supra) at p. 159]. We entertain no doubt that Parliamentary draftsman was aware of this well accepted distinction between "contract of service" and "contract for services" and has deliberately chosen the expression 'contract of service' instead of the expression 'contract for services', in the exclusionary part of the definition of 'service' in Section 2(1)(o). The reason being that an employer cannot be regarded as a consumer in respect of the services rendered by his employee in pursuance of a contract of employment. By

affixing the adjective 'personal' to the word "service" the nature of the contracts which are excluded is not altered. The said adjective only emphasizes that what is sought to be excluded is personal service only. The expression "contract of personal service" in the exclusionary part of Section 2(1)(o) must, therefore, be construed as excluding the services rendered by an employee to his employer under the contract of personal service from the ambit of the expression "service".

It is no doubt true that the relationship between a medical practitioner and a patient carries within it certain degree of mutual confidence and trust and, therefore, the services rendered by the medical practitioner can be regarded as services of personal nature but since there is no relationship of master and servant between the doctor and the patient the contract between the medical practitioner and his patient cannot be treated as a contract of personal service but is a contract for services and the service rendered by the medical practitioner to his patient under such a contract is not covered by the exclusionary part of the definition of 'service' contained in Section 2(1)(o) of the Act.

Shri Rajeev Dhavan has, however, submitted that the expression 'contract of personal service' contained in Section 2(1)(o) of the Act has to be confined to employment of domestic servants only. We do not find any merit in this submission. The expression 'personal service' has a well known legal connotation and has been construed in the context of the right to seek enforcement of such a contract under the Specific Relief Act. For that purpose a contract of personal service has been held to cover a civil servant, the managing agents of a company and a professor in the University. [See : The High Commissioner for India v. I.M.Lall, (1948) L.R. 75 I.A.225; Ram Kissendas Dhanuka v. Satya Charan Law, (1949) L.R. 77 I.A.128; and Dr. S.B.Dutt v. University of Delhi, 1959 SCR 1236]. There can be a contract of personal service if there is relationship of master and servant between a doctor and the person availing his services and in that event the services rendered by the doctor to his employer would be excluded from the purview of the expression 'service' under Section 2(1)(o) of the Act by virtue of the exclusionary clause in the said definition.

The other part of exclusionary clause relates to services rendered "free of charge". The medical

practitioners, Government hospitals/nursing homes and private hospitals/nursing homes (hereinafter called "doctors and hospitals") broadly fall in three categories :-

i) where services are rendered free of charge to everybody availing the said services.

ii) where charges are required to be paid by everybody availing the services and

iii) where charges are required to be paid by persons availing services but certain categories of persons who cannot afford to pay are rendered service free of charges.

There is no difficulty in respect of first two categories. Doctors and hospitals who render service without any charge whatsoever to every person availing the service would not fall within the ambit of "service" under Section 2(1) (o) of the Act. The payment of a token amount for registration purposes only would not alter the position in respect of such doctors and hospitals. So far as the second category is concerned, since the service is rendered on payment basis to all the persons they would clearly fall within the ambit of Section 2(1) (o) of the Act. The third category of doctors and hospitals do provide free service to some of the patients belonging to the poor class but the bulk of the service is

rendered to the patients on payment basis. The expenses incurred for providing free service are met out of the income from the service rendered to the paying patients. The service rendered by such doctors and hospitals to paying patients undoubtedly fall within the ambit of Section 2(1) (o) of the Act.

The question for our consideration is whether the service rendered to patients fee of charge by the doctors and hospitals in category (iii) is excluded by virtue of the exclusionary clause in Section 2(1) (o) of the Act. In our opinion the question has to be answered in the negative. In this context it is necessary to bear in mind that the Act has been enacted "to provide for the protection of the interests of "consumers" in the background of the guidelines contained in the Consumer Protection Resolution passed by the U.N.General Assembly on April 9, 1985. These guidelines refer to "achieving or maintaining adequate protection for their population as consumers" and "encouraging high levels of ethical conduct for those engaged in the protection and distribution of goods and services to the consumers". The protection that is envisaged by the Act is, therefore, protection for consumers as a class. The word "users" (in

plural), in the phrase 'potential users' in Section 2(1) (o) of the Act also gives an indication that consumers as a class are contemplated. The definition of 'complainant' contained in Section 2(b) of the Act which includes, under clause (ii), any voluntary consumer association, and clauses (b) and (c) of Section 12 which enable a complaint to be filed by any recognised consumer association or one or more consumers where there are numerous consumers, having the same interest, on behalf of or for the benefit of all consumers so interested, also lend support to the view that the Act seeks to protect the interests of consumers as a class. To hold otherwise would mean that the protection of the Act would be available to only those who can afford to pay and such protection would be denied to those who cannot so afford, though they are the people who need the protection more. It is difficult to conceive that the legislature intended to achieve such a result. Another consequence of adopting a construction, which would restrict the protection of the Act to persons who can afford to pay for the services availed by them and deny such protection to those who are not in a position to pay for such services, would be that the standard and quality of service rendered at an establishment would

cease to be uniform. It would be of a higher standard and of better quality for persons who are in a position to pay for such service while the standard and quality of such service would be inferior for person who cannot afford to pay for such service and who avail the service without payment. Such a consequence would defeat the object of the Act. All persons who avail the services by doctors and hospitals in category (iii), are required to be treated on the same footing irrespective of the fact that some of them pay for the service and others avail the same free of charge. Most of the doctors and hospitals work on commercial lines and the expenses incurred for providing services free of charge to patients who are not in a position to bear the charges are met out of the income earned by such doctors and hospitals from services rendered to paying patients. The Government hospitals may not be commercial in that sense but on the overall consideration of the objectives and the scheme of the Act it would not be possible to treat the Government hospitals differently. We are of the view that in such a situation the persons belonging to "poor class" who are provided services free of charge are the beneficiaries of the service which is hired or availed of by the "paying class".

We are, therefore, of opinion that service rendered by the doctors and hospitals falling in category (iii) irrespective of the fact that part of the service is rendered free of charge, would nevertheless fall within the ambit of the expression "service" as defined in Section 2(1) (o) of the Act. We are further of the view that persons who are rendered free service are the "beneficiaries" and as such come within the definition of "consumer" under Section 2(1) (d) of the Act.

In respect of the hospitals/nursing homes (Government and non-Government) falling in category (i), i.e., where services are rendered free of charge to everybody availing the services, it has been urged by Shri Dhavan that even though the service rendered at the hospital, being free of charge, does not fall within the ambit of Section 2(1)(o) of the Act in so far as the hospital is concerned, the said service would fall within the ambit of Section 2(1)(o) since it is rendered by a medical officer employed in the hospital who is not rendering the service free of charge because the said medical officer receives amoluments by way of salary for employment in the hospital. There is no merit in this contention. The medical officer who is employed in the hospital

renders the service on behalf of the hospital administration and if the service, as rendered by the hospital, does not fall within the ambit of Section 2(1) (o), being free of charge, the same service cannot be treated as service under Section 2(1)(o) for the reason that it has been rendered by a medical officer in the hospital who receives salary for employment in the hospital. There is no direct nexus between the payment of the salary to the medical officer by the hospital administration and the person to whom service is rendered. The salary that is paid by the hospital administration to the employee medical officer cannot be regarded as payment made on behalf of the person availing the service or for his benefit so as to make the person availing the service a "consumer" under Section 2(1)(d) in respect of the service rendered to him. The service rendered by the employee medical officer to such a person would, therefore, continue to be service rendered free of charge and would be outside the purview of Section 2(1)(o).

A contention has also been raised that even in the Government hospitals/health centres/dispensaries where services are rendered free of charge to all the patients the provisions of the Act shall apply because the expenses of

running the said hospitals are met by appropriation from the Consolidated Fund which is raised from the taxes paid by the tax payers. We do not agree.

The essential characteristics of a tax are that (i) it is imposed under statutory power without the tax-payer's consent and the payment is enforced by law; (ii) it is an imposition made for public purpose without reference to any special benefit to be conferred on the payer of the tax' and (iii) it is part of the common burden, the quantum of imposition upon the tax payer depends generally upon his capacity to pay. [See : The Commissioner, Hindu Religious Endowments, Madras v. Sri lakshmindra Thirtha Swamiar of Sri Shirur Mutt, 1954 SCR 1005 at pp.1040-41]. The tax paid by the person availing the service at a Government hospital cannot be treated as a consideration or charge for the service rendered at the said hospital and such service though rendered free of charge does not cease to be so because the person availing the service happens to be a tax payer.

Adverting to the individual doctors employed and serving in the hospitals, we are of the view that such doctors working in the hospitals/nursing homes/dispensaries/ whether Government or private - belonging to categories (ii)

and (iii) above would be covered by the definition of "service" under the Act and as such are amenable to the provisions of the Act along with the management of the hospital, etc. jointly and severally.

There may, however, be a case where a person has taken an insurance policy for medi-care whereunder all the charges for consultation, diagnosis and medical treatment are borne by the insurance company. In such a case the person receiving the treatment is a beneficiary of the service which has been rendered to him by the medical practitioner, the payment for which would be made by the insurance company under the insurance policy. The rendering of such service by the medical practitioner cannot be said to be free of charge and would, therefore, fall within the ambit of the expression 'service' in Section 2(1) (o) of the Act. So also there may be cases where as a part of the conditions of service the employer bears the expense of medical treatment of the employee and his family members dependent on him. The service rendered to him by a medical practitioner would not be free of charge and would, therefore, constitute service under Section 2(1) (o).

Shri A.M.Singhvi has invited our attention to the

following observations of Lord Denning M.R. in Whitehouse v. Jordan & Anr., (1980) 1 All.E.R. 650 :

> "Take heed of what has happened in the United States. 'Medical malpractice' cases there are very worrying, especially as they are tried by juries who have sympathy for the patient and none for the doctor, who is insured. The damages are colossal. The doctors insure but the premiums become very high : and these have to be passed on in fees to the patients. Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved. In the interests of all, we must avoid such consequences in England. Not only must we avoid excessive damages. We must say, and say firmly, that, in a professional man, an error of judgment is not negligent." [p.658]

Relying on these observations learned counsel has painted a grim picture that if medical practitioners are brought within the purview of the Act the consequence would be huge increase in medical expenditure on account of insurance charges as well as tremendous increase in defensive medicine and that medical practitioners may refuse to attend to medical emergencies and there will be no safeguards against frivolous and vexatious complaints and consequent blackmail. We do not entertain such an apprehension. In the first place, it may be stated that the aforementioned observations of Lord Denning were made in the context of

substantive law governing actions for damages on the ground of negligence against medical practitioners. There too the last sentence in the said observations that "an error of judgment is not negligent" has not been approved, in appeal, by the House of Lords. [See : 1981 (1) All. E.R. 267]. By holding that medical practitioners fall within the purview of the Act no change is brought about in the substantive law governing claims for compensation on the ground of negligence and the principles which apply to determination of such a claim before the civil court would equally apply to consumer disputes before the Consumer Disputes Redressal Agencies under the Act. The Act only provides an inexpensive and a speedy remedy for adjudication of such claims. An analytical study of tort litigation in India during the period from 1975 to 1985 made by Prof. Galanter reveals that a total number of 416 tort cases were decided by the High Courts and this Court, as reported in the All India Reporter, out of which 360 cases related to claims under the Motor Vehicles Act and cases relating to medical malpractice were only three in number. [See : Upendra Baxi and Thomes Paul, Mass Disasters and Multinational Liability, The Bhopal Case, pp. 214-218]. One of the factors inhibiting such claims is the requirement

regarding court fee that must be paid by the plaintiff in an action for damages on the ground of negligence. Since no court fee is required to be paid on a complaint filed under the Act it would be possible for persons who have suffered injury due to deficiency in service rendered by medical practitioners or at hospitals/nursing homes to seek redress. The conditions prevailing in India cannot, therefore, be compared with those in England and in the United States.

As regards the criticism of the American malpractice litigation by the British judiciary it has been said :

> "Discussion of these important issues is sometimes clouded by an over-simplistic comparison between England and American "malpractice" litigation. Professor Miller noted in 1986 that malpractice claims were brought in the United States nearly 10 times as often as in England, and that this is due to a complex combination of factors, including cultural differences, judicial attitudes, differences in the legal system and the rules about costs. She points to the deterrent value of malpractice litigation and resent some of the criticisms of the American system expressed by the British judiciary. Interestingly, in 1989 the number of medical negligence claims and the size of medical malpractice insurance premiums started to fall in New York, California and many other states. It is thought that this is due in part to legislation in a number of states limiting medical malpractice claims, an in part to improved patient care as a result of litigation."

[Jackson & Powell on Professional Liability, 3rd Edn., para 6-25, p. 466]

Dealing with the present state of medical negligence cases in the United Kingdom it has been observed :

> "The legal system, then, is faced with the classic problem of doing justice to both parties. The fears of the medical profession must be taken into account while the legitimate claims of the patient cannot be ignored.
>
> Medical negligence apart, in practice, the courts are increasingly reluctant to interfere in clinical matters. What was once perceived as a legal threat to medicine has disappeared a decade later. While the court will accept the absolute right of a patient to refuse treatment, they will, at the same time, refuse to dictate to doctors what treatment they should give. Indeed, the fear could be that, if anything, the pendulum has swung too far in favour of therapeutic immunity."[p. 16]
>
> "It would be a mistake to think of doctors and hospitals as easy targets for the dissatisfied patient. It is still very difficult to raise an action of medical negligence in Britain; some, such as the Association of the Victims of Medical Accidents, would say that it is unacceptably difficult. Not only are there practical difficulties in linking the plaintiff's injury to medical treatment, but the standard of care in medical negligence cases is still effectively defined by the profession itself. All these factors, together with the sheer expense of bringing legal action and the denial of legal aid to all but the poorest, operate to inhibit medical litigation in a way in which the American system, with its contingency fees and its sympathetic juries, does not.

> It is difficult to single out any one cause for what increase there has been in the volume of medical negligence actions in the United Kingdom. A common explanation is that there are, quite simply, more medical accidents occurring - whether this be due to increased pressure on hospital facilities, to falling standards of professional competence or, more probably, to the ever-increasing complexity of therapeutic and diagnostic methods." [p. 191]
>
> "A patient who has been injured by an act of medical negligence has suffered in a way which is recognised by the law - and by the public at large - as deserving compensation. This loss may be continuing and what may seem like an unduly large award may be little more than that sum which is required to compensate him for such matters as loss of future earnings and the future cost of medical or nursing care. To deny a legitimate claim or to restrict arbitrarily the size of an award would amount to substantial injustice. After all, there is ino difference in legal theory between the plaintiff injured through medical negligence and the plaintiff injured in an industrial or motor accident." [pp. 192-93]
>
> [Mason's Law and Medical Ethics, 4th Edn.]

We are, therefore, not persuaded to hold that in view of the consequences indicated by Lord Denning in Whitehouse v. Jorden (supra) medical practitioners should be excluded from the purview of the Act.

On the basis of the above discussion we arrive at the following conclusions:

(1) Service rendered to a patient by a medical practitioner (except where the doctor renders service free of charge to every patient or under a contract of personal service), by way of consultation, diagnosis and treatment, both medicinal and surgical, would fall within the ambit of 'service' as defined in Section 2(1)(o) of the Act.

(2) The fact that medical practitioners belong to the medical profession and are subject to the disciplinary control of the Medical Council of India and/or State Medical Councils constituted under the provisions of the Indian Medical Council Act would not exclude the services rendered by them from the ambit of the Act.

(3) A 'contract of personal service' has to be distinguished from a 'contract for personal services'. In the absence of a relationship of master and servant between the patient and medical practitioner, the service rendered by a medical practitioner to the patient cannot be regarded as service rendered under a 'contract of personal service'. Such service is service rendered under a

'contract for personal services' and is not covered by exclusionary clause of the definition of 'service' contained in Section 2(1)(o) of the Act.

(4) The expression 'contract of personal service' in Section 2(1)(o) of the Act cannot be confined to contracts for employment of domestic servants only and the said expression would include the employment of a medical officer for the purpose of rendering medical service to the employer. The service rendered by a medical officer to his employer under the contract of employment would be outside the purview of 'service' as defined in Section 2(1)(o) of the Act.

(5) Service rendered free of charge by a medical practitioner attached to a hospital/Nursing home or a medical officer employed in a hospital/Nursing home where such services are rendered free of charge to everybody, would not be "service" as defined in Section 2(1)(o) of the Act. The payment of a token amount for registration purpose only at the hospital/nursing home would not alter the position.

(6) Service rendered at a non-Government hospital/Nursing home where no charge whatsoever is made from any person availing the service and all patients (rich and poor) are given free service - is outside the purview of the expression 'service' as defined in Section 2(1)(o) of the Act. The payment of a token amount for registration purpose only at the hospital/Nursing home would not alter the position.

(7) Service rendered at a non-Government hospital/Nursing home where charges are required to be paid by the persons availing such services falls within the purview of the expression 'service' as defined in Section 2(1)(o) of the Act.

(8) Service rendered at a non-Government hospital/Nursing home where charges are required to be paid by persons who are in a position to pay and persons who cannot afford to pay are rendered service free of charge would fall within the ambit of the expression 'service' as defined in Section 2(1)(o) of the Act irrespective of the fact that the service is rendered free of charge to persons

who are not in a position to pay for such services. Free service, would also be "service" and the recipient a "consumer" under the Act.

(9) Service rendered at a Government hospital/health centre/dispensary where no charge whatsoever is made from any person availing the services and all patients (rich and poor) are given free service - is outside the purview of the expression 'service' as defined in Section 2(1)(o) of the Act. The payment of a token amount for registration purpose only at the hospital/nursing home would not alter the position.

(10) Service rendered at a Government hospital/health centre/dispensary where services are rendered on payment of charges and also rendered free of charge to other persons availing such services would fall within the ambit of the expression 'service' as defined in Section 2(1)(o) of the Act irrespective of the fact that the service is rendered free of charge to persons who do not pay for such service. Free service would also be

"service" and the recipient a "consumer" under the Act.

(11) Service rendered by a medical practitioner or hospital/nursing home cannot be regarded as service rendered free of charge, if the person availing the service has taken an insurance policy for medical care whereunder the charges for consultation, diagnosis and medical treatment are borne by the insurance company and such service would fall within the ambit of 'service' as defined in Section 2(1)(o) of the Act.

(12) Similarly, where, as a part of the conditions of service, the employer bears the expenses of medical treatment of an employee and his family members dependent on him, the service rendered to such an employee and his family members by a medical practitioner or a hospital/nursing home would not be free of charge and would constitute 'service' under Section 2(1)(o) of the Act.

In view of the conclusions aforementioned the judgment of the National Commission dated April 21, 1992 in

First Appeal No. 48 of 1991 [M/s Cosmopolitan Hospitals & Anr. v. Smt. Vasantha P.Nair] and the judgment dated November 16, 1992 in First Appeal No. 97 of 1991 [Dr. Sr. Louie & Anr. v. Smt. Kannolil Pathumma & Anr.] holding that the activity of providing medical assistance for payment carried on by hospitals and members of the medical profession falls within the scope of the expression 'service' as defined in Section 2(1)(o) of the Act and that in the event of any deficiency in the performance of such service the aggrieved party can invoke the remedies provided under the Act by filing a complaint before the Consumer Forum having jurisdiction, must be upheld and Civil Appeal Nos. 688/93 and 689/93 and S.L.P.(Civil) Nos. 6885/92, 6950/92 and 351/93 filed against the said judgment have to be dismissed. The National Commission in its judgment dated May 3, 1993 in O.P. No. 93/92 has held that since the treatment that was given to the deceased husband of the complainant in the nursing home belonging to the opposite party was totally free of any charge it does not constitute 'service' as defined in Section 2(1)(o) of the Act. The Tribunal has not considered the question whether services are rendered free of charge to all the patients availing services in the said nursing home or

such services are rendered free of charge only to some of the patients and are rendered on payment of charges to the rest of the patients. Unless it is found that the services are rendered free of charge to all the patients availing services at the nursing home, it cannot be held that the said services do not constitute 'service' as defined in Section 2(1)(o) of the Act. Civil Appeal No. 254/94 has, therefore, to be allowed and the matter has to be remitted to the National Commission for consideration in the light of this judgment. The judgment of the Madras High Court in Dr. C.S. Subramaniam v. Kumaraswamy & Anr. (supra), holding that the services rendered to a patient by a medical practitioner or a hospital by way of diagnosis and treatment, both medicinal and surgical, would not come within the definition of 'service' in Section 2(1)(o) and a patient who undergoes treatment under a medical practitioner or a hospital by way of diagnosis and treatment, both medicinal and surgical, cannot be considered to be a 'consumer' within the meaning of Section 2(1)(d) of the Act cannot be sustained and Civil Appeals Nos. 4664-65/94 as well as Civil Appeals arising out of S.L.P.(Civil) Nos. 21775/94 and 18445-73/94 have to be allowed and the said judgment of the Madras High Court has to be set aside and the

writ petitions disposed of by the said judgment have to be dismissed. The judgment of the National Commission dated December 15, 1989 in First Appeal No. 2 of 1989 holding that services rendered in Government hospitals are not covered by the expression 'service' as defined in Section 2(1)(o) of the Act cannot be upheld in its entirety but can be upheld only to the extent as indicated in conclusion No.9. Civil Appeal arising out of S.L.P.(Civil) No. 18497/93 has to be allowed and the complaint has to be remitted to the State Commission for consideration in the light of this judgment. S.L.P.(Civil) Nos. 21348-21349/93 have been filed against the judgment of the Kerala High Court dated October 6, 1993 in Writ Petitions filed on behalf of the hospitals claiming that the services rendered by the hospitals do not fall within the ambit of Section 2(1)(o) of the Act. The said Writ Petitions were dismissed by the High Court having regard to the decision of the National Commission in Cosmopolitan Hospital (supra) and the pendency of appeal against the said decision before this Court. Since the decision of the National Commission in Cosmopolitan Hospital (supra) is being upheld by us, S.L.P.(Civil) Nos. 21348-21349/93 have to be dismissed.

Writ Petition (Civil) No. 16/94 has been filed by the Cosmopolitan Hospital (P) Ltd. and Dr. K. Venugopalan Nair who have also filed S.L.P.(Civil) Nos. 6885/92 and 6950/92 against the judgment of the National Commission dated April 21, 1992. In the Writ Petition, the said writ petitioners have sought a declaration that the provisions of the Act are not applicable to alleged deficiency in medical service and that if the said provisions are held to be applicable to the medical profession and hospitals the same may be declared as unconstitutional as being violative of Articles 14 and 19(1)(g) of the Constitution. As regards the first part of the prayer regarding the applicability of the provisions of the Act to the alleged deficiency in medical service, we have already considered the matter and found that the provisions of the Act are applicable to deficiency in service rendered by medical practitioners and hospitals and for the same reason the said prayer cannot be allowed. The other prayer sought for in the Writ Petition regarding the validity of the provisions of the Act is also without any substance. The ground on which the writ petitioners are seeking to assail the validity of the provisions of the Act is that the composition of the Consumer

Disputes Redressal Agencies and the procedure to be followed by the said Agencies is such that it is not suitable for adjudication of the complex issues arising for consideration. We have already considered this grievance urged on behalf of the medical profession and have found that the composition of the Consumer Disputes Redressal Agencies as well as the procedure to be followed by them does not preclude a proper adjudication of the consumer disputes arising out of complaints relating to deficiency in service rendered by medical practitioners and hospitals. In our opinion, no case is made out that the Act suffers from the vice of arbitrariness or unreasonableness so as to be violative of Articles 14 and 19(1)(g) of the Constitution. There is, therefore, no merit in the Writ Petition and it has to be dismissed.

In the result Civil Appeals Nos. 688/93 and 689/93, and S.L.P.(Civil) Nos. 6885/92 and 6950/92 are dismissed. The State Commission will deal with the complaints in the light of this judgment. S.L.P.[Civil] Nos. 351/93 and 21348-21349/93 and Writ Petition (Civil) No. 16/94 are also dismissed. Civil Appeal No. 254/94 is allowed and the judgment of the National Commission dated May 3, 199 is

set aside and O.P.No. 93/92 is remitted to the National Commission for consideration in the light of this judgment. Civil Appeals Nos. 4664-65/94 and Civil Appeals arising out of S.L.P.(Civil) Nos. 21755/94 and 18445-73/94 are allowed and the judgment of the Madras High Court dated February 17, 1994 is set aside and the writ petitions disposed of by the said judgment of the High Court are dismissed and as a result the Consumer Disputes Redressal Agencies would deal with the complaint petitions covered by those writ petitions in the light of this judgment. Civil Appeal arising out of S.L.P.(Civil) No. 18497/93 is also allowed and Complaint Case No. 1 of 1988 is remitted to the State Commission for consideration in the light of this judgment. No order as to costs.

.....J.
[KULDIP SINGH]

.....J.
[S.C. AGRAWAL]

.....J.
[B.L. HANSARIA]

New Delhi,
November 13, 1995.

BRIEFING PAPER

कट्स CUTS
CONSUMER UNITY
& TRUST SOCIETY

Nº. 1/MAY, 1995

ACCESS TO THE CONSTITUTION – A NEGLECTED RIGHT

Introduction

We, the People of India, have given ourselves a Constitution so that there is a rule of law to enable good governance and proper conduct of one citizen against another, and the State. The Constitution has been printed by the government in English and all major languages of the country. The purpose of a written Constitution is that we can know about our country's structure and governance, and our rights and duties by reading the text of the Constitution.

It is reasonably expected that a citizen, desirous of knowing about his or her constitutional rights and duties, more particularly the fundamental rights, would only have to get hold of the text of the Constitution, which, being a complete document, will give a fair understanding of the rights.

In addition to the Constitution, what the Supreme Court says is the law of the land. The Constitution itself is not static. It is dynamic and can be amended by the State to give meaning to it according to the need of the hour. Over 74 amendments have been carried out till now. The last two related to empowering people by legislating better laws for local government i.e. panchayat raj and municipal system.

Does the Constitution give a comprehensive idea about the rights as expanded by the apex court? Is it a complete document ? It is not.

This Briefing Paper examines few key judgements and concludes by advocating why a comprehensive amendment to Articles 19 and 21 of the Constitution is necessary to give proper meaning to the same and empower citizens fully.

Fundamental Rights ?

There are several fundamental rights, but the principal ones are:

- Art.14 - the right to equality before law;
- Art.15 - prohibition against discrimination on grounds of religion, race, caste, sex, or place of birth;
- Art.16 - equality of opportunity in matters of public employment;
- Art.17 - abolition of untouchability;
- Art.19 - freedoms of speech etc.;
- Art.21 - protection of life and personal liberty ;
- Art.22 - protection against arrest and detention etc.

Article 19(1) of the Constitution guarantees to the citizens of India the six fundamental freedoms which are exercisable by them throughout and in all parts of the Union of India. The enumerated freedoms are : (a) freedom of speech and expression, (b) freedom of

assembly, (c) freedom of association, (d) freedom of movement, (e) freedom of residence, [(f) 'the right to property' was dropped by the 1st amendment in 1951] and (g) freedom of profession, occupation, trade or business.

"These rights are not exhaustive of all the rights of a free man who has far more and wider rights", ruled the Supreme Court in A. K. Gopalan vs. State of Madras [AIR 1950 SC 27, 110].

Are these rights justiciable ?

Yes, the fundamental rights are justiciable and the Supreme Court can be approached under Art.32 for any violation of the rights by the State. Several writs have been filed before the Supreme Court particularly for violation of the fundamental rights at Articles 14, 19, 21 and 22.

Most of the public interest cases relate to violation of fundamental rights. **"Article 32 is designed for the enforcement of Fundamental Rights of a citizen by the Apex Court. It provides for an extraordinary procedure to safeguard the Fundamental Rights of a citizen,"** said the Supreme Court in Subhash Kumar vs. State of Bihar [AIR 1991 SC 420]. Article 226 of the Constitution empowers a citizen to approach a High Court for violation of the fundamental rights. Though it creates a precedence, it is not the law of the country, unless settled by the Supreme Court.

The Supreme Court, while interpreting some provisions of the Constitution, have often extended the peripheries of the Articles so as to include some rights which are not there explicitly in the Constitution. And according to the Constitution, interpretations by the Supreme Court become binding on all the lower courts and therefore become the law of the land.

Art.22 read with Art.21 gives protection against state terrorism or tyranny in detaining a person without due process of law through a *habeas corpus* petition. Art.19 has been expanded to include the right to know, while Art.21, the right to satisfaction of basic needs, the right to a healthy environment and the right to health through various judgements. The mockery of such rights, namely in the form of ignorance and non-enforcement, is another story.

In this paper we are focusing on only two of the Articles in the Part III of the Constitution, i.e. 19 and 21, expansion of which will undoubtedly show how important it is to rewrite some of the provisions of our Constitution.

The right to know

Unlike the U.S. Constitution, Article 19(1)(a) does not expressly mention the liberty of press, i.e. the freedom to print and to publish what one pleases without previous permission. But it is settled law that the right to freedom of speech and expression includes the liberty of the press. [Sakal Papers (P) Ltd. vs. Union of India, AIR 1962 SC 305; Express Newspapers (P) Ltd. vs. Union of India, AIR 1958 SC 578; Brij Bhusan vs. State of Delhi, AIR 1950 SC 129.]

The Rajasthan High Court, in the matter of L.K.Koolwal vs. State of Rajasthan [AIR 1988 RAJ 2] which challenged the negligence of the city administration for not ameliorating the unhygenic conditions prevailing in Jaipur city, said: "Citizen has a right to know about the activities of the State. The privilege of secrecy which existed in the old times that the State is not bound to disclose the facts to the citizens or the State cannot be compelled by the citizens to disclose the facts does not survive now to a great extent. Under Article 19(1)(a) of the Constitution there exists the right of freedom of speech. Freedom of speech is based on the foundation of the freedom of the right to know."

The Government of India in the Ministry of Environment and Forests itself published a booklet in 1993 advocating the citizens' right to know based on a public interest litigation involving urban zoning plans in Pune cantonment area. In an appeal concerning the case: Bombay Environmental Action Group and others vs. Pune Cantonment Board, decided by the Bombay High Court, the Supreme Court ruled:

"We would also direct that any person residing within the area of a local authority or any social action group or interest group or pressure group shall be entitled to take inspection of any sanction granted or plan approved by such local authority in construction of buildings along with the related papers and documents if such individual or social action group or interest group or pressure group wishes to take such inspection, except of course in cases where in the interests of security of such inspection cannot be granted."

In M.C.Mehta vs. Union of India [AIR 1992 SC 382] wherein the noted environmental lawyer sought directions propogating education on environmental pollution to the people through the government controlled mass media, the apex court ruled: **"We are a democratic polity where dissemination of information is the foundation of the system. Keeping the citizens informed is an obligation of the government."**

The Supreme Court in the famous case of S. P. Gupta vs. President of India [AIR 1982 SC 149], popularly known as the Judges case, which established the locus standi of citizens to raise public interest issues before the apex court, held:

"This is the new democratic culture of an open society towards which every liberal democracy is moving and our country is no exception. The concept of an open government is the direct emanation from the right to know which is implicit in the right of free speech and expression guaranteed under Article 19(1)(a). Therefore, disclosures of information in regard to the functioning of Government must be the rule and

secrecy and exception justified only where the strictest requirement of public interest so demands."

Article 21, the most flexible !

Article 21 is, perhaps, the most flexible of the fundamental rights provisions. The Supreme Court held that right to life included the right to means of livelihood and right to human dignity [SCC 1993 Vol.III p. 259, 584]. Can a person have the slightest idea about this extended meaning of right to life if he or she goes through Article 21 in its present form?

Article 21 has been expanded in a number of cases to safeguard the rights of specially positioned persons and to include some special rights. The Article has been invoked to protect the rights of prisoners, the rights of inmates of protective homes, right to legal aid, right to speedy trial, right against cruel, inhuman and unusual punishment, right of release and rehabilitation of bonded labour, right to compensation, right to health and right to healthy environment.

In Francis Coralie vs. Union Territory of Delhi [(1981) 1 SCC 608; AIR 1981 SC 746], it was held "that any act which damages or injures or interferes with the use of any limb or faculty of a person, either permanently or even temporarily, would be within the inhibition of Article 21".

To live with human dignity

In the same case, the noted activist judge and former Chief Justice of India, P.N.Bhagwati, said: "**We think that the right to life includes the right to live with human dignity and all that goes along with it, namely, the bare necessaries of life such as adequate nutrition, clothing and shelter over the head** and facilities for reading, writing and expressing oneself in diverse forms, freely moving about and mixing and comingling with fellow human beings".

In early 1994, in a case involving capitation fees, the Supreme court had ruled that under Art.21 read with Art.45, every child upto the age of 14 has a right to free education.

Again relying on Francis Coralie, in Bandhua Mukti Morcha vs. Union of India [(1984) 3 SCC 161; AIR 1984 SC 802], where the question of bondage and rehabilitation of some labourers was involved, Bhagawati held:

"It is the fundamental right of everyone in this country... to live with human dignity, free from exploitation. This right to live with human dignity enshrined in Article 21 derives its life breath from the Directive Principles of State Policy and particularly clauses (e) and (f) of Article 39 and Articles 41 and 42 and at least, therefore, it must include protection of the health and strength of the workers, men and women and of the tender age of children against abuse, opportunities and facilities for children to develop in a healthy manner and in conditions of freedom and dignity, educational facilities, just and humane conditions of work and maternity relief. These are the minimum requirements which must exist in order to enable a person to live with human dignity, and no State has the right to take any action which will deprive a person of the enjoyment of these basic essentials."

After some controversy on the issue of right to livelihood, Supreme Court has clearly held that "**right to livelihood is included in the right to life because no person can live without the means of living, that is, the means of livelihood**". [Olga Tellis vs. Bombay Municipal Corporation (1985) 3 SCC 545; AIR 1986 SC 180,193.]

The right to healthy environment

In several public interest litigations our High Courts and the apex court have held that Article 21 implicitly includes the right to wholesome environment.

Attakoya Thangal, a resident of Lakshdweep Islands off the coast of Kerala challenged the drinking water augmentation scheme of the government saying that it will lead to disequilibrium causing saline water to enter into fresh water aquifers and thus violate Article 21. The Kerala High Court [AIR KLT 580] held that: "The administrative agency cannot be permitted to function in such a manner as to make inroads into the fundamental right under Art.21. The right to life is much more than the right to animal existence and its attributes are manifold, as life itself. A prioritisation of human needs and the new value system has been recognised in these areas. The right to sweet water, and the right to free air, are attributes of the right to life, for these are the basic elements which sustain life itself."

Subhash Kumar of Bihar moved a writ petition under Article 32 before the Supreme Court against the State of Bihar [AIR 1991 SC 420] to prevent the West Bokaro Collieries and the Tata Iron & Steel Co Ltd from discharging slurry/sludge from its washeries at Hatoland Dt Hazaribagh, Bihar into the Bokaro river and polluting it. Though the court dismissed the petition with costs against the petitioner for it was a personally motivated writ, it said:

"**Right to live is a fundamental right under Article 21 of the Constitution and it includes the right of enjoyment of pollution free water and air for full enjoyment of life**. If anything endangers or impairs that quality of life in derogation of laws, a citizen has right to have recourse to Art. 32 for removing the pollution of water or air which may be detrimental to the quality of life."

The right to health

In the Bandhua Mukti Morcha case, the Supreme Court had clearly held that Art.21 read with the directive principles of state policy includes the right to health.

In a recent case (Consumer Education & Research Centre, Ahmedabad vs. Union of India decided in February, 1995) involving the rights of workers in the asbestos industry who unwittingly suffer from an occupational debilitating disease, 'asbestosis', the apex court ruled:

"The right to health and vigour to a worker while in service or post-retirement is a fundamental right under Article 21 and other related articles of the Constitution. The right to health and care is a fundamental right under Article 21 read with Articles 39(e), 41 and 43 of the Constitution and make the life of workmen meaningful and purposeful with dignity of person. Right to life includes protection of the health and strength of the worker which is a minimum requirement to enable a person to live with human dignity."

Conclusion

Reflection of the true extent of the Fundamental Rights enshrined in the Constitution, and expanded by the Supreme Court, is essential for not only the lay public but also the intelligentsia, legal practitioners and judiciary. It has often been reported that under the common law doctrine of *Stare decisis* lower courts have not been able to imbibe the apex court pronouncements in situations where it should have been done, thereby causing injustice to the citizen seeking relief. *Stare decisis* means that courts have to follow the precedents as established by higher courts until they are over-ruled by a superior court.

This calls for quick and easy communication of all law-making decisions to every citizen in the country so that they can be understood and followed. The easiest way to keep students, social activists, lawyers and the judiciary well informed of the latest interpretations is to periodically update the text of the Constitution.

Again, updating of the Constitution is important from another standpoint. Constitution is the 'ground-norm' for our laws. This means that all laws derive their force from the Constitution. Unless the epoch-making decisions of the Supreme Court are followed by adequate amendments to the Constitution, the general public and students will not have a complete knowledge about the laws and the Constitution of the land.

A periodical review of the Constitution may be arranged, when the judicial interpretations be incorporated in the Constitution, by either rewriting the relevant provisions or by adding paragraphs to them. The ultimate object of such review will be to keep the Constitution always updated and complete. It is time to give a serious thought and to start action, to inform people of what they have given unto themselves, but do not know.

Recommendations

CUTS recommends that the Constitution of India be amended by incorporating the judgements of the Supreme Court so as to empower the citizens of India fully:

- **Article 19(1)(a) should read as: "to freedom of *information*, speech and expression;"**
- **Article 21 should read as: " Protection of *the right to* life and personal liberty. - No person shall be deprived of his life or personal liberty except according to procedure established by law. *To live with human dignity every person shall have the right to satisfaction of basic needs, the right to healthy environment, the right to education, the right to health and the right to health care.***

CUTS invites all to join in the campaign for the abovementioned amendments in the Constitution.

Comments on the Draft were received from Justice P. N. Bhagwati and Prof N. R. Madhava Menon. Both recommended that this needs to be disseminated widely in well designed publications, while Justice Bhagwati did not agree that the Constitution should be amended.

This Briefing Paper has been researched and written by Pradeep S. Mehta and Subir Bannerji of and for CUTS. Published by Consumer Unity & Trust Society (CUTS), 3-B, Camac Street, Calcutta 700 016, India. Phone: 29-7391/2786, Fax: 91-(0)-33.29-7665/76-2785.

Monitoring medical malpraxis

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WHEN doctors were brought under the Consumer Protection Act, the consequent fallouts were many. The two most significant ones were: needless investigations leading to a rise in the cost of medical care and the seeking of judicial remedy was responsible for a fall in the quality of doctor-patient relationship.

An analysis of the pattern of cases tried by various consumer panels at the State and National levels in India reveal some disquieting features. Out of 143 cases tried, about 80 per cent of the malpraxis cases were set aside and the medical profession was held not guilty ("Compendium of CPA and Medical Judgments" – Niraj Nagpal, 1996). In the 13 cases referred to the National Consumer Redressal Commission, only one case was established and, in the others, the doctors were exonerated.

The majority of cases are possibly speculative. It may be that the patient or his relative did not have a proper legal guidance or that the plaintiff has become more conscious of his rights. There may be an element of dissatisfaction over the quality of service or the behaviour of the medical profession may have precipitated this emotional reaction. The factors of failure in the doctor-patient relationship on the one side and the presence of possible misleading ambulance chasers (referred to by some as ten per cent lawyers) may be responsible for this. This tends to have a domino-effect. Unnecessary investigations, avoidance of risky investigations, adding of legal expenses and cost of malpraxis insurance to these expenses are just a few aspects of the rise in the cost of medicare.

The other story is the mental agony of the doctor, the hefty compensation if he is held guilty and the glare of publicity from the media – not matter how the judgment goes, his practice, his source of living and reputation are lost. Add to this the delay in justice which goes well past the legal obligation of three or five months before the case is decided. In no other profession do we find such fallouts of a one-time error as in the medical profession.

In these litigations, where frivolity may play a part, would a filtering mechanism help the two parties arrive at an out of court settlement? And if no prima facie case is established, would not advice to the patient to withdraw the complaint help?

In the May '97 issue of the *Bulletin of the American College of Surgeons*, Dr. Kridelbaugh and Dr. Palmisano have published an interesting study – "A 20 year experience with malpractice screening panels" – which refers to the formation of screening panels in the U.S.,

ISSUES

some of which have been functioning since the Sixties, a reaction to the increasing number of malpractice action cases "filling the court dockets". The concept of such a panel, originated from various physicians' organisations who were convinced that many cases had no legal merit. The conclusion apparently was not wrong either.

In 1996, 25 of the 50 States had such panels. The functioning of the panels in New Mexico and Louisiana have been studied. The panel screening has been so successful that, in these States, screening has been made mandatory, before any malpractice case comes to court, though the findings may not be binding.

A look at the figures is interesting. In New Mexico, out of the 2141 cases heard during 1962-76, as many as 1562 (72 per cent) were settled out of court with 344 (18 per cent) favouring of the plaintiff. Of the 577 cases which went to trial only 30 cases (5.4 per cent) were allowed in favour of the plaintiff, the rest were set aside, as medical negligence was not established. In 20 of 497 cases, the verdict was reversed in favour of the plaintiff (five per cent) and, in 10 out 80 cases, in favour of the defendant (12.5 per cent). These figures suggest an element of fairness.

Why should we not emulate this system? It may filter out frivolous cases. It may also help in a quick settlement of deserving cases. Like the Louisiana panels, the body may consist of two doctors (or lawyers) – one each for the plaintiff and defendant. The third member may be a jurist. The plaintiff's and defendant's cases are presented separatelyas are the replies to their contentions. Queries on either side are answered, the entire material scrutinised and the opinion given.

If such a system is set up in our country, a few points have to be considered: The cost of the functioning of the panel has to be looked into and arranged for. The parties will bear the expenses; The acceptance of the verdict by both sides need not be made mandatory. It will be up to either party to ignore the findings and go to the court; Such a panel may be recognised and made a statutory filter, despite the lack of mandatoriness of the verdict. This may help quicker dispensation of justice and lessen the work load of the consumer courts.

This system may be adopted in one or two States and made all pervasive, if successful. Most importantly, it may avoid unnecessary and unfair glare of publicity on doctors. Apart from the hefty compensation paid for a one-time error or negligence, what is not apparent is the undue glare the doctor gets, with its own fallouts, which spell a disaster. ■

M. S. VENKATARAMAN

Con - 1

Consumer Awareness Series - 2

Rights and Responsibilities of Patients & List of Banned drugs

Published by

CREAT

Consumer Rights, Education & Awareness Trust

239, 5th C Main, Remco Layout, Vijayanagar, Bangalore-560 040

PATIENT'S RIGHTS AND RESPONSIBILITIES

PART 1: PATIENT'S RIGHTS:

Section 1: RIGHT TO HEALTH CARE AND HUMANE TREATMENT:-

1. Every individual shall have access to adequate and appropriate health care and treatment.
2. Every patient shall be treated with care, consideration, respect and dignity without discrimination of any kind.
3. A Patient has the right to be treated by fully qualified health care professionals in private or public health care facilities.
4. A Patient has, wherever possible, the right to be treated at a hospital of his choice and to be referred to a consultant of his choice.
5. Every individual shall have the right to prompt emergency treatment from the nearest government or private medical and health facility.
6. Patients have the right to humane terminal care and to die in dignity.
7. A Patient can be transferred to another health care establishment only after an explanation of the need for this transfer and after the other establishment has accepted the patient.
8. A patient has the right to have all identifying information, results of investigations, details of his condition and his treatment kept confidential and not made available to anyone else without his consent.

Section 2: CONSENT:-

1. Before any treatment or investigation, a patient shall have the right to a clear, concise explanation in lay terms of the proposed procedure and of any available alternative procedure. Where applicable, the explanation shall include information of risks, side effects, or after-effects, problems relating to recuperation, likelihood of success, and risk of death. Informed consent of the patient must be obtained prior to the conduct for a treatment or a procedure. In the case of a minor, consent has to be obtained from the parent or guardian. If a patient is incapacitated and any delay would be dangerous, a doctor is entitled to carry out

any neessary treatment or operation after a second opinion is obtained.

2. A Patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his decision.
3. Explicit, informed consent is a prerequisite for participation in scientific experimentation. Experimentation must not be carried out on any patient who is unable to express his will.

Section 3: RIGHT TO INFORMATION:-

1. Information about health services (including recent developments in the field) and how best to use them is to be made available to the public in order to benefit all those concerned
2. Information may be withheld from patients in cases where there is good reason to believe that this information would affect the patient's health adversely but, however, the information must be given to a responsible relative.
3. A patient has the right to know the identity and the professional status of the individuals providing service to the patient and to know which professional is primarily responsible for the patient's care.
4. Patients should have the right to seek a second opinion from another physician.
5. Patients should upon request, be able to obtain a copy of summary of their diagnosis, treatment and care including diagnostic results on discharge from a hospital or other establishment. They shallalso have the right to authorise another medical professional to obtain a copy of the same and to inform the patient of the contents.
6. A patient shall have the right to examine and receive an explanation of his bill after any treatment and consultation.

Section 4: THE RIGHT TO ADEQUATE PRESCRIBING INFORMATION:-

1. While prescribing medication, the patient should be informed about the following:-

   Expected outcome, adverse and after effects, chances of success, risks, cost and availability.

2. All drugs dispensed shall be of acceptable standards in terms of quality, efficinacy and safety.
3. All medicines shall be labelled and shall include the pharmacological name of the medicine.

Section 5: RIGHT TO REDRESS GRIEVANCES:-

1. A Patient shall have access to appropriate redressal procedures.
2. A patient shall have the right to legal advice as regards any malpractice by the hospital. the hospital staff or by a doctor or other health professional.

Section 6: RIGHT TO HEALTH EDUCATION:-

1. Every individual shall have the right to seek and obtain advice with regard to preventive and curative medicine, after care and good health.

PART 2: PATIENT'S RESPONSIBILITIES:

1. The patient shall ensure that he or she knows and understand what a patient's rights are and shall exercise those rights responsibly and reasonably.
2. The patient shall ensure that he or she understands the purpose and cost of any proposed investigation or treatment before deciding to accept it.
3. The patient shall accept all the consequences of the his/her own informed decisions.
4. The patient shall provide accurate and complete information which the health professional requires about his or her health and ability to pay for health services.
5. The patient shall establish a stable relationship with and follow the treatment determined by the health professional primarily responsible for the patient's care
6. The patient shall inform the health professional if he or she is currently consulting with or under the care of another health professional in connection with the same complaint or any other complaint.
7. The patient shall so conduct himself or herself so as not to interfere with the well being or rights of other patients or providers of health care.

8. Every individual has a responsibility to maintain his or her own health and that of society by refraining from indulging in high risk behaviour detrimental to health.
9. Every individual has a responsibility to accept all preventive measures sanctioned by law.

Consolidated List of Drugs/fixed Dose combination of Drugs Banned by The Central Government Under Section 26A of the Drugs And Cosmetics Act 1940

1. Amidopyrine.
2. Fixed dose combinations of Vitamins with antiinflamatory agents and tranquillisers.
3. Fixed dose combinations of Atropine in Analgesics and Antipyretics.
4. Fixed dose combinations of Strychnine and Caffeine in tonics.
5. Fixed dose combinations of Yohimbine and Strychnine with Testosterose and Vitamines.
6. Fixed dose combinations of Iron with Strychnine, Arsenic and Yohimbine.
7. Fixed dose combinations of Sodium Bromide/Chloral hydrate with other drugs.
7. Fixed dose combinations of Iron with Strychnine, Arsenic Yohimbine.
8. Phenecatin.
9. Fixed dose combinations of Anti-histaminics with anti-diarrhoeals.
10. Fixed dose combinations of Penicillin with Sulphonamides.
11. Fixed dose combinations of Vitamins with Analgesics.
12. Fixed dose combinations of Tetracycline with Vitamin C.
13. Fixed dose combinations of Hydroxyquinoline group of Drugs except preparations which are used for the treatment of diarrhoea and dysentry and for external use only.

14. Fixed dose combinations of Corticosteroids with any other drug for internal use.
15. Fixed dose combinations of Chloramphenicol with any other drug for internal use.
16. Fixed dose combinations of Ergot.
17. Fixed dose combinations of Vitamins with anti-T.B. drugs except combination of Isoniazide with pyridoxine Hydrochloride (Vitamin B_6).
18. Penicillin Skin/Eye Ointment.
19. Tetracycline liquid oral preparations.
20. Nialamide
21. Proactolol.
22. Methapyrilene, its salts.
23. Methequalone.
24. Oxytetracycline Liquid Oral Preparations.
25. Demeclocycline Liquid Oral Preparations.
26. Combination of Anabolic Steroids with other drugs.
27. Fixed dose combinations of Oesterogen and Progestin (Other than oral contraceptives) containing per table estrogen content of more than 50mg. (equivalent to Ethenyle Estradiol) and of progestin content of more than 3 mg. (equivalent to Norethisterone Anetate)
28. Fixed dose combinations of Sedatives/hypnotics/anxiolytics with analgesic- antipyretics.
29. Fixed dose combinations of Pyrazinamide with other anti- tubercules drugs except combination of Pyrazinamide with Rifampicin and INH as per recommended daily dose given below.

Drug	Minimum	Maximum
Rifampicin	450mg.	600mg.
INH	300mg.	400mg.
Pyrazinamide	1000mg.	1500mg.

30. Fixed dose combination of Histamine H2-receptor antigonists with antacids except for those combinations approved by the Drugs Controller (India).

31. The patent and proprietory medicines of fixed dose combinations of essential oils with alcohol having percentage higher than 20% proof except preparations given in the Indian Pharmacopoeia.
32. All Pharmaceutical preparations containing Chloroform exceeding 0.5% w/w or v/v whichever is appropriate.
33. Fixed dose combination of Ethambutol with INH other than the following:

INH	Ethambutol
200 mg.	600 mg.
300 mg.	800 mg.

34. Fixed dose combinations of Containing more than one antihistamine.
35. Fixed dose combinations of Anthalmintic with cathetric/purgative except for piperazine. ,
36. Fixed dose combinations of Salbulamol or any other bronchodilator with central acting anti-tussive and/or, antihistamine.
37. Fixed dose combinations of Laxatives and/or, antispasmodic drugs inenzyme proparations.
38. Fixed dose combinations of Metoclopramide with other drugs except for preparations containing metoclopramide and aspirin/ paracetamol.
39. Fixed dose combinations of Centrally acting, antitussive with antihistamine having high atropine like activity in expectorant.
40. Preparations claiming to combat cough associated with asthma containing centrally acting anti-tussive and/or antihistamine.
41. Liquid oral tonic preparations containing glycerophosphates and/or other phosphates and/or central nervous system stimulant and such preparations containing alchol more than 20% proof.
42. Fixed dose combinations of Containing Pectin and/or Kaolin with any drug which is systemically absorbed from GI tract except for combinations of Pectin and/or Kaolin with drugs not systemically absorbed
44. Dovers Powder I.P.
45. Dovers Powder tablets I.P.
46. Chloral Hydrnte as a drug

TIPS TO CONSUMERS

1. Always buy drugs from a licenced dealer
2. Avoid self modification. Consult qualified Doctors and obtain prescription
3. Insist on Cash bill. The dealer is required by law to issue cash bill for every transaction.
4. Check the drugs before leaving te counter and ensure that what has been dispensed is the one that is prescribed. Preferably go back to the Doctor to show the drug purchased
5. Check expiry date and the maximum retail price printed on the label/container
6. Certain drugs have to be stored in the refrigerator to preserve potency. The storage condition will be mentioned on the label. Refuse to accept if the storage is improper.
7. Report any untoward reaction to your physician
8. Follow the instructions while taking the drugs. Always complete the course of treatment. Do not discontinue in the middle unless advised by your physician
9. Destroy the containers after use or destroy the label before disposing
10. In case of doubt on the quality or price charaged do not hesitate to report to the nearest office of the Assistant Drugs Controller or Drugs Inspector

Bangalore Address:

Drugs Controller Office,
Palace Road, Bangalore-560 001
Phone No: 2264760

Based on the Resulations adopted at the Workshop on Medicine, Media and Consumer Education held at Pondicherry and guidelines issued by Drugs Controller, Karnataka

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Consumer Awareness Series - 3

CPHE

GUIDELINES FOR R. T. O. PROCEDURES

Published by

CREAT

Consumer Rights, Education and Awareness Trust (R)

239, 5th 'C' Main, Remco Layout, Vijayanagar,

Bangalore-560 040

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CPHF

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3. Rights & Repsonsibilites of Paitents & List of banned drugs (Kannada)	3.00
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c) Consumers and Drug Policy	50.00

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2. Domestic LPG safety code
3. Guidelines for purchasing a Flat.

The above publications may be obtained in person or by sending the amount through DD/ Cheques drawn in favour of CREAT, Bangalore. Please add Rs. 10/- for outsation cheques.

PREFACE

The Consumer Rights, Education and Awarness Trust (CREAT) has launched a programme "Consumer Awarness Series" under which it is planned to publish a series of leaflets, booklets and guides on various subject of interest to consumers. The objective of this series is to educate consumers, provide them with information and to create an awarness about their rights and responsibilites.

CREAT belives that providing information to consumers is one way of creating a responsible citizen who can always guard his rights and take remedial measures in case they are violated.

So far five leaflets and two booklets have been published in this series. Subjects for few more booklets have been identified and CREAT hopes that the same will be made available at the earliest.

Our thanks to Mr. Vijay Vikram, Joint Commissioner (Transport/Admn.) for having gone through the booklet and giving suggestions in preparing this booklet.

Bangalore
April, 1995

Executive Trustee
(CREAT)

GUIDELINES TO R.T.O. PROCEDURES

It is everybodys experience that information about the procedures to be followed and documents to be furnished for various works at the RTO is not known well although the details are made known over display boards. An effort has been made in the following lines, to help the public by providing broad guidelines to be followed for obtaining the services of RTO.

Every Regional Transport Office deals with all transactions relating to Drivers, Conductors, TravelAgents as well as Transport Vehicles. The important works in which common man is interested are:

A. Learners driving licence
B. Permanent driving licence
C. Renewal of driving licence
D. Registration of vehicles

A - LEARNER'S LICENCE

Every person who wants to drive a vehicle should possess a valid learners or permanent driving licence. At the first instance, a person should obtain a learners licence. The eligibility conditions for obtaining a learners licence is as follows:

AGE LIMIT

1. Should not be less than 18 years for all Motor Vehicles other than transport vehicles.
2. Should have attained 16 years for Motor Cycles without gears. A consent of the parent or guardian should be obtained and produced.
3. Should not beless then 20 years for transport vehicles

APPLICATION

An application for grant of learners licence is to be made in Form 2 to the RTO/ARTO having jurisdiction in the area in which the candidate ordinarily resides or carries on business or the school in which he is receiving or has received instruction is situated.

DOCUMENTS TO BE ANNEXED

The following documents should be annexed along with the application for grant of learners licence.

1. A medical certificate in Form IA, issued by a Registered Medical Practitioner. This is only for transport vehicles
2. Three copies of recent photographs of size 3 cm X 6 cm. Photographs may be black and white or colour
3. A fee of Rs. 15 (Rupees fifteen only) is to be remitted in the Treasury Counter in the RTO and the challan is to be submitted along with the application.

   (Note down the number and date of the challan or take a xerox and keep for your records)
4. Any document mentioned below, as proof of your age and bonafide residential address
   a) Ration card wherein your name is included
   b) Electrol Roll slip or Voters Identity card
   c) LIC policy with your address mentioned therin
   d) Electricity or Telephone Bill
   e) Pay Slip/Salary packet issued by your employer, in case of State or Central Government employees
   f) House Tax receipt
   g) Birth certificate issued by Corporation.
   h) School certificate (S.S.L.C marks card)

Original marks card of SSLC should be produced and taken back before leaving the RTO. Better you have two xerox copies of the marks card duly attested by a Gazetted Officer.

To have a driving licence you should not be suffering form any disease or disability likely to cause your driving of a motor vehicle a source of danger to the public or passenger.

If the application is proper in all respects and if all the documents are submitted, you will be called for a simple test. Users have the right to ask the concerned officer to send the intimation regarding the date and time of the test by post.

CONTENTS OF THE TEST

Granting of the learners licence involves passing of a simple test in which you will be tested whether you possess adequate knowledge and understanding on the following matters:

a. Traffic signs, traffic signals, rules and regulations of the road

b. Duties of driver when the vehicle is involved in an accident causing, death, injury of a person or damage to property or party

c. Precautions to be taken while passing unmanned railway crossing

d. Documents the driver should carry while driving a motor vehicle

The test will be conducted by the licencing authority or Inspector of Motor Vehicles or through a computer.

Learners licence will be issued subject to pass in the test. Vehicle users should follow the instructions to avoid penalty or confiscation of the licence.

B - GRANTING OF PERMANENT LICENCE

1. A permanent licence will be issued to persons who have a valid learners licence, subject to other conditions. Eligibility conditions as far as age in case of getting learners licence is valid for getting a permanent licence also.

2. An application for a permanent driving licence should be made in Form No.4 to the RTO/ARTO in whose jurisdiction the applicant resides or carries on business or the school where he is receiving or has received instructions is situated after the candidate has held a learners licence for a period of atleast thirty days

3. The application should be accompanied by the following documents.
   a. Challans for remittence of the Test fee of Rs. 15/- (Fifteen only) and
   b. Driving licence fee of Rs. 20 (Twenty only)
   c. Valid learners driving licence in original
   d. Three copies of the applicant's recent photographs of size 5 cms X 6 cms
   e. Driving certificate in Form 5 issued by the school where the applicant received the instructions, if any. This is not applicable in case the user has learnt driving on his own

4. If the application and documents are proper in all respects, the concerned RTO/ARTO will call the user to appear for a test of competence to drive. You should be ready to appear for the test with a serviceable vehicle of the class for which you have applied for licence. It is not necessary that you should be the owner of the vehicle

5. If you pass the test you will be granted with a permanent driving licence which will be valid for a period of 20 years or till you attain the age of 50 years whichever is earlier in case of non- transport vehicles and three years in respect of transport vehicles.

6. In case you fail in the test you will have to reappear after seven days upto three attempts. Thereafter it is after 60 days. In such a case you will have to remit the test fees once again. It is better you appear for the test after you have acquired adequate proficience and competence in driving.

C - RENEWAL OF DRIVING LICENCE

As a user of the vehicle you should remember that a driver is expected to carry with him/her a valid driving licence. The word 'valid' indicates that it is not expired. Driving with an outdated licence attracts all penalties as if driving without a licence . So watch the date of expiry and apply for renewal without waiting for the last day. The procedure for renewal is an follows:

1. Application for renewal of driving licence should be made in Form No. 9.

2. If the application for renewal is made within thrity days from the date of expiry of the licence, the licence will be renewed from the date of expiry. For example if your licence expires on 1st March, your licence will be renewed from 1st March if you apply within 30 March.

3. If the application is made after thirty days of the date of expiry of the licence, renewal will be made from the date of renewal. If appication is made after five years of the date of expiry the applicant will have to appear for a re-test.

4. Fees for Renewal

   a. If renewal of licence is made within thirty days of the date of expiry Rs. 15/- (Fifteen only)
   b. If renewal of licence is made thirty days after the date of expiry Rs. 15/- (Fifteen only) plus Rs. 10/- (Rupees ten only) will have to be paid for dalay of one year or part thereof, reckoned from the date of expiry
   c. If you hold a licence for both Non-transport and transport vehicles, separate fees is to be paid for each category.

5. The application for renewal of licence should be accompanied by the following:

   a. Challan of fees paid
   b. Three copies of recent photograph of size 5 X 6 cms
   c. The Driving licence
   d. Medical Certificate in Form 1A

6. In case of Non-transport vehicles the licence will be renewed:

   i. For a period of 20 years or till the applicant attains the age of 50 years
   ii. If the applicant has attained the age of 50 years, for a period of five years.

7. In case of Transport vehicles licences will be renewed for three years only. If the applicant is a holder of a licence issued outside the region, such licences will be renewed after receipt of antecedent from O.L.A. or after fifteen days after the date of application.

D - REGISTRATION OF VEHICLES

Every vehicle purchased, either new or old, has to be registered and an R.C. book obtained.

Application for registration of a motor vehicle should be made in Form 20 to the Registering Authoring in whose jurisdiction the applicant thas the residence or place of business or where the vehicle is normally kept.

Application should be submitted within seven days from the date on which the vehicle was purchased or taking delivery of the vehicle.

The present fee for registration of a motor vehicle is as follows:-

	Rs.
Invalid carriage	10/-
Motor Cycle	30/-
Light Motor vehicle	100/-
Medium Goods/passenger vehicle	200/-
Heavy goods/Passenger vehicle	300/-
Imported vehicle	100/-
Imported motor vehicle	100/-
Any other vehicle	150/-

In addition to registration fee, taxes at the rates specified in part A of the schedule to Karnataka Motor Vehicles Tax Act 1957 will have to be remitted.

The life time tax for motor cycles is as follows:

a. Below 75 cc Rs. 1000/-
b. Between 75 and 300 cc Rs. 2000/-
c. Above 300 cc Rs. 3000/-

The taxes in respect of motor cars other than imported cars or cars owned by companies is as follows:

a. Vehicle upto 800 cc Rs. 10.000/- (Life Time Tax).

b. Vehicle of 800cc to 1500cc Rs. 15,000/- (Life Time Tax)

c. Above 1500 cc Rs. 20,000 (Life Time Tax)

DOCUMENTS TO BE FURNISHED ALONG WITH APPLICATION

1. Sale certificate in Form 21
2. Valid Insurance Certificate
3. Proof of address by producing any one of the following:
   a. Ration card
   b. Electrol roll or identity card
   c. Life Insurance policy
   d. Passport
   e. Electricity or telephone Bill
   f. Pay slip issued by State or Central Govt. offices
   g. House tax receipt
   h. School certificate
   i. Birth certificate
4. Temporary registration if any, or extract of From 19 if the vehicle is covered by trade certificate
5. Roadworthiness certificate issued by the Manufacturer in Form 22
6. Receipt for having paid Registration fee and tax

After filing the application along with the documents detailed above, the vehicle should be produced for inspection so that the Registering authority will satisfy that the particulars contained in the application are true and that the vehicle compleies with the requirements of M.V. Act 1988 and rules made thereunder.

After satisfying that the particulars contained in the appplication are true and the vehicle complies with the requirements of the Act, the RTO will register the vehicle, assign a registration mark and will issue registration certificate (RC book)

The applicant/owner should exhibit the registration mark assigned on the vehicle in the manner prescribed on black background with white letter in repect of Non Transport vehicles and white background and black letters in respect of Transport vehicles.

If the vehicle is covered by Hirepurchase/hypothecation/lease agreement the signature of the other party to such agreement shall be obtained in the application in the column provided for the purpose and additional fee of Rs. 50/- (Fifty only) shall be remitted for recording such agreement.

If the vehicle is to be registered as a Transport vehicle a separate application in the prescribed form, with prescribed fee should be filed for grant of fitness certificate and permit

The certificate of registration of a motor vehicle other than a transport vehicle will be valid for fifteen years and is renewable.

GENERAL GUIDELINES

A driver of a vehicle should carry with him/her the following documents in original or xerox copies duly attested by a State Government Gazetted Officer

1. Registration Certificate (RC Book)
2. Valid driving licence
3. Valid Insurance Policy or receipt of premium

The Traffic police can ask the driver to produce the following documents within Corporation or Municipal limits:

1. Valid driving licence

The Regional Transport Officials can ask the driver to produce the following document for verification:

1. Registration Certificate
2. Any other documents pertaining to he vehicle

LOCAL R.T.O. ADDRESSES

Bangalore City has five Regional Transport Offices, the details of which are as follows:

Division	Address	Phone No.
North	Corporation Complex Yeshwanthpur BANGALORE-560 022	3376039
South	Shopping Complex Jayanagar IV Block BANGALORE-560 011	6630989
East	BDA Shopping Complex Indiranagar BANGALORE-560 038	562726
West	BDA Shopping Complex Rajajinagar II block BANGALORE-560 010	3324288
Central	BDA Complex Koramangala BANGALORE-560 035	5533525

Office of the Transport Commissioner
4th Floor, Multistoreyed Buildings
Dr. Ambedkar Veedhi
BANGLORE - 560 001
Phone No: 2253717

TRAFFIC CONTROL DEVICES

Traffic signs, signals and markings are designed to regulate, warn and guide the flow of traffic. These devices are standardised so they have the same meaning in every State.

Traffic signs are used to convey specific information.Theytellyouaboutregulations,warnyouofhazardsorpotentialhazardsand helpyoufind your way.

Signs are divided into four basic categories:

Regulatory
Warning
Construction
Guide

Regulatory signs tell you what you can or cannot do. They advice you on the regulations concerning speed, the direction of traffic, turning restrictions and parking.

Warning signs tell you what you expect ahead. They warn you about existing or potential hazards on or near the roadway and are posted before the hazard so you can be prepared.

Constructions signs indicate that some repair, construction or maintenance work is in progress

Guide signs tell you shere you are going and how to get there. They provide information on intersecting roads, help direct you to cities and towns and note points of interest along the highway. Guide signs also help you find hospitals, service stations, restaurants etc.

SEEING WELL AT NIGHT

It's harder to see things at night than during the daytime. Here are some things you can do to help you see better.

Use your high beams whenever there are no oncoming vehicles. You can see twice as far with high beams than with low beams. It's particularly important to use your high beams when driving on unfamiliar roads, in construction areas or where there may be people along the roadside.

Dim your lights when following another car or when car coming toward you.

Use low beams when driving in fog, snow or heavy rain. Light from high beams will reflect and cause glare.

COMMUNICATING

Accidents often happen because one drived doesn't see another driver, or one driver does something the other driver doesn't expect. It's important that drivers COMMUNICATE.

Communicating means letting others know where you ar and what you plan to do:

By using yours lights
By using your horn
By making sure your vehicle is seen
By using emergency signals
By positioning your vehicle
By signaling when changing directions
By signaling when slow or stopping

USING HORN

Your horn can get the attention of other drivers. Use it whenever you suspect another driver or a pedestrain doesn't see you, but don't abuse it.

If there is a real danger, don't be afraid to sound a SHARP BLAST on your horn. For example use your horn

a. When a child is about to run into the street
b. When another vehicle is in danger of hitting you
c. When you have lost control of your vehicle

DRIVING ON A WET ROAD

While driing on a wet or slippery road be careful. If the road is slippery, your tyres have less traction. Drive slower on wet roads then you would on dry droads. Exercise special caution on roads posted with warning signals.

At speeds upto 35 mph most tyres will wipe water from the road surface similarly to the way a sindshield wiper cleans water off the window. As you go faster, your tyres cannot wipe the road as well. They start to ride on a film of water like water skis. This is called Hydroplaning.

In a heavy rain your tyres can lose all contact with the road at higher speeds. Bald tyres lose contact more readily. A slight change in direction or a gust of wind could throw you vehicle into a skid. The best way to prevent hydroplaning is to keep your speed down.

ALCOHAL AND DRIVING IMPAIRMENT

It is highly dangerous and illegal to drive when you are under the influence of alcohal and drugs. No one can drive safely no matter how long he or she has been driving.

Alcohal is a depressant. It affects all the cells of the body, especially the main and central nervous system. As a resul, alcohol dulls your memory, concentration, insight, perception and judgement

When high levels of alchol are absorbed into your blood stream, it affects your ability to distinguish different light intensities. This may be particularly dangerous when driving. Your eyes taken longer to read just when exposed to glare from bringt lights. It also impairs your eyes sensitivlty to certain colours, especially red.

As the alcohol concentration increases in your blood, so will you driving errors. You will reach slower and fluctuate between driving fast and driving slow. Your ability to brake and drive will be impaired so that your vehicle swerves and stalls. In general, your driving will become careless after drinking.

You don't have to drink much to be affected by alcohol. Studies indicate that driving skills begin to deteriorate at blood- alcohol levels below 0.05 per cent.

Finally, it's important to remember that alcohol gives a driver a false sense of security. The driver thinks that he or she is driving well. In reality the driver is endangering himself and others on the roads.

Alchohol is not the only drug that can adversely influence your driving performance. Many other drugs either used alone or in combination with alcohol, increase your risk of having an accident.

Every drug has some effect on the person using it. Befoer taking a drug, find out from your doctor how the particular drug might affect your sight, coordination, timing and general ability to drive.

HEALTH

Some of the diseases or ailments may be dangerous for driving. Persons with the following health problems should be careful while driving. Better they do not drive alone.

Epilepsy - As long as it is under medical control, epilepsy is not dangerous. Persons with known instances of epilepsy should not drive alone

Diabetes - Diabetics on insulin should not drive when there is any danger of going into shock. This danger could result from skipping a meal or snack or from taking amount of insulin. It is better, a friend or a relative drive you. Diabetics should also have their eyes checked for possible night blindness.

Heart condition - People with heart disease, high blood pressure or circulation problems should be aware of the impact of these conditions on ther driving ability. There is danger of a black out, fainting spell or heart attack.

GOOD DRIVING HABITS

1. Drive slow and steady
2. Keep your engine healthy
3. Use brakes sparingly
4. Let go of your clutch
5. Clean air filter regularly
6. Watch your tyre pressure
7. Stop fuel leaks
8. Stop the engine if you stop for more than 2 minutes
9. Use the right lubrication.

The information is based on the leaflets issued by the Department of Transport, Government of Karnataka and Pennsylvania manual for drivers published by Department of Transportation, Commonwealth of Pennsylvania.

CREAT

Established in December 1993, CREAT is a non political, non-profit, voluntary organisation devoted to the cuase of consumer protection and welfare.

The objective of CREAT is to act as a platform for consumers to raise their grievance on issues relating to consumer protection, environment, health, public issues etc. To achieve its objectives CREAT has chalked out the following programmes:

1. To set up a consumer information centre
2. To publish books, leaflets and other literature
3. To bring out a periodical
4. To set up a food testing laboratory
5. To arrange lectures, demonstrations, exhibitions, seminars and workshops
6. To arrange programmes to train consumer activists
7. To take up individual/class cases for redressal
8. To provide faculty, trainig material etc, for consumer groups
9. To conduct surveys, product evaluation studies and print reports

CREAT is an organisation depending entirely on contributions from the general public, philonthropists and social organisations. While the trust welcomes donations, interested persons can join CREAT as donor members on payment of Rs. 50/- (fifty only) per annum. For details contact:

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