

that India set up a body like NICE (UK) to evaluate cost-benefit of public health interventions before they are introduced in the country². Dr Lahariya says the idea sounds good but wonders how this institution would be better than the existing national and international expert advisory groups.

The distinction from existing advisory groups will be clear. Let me start with the national expert advisory groups. The India Expert Advisory Group (IEAG) on Polio is an example of an existing national expert group. It is interesting to understand how this body functions. This is detailed in a recent article³. A few weeks prior to the IEAG meetings the Ad hoc Advisory Group of Polio Eradication (AAPGE) of WHO meets and actually decides about the plan of action for next 6 months. This is simply adopted by the IEAG as its 'own' decision³.

Regarding international advisors, I will illustrate with two instances related to the pressure being brought from overseas to introduce hepatitis B and Hib into the national immunization programme.

Hepatitis B: To get India to accept hepatitis B, Dr M.A. Miller from the Centre for Disease Control (CDC) in Atlanta, authored an article in Health Economics⁴. He wrote that 189,000 people die each year of hepatitis B in India. He claimed to have used a model 'stratified by geographic area and income group' to arrive at his estimate. The ICMR cancer registry using a population - based register, suggests that only 5000 die of hepatocellular carcinoma (HCC) related to hepatitis B. HCC is the major cause of death from the disease and so we wrote to the journal, Health Economics, that the figure of 189,000 deaths was an exaggeration. Dr Miller was asked to publish his model or else retract his paper. Dr Miller wrote the model was "lost". The paper however, has not been retracted to date although the call for a retraction and his explanation of the model having gone missing were published⁵.

Authors' Response

Sir,

We thank Dr Lahariya for his interest in our paper¹.

I will address his last point first as it comes up in the introductory paragraph as well. We suggested

H influenzae b (Hib): Paediatricians and pathologists have long known that Hib disease in Asia is very low - about six in 100,000 compared to 109 in 100,000 in the Western Pacific⁶. It is speculated that cross immunity with organisms like *Escherichia coli* may be responsible⁷. Yet the thrust of international research on Hib in India has been to convince health planners that the problem was unrecognized due to poor microbiological facilities and the technical inability to culture the organism. The Invasive Bacterial Infections Surveillance Group (IBIS) conducted a study over 4 years in six large referral hospitals in India using the most sophisticated culture techniques. In the end they detected only 125 isolates⁸. Not convinced, the WHO undertook a large population based study. This reported the incidence of Hib disease at nine per 100,000⁹. Selective publication results in bias in the literature and should not be acceptable for internationally funded research. Yet, although completed in 2002, and the findings were presented at a conference, these results have not been published in the last 5 years.

'NICE India' will be able to evaluate the evidence such that the decision making process becomes transparent. If hepatitis B is to be introduced, NICE India will at first publish its intention to evaluate the vaccine. It will invite stakeholders to register their interest. Vaccine manufacturers, the WHO, civil society, patient interest groups, individual researchers and research institutes like the ICMR can all register. The body will then, independently, gather data and information. All stakeholders will contribute the evidence they hold. The mathematical model used to arrive at decisions on cost-effectiveness, cost-utility, affordability, and allocative efficiency described elsewhere¹⁰ can be applied to the data. A draft guideline will be written with these data. The draft and all the calculations will be sent to the registered stakeholders who will be invited to check if the guidelines can be challenged on the basis of evidence. NICE India will revise the draft with their inputs. The final report is sent to an independent

review panel that examines if all stakeholder evidence has been taken into account before it is published.

The correspondent asks who the selected experts will be. NICE India must include epidemiologists, health economists, public health specialists and other health professionals and representatives from a citizens' council. If the process is established and is transparent, it will matter little who is selected as expert. It is the procedures that need to be established and these must be completely transparent.

Other points raised are:

(i) Dr Lahariya¹ feels that, after the WHA passed the resolution to eradicate polio, it is not important that the first initiative was taken by Rotary. We feel differently. Health priorities and health targets should be made on firmer grounds than to coincide with the centenary celebrations of Rotary international.

(ii) We have not rejected or accepted the figure of 350,000 cases of polio in 1988. We only commented on how the figure was arrived at. The number of known cases of 'acute flaccid paralysis with residual paralysis' was simply multiplied by a factor of 10. We also commented on the fact that, when this exercise of counting cases of polio was redone in 2000, only stool culture positive cases qualified for inclusion. We agree with the correspondent, the two data are not comparable (Point 3).

Point 2 (continued): We can confirm that the reference is correctly cited for the statement. Dr Jacob John has indeed written in this article that 'polio eradication was not the priority number one for India'¹¹.

(iv) The strategy of 'name and shame' is described in the WHO Bulletin. It was not devised by us.

Dr Lahariya says mid-term corrections and adaptation are signs of a mature health programme and this is clearly visible with the polio programme. We admire the adaptations undertaken by the programme and the benefits in terms of surveillance. We cringe at the cost. Not only have we not got rid of polio, the attention given to this one programme has reduced overall immunization and we are seeing more and more cases of vaccine preventable diseases like diphtheria and measles.

The authors are active paediatricians who have deep interest in eradicating polio and who have worked to make the programme a success, but that has not blinded them to the folly of reaching out with more and more doses of a vaccines, where attention to water and sanitation can yield more returns.

Dr Lahariya concludes with the statement that a debate on our idea may be a foundation stone of future public health planning. We sincerely hope so.

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