A I P N O

Pulse

AIPNO | **5/1/2012** | 2012, Volume 1

PRESIDENT'S PERSPECTIVE

ELUMALAI APPACHI, MD

Dear Friends,

I stand humbly in front of you and seek your support and best wishes to have another fantastic year for AIPNO. I am anticipating an exciting year full of fun activities and social functions, while we continue our tradition of outstanding charity work.

I am really looking forward to working with our brilliant executive committee to upkeep the integrity AIPNO bolsters. I am open to suggestions and constructive criticisms. I am available to our community and friends, and will always be there when you need me. As an organization we will support our members' special interests and support educational and charitable activities.

The foundation of our organization is a strong membership base. We will actively recruit younger generations of physicians. I request all our friends and colleagues in the teaching hospitals to recruit fellows and residents to become members of AIPNO. Most importantly we shall try to contact any new physician of Indian origin who moves to our region. It is very important to always showcase our organization's activities in order to encourage new physicians to join.

I request our senior members to mentor our new members, allowing them to become well-acquainted with the organization. Let us all strive to make our organization strong and vibrant.

Calendar of Events for 2012

The following is a tentative list of upcoming events. Invitations to these events are e-mailed and snail-mailed to members. Please make sure **Binnie** has your correct e-mail address so we can keep you updated with events, changes, links to maps and allow you to RSVP easily.

May 19, 2012
AIPNO's Annual Chiraag Dinner, at Executive Caterers of Landerhaven, 6111 Landerhaven Dr., Mayfield Hts. OH 44124
(5:30 Cocktails, Program 7:00, Dinner & Dancing 8:00)
CME Seminar - 9:00 to noon at Hillcrest Hospital
To support the Chiraag Fundraising dinner click here

September 16, 2012
Greater Cleveland Shiva Vishnu Temple & AIPNO Health Fair
7733 Ridge Road, Parma, OH 44129
(440)888-9433
9:00 am to 3:00 pm
to volunteer, click here

November 10, 2012
AIPNO's Annual Dinner

Medical YATRAs making a big difference!

Dr. Jaya Shah
Chair- Humanitarian committee

"To give service to a single heart by a single act is better than a thousand heads bowing in prayer."- M.K.Gandhi

Gomatiben, 72 yrs. complaining about her poor vision, not able to do any house work or enjoy her grandchildren for last 10 yrs. *"Bhagavane dharyu hoi te thai, apnu shun chale*" she said in rural Gujarati. Ophthalmologist Dr. Solanki examined her eyes, asked her to come to the hospital in Gondal next day and assured her that her eye problem would be corrected. Reluctantly with skepticism, she did come with her husband, got Cataract surgery done; after two days, she saw her husband and grandchildren; she was amazed & happiest soul ever enjoying her life again! She blessed the physician and AIPNO for this "miracle' of her life!

Also they did get 600 Cataract Surgeries done in Gondal & @ Global Hospital, Mt. Abu together. That is long term legacy of AIPNO in our motherland India.

YATRA Team is getting younger!

AIPNO-humanitarian committee completed two YATRAs- Gondal & Ambaji in January-February. YATRA is in its 11th year. From Medical mission website and AIPNO website, it recruited 3rd year dental student from Philadelphia and two graduate dentists from New Delhi. Also Dr Laura Brown & Karen Cahoy, RN form John Hopkins University joined in both YATRAs. Rotarians Dave & Laura Diffendal joined with us in Ambaji YATRA.

Two- YATRAs together serviced more than 20,000 patients from about more than 100 villages around Gondal & Ambaji. To date being in 11th year, AIPNO has provided Humanitarian services in 6 states of India- Tamilnadu, Kerala, Gujarat, Orissa, Rajasthan, Uttarkhnad- 2 earthquakes, 2 hurricanes, 1 tsunami and helped more than 120,000 indigent people in dire need of good health care and FREE medicines. In year 2013, YATRA is planning to go to Shantiniketan, W. Bengal. To date more than 100 Physicians and volunteers from all around USA, Canada, United Kingdom and India have happily taken the advantage of AIPNO Medical YATRA program.

YATRA Team @ Gondal

YATRA Team @ Ambaji

AAPI Report for AIPNO

Mohan Durve

Chairman AAPI Committee of AIPNO

AAPI's 2012 convention is going to be in Long Beach, CA from June 28 - July 1, 2012.

Something nice and new about this convention is that first time in the history of AAPI they are allowing free access to exhibits, CME and other non ticketed seminars to anyone who does not want to spend too much money on food & entertainment! Is not that nice?

Also, those of us who are not going there till Friday can pay for only Fri / Sat nights diner & entertainment package for only $350 per person.

So I would definitely like to see more representation from AIPNO for this meeting. Also mark your dates for AAPI May 23 – 26, 2013 convention in Chicago and June 25 – 29, 2014 convention in San Antonio, TX

ClevelandPeople.Com

is proud to announce the 2012 Class of the

Cleveland International Hall of Fame

Please join us in celebrating the remarkable contributions that these men and women have made to the ethnic and cultural diversity of Northeast Ohio.

The 2012 class consists of (in alphabetical order)

Jose Feliciano – inducted by Alex Machaskee

Ken Kovach – inducted by Dick Russ

Milton Maltz – inducted by Sam Miller

Mary Rose Oakar – inducted by Dr. Wael Khoury

Fr. Jim O'Donnell – inducted by Jack Kahl

Vlad Rus – inducted by Joe Cimperman

Dr. Jaya Shah – inducted by Ratanjit Sondhe

Anthony Yen – inducted by Margaret Wong

Socio-economic inequality and its effect on healthcare delivery in India

Milind Deogaonkar, MD

"In the beginning, there was desire which was the first seed of mind," says Rig-Veda, which probably is the earliest piece of literature known to mankind. This desire for a healthy family, healthy society and a healthy country drives individuals and governments alike. The government is supposed to create settings that will provide equal opportunity for an individual to fulfill these desires. There is an undisputed association between this social equality, social integration and health. The effect of social integration on health is conclusively documented in the theory of 'social support' [Cassel, 1976]. The effect of social and economic inequality on health is profound too. Poverty, which is a result of social and economic inequality in a society, is detrimental to the health of population. The outcome indicators of health (mortality, morbidity and life expectancy) are all directly influenced by the standards of living of a given population. More so, it is not the absolute deprivation of income that matters, but the relative distribution of income [Wilkinson, 1992] . Various international studies have documented a strong association between income inequality and excess mortality. In a study by Kennedy et al, income inequality was shown to directly affect the total mortality in a given population [$p<0.05$]. The same study measure income inequality by 'Robin Hood Index', which is the part of income that needs to be redistributed from the rich to the poor to achieve economic equality. 1% rise in this index led to 21.7 excess deaths per 100,000 populations. This shows the profound effect income inequality has on the health of a population. When applied to Indian context these social theories translate into millions of lives that perish due to a lack of socio-economic equality. Since the emergence of free India in 1947, economic egalitarianism dominated the economic policies. Socialism and government-centered economic policies were favored over the profit-making private enterprise and capitalism. Though admirable for its motives, these policies led to over-dependence on the bureaucracy and stifled the growth of free enterprise. Slow and unequal social mobilization in various parts of India led to an uneven economic growth. Caste and social polarization, literacy and educational levels, natural resources, levels of corruption and role of political leadership has resulted in some Indian states doing better than others on the economic front6 . This basic inequality was magnified by the rapid but unequal economic growth that India has witnessed in the last two decades. Amidst the rising standards of living, lie pockets of terrible poverty and deprivation.

Healthcare resources in India though not adequate, are ample. There has been a definite growth in the overall healthcare resources and health related manpower in the last decade. The number of hospitals grew from 11,174 hospitals in 1991 (57% private) to 18,218 (75% private) in 20007 . In 2000, the country had 1.25 million doctors and 0.8 million nurses. That translates into one doctor for every 1800 people. If other systems including Indigenous System of Medicine (ISM) and homeopathic medicine are considered, there is one doctor per 800 people. It not only satisfies but also betters the required estimate of one doctor for 1500 population . Approximately 15,000 new graduate doctors and 5,000 postgraduate doctors are trained every year. The country has an annual pharmaceutical production of about 260 billion (INR) and a large proportion of these medicines are exported. To a casual observer this looks like a good proportion, however on further study, unequal distribution of resources becomes apparent. The ratio of hospital beds to population in rural areas is fifteen times lower than that for urban areas. The ratio of doctors to population in rural areas is almost six times lower than that in the urban population. Per capita expenditure on public health is seven times lower in rural areas, compared to government health spending for urban areas. Though the spending on healthcare is 6% of gross domestic product (GDP), the state expenditure is only 0.9% of the total spending. People using their own resources spend rest of it. Thus only 17% of all health expenditure in the country is borne by the state, and 82% comes as 'out of pocket payments' by the people. This makes the Indian public health system grossly inadequate and under-funded. Only five other countries in the world are worse off than India

regarding public health spending (Burundi, Myanmar, Pakistan, Sudan, Cambodia). As a result of this dismal and unequal spending on public health, the infrastructure of health system itself is becoming ineffective. The most peripheral and most vital unit of India's public health infrastructure is a primary health centre (PHC). In a recent survey it was noticed that only 38% of all PHCs have all the essential manpower and only 31% have all the essential supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs. The reduction on public health spending and the growing inequalities in health and health care are taking its toll on the marginalized and socially disadvantaged population. The Infant Mortality Rate in the poorest 20% of the population is 2.5 times higher than that in the richest 20% of the population. In other words, an infant born in a poor family is two and half times more likely to die in infancy, than an infant in a better off family. A child in the 'Low standard of living' economic group is almost four times more likely to die in childhood than a child in the 'High standard of living' group. Child born in the tribal belt is one and half times more likely to die before the fifth birthday than children of other groups. Female child is 1.5 times more likely to die before reaching her fifth birthday as compared to a male child. The female to male ratios for children are rapidly declining, from 945 girls per 1000 boys in 1991, to just 927 girls per 1000 boys in 2001 . Children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups. A person from the poorest quintile of the population, despite more health problems, is six times less likely to access hospitalization than a person from the richest quintile. This means that the poor are unable to afford and access hospitalization in a very large proportion of illness episodes, even when it is required. The delivery of a mother, from the poorest quintile of the population is over six times less likely to be attended by a medically trained person than the delivery of a well off mother, from the richest quintile of the population. A tribal mother is over 12 times less likely to be delivered by a medically trained person . A tribal woman is one and a half times more likely to suffer the consequences of chronic malnutrition as compared to women from other social categories. These figures speak for themselves and bring to the fore unequal distribution of resources and the effect of it on public health parameters. This unequal distribution of resources is further complimented by inability of universal access to healthcare due to various access difficulties.

Universal access to healthcare is a norm in most of the developed countries and some developing countries (Cuba, Thailand and others). In India though, pre-existing inequality in the healthcare provisions is further enhanced by difficulties in accessing it. These access difficulties can be either due to

1. Geographical distance

2. Socio-economic distance

3. Gender distance

The issue of geographic distance is important in a large country like India with limited means of communication. Direct effect of distance of a given population from primary healthcare centre on the childhood mortality is well documented. Those who live in remote areas with poor transportation facilities are often removed from the reach of health systems. Incentives for doctors and nurses to move to rural locations are generally insufficient and ineffective.

A different aspect of healthcare access problem is noticed in cases of 'urban poor'. Data from urban slums show that infant and under-five mortality rates for the poorest 40% of the urban population are as high as the rural areas. Urban residents are extremely vulnerable to macroeconomic shocks that undermine their earning capacity and lead to substitution towards less nutritious, cheaper foods. People in urban slums are particularly affected due to lack of good housing, proper sanitation, and proper education. Economically they do not have back-up savings, large food stocks that they can draw down over time. Though the healthcare facilities are overwhelmingly concentrated in urban areas, the 'socio-economic distance' prevents access for the urban poor. These socioeconomic barriers include

cost of healthcare, social factors, such as the lack of culturally appropriate services, language/ethnic barriers, and prejudices on the part of providers.

The third most important access difficulty is due to gender related distance. It is said that health of society is reflected from the health of its female population. That is completely disregarded in many of the south Asian countries including India. Gender discrimination makes women more vulnerable to various diseases and associated morbidity and mortality. From socio-cultural and economic perspectives women in India find themselves in subordinate positions to men. They are socially, culturally, and economically dependent on men . Women are largely excluded from making decisions, have limited access to and control over resources, are restricted in their mobility, and are often under threat of violence from male relatives. Sons are perceived to have economic, social, or religious utility; daughters are often felt to be an economic liability because of the dowry system. In general an Indian woman is less likely to seek appropriate and early care for disease, whatever the socio-economic status of family might be. This gender discrimination in healthcare access becomes more obvious when the women are illiterate, unemployed, widowed or dependent on others.

The growth of private healthcare sector has been largely seen as a boon, however it adds to ever-increasing social dichotomy. The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards urbanbiased, tertiary level health services with profitability overriding equality, and rationality of care often taking a back seat. The increasing cost of healthcare that is paid by 'out of pocket' payments is making healthcare unaffordable for a growing number of people. The number of people who could not seek medical care because of lack of money has increased significantly between 1986 and 1995. The proportion of people unable to afford basic healthcare has doubled in last decade. One in three people who need hospitalization and are paying out of pocket are forced to borrow money or sell assets to cover expenses. Over 20 million Indians are pushed below the poverty line every year because of the effect of out of pocket spending on health care. In the absence of an effective regulatory authority over the private healthcare sector the quality of medical care is constantly deteriorating. Powerful medical lobbies prevent government from formulating effective legislation or enforcing the existing ones. A recent World Bank report acknowledges the facts that doctors over-prescribe drugs, recommend unnecessary investigations and treatment and fail to provide appropriate information for patients even in private healthcare sector 28 . The same report also states the relation between quality and price that exists in the private healthcare system. The services offered at a very high price are excellent but are unaffordable for a common man. This re-emphasizes the role socio-economic inequality plays in healthcare delivery.

Conclusions

Effects of social and economic inequality on health of a society are profound. In a large, overpopulated country like India with its complex social architecture and economic extremes, the effect on health system is multifold. Unequal distribution of resources is a reflection of this inequality and adversely affects the health of under-privileged population. The socially under-privileged are unable to access the healthcare due to geographical, social, economic or gender related distances. Burgeoning but unregulated private healthcare sector makes the gap between rich and poor more apparent.

DR MOHAN DURVE PRESENTS CME PROGRAMS FOR YEAR 2012-2013

Antarctica (15 days) Dec 4, Dec 29, 2012 Jan 7, Feb 9, 2013 From $8049 inside cabin

Australia/New Zealand (14 days) July 23, Aug, 6 Sept 10, Oct 15, 2012 From $2499

July 23 or Oct 15 air promo $1000.00 off companion air

***Bhutan & Sikkim Sept 6 – 19, 2012 Approx $4000 w/air**

*__Caribbean, S Cruise (Miami) Grand Turk, Dominican Republic, Curacao, Aruba Jan 5 – 13, 2013 From $840__

China w/Yangtze cruise (16 days) June 15, Oct. 5 2012 April 18, May 20, 2013 From $2349 + Internal air $720

Cuba Aug 23 – 31, 2012 call for other dates in 2012 or 2013 From $3799

***Equidor(S. America) Avenue of Volcanoes Jan 21**, Feb 18, April 5 2013 From $2099

Holland, Belgium & Paris (Flower Exhibition from around the world only q 10 yr) 6/15, 7/19, 7/23, 9/3 From $2599

Italy (9 days) Rome, Florence, Siena, Venice, Lake Como 6/11, 7/23, 9/3, 9/24, 10/3 2012 From $2199

***Madagaskar Oct 27 – Nov 8, 2012 From $3995**

National Parks of America 6/17, 7/7, 7/14, 7/21, 8/11, 8/19, 9/16, 9/22/2012 From $2999

Palace on Wheels, India Departure Every Wednesday From $3500

***Patagonia (S. America) *Feb 14** , March 7 2013 From $5379 with internal air

***Portugal** (Estoril Coast, Azores & Madeira Islands) (13d) **Sept, 21, 2012** or 2/15/13From $2099+$540 Internal air

Russian River Cruise (St. Petersburg to Moscow) 6/18, 7/7, 9/2, 2012 From $2099

S. America (Buenos Aires, Iguassu & Rio) 9 days Travel any day you wish From $2899

Scotland June 18, Aug 13, Aug 20, Sept 10 From $2049

South Africa (13 days) 7/5, 9/22, 10/25, 11/8, 2012 From $2599 + Internal Air $320

Switzerland & Italy (Alpine Lakes & Scenic Trains) (10 days) 5/11, 6/8, 7/6, 8/17,10/12/2012 From $2999

Thailand (14 days) Nov 2, 2012 or Feb 15, 2013 From $1349 + Internal Air $360

Vietnam, Loas & Cambodia (19 days) 9/20, 11/1 2012 2/14/2013 From $3249

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dream destination on your dates of choice all around the world!

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Thanks

Milind and Anupa Deogaonkar
Editorial team