Letter from Chennai

THE MEDIA AND SUICIDE

Dr Lakshmi Vijayakumar, founder of Sneha, the trust that aims to prevent suicide, organized a workshop on the role of the media in suicide. I was keen on attending and giving you a report, but unfortunately other commitments kept me away. However, she was kind enough to give me an outline of what she said on the occasion, and the comments of the media persons, and to permit me to present it to you in this column.

Goethe wrote a novel, *The sorrows of young Werther*, in which a disappointed lover committed suicide. A few young lovers who read the book were led to follow suit, and this phenomenon is known as the Werther effect. The largest effect, said Dr Lakshmi, was after Marilyn Monroe committed suicide in August 1962. That month the suicide rate was 12% higher than that in August 1961. She listed many other instances of the Werther effect and offered certain guidelines to the media persons present, such as avoiding sensational language, not providing prominent placement for the story or much repetition, never giving the method in detail, respecting the privacy of the bereaved family members, and mentioning ways to seek help.

The media representatives, in turn, made their excuses, and Dr Lakshmi summarized them for me, and for you. There is competition among reporters to be the first to submit a story, and hence they do not have time to formulate their report. Their career depends on their target rating points (TRPs), and a sensational headline is more likely to raise their scores. Reporting of suicides is allotted to crime reporters and not to health reporters, and hence the reports are slanted in their perspective. And finally, they lack specific training in how to cover these topics, and learn on the job, especially in the television industry. They would, in fact, be grateful for any training that could be offered.

The Hindu, of 5 December 2018, carried a report on a Netflix serial about a teenager who kills herself. Mass media that deal with suicide are required to mention helplines for any viewer who needs psychological support, and Sneha was one of the two Indian organizations listed. There has been a rise in the calls to Sneha (by phone or email) from 30–40 daily a year ago to 50–60 now, and the number of people who said they were depressed has increased from 50% of the callers to 90%. Dr Lakshmi made an appeal through newspapers for more volunteers. Sneha has 45 at present, but needs twice that number. Volunteers should be above the age of 20 years, and should be ready to take turns at the night shift too.

I wondered whether, by analogy, the epidemic of rape we seem to be going through could also be driven by reports in the daily press, but Dr Lakshmi did not agree. She said more women are now emboldened to report the crime, and that explains the apparent increase in these crimes.

THE FIRST AUDIT OF HAEMODIALYSIS UNDER A GOVERNMENT HEALTH INSURANCE SCHEME

A group of nephrologists and public health workers analysed the use of maintenance haemodialysis in all 23 districts of undivided Andhra Pradesh from mid-2008 to mid-2012.[1] I am not aware of any detailed audit of the outcomes from the health insurance schemes of any of the other southern states, and am grateful to the authors for this reality check. They say WHO has classified maintenance haemodialysis as a low priority service in view of poor cost-effectiveness. However, the southern states of India, and even the Central Government, have made this the major item of their health budget, because it captures the attention of the public and has proved to be an excellent way of gathering votes, and winning elections for many parties that offered this procedure. Government hospitals do not have adequate numbers of artificial kidneys or dialysis staff to cover the demand, so patients are reimbursed for dialysis in private hospitals, and governments end up paying the private sector, which earns enough without needing public funds.

Estimates of the annual incidence of end-stage renal disease vary from 229 to 870 per million Indians per year.[2] The intake of new patients for maintenance haemodialysis in Andhra Pradesh was 69.8 per million population, so a number of people have availed of this facility. Of the patients who received dialysis from 2008 to 2012, 17.1% died, and 63.5% withdrew from dialysis. I believe any reasonable dialysis programme should have at least 10 years of healthy survival. The more important finding is the high dropout rate. Why should anyone leave a free dialysis programme, especially as the alternative is a miserable death? Possibly the cost of travel to a dialysis centre may be too high for a really poor man to bear. Perhaps the patient is too ill to travel on his own, and there is no relative with the spare time to escort him or her to the dialysis centre. The most likely reason is poor rehabilitation. After a month, if dialysis is successful in restoring well-being, the patient could travel on his own.

The costs of the programme are increasing each year, and dialysis is taking an ever larger proportion of the expenses. Funds are limited, and something else will have to yield to make way for maintenance haemodialysis. Would it not be better to spend funds on some treatment modality that would yield long-term results and restore a patient to health, akin to surgery for cardiac disease, congenital or valvular? Funds spent on renal transplantation would be more productive. It would be easier for a working person to go to hospital once a month to receive a supply of immunosuppressives than go twice a week (all that government subsidized programmes offer) and spend an unproductive day in travel and on dialysis.

Tamil Nadu has an active dialysis programme under the chief minister's health insurance scheme. While there has been no audit of the efficacy and outcomes on the lines of that of Shaikh *et al*.,[1] an analysis has been done of the financial claims under this scheme,[3] and the results bear out my long-held views.[4] Extrapolating from the Global Burden of Disease study and the SEEK–India study, Selvavinayagam[3] estimates an incidence of end-stage renal disease at around 125 000 in Tamil Nadu. He finds only 4302 patients per year have benefited from the chief minister's programme of renal replacement. Around 3% of the need has been met.

The Times of India's Chennai edition of 26 November 2018 says the expense of dialysis is now the largest item of the scheme, taking 10% of the total, having overtaken cardiac surgery that consumed 7%. If we keep patients alive for 10 years at least, as a good dialysis programme ought to, these expenses will keep rising, and there will soon be no money for any other health-related activity. Ten per cent of the total health budget is spent on meeting just 3% of the 'renal' need. This programme is sure to fail.

It is not based on realistic plans, but just aims to make the public feel that something is being done.

Shaikh *et al.*[1] suggest that dialysis must be made more accessible by opening satellite dialysis units or promoting peritoneal dialysis, and the quality of care must be improved which suggests that the present funding of dialysis is probably inadequate. They mention an urgent need for 'development of a programme of care that includes early detection and prevention of kidney disease…'.

That programme of care has already been developed and sustained for almost 25 years, but governments in India have firmly shut their minds against it, because of the popularity of dramatic treatments. For a fraction of these costs, we could prevent 60% of renal failure in the community, and also produce major declines in the rates of coronary and cerebrovascular disease.[4] What is being done by all these State- and Centre-sponsored dialysis programmes is to divert precious funds away from more productive uses, and the recipients are not restored to health or productive life. This is money wasted. It does not prolong life, but merely extends the process of dying.

REFERENCES

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