HEALTH at whose cost?

THE REGISTERED MEDICAL PRACTITIONERS IN DELHI

A REPORT
on the status and services of RMPs in Delhi

Hazards Centre (Sanchal Foundation)

2006

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A unit of Sanchal Foundation

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Publication: 2006

Financial Support: Ford Foundation
Action Aid India

Publisher: Hazards Centre
92-H, III Floor, Pratap Market,
Munirka, New Delhi – 110067

Printer: Laxmi Paper Sadan & Printers,
9891094240

Suggested Contribution:

* The Material provided in this book may be used freely with due acknowledgement to authors and Hazards Centre

Work and health

In October 2003, responding to a writ petition (No. 657 of 1995) by the Research Foundation for Science Technology and National Resource Policy, the Supreme Court appointed a Monitoring Committee to look into the issue of safe disposal of hazardous waste from industrial areas. This Committee (SCMC) also began an enquiry into the status of hazardous waste disposal in Delhi and a small group came together in June 2004 in Delhi, calling itself the Delhi Suraksha Samiti (DSS), to provide independent evidence before the SCMC. Hazards Centre was part of the DSS, which conducted extensive surveys in different industrial areas of Delhi and presented a report titled "Hazardous Waste (mis)Management in Delhi", before the SCMC, arguing for putting in place an integrated waste management system, and holding those to account who were supposed to put such a system in place. Taking cognisance of the many startling facts that came to light from the DSS report, the SCMC undertook a tour of the Wazirpur, Nangloi, and Mangolpuri industrial areas and this was facilitated by DSS. But, after mildly admonishing the Delhi Government and the Delhi Pollution Control Committee, the SCMC ordered that 1,777 "hazardous industrial units" in these industrial areas be sealed within the next 24 hours! This meant that at least 20,000 workers and their families (all in the informal sector) would have lost their livelihoods.

Hence, the DSS renewed its efforts to persuade the SCMC that closure of industries was not the answer but that there was a greater need to get the appropriate regulatory authorities to put an integrated hazardous

waste management system in place, that would consist of primary treatment at the unit level, transportation of the hazardous waste, and final disposal in an engineered landfill. These efforts paid off when the SCMC appointed a Supervisory Group (SG) in September 2004 to supervise the operation of the Common Effluent Treatment Plants in the industrial areas, and one of the DSS members was nominated as part of this SG. Once the SG ceased its work, the SCMC appointed a Local Area Environment Committee (LAEC) in March 2005 to study the waste management practices and suggest improvements. This time a member of Hazards Centre was nominated to the LAEC. From April 2005 to January 2006 the LAEC paid several visits to the different industrial areas, and it was during this period that the researchers of the Centre began to appreciate the magnitude of the occupational health problems of the workers in the industries and the estates who were handling the hazardous waste. Consequently, they attempted to take up issues of safety, treatment, and compensation with the workers.

For instance, in discussions with the workers and the labour community at Wazirpur, a few facts came to light regarding the consequence of injuries and accidents at work. Workers mentioned that whenever any untoward accident occurs in the factory and, if the victim is willing to fight for compensation, then the only way is through the trade unions. There are around 200 such unions functioning in the industrial area and they charge a fixed percentage from the workers for their 'service', irrespective of the decision of the labour court. Therefore, most of the interviewed workers did not consider this to be an action that would actually get them any compensation. They also noted that the factory owners have appointed two doctors in the area, and if any accident occurs the workers are forced to approach these doctors. Being loyal to the owners the doctors don't give any certificate of illness to the

workers. The adjoining Employees State Insurance (ESI) hospital is in a bad state, lacking basic equipment and with insufficient doctors. The nearby government hospital is also in a similar condition. The workers usually get only Rs 1,500 per month, half the official minimum wage. Only the workers in the steel-plating factories receive Rs 3,000 per month, and this is considered to be a high wage in the community, although the industry is a very high risk one. Hence, the only accessible and affordable treatment available was from the Registered Medical Practitioners (RMP).

RMPs – providers of health

It was thus that the researchers realised that the primary level of treatment that the workers received was from the RMPs who were local residents or had their clinics in the worker colonies (or jhuggi bastis). These RMPs, often referred to as jhola chhap or Bangali doctors, had some qualification or association with one or the other of the indigenous systems of medicine but were not authorised to practice allopathic medicine. However, many of them took recourse to commonly available allopathic drugs in order to alleviate what they could of the suffering of the workers. Thus, they fell afoul of the law in this regard and, it was further learnt, there was a recent ban on their ability to practice in Delhi. Hence, even this first line of defence for health was in danger of collapsing and, in the absence of any other affordable and accessible system, this would have grievous consequences for the workers in the industrial areas. Hazards Centre, therefore, began interacting with the RMPs to try and understand their problems, their strengths and limitations, and the potentials implicit in having a low-cost medical response team immediately available at the hazardous site itself. Eventually, this led to the idea of organising a public hearing on the situation of the RMPs in order to bring to public notice the problems faced by this somewhat unique group of para-professionals in the health arena.

After a three-month preparation, the public hearing was organised on July 29, 2006 at the Jawharlal Nehru University City Centre on

Ferozeshah Road. It was attended by 71 RMPs and presided over by a panel consisting of the following members:

1. Dr Imrana Qadeer, Retired Professor, Jawaharlal Nehru University
2. Dr Alpana Sagar, Centre for Social Medicine and Community Health, JNU
3. Dr Rajib Dasgupta, Centre for Social Medicine and Community Health, JNU
4. Dr Mira Shiva, All India Drug Action Network
5. Dr Amod Kumar, Community Health Centre, St Stephen's Hospital
6. Dr P K Malakar, ex-President, RMP Association, and
7. Mr Dunu Roy, Hazards Centre.

After a brief introduction by Mrinalini Goswami and Sadre Alam of Hazards Centre, the hearing was initiated and extended over two sessions during the whole day. A small survey form was also filled in by the RMPs during the lunch break so that their status could be quantified in some rudimentary manner. A brief summary of the survey findings was presented after lunch by Banajyotsna Baruah of the Hazards Centre. This report gives a brief account of the proceedings of the hearing, along with the specific suggestions and recommendations that emerged at the end of the hearing.

Initially, it would be useful to give the findings of the survey that was conducted during the lunch break, in order to set the context within which the RMPs see the situation in which they operate.

The RMPs, as described above, are those medical professionals, who may not be recognised by the India Medical Council Act, 1956, or the Indian Medical Degrees Act, 1916. Prior to 1954, recognising the paucity

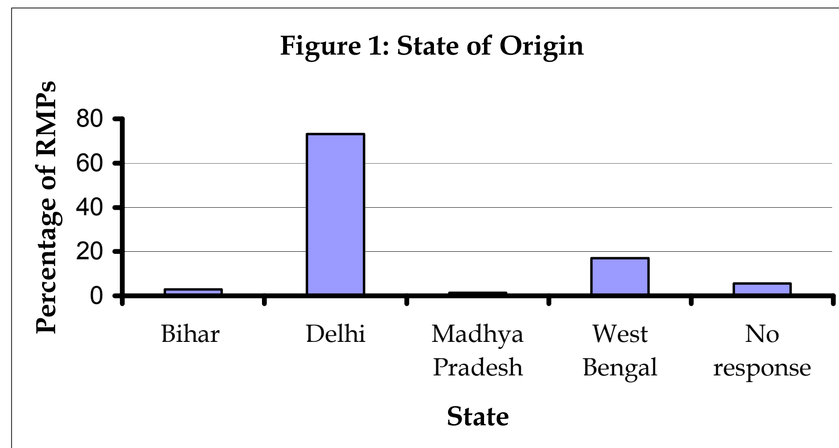
of health care available in rural areas, the Medical Council of India used to register them as Rural Medical Practitioners (RMPs), but the India Medical Council Act was amended in this regard in 1964, to insert sub section 2 in section 15 which made a statutory provision not to recognise the RMPs. The new sub-section also prohibits the practice of medicine in any state by a person who is not enrolled as a medical practitioner as per the Act. Any person who acts in contravention to this provision has been made liable to a fine up to Rs 1,000 and/or imprisonment for a term of one year.

Age and origin

There were 71 RMPs who attended the hearing and filled in a questionnaire. It was clear that 55 of them (77%) were in the age group 25 to 45 years (Table 1), and most of them (76%) had been in Delhi for more than 10 years (Table 2). The RMPs are commonly known as 'Bangali' doctors, which have also given a handle to their detractors to claim that they are 'foreigners' from Bangladesh. However, of the 71 respondents, only 12 claimed to be from West Bengal. The huge majority (73%) identified themselves as belonging to Delhi (Figure 1).

Table 1: Age of RMPs (percentage)	
25--35	32.4
36--45	45.1
46--55	19.7
56--65	2.8
Total	100

Table 2: Years of stay in Delhi (percentage)	
1--10	24.0
11--20	53.5
21--30	12.7
31--40	2.8
41--50	2.8
No response	4.2
Total	100



Education and experience

The educational background of the RMPs was varied. A majority of them (70%) had completed their secondary or higher secondary schooling, only 19 (26%) of them were graduates or post-graduates (Figure 2). Yet, several of them claimed to have acquired experience and qualifications in different practices of traditional medicine as well as allopathy (Table 3). A large number (72%) said that they had acquired the skills while "training" with MBBS doctors, while almost half (44%) said they had gone through some formal course, and a few (28%) had an ancestor who practised the same discipline (Table 4). However, it was apparent that there was no one path through which the RMPs had become medical practitioners. As many as 62% of them had tried more than one route for obtaining the experience, in combinations of formal and informal methods, including Chinese herbal medicine and electrotherapy.

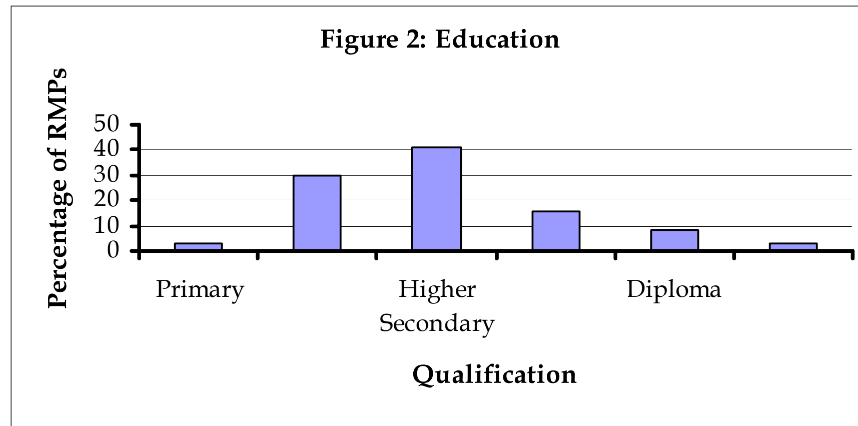
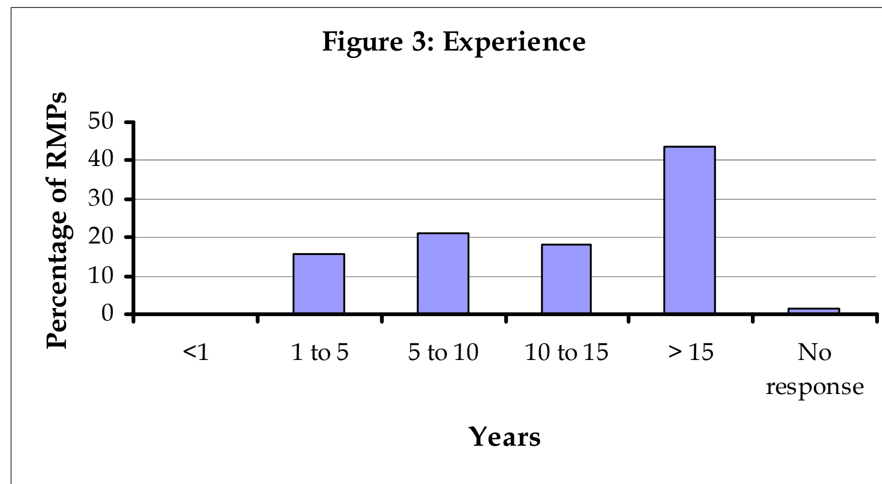


Table 3: System of Medicine Practised (percentage)	
Allopathy	69.4
Homeopathy	5.6
Ayurveda	66.2
Unani	31.0
Others	2.8

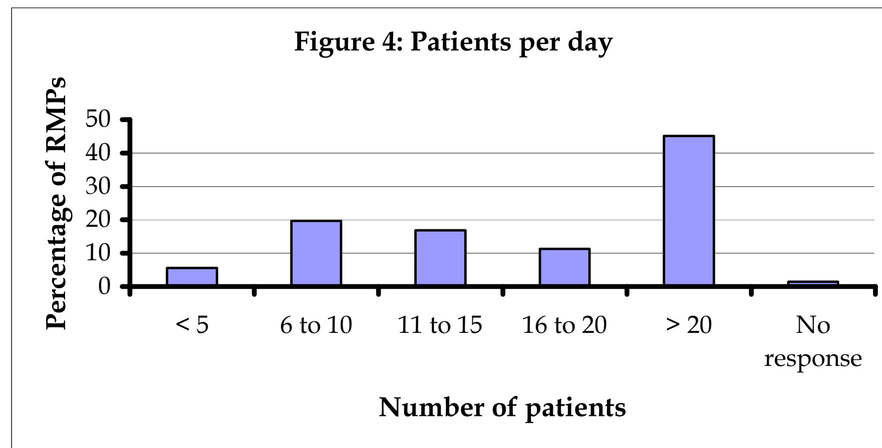
Table 4: Skills developed through (percentage)	
Training with MBBS doctors	71.8
Ancestral profession	28.2
Formal training	43.7
Self taught	5.6
Others	62.0

The experience of the RMPs was, in fact, their most valuable asset since it provided them the basis for diagnosing and treating various illnesses prevalent in the labour colonies where they practised. The survey revealed that 44 of the RMPs (62%) had a base of more than 10 years experience, while 31 (44%) had been practising for more than 15 years (Figure 3).



Patients and cost

It is perhaps this experience that generates the confidence within the labour colonies for treatment by the RMPs. The RMP respondents themselves estimate that they receive, on an average, more than 10 patients a day and, in the case of 32 (45%) RMPs, they are reporting more than 20 patients a day (Figure 4).



The other important factor is the cost of the treatment. The RMPs reported that their visiting fees largely lay within the range of Rs 5 to Rs 30 (Tables 5 and 6). This is an amount that is within the reach of workers earning between Rs 1,500 to 3,000 per month. Furthermore, the patients do not need to take an appointment before coming and the RMPs are easily accessible for most of the 24 hours since they are often living within the community or just next to it.

Table 5: Minimum fees taken (percentage)	
Less than Rs 5	1.4
Rs 5 - 10	46.5
Rs 11 - 15	19.7
Rs 16 - 20	24.0
More than Rs 20	5.6
No response	2.8

Table 6: Maximum fees taken (percentage)	
Rs 10 to 20	29.6
Rs 21 to 30	31.0
Rs 31 to 40	11.3
Rs 41 to 50	15.5
Rs 51 to 60	8.5
More than Rs 60	1.4
No response	2.8

The charges for different illnesses also seem to compare favourably with the charges levied by MBBS doctors for similar illnesses (Tables 7 to 14), as per the information given by the RMPs. Thus, for instance, the charges taken by the RMPs for most

illnesses range between Rs 15 to 50 as compared to the Rs 75 to 200 (and upwards) charged by MBBS doctors.

Table 7: Charges for Diarrhoea			
RMP charges (percentage)		***MBBS charges (percentage)***	
< Rs 5		< Rs 25	
5 to 10	4.2	25 to 50	1.4
10 to 15	7.0	50 to 75	1.4
15 to 20	22.5	75 to 100	24.0
20 to 50	28.2	100 to 200	12.7
50 to 100	4.2	200 to 500	12.7
> Rs 100	5.6	> Rs 500	19.7

Table 8: Charges for Fever			
RMP charges(percentage)		***MBBS charges (percentage)***	
< Rs 5		< Rs 25	2.8
5 to 10	1.4	25 to 50	2.8
10 to 15	5.6	50 to 75	1.4
15 to 20	26.8	75 to 100	18.3
20 to 50	37.1	100 to 200	26.8
50 to 100	14.1	200 to 500	21.1
> Rs 100		> Rs 500	2.8

Table 9: Charges for Fever with chills			
RMP charges (percentage)		***MBBS charges (percentage)***	
< Rs 5		< Rs 25	4.2
5 to 10	2.8	25 to 50	4.2
10 to 15	8.5	50 to 75	
15 to 20	28.2	75 to 100	21.1
20 to 50	23.9	100 to 200	19.7
50 to 100	9.9	200 to 500	12.7
> Rs 100		> Rs 500	5.6

Table 10: Charges for Fracture			
RMP charges (percentage)		**MBBS charges *(percentage)***	
< Rs 5		< Rs 25	
5 to 10		25 to 50	
10 to 15		50 to 75	
15 to 20		75 to 100	1.4
20 to 50	2.8	100 to 200	1.4
50 to 100	2.8	200 to 500	1.4
> Rs 100		> Rs 500	1.4

Table 11: Charges for Jaundice			
RMP charges (percentage)		MBBS charges (percentage)	
< Rs 5		< Rs 25	2.8
5 to 10		25 to 50	
10 to 15	1.4	50 to 75	
15 to 20	5.6	75 to 100	5.6
20 to 50	8.5	100 to 200	4.2
50 to 100	7.0	200 to 500	7.0
> Rs 100		> Rs 500	

Table 12: Charges for Cuts			
RMP charges (percentage)		MBBS charges (percentage)	
< Rs 5	2.8	< Rs 25	
5 to 10	1.4	25 to 50	1.4
10 to 15	4.2	50 to 75	2.8
15 to 20	12.7	75 to 100	5.6
20 to 50	26.8	100 to 200	21.1
50 to 100	7.0	200 to 500	14.1
> Rs 100		> Rs 500	9.9

Table 13: Charges for sprains			
RMP charges (percentage)		MBBS charges (percentage)	
< Rs 5	1.4	< Rs 25	
5 to 10		25 to 50	
10 to 15		50 to 75	1.4
15 to 20	8.5	75 to 100	4.2
20 to 50	7.0	100 to 200	2.8
50 to 100	2.8	200 to 500	4.2
> Rs 100		> Rs 500	7.0

Table 14: Charges for Malaria			
RMP charges (percentage)		MBBS charges (percentage)	
< Rs 5		< Rs 25	
5 to 10	1.4	25 to 50	1.4
10 to 15	4.2	50 to 75	2.8
15 to 20	8.5	75 to 100	5.6
20 to 50	15.5	100 to 200	9.9
50 to 100	5.6	200 to 500	9.9
> Rs 100		> Rs 500	4.2

Note: Percentage may not add up to 100 because of multiple replies or no replies.

Ailments and treatments

However, as is obvious even from the responses given above (Tables 10, 11, and 13), the RMPs do not seek to treat all diseases and all patients. When asked about the ailments that they commonly deal with, they listed out several illnesses, which they are comfortable treating or for which they seem to have the requisite skills and experience (Tables 15 and 16). Thus, ordinary fevers, coughs and colds, gastro-intestinal complaints, and skin diseases are treated, as are mild burns and cuts. But more serious ailments, for which they feel they are not equipped, such as typhoid and pneumonia and allergies, as well as severe burns, cuts, and fractures, are apparently referred to more competent authorities and facilities - almost entirely in the public sector (Table 17).

Table 15: Common ailments treated by RMP ***(percentage)***					
Fever	71.8	Itching	21.1	Typhoid	7.0
Cough	56.3	Wound	21.1	Pneumonia	5.6
Dysentery	47.9	Skin	17.0	Gastric	5.6
Piles	47.9	Fistula	8.5	Allergy	5.6
Pain	33.8	Jaundice	8.5	Dental	4.2
Cold	33.8	Asthma	8.5	Bleeding	2.8
Nausea	28.2	Arthritis	7.0	Others	53.5

Table 16: Injuries treated ***(percentage)***	
Mild burns	74.6
Severe burns	4.2
Fractures	4.2
Mild cuts	81.7
Severe cuts	7.0
Others	25.4

Table 17: Referrals to other service providers (percentage)	
Public health services	81.7
Private services	1.4
Others	14.1
No response	2.8

What is also notable is the nature of commonly available drugs that are prescribed by the RMPs (Table 18), the sources from which these are acquired (Table 19), and how many RMPs say they give written prescriptions to the patients (Table 20). As is evident from their statements, the RMPs focus on ayurvedic drugs, but some do prescribe common allopathic drugs such as tetramycin, amoxycilin, analgesics and anti-pyretics like paracetamol, and vitamins and antacids. A few also combine one system with the other. But, by and large, they source their medicines from medical stores and dispensaries. A little over half are confident enough to give prescriptions to their patients too.

Table 18: Drugs prescribed by RMPs (percentage)	
Ayurvedic	29.4
Allopathic	31.0
Analgesic anti-pyretic	28.1
Combined	17.0
Tonics and vitamins	8.5

Table 19: Source of drugs *(percentage)*	
Medical stores	74.6
Wholesalers	9.8
Dispensaries	4.2
Ayurvedic stores	2.8

Table 20: Prescription given *(percentage)*	
Yes	53.5
No	46.5

The Hearing

Several RMPs gave brief accounts of their personal experiences and also provided insights into the problems faced by the RMPs in general. In particular, many of them highlighted the campaign launched by the Delhi Government to illegalise the RMPs under pressure from the Association of the MBBS doctors.

A K Biswas began his career in 1979 with a fee of Re 1.50. He learnt from his guru in Gwalior where he had worked as a compounder, then joined Kurukshetra University for a course in ayurveda, was registered in Patna, received a certificate in Unani from Allahbad, initially practised in Muzaffarpur, and then moved to Nangloi in Delhi where he began providing cheap health services to poor patients in the industrial slums. He currently specialises in piles and abscesses and refers other patients to MBBS doctors. This was a typical trajectory for the RMP. According to him, the condition of the RMPs was satisfactory until 1990, when the BJP government began proceeding against the RMPs classifying them as ignorant and *jhola chhap*. In 1994, the RMPs organised a dharna at Rajghat before the Union Health Minister and the Delhi Chief Minister (both from the BJP), demanding an end to police harassment and extortion. Later they also organised a 9 day dharna at Jantar

Mantar protesting against the ban on their practice, but the then Congress Chief Minister refused to recognise them. The on-going industrial closures served to intimidate the RMPs and ignore their demands for proper training in hospitals. He commented on how the RMPs were able to provide cheap services as compared to the MBBS doctors because they did not have to recover the large amount of money spent on their medical education. The UMP (Unqualified Medical Practitioner) recognition offered by the Tamilnadu Government to non-MBBS doctors was a scheme which could be duplicated in Delhi too.

D K Arora observed that there were graduates and post-graduates in the ranks of the RMPs with certificates from government boards. Allopathic medicines were being banned for the RMPs although they are freely advertised in the media. This was being done at the instance of the Delhi Medical Association (DMA), which was powerful in resources, media access, and political connections. This was despite the fact that there were 40,000 RMPs in Delhi, organised into a Federation of 13-14 associations, and these RMPs were providing health services to a minimum of 400,000 patients per day at Rs 20-50 per patient, as compared to the Rs 500-1000 charges levied by MBBS doctors. If the RMPs were removed how would the government hospitals be able to replace their services? Individuals like Asa Ram Bapu and Baba Ramdev have no degrees either but they distribute medicines and are highly regarded as godmen! Ayurveda has a much longer tradition than allopathy, particularly for chronic

diseases, but if the RMPs are unable to treat some cases then it should be recognised that allopathic doctors too fail from time to time, and both failures are unintended. If the RMPs are provided proper training with referral facilities to hospitals, they can be brought into the mainstream. This was the recommendation of a Select Committee but the government has not taken any action on this so far.

G S Gehlot emphasised that the RMPs provided cheap and appropriate primary services to those people who are not touched by the MBBS doctors. The Act of 1945 prescribes the legal status of RMPs, as registered under Regional Boards. In addition, the Drugs and Cosmetics Act gives the authority to RMPs to practice. The RMPs had even acquired No Objection Certificates (NOCs) in 2000. The experience certificate given by government to compounders in rural areas also provided the basis for practising in Delhi. In 1974/75, when the slums were being demolished in Delhi and resettled in uninhabited areas, it was the RMPs who provided affordable services in places like Nandnagari. Thus, the RMPs had a Constitutional right to pursue their profession. However, the DMC Act was passed in 1997 because of pressure from the DMA. The government had, at that time, given an assurance to pass an amendment to favour the RMPs but this promise was not implemented. He repeated the demand that the RMPs in Delhi should be recognised under a scheme similar to the UMPs in Tamilnadu.

A K Roy also highlighted the old heritage of Ayurveda and regretted that vaids were now being classified as RMPs and *jhola chhap*. He asked, what is the experience certification of MBBS doctors, and how does it compare with the hands-on experience of the RMPs? The MBBS doctors don't want the RMPs and it is an unequal struggle but, in fact, the two are complementary. Since it is the Boards who are certifying the RMPs, it is the Boards who should be held responsible for irregularities. If the Medical Council of India (MCI) certification permits MBBS doctors to practice anywhere in India, then why does Board certification not allow RMPs to do the same? Now that Board registration has been closed after March 1994, what will happen to the pre-94 RMPs and to the people they treat? If the RMPs are provided proper enrolment and training, they will not only be able to provide better services but also add to the revenue of the government. The RMPs already provide health services in the dirtiest of slums, sometimes on credit, to the poorest of the poor, and it is necessary to remove the fear from the minds of the RMPs.

Manoj Roy illustrated that the police had been given the authority to prosecute the RMPs for their supposed incompetence, but the police have no idea of the medical profession and only know about the requirement for registration with the Boards, thus harassing the RMPs. As per the classification by Central Council for Indian Medicine 1971 (CCIM), constituted under the Indian Medicine Central Council

Act 1970 (IMCC), both MBBS and RMPs are actually medical practitioners, but since the MBBS doctors are unwilling to go to rural areas, hence the RMPs were registered to provide services there. The notification by the DMA for banning of RMPs was challenged in the High Court and subsequently, the IMCC Act and East Punjab Ayurvedic Unani Act were presented for consideration before the Supreme Court. But the BJP-led Delhi Government presented the DMC Act (replacing CCIM as the registering authority), the Delhi Homeopathic Board Bill, the Delhi Bharatiya Chikitsa Board Bill (replacing the Ayurvedic Unani Board), and the Neem Hakeem Nishedh Vidheyak before the legislature. This was opposed through a dharna at Jantar Mantar and a Select Committee was formed, which gave its recommendations as follows: to practice in Delhi, a RMP had to be registered in Delhi; the RMPs should be assessed for their knowledge; they should be provided adequate training; and loans should be given for facilitating employment. But the recommendations were ignored and 3 of the Bills passed after incorporating provisions from the 4th, taking away the right of RMPs to practice in Delhi. He, therefore, repeated the proposals that RMPs should be given adequate training, the 1998 Act should be amended to recognise non-Delhi Board certifications, and Primary Health Centres could be started in slums where the RMPs would provide free services by turn.

A K Malakar recommended that the centuries old vaid tradition could be preserved by registering them at the State Government

level, and allowing them to train with MBBS doctors. They could then treat the non-serious cases, while referring the serious ones to MBBS doctors and hospitals. They would thus be able to serve the poorest people, whom the MBBS doctors are unwilling to treat, and do this with the minimum of infrastructural needs. It was their treatment, which won the confidence of the people, and enabled them to serve the poor. He himself had not lost a single patient in 15 years of practice, so there must be some proof of the supposed incompetence of the RMPs. In fact, no RMP is invited to lecture at the Indian Medical Association when he saves a patient. Even the two-dozen medicines that the RMPs prescribe are commonly available at grocery stores, while 75% of the nursing homes are dependent on the RMPs for their custom. The supposed lack of knowledge of the RMPs only impedes their curative ability, hence only further emphasising the need for proper training. But for this, police harassment for not possessing appropriate certificates had to be immediately stopped.

Mukul reiterated that the RMPs have the experience in curing chronic diseases under adverse circumstances. The registers of the RMPs could even be used to establish the disease patterns of the unserved poorer population. But they need to have more knowledge about diseases and medicines and their side effects. ***B S Thakur*** described the changing face of 'world-class' Delhi as an attempt to shut out the poor. Within this context, if the RMP were to be eliminated then the poor too would die. By illegalising the RMP, the government would be forcing the RMPs to engage in

'illegal' activities and lose the respect gained after years of struggle in serving that social group whose income is between Rs 1500 to 3000 and which is unwilling to go to the unresponsive government hospital and dispensary. The financial earnings of the RMPs are, in fact, a reflection of the paying capacity of the poor and the limits of their practice. But the real earning of the RMP is the respect and reputation he gains by providing satisfactory services to the community. What will happen to this community if they are deprived of the services of the RMP, given their financial position and their inability to afford the MBBS doctor? ***R K Roy*** repeated the charge that the government has allowed 20 drugs to be sold through grocery stores, but objects to the RMPs prescribing the same drugs. While the DMA has been active in banning the RMPs, the MBBS doctors have to maintain good relations with the RMPs because they refer patients to the doctors. Hence, better training and a proper certification procedure would only assist the RMPs to perform better.

Mohammed Mushtaq reasoned that homeopathy requires both time as well as pure German medicines to be effective, and the poor may not be able to afford either. Even though, within these adverse circumstance, the RMP was able to treat patients, the social status of the RMPs was a matter of concern and could only be achieved through united action. ***P S Puri*** also concurred with the observation that the government was trying to convert Delhi into Paris and therefore, the poor have to be removed. But the poor constitute the majority of the population and it is them that

the RMPs are providing services to, doing what the government is unable or unwilling to do. ***Chandrajit*** explained that the unqualified individuals who work in hospitals and with doctors as assistants and compounders eventually become RMPs through experience. The RMPs are also grounded in age-old traditions of ayurveda and unani. Hence, if the RMPs are to be banned, then so should the nursing homes who also employ unqualified persons. ***Shamim*** claimed that the experience of the RMP was sometimes superior to that of the MBBS doctor. ***G K Gehlot*** summarised some of the arguments by commenting that training schemes for RMPs had been started in Madhya Pradesh under the Digivjay Singh government. It was recognised that the RMP was characterised as '*jhola chhap*' not because of his lack of qualifications and skills, but because of his ability to serve the poor. Incorrect practices are being followed even in the hospitals by MBBS doctors, which results in death, but the hospitals do not fail to charge heavily for these. To, therefore, call RMPs 'looters' merely because they charge Rs 10-20 from their patients is an insult to their service to the community.

In Conclusion

Before the panel gave its observations on the proceedings of the public hearing, a representative of the ***Mahanagar Mazdoor Sangathan*** extended the support of the Sangathan to the RMPs in their struggle to legally provide better health services to the poor.

Dr P K Malakar agreed that the city of Delhi is rapidly changing. While on one hand, the city is catering the needs of the rich, on the other, it is becoming worse for the slum dwellers. In the name of 'clean environment', the poor are being thrown to the margins. Money is the norm against which everything is judged. If the RMPs had money, they would also have become MBBS doctors and earned more money. But now they are being asked to leave the city. However, the RMPs have Constitutional rights to work in Delhi. In order to protect those rights, the RMPs will have to inevitably come together and unite for a common struggle. He welcomed the hearing as a welcome step in this direction.

Dr Rajib Dasgupta commented that he had learnt a great deal about the problems of the RMPs during the course of the hearing. He observed that the National Rural Health Mission provides space for informal practitioners and the RMPs could profitably examine how they could use the Mission to achieve their goals.

Dr Amod Kumar explained that the RMPs were very much a part of the outreach programme of St Stephen's Hospital because they are the only resource available at the slum level. This has

happened in spite of the opposition by the DMA within St Stephen's. He agreed that the RMPs should demand training to establish parity with the MBBS doctors because there is a need to work together to provide common services to the entire city.

Dr Alpana Sagar observed that the MBBS training was implicitly in conflict with the vocation of the RMPs. She suggested that the RMPs should maintain detailed records about their occupation and the number of patients who came to them so as to establish the value of the service that they provided. She welcomed the wider knowledge base of the RMPs because they practiced and benefited from different systems of medicine. She also concurred with the demand for better training at government hospitals. But since the RMPs provide basic care, they also need basic training which has to be clearly identified.

Dr Imrana Qadeer gave a brief summary of the hearing and thanked everyone for contributing to the informative discussion. She highlighted the following concerns:

- The issue of services for the urban poor should be emphasised as well as the weaknesses of the RMPs identified;
- There are 40,000 RMPs in Delhi as against a membership of 10,000 in DMA: this underlines the need for organisation;
- Therefore, all the RMPs should also be well informed about their legal rights, which should be documented and disseminated;

- The provisions for informal practitioners under schemes like the National Rural Health Mission should also be examined;
- Training is crucial to enable RMPs to overcome their limitations, particularly in the area of sanitation and hygiene;
- In this regard, it would be necessary to quantify the number of patients, the pattern of diseases, and the social group to which the patients belong;
- There is a need to work out a via media that would resolve the conflict between the MBBS doctors and the RMPs;
- The RMPs could make the '*jhola*' their symbol of identity, rather than regard it as a sign of inferiority.

Dr Mira Shiva identified the people's requirements for health and praised the RMPs for serving the poor and the community. She encouraged them to approach the Planning Commission with their recommendations for urban health planning. She also emphasised on the need to analyse the various Acts pertaining to health, and on a sound knowledge of drugs, diseases, and safe and affordable treatment as outlined in classics like "Where there is no Doctor". The new Drug Policy will increase the price of medicines and, thus, she called upon the RMPs to resist it as part of their campaign for better health.

Mr Dunu Roy suggested four points for carrying the process of the hearing further:

- A survey has to be conducted, somewhat on the lines of the questionnaire filled in during the course of the hearing, to

quantify the value of the services being provided by the RMPs.

- The legal position has to be critically analysed and a campaign launched for the revision of the DMC Act to legalise the RMPs, with provisions for self-regulation.
- A demand for proper training of the RMPs has to be made to the Government, which would include aspects of occupational and environmental health.
- Another larger hearing with the help of the communities from the poorer settlements would help in mobilising public opinion for this purpose.

The above suggestions were endorsed by the gathering and a committee was immediately constituted to carry the process further. The hearing then concluded with a vote of thanks and on a note of optimism.

Members of the Committee:

- Mr G S Gehlot
- Mr P K Malakar
- Mr A K Roy
- Mr D K Arora
- Mr Manoj Roy
- Dr Imrana Qadeer
- Mr Dunu Roy

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