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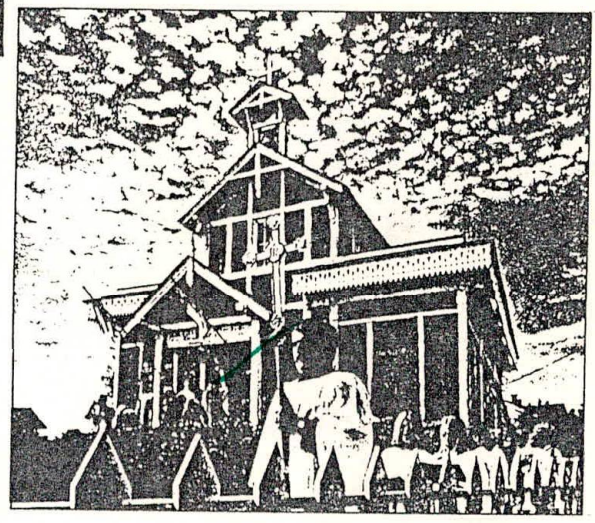
The Health Advocate

Will There Be Mission Hospitals In 2000 AD?



Various developments in the country's health policy, as well as disturbing trends within the voluntary sector, have led the author to question the permanence of mission hospitals

Dear Friends,

Having been closely involved with health action for over two decades — especially in the voluntary sector of the country, both Christian and non-Christian — I have gladly agreed to reach out to all the *CMJI* readers through this column, "The Health Advocate".

I will be regularly bringing to you my concern about the crises in the health missions, unmet needs, distortions in health care and disturbing trends in the emerging health policies, all of which could become obstacles to our commitment to Health For All by 2000 AD. I believe our concern should be supported by collected reflection and collective action in solidarity. Reflective action is the key to change and I hope this column will stimulate such a process among *CMJI* readers. Please write and let me know your own experiences and perceptions about the issues I will be raising in this column, so that I can weave them into subsequent columns and build further reflections in an interactive way.

In this first issue I would like to share one of my growing concerns, which would be of particular interest to you. It is a question that is beginning to loom on the horizon of voluntary health work in the country because of various developments in the country in the health policy, and also because of various disturbing trends within the voluntary sector and in the large societal universe around it — will there be 'mission' hospitals in 2000 AD?

Some 20 years ago, on a visit to Kerala, I was told by a group of young, committed social workers that mission hospitals in Kerala would disappear in the 1990s!! It seems, as they explained it to me, that most mission hospitals in Kerala were customarily referred to in the 1960s as St X's Charitable Mission Hospital. The social workers reckoned that 'value orientation' or saintliness had eroded in the 1960s, the charity dimension was disappearing in the 1970s and the 'mission' thrust would evaporate in the 1980s, leaving X's Hospital without 'saintliness', 'charity' and 'mission' in the 1990s — no different from the large numbers of private sector, profit-oriented hospitals which have developed in response to the market economy.

While this was said in utmost seriousness, my own understanding and field observations of mission hospitals were too limited at that time to assess the 'prophetic nature' of this concern or to reject it as mere fancy! As the years went by, in my increasing contacts with

the staff of mission hospitals through seminars and workshops, I have been picking up many interesting 'confessions'.

- I have been told by many that the number of poor, needy and indigent patients being cared for by mission hospitals are going down rapidly, not because the purchasing capacity of the poor Indian has gone up through post-Independence economic development, but because the only way to make enough money to run the hospital without regular doses of foreign donation is to shift the focus on the paying patient.

Somehow the thought that the 'mission of healing' finally gets experienced only as 'clean floor and white sheets' has always disturbed me

I have been told that the ways to balance the budget in order to continue the vocation has been to increase unnecessary investigations under the euphemism of 'routine tests' to increase unnecessary prescriptions, even promote surgery and increase the length of hospital stay — especially of paying patients!!

- I have been told that many mission hospital pharmacies are stocked not only with banned, bannable and hazardous drugs but also with inessentials of high cost and cosmetic embellishments. This is evidently not by accident, but for the simple reason that they provide better profit margins, inessentials being allowed a higher mark-up in the present irrational drug pricing policy and thus companies producing them offer greater 'unethical' trade discounts.
- I have heard that in many institutions doctors are paid larger and larger sums 'over' and 'under' the table since they are the best contributors to the profit margins, while paramedicals and auxiliaries who do most of the work are generally underpaid by government standards.
- On the contrary, I believe that many institutions are also closing down because they are not able to generate enough money to meet the increasing costs of medical care and, what seems even more significant, they are unable to get committed professionals to work in situations that are more peripheral and designed to serve the needy and underprivileged!
- Some, on the other hand, are linking up with 'big business' so that they can survive the pressures of the market economy and many are dreaming of attaching a self-financing or capitation fee for medical/nursing colleges to their institution to help them over the crisis — not recognising the value crisis they may be inadvertently moving into through such an initiative.
- One of the most interesting feedbacks that I have had, when asked why people prefer mission hospitals to government or other institutions is a pavlovian response about the former being 'cleaner and more efficient'. Somehow, the thought that the 'mission of healing' finally gets experienced only as 'clean floor and white sheets' has always disturbed me.

As I ponder over these confessions I often wonder whether the young social workers in Kerala were being prophetic. There are no signs that mission hospitals are disappearing from the national scene - take a look at the membership statistics of associations such as CMAI and CHAI. But membership of an association is one thing, commitment to a mission is quite a different matter.

If you consider some of the 'confessions' — even though they were not based on rigorous study but were hearsay evidence (maybe only partially true) — then the question posed does not seem just fancy.

- If mission hospitals continue to close down because of the shortage of funds or committed personnel at the rate they are closing down at present (a CMAI estimate I believe is 10 a year).
- If others opt out of the 'mission' sector into the 'market economy' for the sake of survival.
- If still others opt out of 'preferential option for the poor' because it just doesn't work 'to rob Peter to pay Paul' today.
- If still others accept unquestioningly the 'unethical practices' that are bound to balance their budgets.
- And still others are known only for their 'clean floors and white sheets' and nothing else.

... then will 'hospitals' with a 'mission', as we have known them all through these years, actually survive till 2000 AD? I wonder!

Ravi Narayan
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HEALING OF CREATION

If our earth is to be protected adequately, guardianship must be exercised in every field, lake or sea, on every hillside or reef, from every village or city. Success will come only when ordinary people assume that guardianship.

Rev Boyd Lowry
Executive Director, Codel

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HRG/HA II

The Health Advocate

The Great Indian Medical Education SCAM

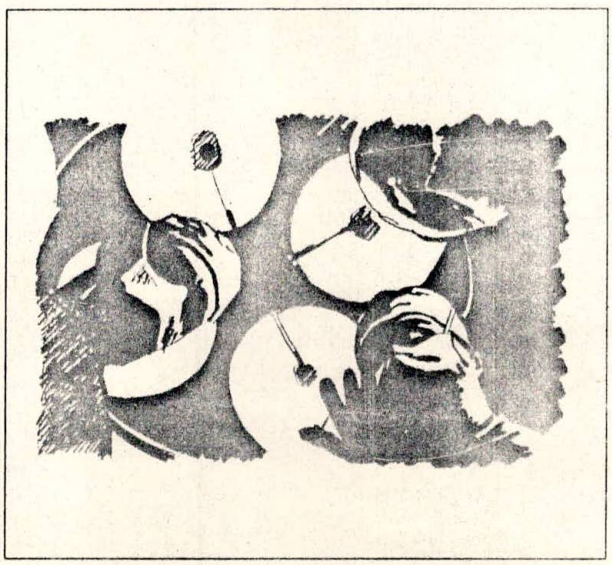
Dear Friends,

Recently the papers have been full of the Stock Exchange Scam. Mr Harshad Mehta of Growmore Incorporated and his network of associates in all our 'not so national' banks managed to get Rs 3,078 crore to reach accounts they were not legally meant to reach. Or have I got the implications all wrong? Anyway 'Stock Exchange bulls' and 'banker's receipts' have never been my cup of tea and whatever the final extent or nature of the swindle, there is no denying that the matter is under effective scrutiny today — what with public debate, parliamentary debate, policy debate, legal action, media hype, police action etc.

The entrepreneurs are in the 'jug'. The 'national psyche' is recovering from a rude shock. Public fears about the health of the banking system are being systematically allayed by the Government. The detailed investigations are on. May our deposits rest in peace!

However, there is another 'scam' rather well entrenched in the system, that is aided and abetted not by unknown bulls of Mr Mehta's kind but actively by the decision-makers and the powers-that-be. This is presently not being subjected to policy debate, nor public debate; it is nowhere near the fringe of legal action, leave alone police action. This 'scam' is reported in the papers nearly every day but is beginning to lose its newsworthiness and to affect our health and the future health of the nation. It goes by the name of 'The Great Indian Medical Education Scam' and, one day, when it is recognised for what it is, the stock scam will be pushed into pale insignificance. But will this happen?

Interestingly, this month, I and my team of co-researchers are on the final phase of a two-year project co-sponsored by CMAI and CHAI and supported by the emerging Christian Medical Colleges Network. For over 24 months, we have searched for social relevance and community orientation in the medical education experience in India. The final output of this study (now an impressive 600 sheets of typed and photocopied manuscripts) focuses on the efforts of about two dozen 'forerunners', including the three CMCs (Vellore, Ludhiana and Bangalore), and is definitely a cause for great satisfaction. However, it is the increasing evidence about the wider world of medical education picked up by our study, not the innovators but the 'mainstreamers', that has convinced us of the existence of an entity far greater than the current stock market one.



Here are some bits of indirect evidence to sour your daily morning cup of tea:

- The ICSSR/ICMR study group recommended in 1981 that 'there should be no new medical colleges and no increase in the intake of existing colleges'. By 1992 there has been an unchecked growth (!) from 125 to over 170 (mostly private capitation fees colleges). This is an official 'guesstimate', since even the Planning Commission itself has not been able to keep pace with the phenomenon.
- Three states in the country, Karnataka, Maharashtra and Tamil Nadu, have been vying with each other for 'top of the league' status in promoting these institutions through political patronage, state subsidy and 'cabinet fiat'. While political coffers get donations, the state treasury fails to receive crores of rupees in payment for 'state-provided' clinical facilities.
- An MCI Bill passed in

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Parliament, explicitly to control this commercialisation of medical education, has failed to make the grade, the 'official' support of three recent governments in these past months notwithstanding!

■ Leaks in the test papers of undergraduate or postgraduate examinations are now far too common to raise any eyebrows, least of all those of the examiners.

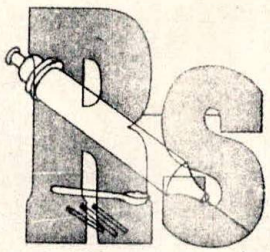
■ The deliberate postponement of a PG entrance test by a few weeks to allow a high official's daughter to complete her internship and attend the examination (a recent scandal), takes the cake in official indulgence in the midst of medical education reform.

■ While MCI, the watchdog body on quality and standards in medical education, is caught up in a web of legal action and writ petitions, the Indian Association for the Advancement of Medical Education is fast sliding into irrelevance due to a mixture of membership apathy and internal 'sycophancy', all too common in the culture of our times.

■ Every other day, heads of government at the central and state levels and politicians of lesser stature, declare open high technology diagnostic centres and corporate medical enterprises for the 'classes' of India. During the inaugural rhetoric the pious promise of doctors for the 'masses' of Bharat is made with predictable regularity, unmindful of the obvious paradox involved therein.

■ A report on who pays for medical education in India clearly demonstrates that after massive state investment in health, 75 per cent of the graduates reach the private sector. The same study computed that the number of graduates migrating 'westward ho' in 1986-87 is 40.8 per cent.

■ A report from West Bengal, on the mainstreamers in the state, admits candidly that 'the teacher's admonition against indiscriminate use of antibiotics or random use of steroids cuts little ice with the student when the latter discovers that very teacher's indiscriminate and random prescription in private practice. The student thus learns the difference between theory and practice and in the conflict between the pursuit of science and commercial gain, the latter generally prevails'.



IN THE CONFLICT BETWEEN THE PURSUIT OF SCIENCE AND COMMERCIAL GAIN, THE LATTER GENERALLY PREVAILS

And as if to give a final confirmation of the diagnosis of scam in the system, two reports, one on the quality of graduates being churned out by the mainstreamers and the second, on the quality of care being dished out to the people impart very little comfort.

■ A recent study (1991) on interns of Bombay medical colleges discovered the shocking fact that 70 per cent of the interns of 1991 prescribed wrong dosages of drugs for leprosy; 71 per cent could not give a correct prescription for an adult male suffering from symptoms of 'flu; 72 per cent did not understand the concept of Primary Health Care 12 years after the Alma Ata Declaration.

■ A young doctor couple from the tribal regions of Central India wrote to us that medical graduates from Madhya Pradesh and Bihar colleges working in their hospital are poor diagnosticians and, what is worse, they do not worry about it. They admit patients without any diagnosis...the prescribing practices include syrups, tonics, antidiarrhoeals and multivitamin injections. The patients have to pay an enormous bill for drugs.

Where are we heading in the great enterprise of medical education today? Will the dozen frontrunners have any influence in the years to come on the mainstreamers who are caught up in the new corrupting market economy of commercialisation, communalisation and corporate competition?

Some of the CMAI and CHAI member institutions are themselves being tempted to join in the medical education game with overtures from the corporate network and the new 'money bags' for permission to use their quality institutions for the new initiatives! Dear *CMJI* readers, this is an appeal to look at the proposition squarely in the face, and identify its inspiration. God or Mammon, I ask?

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A HEALER'S HUMAN TOUCH AND A PATIENT'S RESPONSE

Recently it was necessary for me to report for another series of X-rays. These cold and impersonal events are no joyous occasions. Usually I am ushered into a chilly room by an insensitive technician who orders me to lie down on a frigid table and hold my breath while they take a series of pictures. Imagine my pleasant surprise to find that a friendly lady technician had warmed the X-ray table with a heating pad before I came in. That simple act of kindness in the midst of imperceptive technology brought tears to my eyes. This lady cared about the people she served.

Rebecca A. Egbert, Washington, USA, in Christian Medical and Dental Society Journal

HOSPITALS AND HEALTH

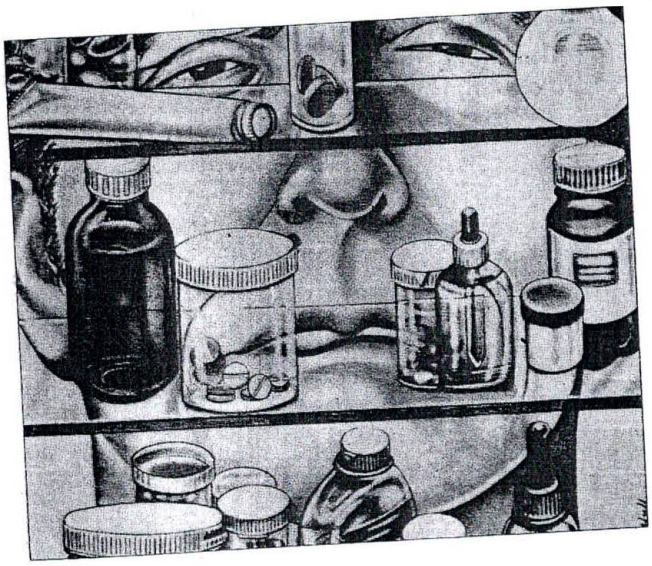
LOOKING WITHIN

The model of health services that we have uncritically adopted from the industrially advanced societies of the West has its inherent fallacies. It tends to distort the basic values of life and ultimately affects the happiness of the people

Dear Friends,

As a young doctor, early in my professional career in the mid-1970s, I remember reading a Government of India policy report — 'Health Services and Medical Education — a programme for immediate action'. This report, more commonly known as the Srivastava Report of 1975, had an intriguing paragraph that came as a rude shock to me. It said:

"We have adopted tacitly and rather uncritically the model of health services from the industrially advanced and consumption-oriented societies of the West. This has its inherent fallacies: health gets wrongly defined in terms of the consumption of specific goods and services; the basic values in life which essentially determine its quality get distorted; over-professionalisation increases costs and reduces the autonomy of the individual; and ultimately there is an adverse effect even on the health and happiness of the people. These weaknesses of the system are now being increasingly realised in the West and attempts are afoot to remedy them ... It is therefore a tragedy that we continue to persist with this model even when those we borrowed it from have begun to have serious misgivings about its utility and ultimate viability."



The conclusion was particularly surprising since all through my medical education in the late 1960s and early 1970s not one of our teachers had given us the faintest indication that there were any 'inherent fallacies', 'weaknesses' or 'misgivings' about the Hospital-Doctor-Drug-High Technology model that our education was based upon. That anyone could have questions about its utility or viability was unthinkable.

The dictum that had been ingrained in our impressionable minds was that health was medicine; medicine was hospitals, doctors, drugs and technology; and that health care was reaching these packages to as many, as soon, and as effectively as possible.

That paragraph has continued to worry me all these years as my involvement in community health grew and matured and found various professional expressions. I am not sure I still understand the true impact of that paragraph, but increasingly some questions have bothered me about hospital based health care. May be these bother some of you as well:

- Why are hospitals so preoccupied with an understanding of human illness that is organ centred and primarily at intracellular-molecular levels, forgetting the whole 'being' of the human patient in the process ?
- Why do we overemphasise the physical dimensions of health and disregard the psychological, social, cultural, spiritual, ecological and political dimensions of health?
- Why do we see the specialisation and compartmentalisation of professional activities as the only way of properly organising a hospital?
- Why is there an over-emphasis on drugs and technology and a complete disregard for non-drug therapy and other skills ?
- Why is there a watertight division of responsibilities and an over-emphasis on the role of doctors?
- Why do we overprofessionalise the system and control the spread of technical knowledge and skills even to other members of the health

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team and to the people at large?

- Why are we so preoccupied with the allopathic system of medicine, ignoring the existence or utilisation of the beneficial culture and practices of other systems of medicine and healing?
- Why are we so preoccupied with providing services, rather than enabling patients to play a greater role in their own health care ?
- Why is it that our hospitals are so westernised and elitist that they produce a 'culture shock' to many of our patients, particularly those who come from the lower socioeconomic classes — the poor whom we want to serve?

During my travels all over India as a 'Health Evangelist', I have often been asked by committed people working in hospitals and dispensaries: Can hospitals become more health oriented ? Can hospitals become more community health-oriented?

I believe they can, but I also believe that they need to look at the above questions seriously if they want to know why they cannot, at present. Somewhere in the answer to these questions, through collective reflection, one can find the 'inherent fallacies', the 'misgivings' and the 'weaknesses' the Srivastava report mentioned in 1975.

Not one of our teachers had given us the faintest indication that there were any 'inherent fallacies', 'weaknesses' or 'misgivings' about the Hospital-Doctor-Drug-High Technology model that our education was based upon. That anyone could have questions about its utility or viability was unthinkable

Through this process of 'looking within' one may discover, as many all over the country are discovering, that if hospitals have to be part of the new 'primary health care' movement, then there is an urgent need to evolve new policies, new attitudes, new skills and new approaches. These would increase the subservience of medicine, technology, structures and professional actions to the needs and hopes of the patients or the consumers, and the community which we seek to serve.

Professor D. Banerji of the Jawaharlal Nehru University has put it succinctly: "Starting as an inward looking, market-dominated, technology-oriented institution, a hospital opens itself to the community, to respond to its requirements, bringing about the necessary reorientation in its technology, organisation and management." How many of our hospitals are ready for this challenge ?

Ravi Narayan

Ravi Narayan is the co-ordinator for the Society for Community Health Awareness Research & Action and a regular columnist for *CMJI*.

The Health Advocate looks forward to receiving letters from you on the issues raised in the column. You may disagree with me — which is most welcome — but we would like to know why. You may agree with me which is also okay, we would still like to know why.
Silence is no dialogue.
So do get down to putting your thoughts on paper.
Waiting in anticipation.

Post Script

THE INDIAN MEDICAL EDUCATION SCAM

Dear Friends,

In the last issue I shared my concerns about the way the great enterprise of medical education was progressing in the country. Three events in the last month have injected a greater significance to my concerns and I thought you must know about it.

The Andhra Pradesh Government has permitted the starting of 12 private medical colleges with a total intake of 1200 students through one controversial government order on July 28 (SCAM positive).

The Supreme Court in a significant judgement, has ruled that 'Capitation Fees' in any form is not permissible because

- it violates the right to education under the constitution;
- it is wholly arbitrary;
- it is unconstitutional according to article 14 — equality before law;
- it is evil, unreasonable, unfair and unfit;
- it enables the rich to take admissions whereas the poor have to withdraw due to financial inability (SCAM negative).

The medicos and junior doctors of Tamil Nadu are on strike against commercialisation of medical education; student groups in Andhra have challenged the AP Government order through public interest; students in Karnataka have been holding anticapitation fees rallies showing that the younger generation still have a commitment to social justice (scam NEGATIVE). Doctors and professional associations have mostly either stayed quiet or at best made fervent pleas through letters for privatisation of medical education justifying 'capitation fees' in various arguments.(SCAM positive)

On which side are you going to stand?

Ravi Narayan

The Health Advocate

NGOs AND THE GOVERNMENT

Working Together

Dear Friends,

The Government has recently announced its intention of reviewing the National Health Policy enunciated in 1982. This policy document was significant in many ways. It was the first time in post-Independent history that the country outlined its hopes and aspirations in health and health care with some clarity and in some detail. It was also the first time that a policy document was self-critical and acknowledged some of the failures and shortcomings of our health care delivery system and policy.

However, for a group like CMAI and its membership, the document was particularly relevant, since it recognised the active partnership of voluntary agencies in the challenging tasks ahead — towards the goals of Health For All.

Voluntary agencies, including mission hospitals, had played a role in health care in pre-Independence times but, in the first three decades after Independence the linkage between them and the government health service could probably best be described as 'peaceful co-existence'. Each worked within its own framework and there was occasional dialogue, some communication, sometimes even local competition, but very little active collaboration.

The policy statement of 1982 perceived a rather different scenario. The 19-page document was interspersed with references to voluntary agencies/NGOs and suggested various ways in which this collaboration between the two sectors could take place.

Having been used to over three decades of non-interest and non-interference by the Government, these new policy statements were not heralded by much fanfare by the voluntary or 'mission' sector. However, a decade has passed since the policy was outlined.

A time has come to examine whether this has been 'populist rhetoric', 'pious resolution' or 'realistic partnership' at the local, regional and national level.

This is the right time to look at this proposition seriously and to assess whether it has been an opportunity or a threat.

Some issues and questions that come to my mind, which the CMAI membership and the *CMJI* readership could reflect on, are:

■ How successful has the voluntary (including 'mission') sector been in receiving organised, logistic and financial support from the Government to invest in curative and health field services as promised in the 1982 policy document?

■ If the NGO-Government collaboration has not been a successful experience, has this been due to :

✓ the lack of attempt by this sector to tap the tax-payers' money for its effort, since it has continued to have access to a steady infusion of 'foreign donations' to meet its requirements;

✓ any bias or prejudice on the part of the authorities who suspect the 'voluntary sector' of hidden motives, or consider it no longer as 'voluntary' as it claims to be?

■ If the NGO -Government collaboration has been successful

✓ has this success been at local or regional or national level?

✓ has this success been at the cost of 'values' being sacrificed to the demands of 'corruption' and 'leakages' that are in the system?

✓ has this success led to a reduction in the reliance on 'foreign infusions' since the Government has become an 'alternate' and 'dependable' source?

■ Does the 'voluntary sector' see

National Health Policy, 1982

■ There are a large number of private, voluntary organisations active in the health field all over the country. Their services and support would require to be utilised and intermeshed with governmental efforts, in an integrated manner...

■ With a view to reducing governmental expenditure and fully utilising untapped resources, many planned programmes may be devised, related to the local requirements and potentials, to encourage the establishment of practice by private medical professionals, increased investment by non-governmental agencies in establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the health field...

■ Organised effort would require to be made to fully utilise and assist in the enlargement of the services being provided by private voluntary organisations active in the health field. In this context, planning, encouragement and support would also require to be afforded to fresh voluntary efforts, specially those which seek to serve the needs of the rural areas and also the urban slums...

the increasing realisation, in policy documents, of the need for Government-voluntary agency collaboration, as a threat to their autonomy, style of functioning, independence, or belief systems?

Or do they see it as an opportunity, a welcome, supportive partnership, an encouragement, and a recognition of their efforts?

■ Some broader issues have also emerged in the debates that have been recently stimulated.

☛ Is the Government consciously trying to blur the difference between the voluntary sector or the mission sector (non-profit sector) with the private sector (profit sector) by using the term NGOs for both collectively, rather than separately use the more meaningful term 'voluntary agencies'?

☛ Has the Government purposely focused on voluntary agencies only as 'alternative service providers' rather than as alternative trainers, alternative issue raisers, alternative policy generators — all of which roles the voluntary sector is beginning to play?

☛ Is the motivation for increasing partnership with voluntary agencies truly a recognition — in planning circles — of their potential or contribution or is it at the behest or compulsion of the bilateral or multilateral international aid agencies who see them as more amenable to their game plans ?

In the 1980s this policy led at least to the Government's recognition of NGOs as alternative service providers and the NGOs recognising the Government as an alternative funder. Can collaboration in the Health For All Strategy in the 1990s mean more than this ?

As we enter the last 100 months for achieving Health For All by 2000 AD, a time has come for the 'mission sector' to seriously reflect on the options and be actively involved in the emerging debates and dialogue on the evolving partnership between the Government and the voluntary sector. Are we gearing up for the task ?

Dr Ravi Narayan

We invite you to help us document your experiences of NGO-Government collaboration in the following areas:

1. How much financial assistance has your institution received from the Government (State and Central) since 1982? For what projects?In retrospect, has this assistance been beneficial or not?
2. Do you receive regular information about government schemes? Have you used government schemes?
3. Do you get drugs or other supplies from the Government? If so what?
4. Have government personnel participated in your training programmes?
5. Have you experience of the Government delegating either a geographical area or a particular activity to your NGO? What has been your experience?

Editor

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HR9/HA V

Health Advocate

Robbing Peter To Pay Paul

Dear Friends,

Dr Paul's letter in an earlier *CMJI* (Vol 7, Number 3, July-September 1992) was a very welcome response to my reflections on the question "Will there be mission hospitals in 2000 AD?" I appreciated the very relevant steps which hospital was taking to get beyond the looming crisis, so that they could continue to serve all those for whom the mission hospital was set up in the first place. However, the last line of his letter... 'And by attracting richer patients, more poor patients are helped...' set me thinking and it also provoked this column of the Health Advocate.

Robbing Peter to pay Paul — has it helped?

All mission hospitals without exception were started by their inspired founders to reach medical care to those sections of society that were not being served by the available services of their times. Supported by large grants from foreign missions and regular infusions of donated drugs and hospital technology, they managed to reach hospital care to many who would have been denied this service as they could not pay.

For long, the 'mission economy' managed to beat the 'market economy' that operated in the wider world around it. However, as times changed and these foreign infusions dwindled, due to a variety of factors, local mission hospital managements were forced to explore alternative methods to make budgets balance. Tapping local resources became imperative.

The most popular initiative was the adaptation of the Robin Hood principle — robbing Peter, the rich man, to pay for the medical care of Paul, the poor man.

The tradition of pay-wards and private wards was introduced and Peters in these wards were charged for services at rates that helped to subsidise the cost of Pauls in the general ward. For some years the proposition had a very effective response. The mission economy beat the market economy once again! But not for long.

A review of mission hospital experience and realities currently highlight a new development. The paying ward introduced as a relevant move, towards self-sufficiency and sustainability, stimulated the market economy forces leading to surprising results.

Patients in private wards are charged at rates that help to subsidise the cost of treatment in the general wards

The growing dilemmas have been shared by health administrators and hospital staff over and over again in our interactions. What are these dilemmas?

- Over the years the number of poor and indigent patients being cared for by mission hospitals has come down drastically. While services to Peters have increased, Pauls find it increasingly difficult to avail of the same.
- There are more and more Pauls in the general ward (which are no longer free but include part-payment) who have to pay more than they can afford leading to greater indebtedness, social stress and family crisis.
- The Peters, belonging to more literate and demanding sections of the society, are constantly pressurising hospital leadership and staff to provide better services, greater variety of facilities and more luxuries in the pay-wards, so that the subsidy factor for the Pauls has drastically reduced now. Most of the pay-ward cost recovery gets reinvested in pay ward facilities. Not surprising when you find coarse cotton sheets in the general nursery and terrycot kiddy cloth in the pay-ward ones
- The Peters make greater demands on the time and skill of the hospital staff, which is not at all surprising since we health professionals relate more easily to the growing middle class elite who constitute the pay-ward patients.
- Many junior staff complain that the seniors are more pre-occupied with the neurotic demands of the paying Peters while they are left to manage the life and death crises of the Pauls in the general ward.
- Gradually as general wards begin to look duller and shabbier due to constraints in maintenance funds, the Peters wards grow in cosmetic embellishments in competition with the for-profit private sector. The glamour of technology and super-speciality also begins to creep in.
- As the profit margins from services to Peters are increased, the staff of the hospital are motivated

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overtly and covertly to prescribe more, investigate more, intervene more and even visit more — leading, not surprisingly, to a culture of over-investigation, over-prescription, with its resultant iatrogenesis.

❑ Gradually, as all aspects of the growing dilemma set in, the market economy wins the battle over the mission economy. While Peters feel robbed and get more iatrogenesis, Pauls find it more difficult to avail of the services.

Conclusion: It does not pay to rob Peter for the needs of Paul in the long run.

A question that has been put to me persistently about this result is — is it inevitable?

I believe that it isn't. Crisis managers of mission hospitals all over the country are experimenting to stay with the mission economy rather than surrender to the market economy. Scattered examples of creative initiatives abound. In my travels, I have discovered at least four propositions on trial.

★ Mission institutions trying not to discriminate in quality of services between Peters and Pauls, at the same time encouraging Peters to pay for Pauls as well (Dr Jesudasan's experiment *CMJI*, Vol 7, No 3, Page 25).

★ Mission institutions exploring financial support by methods other than payment for services — for example, insurance schemes, cooperatives, health funds, bank schemes, friends schemes — so that the subsidies for the Pauls come from a multi-pronged strategy of tapping community sources and resources.

★ Mission institutions changing the western cultural embellishments that have crept into the hospital culture which increase costs of services and facilities and instead bringing them more in line with Indian grassroots realities. For example, one hospital in Tamil Nadu got rid of all the hospital beds and decreased overall maintenance costs, recognising that all their patients anyway slept on mats at home, be they Peters or Pauls.

★ Mission institutions introducing a rational drug technology and investigation policy in their hospitals to cut costs and to use available resources more efficiently so that more Pauls could be treated without subsidies from Peter.

I believe Robin Hood of Sherwood Forest and his merry men, were successful in their efforts in robbing Peter to pay Paul since they chose not to provide their services to Peter. The mission economy has thought otherwise. So the emerging way to make this principle work, it seems to me, is to accept these four new commandments:

✔ Thou shalt not discriminate between Peter and Paul

✔ Thou shalt look beyond Peter's purse

✔ Thou shalt adapt hospital culture to the realities of Paul and not the whims of Peter

✔ Thou shalt investigate, intervene and treat both Peter and Paul rationally.

Maybe accepting these commandments will give the mission economy another chance.

Dr Ravi Narayan

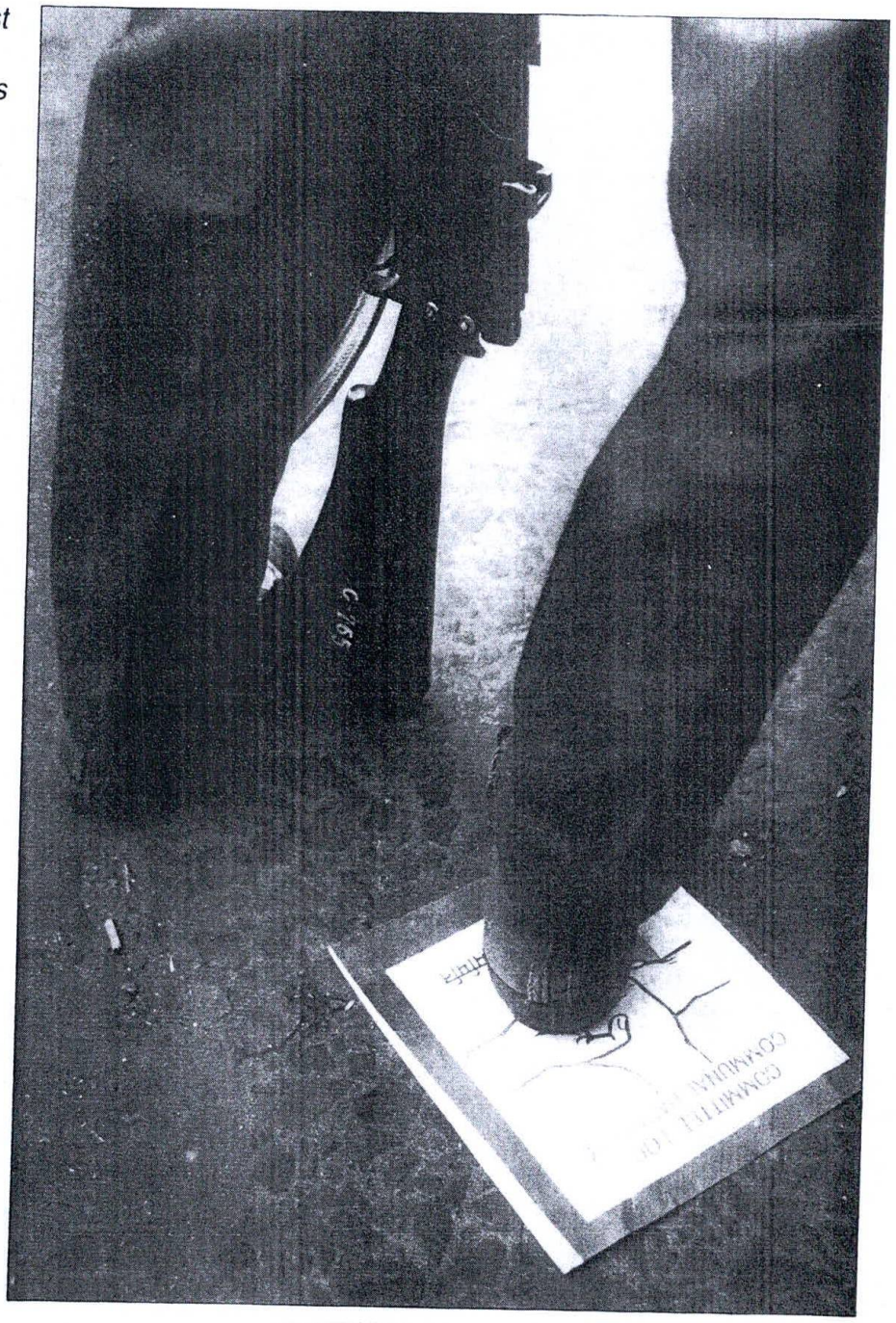
Dr Ravi Narayan is the coordinator for the Society For Community Health Awareness Research and Action, and a regular columnist for *CMJI*.

Health Advocate VI

The "Virus" Of Communalism: What Will Be Our Response?

In Germany, the Nazis came first
for the communists and
I did not speak up because I was
not a communist.
Then they came for the Jews
and I did not speak because I
was not a Jew.
Then they came for the trade
unions, and I did not speak up
because I was not a trade
unionist.
Then they came for the Catho-
lics, and I was a Protestant and
so I did not speak up.
Then they came for me, and by
that time there was no one left to
speak for any one.

Martin Niemoller (1892-1984)



CMJI, April-June 1993

In the last few months, we have witnessed the re-emergence of a particularly virulent form of an old 'virus' — the 'virus' of communalism, with explosive outbreaks all over the country. The recent epidemic even reached pandemic dimensions, spreading rapidly to our immediate neighbours, then on to the Middle East and finally all the way to the UK as well. Bombay, among the most cosmopolitan of all our metropolises, also suffered a particularly vicious attack, the acute phase of which lasted for over 10 days.

Since Independence, this 'virus' has been localised to a few endemic pockets showing sporadic outbreaks. However, in recent years, it has seen a re-emergence with greater severity, and the December-January outbreaks have proved beyond doubt that the virulent 'virus' is going to be with us for a long, long time.

Much has been written about this 'virus' in recent weeks and months, but our knowledge of its socio-epidemiology is still relatively confused and our skills in its prevention are rather undeveloped. However, what little is known is enough to establish that, if left unchecked by concerted public health action, this 'virus' could well prove to be the greatest threat to the physical, mental and social well-being of the Indian people that we have had to face in the last few decades.

For example, it is now relatively well-established that:

❑ The 'virus' affects the minds of people, especially the young, and makes them indulge in pre-meditated acts of violence, especially directed towards innocent and defenceless people of communities and faiths perceived as different from their own. Epidemics thus create the double burden not only of deranged affected youth, but additionally, and more poignantly, of the innocent victims of these violent acts.

❑ It thrives in urban pockets, particularly in over-crowded slums, affecting young people, who are pre-disposed towards violence due to unemployment, urban lumpenisation and alienation. While males are usually affected, the recent episode in Bombay has shown the disturbing trend towards female affliction as well.

❑ The 'virus' thrives in an unstable political climate and has its roots in religious bigotry, cultural fanaticism and ethnic chauvinism. While Germany saw a particularly virulent subspecies in the early part of the century, similar episodes have been seen in Iran more recently, and in some states of Russia and parts of eastern Europe as well.

The most disconcerting aspect of the available epidemiological evidence is that each epidemic leaves behind shattered families, devastated households, traumatised and scarred individuals, particularly women and children, and pushes whole communities into a vicious cycle of fear, distrust, anxiety, anger and deep antipathy.

All this should be adequate evidence to jolt us out of our usual apathy and it is time we sat up and reflected on what we are going to do — each of us as individuals, each of us as members of an institution, and all of us as members of a national network, involved with the health of the people. What will be our response to control or eradicate this 'virus'?

It is the darkest night that prepare the greatest dawns.
Sri Aurobindo

I believe there are many possibilities open to us:

✔ We could get involved in bridge building efforts between communities of all faiths and cultures using educational efforts — both formal and non-formal.

✔ We could initiate collective dialogues to build new attitudes, greater harmony and increasing trust and respect between different communities.

✔ We could tackle prejudice, animosity and unhealthy stereotyping, by focussing our efforts on the youth and strengthening the value reorientation of our educational system.

By doing this, we would have helped to create an environment

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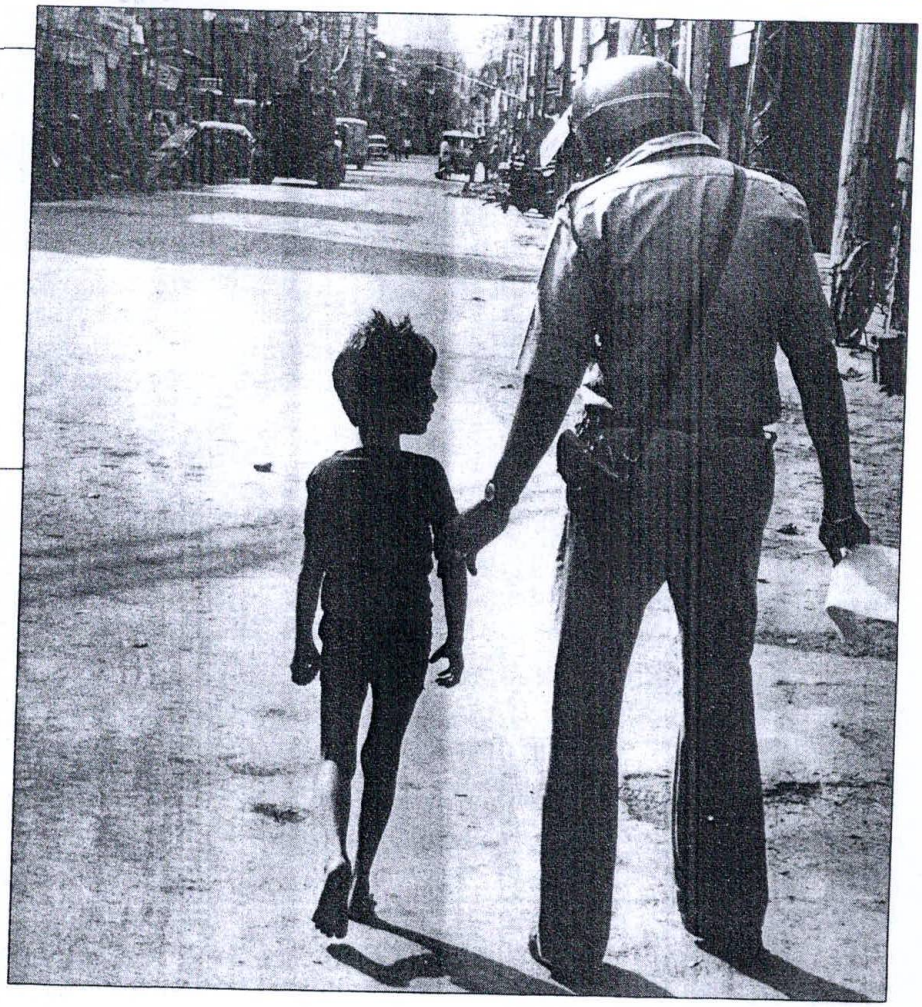
If left unchecked by concerted public health action, this 'virus' could well prove to be the greatest threat to the physical, mental and social well-being of the Indian people



that immunises minds against the effects of this 'virus'.

Our efforts would have been focussed on primary prevention, that is, health promotion and specific protection. We could get involved in pastoral and counselling initiatives at the community level, reaching out to affected communities of patients and victims, providing a supporting hand to the devastated; courage to the affected; comfort to the distressed, and various other supportive services that would help families and communities to come to terms with the crisis and get beyond it. Our efforts would have been focussed on secondary prevention, that is, on early diagnosis and treatment.

We could get involved in the active provision of the 'palliative' and 'patch up' services that our institutions are now fairly renowned for, all over the country. Reaching out to victims of the acute epidemics, we could provide holistic care — primarily curative, but in an atmosphere of concern and service and with sensitivity. Our efforts would then have been focussed on tertiary prevention, that is disability limitation and rehabilitation. All the three levels of prevention — the sheet anchor of public health are urgently required and the challenge is getting greater, day by day.

CMJI

However, there is still another type of response, which seems to be unfortunately and inexplicably more popular than the alternative outlined above. It is a response characterised by the combination of the following types of reactions:

- This is none of my business!
- It does not affect me or my community!
- I do not have time to do much, because I am so busy!
- I have neither the skill nor the inclination!
- This problem is not of my calling!
- There are people better qualified and skilled to deal with it!
- It is only a passing aberration!

It is this response that allowed the 'virus' of casteism to strike deep roots in the country. It is the same response that allowed Nazism to devastate Europe in the early part of this century. It is the same response that allowed apartheid to affect the mental health of generations of South Africans. It is the same response that for generations, and through the centuries, has allowed man's brutality against man.

What will be our response? Healer and samaritan or pharisee and levite? The choice will face us squarely in the days ahead.

Dr Ravi Narayan

Dr Ravi Narayan is the coordinator for the Society for Community Health Awareness Research and Action, and a regular columnist for *CMJI*.

Health Advocate

DRUG PUSHER OR HEALER
What are you ?

◆ DR RAVI NARAYAN ◆

The commercialisation of the medical system today has led to many doctors overprescribing costly drugs or recommending unnecessary tests, even within the voluntary health care sector. This article raises some questions to differentiate the drug pushers from the healers

IN 1980, THE ICSSR-ICMR 'HEALTH For All' study group reviewed the drug and pharmaceuticals situation in India and came up with an assessment of the realis and a clear warning against the overmedicalising of the health system. They identified the doctor-drug producer axis as the major villain and the prescribing practices of doctors as the key culprit.

Two years later, at an MFC meeting, I had raised 10 questions, as a kind of checklist for participants, helping them to decide whether they or their health institutions could be classified as 'drug pushers' or 'healers' (rational prescribers).

A decade later, I discover that those questions are still relevant. What is even more disconcerting is that even within the voluntary sector of health care, drug pushers still far outnumber the healers. This is particularly shocking since much has been done since the early 1980s to tackle the situation:

- the evolution of the All India Action Network;
- the publication of banned and bannable drug lists;
- the outlining of rational formularies (the CHAI-CMAI formulary is a case in point);
- numerous workshops on the theme and innumerable books, booklets, bulletins and handouts;
- public interest litigation to control irrationalities in the drug situation.

The questions, some of them reworded in today's context, are:

❑ Have you accepted the concept of an essential, selected, restricted drug list in your practice to help select efficacious, safe and good quality low-cost drugs from the over 60,000 formulations that abound in the market today?

❑ Have you accepted the concept of generic prescribing to prevent 'misuse' and 'misinformation' by pharmaceutical companies on brand specialities, formulations and bio-availability claims ?

❑ Have you stopped prescribing drugs whose only additional advertised value is — a cosmetic embellishment, for ex-

Even within the voluntary sector of health care, drug pushers still far outnumber the healers

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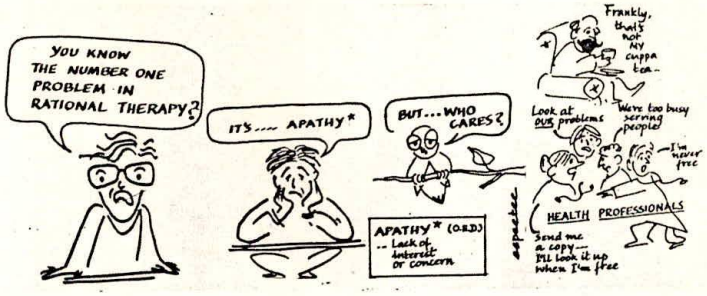

ample, a special flavour; elegant packing for example, a nice container; or an irrational combination?

❑ Have you stopped promoting 'tonics' whose only present value is the vitaminising effect on our sewage systems? Do you accept that what the poor need is food and what the rich need is health education to prevent overeating?

❑ Do you have a policy against accepting physician's samples and other forms of inducement, both refined and blatant, from medical companies, including unethical trade discounts and offers?

❑ Do you propagate simple home remedies, home-based preparations, pharmacy-based low-cost preparations and even locally available herbal remedies that are not totally integrated with the 'market economy'? Have you closed all your efforts at the local 'cottage industry'?

❑ Does your health centre practice also offer people various forms of non-drug therapies, including holistic health, counselling and caring techniques?

❑ Does your selection of drugs for prescribing depend on rational issues like management practices; costing rationale, standardisation and so on, and not, by the craze for *'phoren'* multinational, private and large companies, or the equally irrational emphasis on the lowest priced drug in the market?

❑ Have you stopped having a 'colonial western, ethnocentric' policy towards alternative systems and therapies and adopted a more open policy of enquiry and evaluation to use traditional medicines and other therapies in a plural practice?

❑ In spite of your preoccupation with medical care, do you promote:

★ Clean water rather than antibiotics?

★ Food rather than pills?

★ Immunisation rather than high-tech diagnostics?

★ Mothers' milk rather than manufactured infant foods?

★ Primary health care rather than tertiary super-speciality?

★ Health rather than medicine?

The answers to these questions may help you determine what you really are: a drug pusher or healer (rational prescriber). If you have 10 affirmative answers, then you are the model CMAI member for 2000 AD. If you have 10 negative ones, it is perhaps time to stop paying your CMAI membership since you now qualify for the membership of the ever-expanding 'MMC' — 'Medical Marketing Club'.

If you are somewhere in the middle, it is time to sit up and reflect collectively in your group. What would you like to be — drug pusher, or healer?

> There are two types of physicians — those who promote life and attack diseases; those who promote diseases and attack life
>
> ***Charaka Samhita***

Aspects of Over-medicalising

◆ Vigilance is required to ensure that the health care system does not get medicalised, that the doctor-drug producer axis does not exploit the people and the abundance of drugs does not become a vested interest in ill health.

◆ One of the most distressing aspects of the present health situation in India is the habit of doctors to overprescribe glamorous and costly drugs with limited medical potential. It is also unfortunate that drug producers always try to push doctors into using their products by all means — fair or foul. These are responsible for distortions in drug production and consumption more than anything else.

◆ There is now an over-production of drugs (often very costly ones) meant for the rich and well-to-do, while the drugs needed by the poor people (and these must be cheap) are not adequately available. This skewed pattern of drug production is in keeping with our inequitable social structure which stresses the production of luxury goods for the rich at the cost of the basic needs of the poor.

Health for All: An Alternative Strategy, ICSSR-ICMR Study Group 1981

(Repeat)

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Health Advocate VIII

Overcoming New Challenges

◆ DR RAVI NARAYAN ◆

IN THE JULY - SEPTEMBER ISSUE OF *CMJI*, I read an obituary of Dr Denis Burkitt, a famous mission hospital doctor and medical researcher from Africa, who, for many years, directed the Medical Research Council of the UK and promoted a rethinking in the focus of medical research – from a preoccupation with 'intracellular research' to a new commitment to 'behavioural and societal research'. His own exploration of the aetiology of what is well-known as 'Burkitt's Lymphoma' and later, his participation in establishing the relationship between the western, low fibre, processed diet and the diseases of 'civilisation' (which included diverse conditions such as diverticulosis, intestinal cancer, varicose veins and heart disease), was significant to this new vision.

As a young postgraduate student of public health in 1973, I had the opportunity to listen to Dr Burkitt's lecture on 'Future directions and challenges in research'. The core of this lecture was an important question he presented to all of us youngsters, as a challenge in our future vocation. This question has been a great stimulus to me for the last 20 years, helping me explore a new meaning for the role of the doctor and a new vision for the health ministry. In memory of this late medical prophet, I share this question with the readers of *CMJI*, using an illustration (*alongside*) which he used in that summer of the year 1973.

Imagine a room with a wash basin. On entering the room, you find that water is pouring out of the tap, the sink is overflowing and there is a mess on the floor. What would your first response be to tackle the situation? Will you be a floor-mopper or a tap turner-off?

The medical and nursing profession have long been floor-moppers, using drugs and technology to floor-mop the overflow of illnesses and disabilities in the community. With the knowledge of preventive medicine being limited, this seemed the most logical response and therefore, the clinically-oriented drug-technology-dispensary-hospital-oriented healing ministry developed.

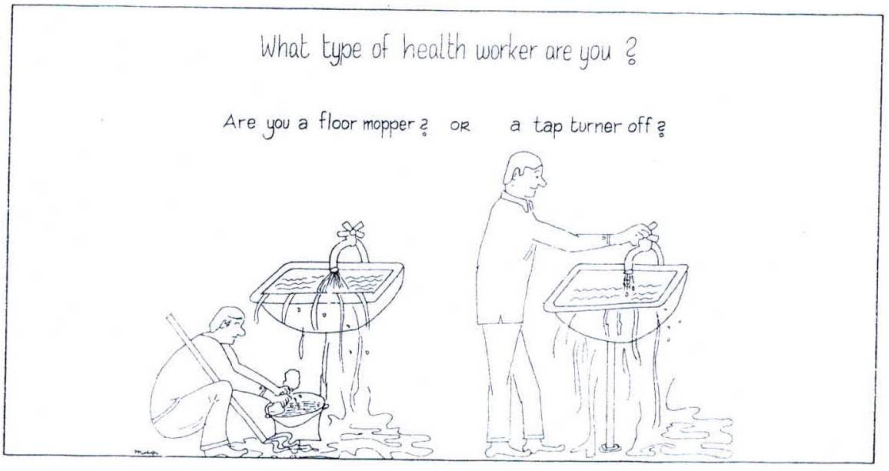
As we reach the end of the millennium, medical knowledge has grown and our knowledge of diseases has also improved greatly. Many more of the preventable causes of illness are known and tap-turning-off skills developed to varying levels of competence.

Are the healers in the ministry ready to become tap turners-off or are they going to continue to 'floor-mop' in the old tradition, getting distracted and carried away by the glistening versions of floor mops being produced by the multinational medical industry today?

For many in the ministry, this question will be a very disturbing one as it was for me 20 years ago. Brought up on the white coat, stethoscope and Pavlonian prescribing reflexology of orthodox medicine, I failed to understand what tap turning-off meant and its relevance to the medical vocation, when I first heard about this idea. Today, two decades later, I have become a little wiser.

The floor-mopper in me had stressed the relevance of coronary care units and promoted coronary bypass surgery, till the tap turner-off in me took over to promote exercise, cycling, diet modification, reduction in smoking and various other lifestyle changes.

The floor-mopper in me had stressed trauma surgery and neurosurgical care as a response to the increasing epidemic of accidents till the tap turner-off in me took over to promote road safety, occupational hygiene, helmets and belts.



◆ **Dr Ravi Narayan is the Coordinator for the Society for Community Health Awareness Research and Action, and a regular columnist for *CMJI*.**

CMJI, oct. - Dec 1993

The floor-mopper in me had promoted vitamins — pills, tonics, enriched and fortified foods in response to the continuing problem of malnutrition — till the tap turner-off in me took over to promote low-cost, local food mixes, vegetable gardens and efforts to make our institutions more baby-friendly!

The floor-mopper in me had stressed intravenous fluids and antidiarrhoeals for the treatment of childhood diarrhoea till the tap turner-off in me took over to promote home-based ORT, clean water and environmental sanitation.

As a medical college teacher for a decade (1973-83), and as a community health trainer in the next decade (1984-93), I discovered an additional challenge in Prof Burkitt's question. Could education of the health team geared to the floor-mopping tradition of orthodox medicine be reoriented to the tap turning-off challenges arising out of the new medical knowledge of today? Was socially relevant and community-oriented education of such a health team possible?

Today, two decades after hearing that disturbing question, I can unrepentantly affirm that floor-moppers among us can become tap turners-off. But floor-moppers need a new understanding of medicine — a 'conversion' if you please.

This new vision calls for a paradigm shift in our thinking — a shift to a new people/community-centred, pro-life, holistic health programme promoting people's empowerment, behavioural and societal processes, and creating autonomy and awareness-building.

The Vatican Cor Unum document on the new orientation to health care calls us to 'a true conversion of our hearts and also of our methods'.

The Christian Medical Commission study on 'Health and wholeness: the Christian role in health' emphasises the same need for conversion in a different way. Its study recognises a simple fact:

"From around the globe, the 10 regional grassroots consultations on 'Health, Healing and Wholeness' wove a tapestry depicting their understanding of health. The major recurrent thread throughout that fabric is the fact that health is not primarily medical. Although the 'health industry' is producing and using progressively sophisticated and expensive technology , the increasingly obvious fact is that most of the world's health problems cannot be best addressed in this way".

Twenty years ago, I was asked the question: Are you a floor-mopper or a tap turner-off? Today, the question I would like to put to you for serious reflection is: Can the healing ministers continue to be floor-moppers when they are being challenged to become tap turners-off? Are we ready for this conversion?

THE NEW DOCTOR

THE new doctor will consider his or her service as an agent of social improvement. So he or she will understand and be aware of the social and ethical foundations of medicine.

The new doctor will be conversant not only in the language of science but in the language of the people as well. He will be comfortable with people from all walks of life — not only in doctor-patient relationships but in social relationships as well.

The new doctor will not be afraid to act on evidence that is available today and will not only know how to do things, but why.

The new doctor will be aware that the patient and nature are the ingredients, not merely the medium, of expression of technique. He will regard natural supports of health, such as the family, as having supreme importance in the healing process.

The new doctor will treat the whole person in the context of the family as well as the religious and social system.

The new doctor will heal with himself and prescribe himself in generous doses: meaning that he or she will use all resources of personality and human caring possible.

The new doctor's use of guilt will motivate people to healthy habits rather than frustration and fear.

The new doctor's honesty will extend to denying modern medicine's mythical claim that everything can be cured, and no matter how you mess yourself up, the skills of the doctor can put you back together.

The new doctor will be knowledgeable in unorthodox methods of treating diseases, including nutritional therapy, acupuncture, kinesiology, chiropractice, homoeopathy, etc.

The new doctor will protect patients against excesses by specialists.

The new doctor will be committed not only to putting the specialists out of business, but to putting himself out of business as well.

Robert S. Mendelsohn, MD
Confessions of a Medical Heretic

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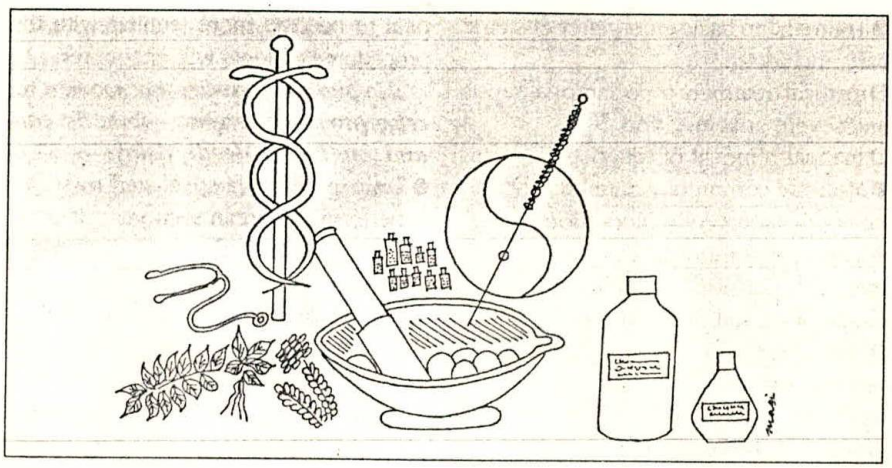
Health Advocate

What Will Prevail: Science Or Prejudice?

Integrating Medical Systems

◆ DR RAVI NARAYAN ◆



AS A POSTGRADUATE AT THE ALL India Institute of Medical Sciences (AIIMS), New Delhi in 1977, I chanced upon an announcement of a workshop on 'Ayurvedic concepts and nomenclature', being organised by the Advisor to the Government of India on indigenous systems of medicine. Some of us thought that it would be an excellent opportunity to explore an area that our undergraduate and postgraduate studies, based on modern scientific medicine, had ignored. To our surprise, all the other participants turned out to be pharmacology professors and researchers from American universities. Not a single Indian professor or researcher, including from the host institution, had cared to participate!

The excellent discussion, for instance an exposition of the *Tridosha* concept — *vatta*, *pitta* and *kapha* — and the principle of balance, were very thought-provoking. However, the absence of local professors and researchers was very disturbing. Had the glamour of 'western' medicine so mesmerised us that we were not ready to explore the science of ideas from our own heritage, that which was so integral to our history and culture? Or was it inevitable that, as in most aspects of scientific and technological development in our country, the medical profession in India was awaiting a *Textbook of Ancient Indian Medicine*, by a collective of American professors and published by McGraw Hill or Wiley, before we would begin to take our own plural medical inheritance seriously.

> India has a rich historical diversity of medicine. We must integrate all that is best from every system: ayurveda, naturopathy, unani, homeopathy and Tibetan medicine

The diversity and plurality of medicine in India is a historical fact. A WHO report in 1983, quoting Government of India sources, estimated that this plurality was symbolised by the presence of 8 lakh practitioners of which only 2 lakh were allopaths; eight systems of medicine — ayurveda, siddha, yoga, naturopathy, unani, homeopathy and Tibetan medicine and allopathy; 108 undergraduate training institutes, two postgraduate training institutes, 21 postgraduate departments and one university in the other systems; 215 hospitals and 14,000 dispensaries offering services of other systems, four central councils of training and research to determine standards; and 50 institutes and 200 research units undertaking research in these systems. Today, a decade after this report, the quantitative and qualitative situation of this plurality must be much richer.

The historical prejudice of the promoters and practitioners of allopathic medicine in India is also an indisputable fact. In 1833, a committee appointed by Lord William Bentinck opined that all medical teaching in India be on "the principles and practice of medical science in strict accordance with the mode adopted in Europe". One hundred and sixty years later, the situation has not changed, and the brown *sahebs* who dominate our medical colleges, professional associations and health care institutions, have remained faithful to this dictat. The mission health sector is no exception to this rule.

The prejudice of professionals trained in 'modern western scientific medicine' towards all the other systems that do not come in American or British 'packages' is more symbolic of the 'cultural colonialism' of the transplanted medicine rather

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Towards A National System Of Medicine

THE COUNTRY HAS A LARGE stock of health manpower comprising private practitioners in various systems ... This resource has, so far, not been adequately utilised. The practitioners of these various systems enjoy high local acceptance and respect and, consequently, exert considerable influence on health beliefs and practices. It is therefore necessary to enable each of these various systems of medicine and health care to develop in accordance with its genius. Simultaneously, planned efforts should also be made to dovetail the functioning of the practitioners of these various systems and integrate their services at the appropriate levels, within specified areas of responsibility and functioning in the overall health care delivery system, specially in regard to the preventive, promotive and public health objectives. Well-considered steps would also require to be launched to move towards a meaningful and phased integration of the indigenous and the modern system ...

National Health Policy, 1982-83

than its scientific ethos. How else can one explain the fact that the majority of care-providers within our network regard other systems with disinterest, apathy and often hostility. Many club the alternate systems of medicine under 'traditional superstition' and as an 'inferior health culture' waiting to be transplanted by a better, 'super system'.

A truly scientific approach to medicine would require us to have a rational, open attitude to accepting ideas from 'modern' or 'traditional' systems that have proven to be effective, on the basis of scientific enquiry. Such an attitude, free of professional or cultural prejudice, would be willing to accept:

- garlic and Bengal gram as protection against heart disease;
- salt water gargles, steam inhalations and yogic breathing exercises as better antidotes to upper respiratory infections than all the overused and often unnecessary antibiotics;
- home based *kanji*, rich gruel or ORT as a better antidote to childhood diarrhoeas rather than the range of irrational antidiarrhoeals available in the market today or even the over-mystified intravenous fluid therapy;
- acupressure, homeopathy and acupuncture as useful adjuncts to allopathic practice;
- the need to depromote irrational injection/tonic practice and be less enthusiastic about episiotomies, tonsillectomies and CCU's, all of which are yet to prove their efficiency, on rigorous scientific review.

Are we ready for this open attitude to all systems of medicine including our own? Will we promote the integration of all that is best from every system and tradition, and weed out all that is not of proven value?

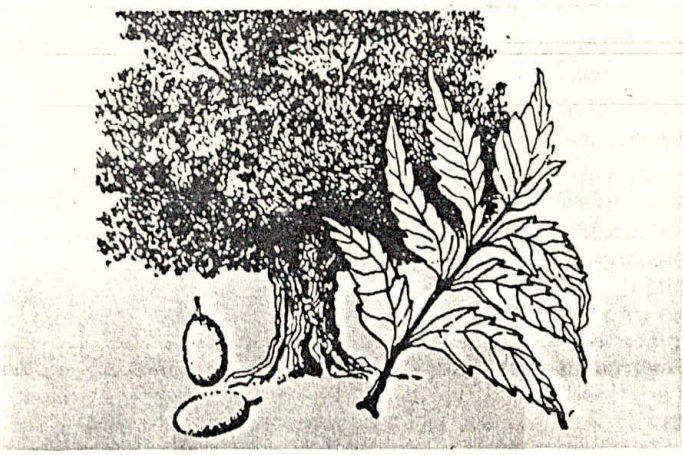
The Shrivastava Report (1975) had recommended the "need to evolve a national system of medicine for the country through the development of an appropriate and integrated relationship between modern and indigenous systems of medicine". The ICSSR/ICMR Health For All Report (1981) has exhorted that the "alternative model of health care ... will strive to create a national system of medicine by giving support to synthesising the indigenous systems".

What will be the contribution of the mission health sector to this goal?

In the 1990s, non-allopathic systems are getting a new lease of life. The factors for this revival and increasing popularity are many. There is growing disillusionment with the excesses and hazards of allopathy; there is a nationalistic revival that is promoting all that is 'old' as gold; the market economy has discovered the profit potential of investing in the 'back to nature and tradition' fad; there is the (misplaced) economic common sense which promotes other systems in the mistaken belief that they are necessarily cheaper; there is the populist rhetoric that seeks to promote such systems because they are more acceptable to the people. Much of what is going on is either populist politics or the forces of 'market' or 'tradition'.

What will be our attitude? What will be our policy? What will prevail: science or prejudice? ■

Many still regard alternate medical systems with apathy, and often hostility. They are clubbed together as superstition or inferior health systems



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HR-17/HA X

UPDATING THE HOSPITAL HEALTH TEAM

Are We Investing Enough?

◆ DR RAVI NARAYAN ◆

The author issues a heartfelt plea for continuing education for medical personnel

IF YOU WERE TO CONDUCT AN INformal survey in your own hospital — big or small, rural or urban, primary, secondary or tertiary care oriented — and if your findings were:

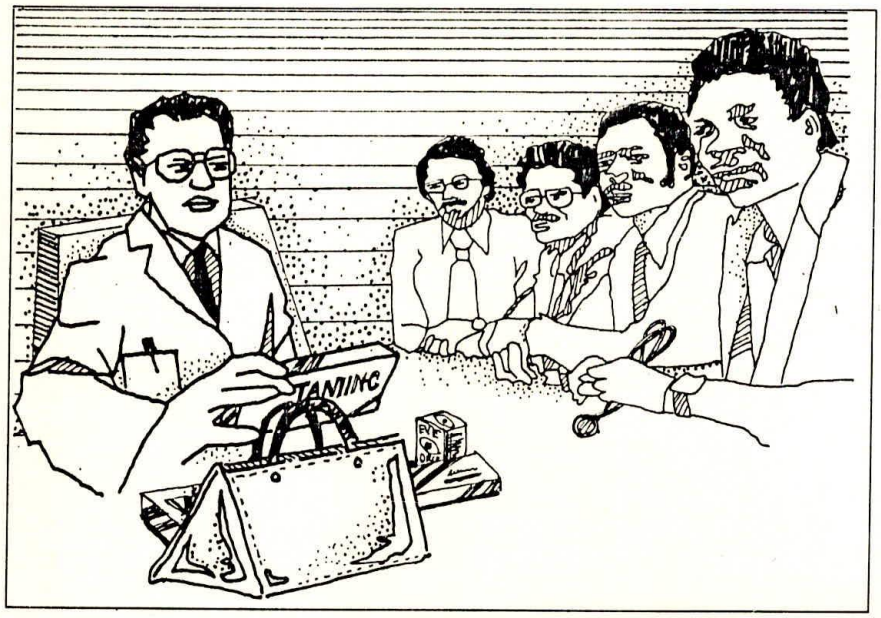
▲ That the doctors (a majority of them, at least) who were working there had not gone back to a workshop, seminar or professional update at a medical college or their nearest local IMA or even a CMAI-organised one for over a decade since their graduation!

▲ That the only professional reading they had done was the glossy literature, handouts and newsletters provided by medical companies full of high pressure advertising of 'tall claims' and 'half truths' about their company product's role in medical treatment, supported amply with the paraphernalia of calendars, diaries, pens, torches, stick-me-ups and other such 'tabletop glitterati' that now adorn the hospital clinics.

▲ That the only continuing education they had received, in recent years, was the monotonous monologues of young aggressive medical reps, presented to them at weekly or fortnightly intervals, flipping flip charts and flashing flash cards, full of subtle medical misinformation about their company products that increased indications; soft-pedalled contra-indications; suppressed caution; and disregarded reported side-effects for the sake of profit margins and sales.

A MAJOR failure of our entire education system, including that of medical education, is that it is a once-for-all phenomenon. Whether it be the doctor, nurse or paramedical worker, there is neither the facility nor the incentive for further education after passing the qualifying examination. This leads to stagnation of knowledge and skill. Expenditure on providing facilities and incentives for continuous training would be amply repaid in the improved quality of services rendered.

National Education Policy for Health Sciences, The Bajaj Report, 1989

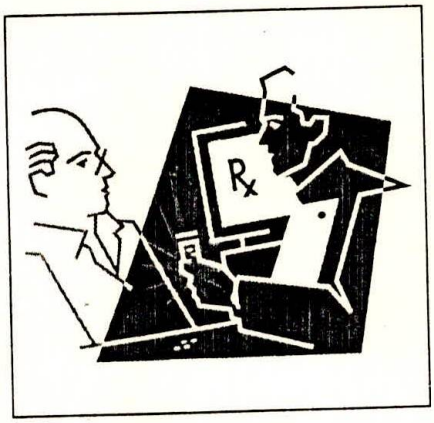


▲ And that the nurses, who were members of the hospital and health teams, had no opportunity to refresh their knowledge at all, except through:

- The routine supervisory weekly meetings of their stern nursing superiors;
- The chance information of a stray comment by a consultant, on a patient round, as they stood at the periphery of the circle; or
- The occasional perusal of company literature that was focussed more on doctors — 'the curers' — rather than the nurses — 'the carers'.

◆ **Dr Ravi Narayan is the coordinator of the Society for Community Health Awareness Research and Action, and a regular columnist for *CMJI*.**

CMJI, April-June 1994



There is no facility or incentive for further education after passing the qualifying medical examination. This leads to stagnation of knowledge and skill. Our investment in continuing education of our hospital teams is still abysmally poor and shockingly inadequate

Would you be shocked? Would you be surprised? What would your response be if you were to further identify via your survey that:

▲ All the rest of the hospital staff — allied, para or auxiliary, who could not be classified into the above two genera of 'misinformed doctor' or uninformed nurse — had no continuing education worth mentioning at all, except perhaps the Sunday magazines of national newspapers or radio and TV jingles devoted mostly to consumerist medicine.

▲ The reason why a particular remedy was being prescribed in abundance in your hospital, had little to do with the latest advances in medical knowledge and more to do with unethical trade discounts or other perks or inducements that a specific company had offered your hospital purchase section.

▲ Some of the standard routines of treatment and regimens of medication in many departments of your hospital had long been discarded in many other, more updated, ethical centres of healing either because they had been proven to have unacceptable side-effects or to be of little value except for their placebo effect.

▲ Your hospital had:

- No policy of continuing education of its staff;
- No policy that promoted 'updates in professional knowledge' as a prerequisite for promotion;
- No policy to invite resource persons for in-house refresher sessions or orientation workshops;
- No policy of investment in a minimum but adequate library facility with basic journals, newsletters and recent textbooks for the use of staff;
- No regular weekly or monthly in-service training programmes;
- No policy of membership or participation in programmes organised by professional organisations, like IMA, CMAI, CHAI and VHAI and the CME of CMC, Vellore.

Would you be surprised? Would you be shocked?

Frankly, I would not at all be surprised by your findings since I am convinced that the situation described above would be very truly representative of the scenario in most centres of care — mission, private or government.

In spite of some efforts by national coordinating agencies like the CMAI, VHAI and CHAI, the initiatives of some IMAs and professional bodies, the efforts of CMC, Vellore (CME Department), and the regular, periodic rhetoric of government policy reports — the state of continuing education of our health care staff is a serious embarrassment.

It has been aptly described by the National Education Policy for Health Sciences as "restricted to sporadic efforts made at undefined intervals and unspecified locations".

> IN the system prevalent today, any doctor who goes out of the system of medical college has little opportunity to come back to update his medical knowledge and skills; and no facilities exist outside the system of medical education to achieve this objective...
>
> In the modern world, where a virtual explosion of knowledge is taking place in most sciences and the existing stock of knowledge is being doubled every seven years or so, a programme of continuing education assumes immense significance...
>
> Continuing education for physicians must concern itself with those issues that are of deep significance to the health of the community and also with educational activities for mixed teams of health workers. Inter-professional education is of critical importance for the members of the health team to learn together how to solve problems.
>
> ***Report of the group on Medical Education and Support Manpower, The Srivastava Report, 1975***

Our investment in continuing education of our hospital teams is still abysmally poor and shockingly inadequate; in fact, continuing education as a policy is probably the lowest on our hospital policy makers' agenda.

I believe that in 2000 AD, when we are likely to discover that the HFA goals were not reached, the evaluation would definitely identify the lack of continuing education of the health team as the main stumbling block. Are we waiting for this indictment? Or are we going to do something about it in the interest of patient care, quality service and our mission? ■

(11)

Health Advocate XI

CRISIS IN SHANGRILA — EUPHORIA AT HOME

◆ DR RAVI NARAYAN ◆

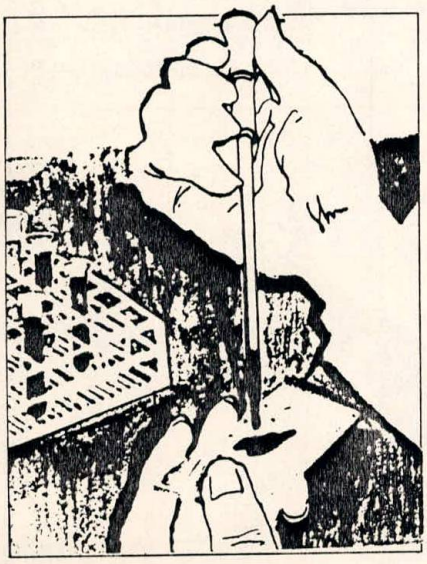
The author takes a hard look at the health care crisis in the Americas

TRAVELS IN 1993 IN THE EAST Coast of North America (regarded for a whole generation as the Shangrila of modern western medicine) proved to be a rather thought-provoking experience for me.

Having grown up in the dominant medical culture of the Indian health service — which believes, with an unshaken faith, that *'what is good for New England is good for us'* — the experience of the growing crisis, the debates, the sobering facts and harsh realities of medical care in Shangrila were both, at the same time, prophetic and disturbing!

A few snippets from the statistics, the debates, and the public outcry will give you a feeling of the state-of-the art available on the East Coast today:

- The American health care budget is $912 billion but the American health care system is able to immunise only 50 per cent of its under-twos. In 1981, the cost of immunising a child was $6.69; in 1991, it increased to $90.43 — an increase of 1,250 per cent.
- A recent *Newsweek* poll found that 81 per cent of Americans feel that doctors charge too much and 60 per cent blame the doctors for today's crisis.
- A routine appendicitis, which years ago would be associated with only about six pre-operative tests, now has at least 31 such tests — the technological imperative, as it is called.
- Forty per cent of doctors in a poll said they would not enter the profession, if they had to do it all over again. The profession feels that a population that is getting older, sicker, more violent and more litigious is the cause of the crisis.
- Solutions to the medical crisis being debated include, among others, emphasis on prevention; employment mandated insurance; malpractice reforms; and, finally, reorientation towards general practice and family medicine.
- Doctors are being exhorted to think not only of what is good for their patients but what is best for society, when they make treatment decisions. Simultaneously, patients are being weaned away from the idea that good care means more care and that they need a CT-scan for their recurrent headaches!



Just across the border, the Canadian Ministry of National Hhealth and Welfare was promoting an expert document on 'Achieving Health For All' which had most interesting observations and goals.

The report recognised that there were three important challenges not being addressed by the health care system:

- Groups at a disadvantage having significantly lower life expectancy, poorer health and a higher prevalence of disability than the average Canadian.
- Various forms of preventable diseases and injuries continuing to undermine the health system and the quality of life of many Canadians.
- Many thousands of Canadians suffering from chronic diseases, disability of various forms of emotional stress and lacking adequate community support to help them cope and live meaningful, productive and dignified lives.

The report, therefore, stressed not the

◆ Dr Ravi Narayan is the Coordinator for the Society for Community Health Awareness Research and Action, and a regular columnist for *CMJI*.

CMJI, July - Sep. 1994

pursuit of more high-tech medicine, but efforts to reduce inequities; widen prevention strategies and initiate efforts to enhance people's abilities to cope.

By the end of my travels, it was clear to me that the East Coast was coming to terms with the harsh truth that market economy-determined, high-tech hospital medicine was a major stumbling block to the 'Health For All' revolution. The state, the profession, the institutions, the policy-makers and the consumers were all therefore gearing themselves for some far-reaching reform in the years ahead.

Back home from my travels, I chanced upon an interesting full-page advertisement in a national newspaper that shocked me out of my wits! The ad was celebrating the first decade of a well-known private hospital group and after listing out nearly 17 urban centres where it had established (or was on its way to establishing) high-tech hospitals, it claimed to have transformed the health care scenario in India. It then prophesised that India would emerge as the medical mecca of the world because it has the doctors to make it a sterling leader in the field. The advertisement, with euphoria and perhaps misplaced revolutionary zeal, exhorted all the readers to come and join the revolution and lead a historic movement in the Indian health care industry. Inject India with the power to lead the medical world! Accelerate the revolution!

Coming so soon after experiencing the crisis in Shangrila, I was rather disturbed. Whom would we need? The depressing prophets of Shangrila or the euphoric prophets back home?

Having been associated with the future of mission dialogue that preoccupies the mission hospital network today, I believe that this dilemma, will soon become central to the debate. Caught on the horns of a dilemma, the network has hard, and perhaps uncomfortable, choices ahead. There is a need for a calm assessment of the network of hospitals, their role in health care and health promotion and their contribution to the health of the poor, for whom we claim a preferential mission. I believe there is a role, though this may be more limited than the expectations of the early pioneers. However, even this limited mission needs sober appraisal and rigorous situation analysis.

Last week, I came across one such sober appraisal in a book which was the last testament and legacy of a respected and humane physician, world-renowned epidemiologist, committed Christian and inspiring teacher — the late Geoffrey Rose. In a chapter entitled 'In Search of Health', he notes with deep sincerity, after a life-time of commitment and scholarship, that in the age of scientific optimism it was believed that medicine had, or was soon to discover, the answers to our health problems.

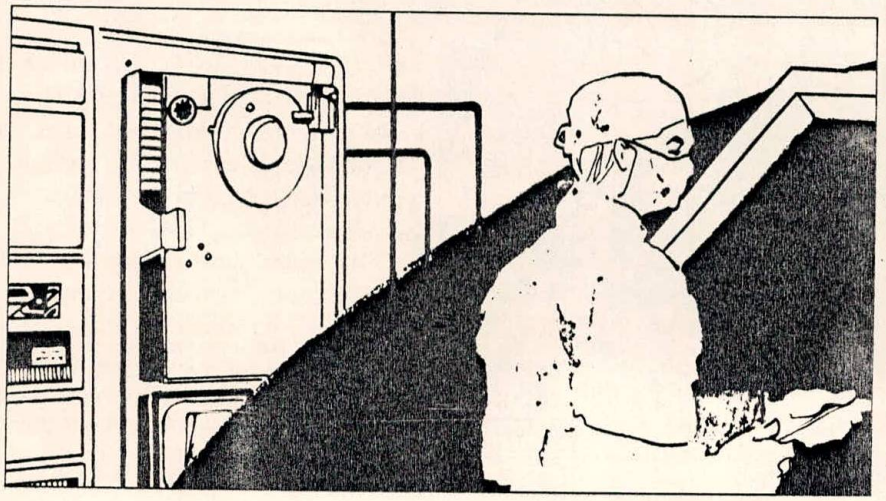
Thus, for example, if the President of the United States gave enough millions of dollars, then cancer would be conquered. That optimism has passed (except in the popular media) and we are starting to sober up. Medicine has indeed delivered effective answers to some health problems and it has found the means to lessen the symptoms of many others. But by and large, we remain with the necessity to do something about the incidence of disease, and that means a new partnership between the health services and all those whose decisions influence the determinants of incidence.

The primary determinants of disease are mainly economic and social and therefore its remedies must also be economic and social. Medicine and politics cannot, and should not, be kept apart. A time has come for more of the leadership of the mission sector to make such sober reappraisals of what they seek to achieve through their institutional investments and their professional exertions, and to discover what the future mission will be:

- ❑ Bone marrow transplants or initiatives in building community capability for health?
- ❑ Magnetic resonance imaging or family life education?
- ❑ Organ transplants or caring/counselling services for AIDS victims?
- ❑ The pursuit of high-tech services or enabling the marginalised to fight for basic rights, central to their health?

The choices are hard. But choices have to be made. The question is: are we ready for the task?

We need to choose between the pursuit of high-tech services and enabling the marginalised to fight for basic rights central to their health



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Health Advocate

THE HEALING MINISTRY AT THE CROSSROADS

Towards A Paradigm Shift

◆ DR RAVI NARAYAN ◆

This article is the last of a series of critiques of the present-day health scenario. Dr Ravi Narayan was the Coordinator of the Society for Community Health Awareness Research and Action, and has been a regular columnist for the *CMJI*. He is at present based in London

Dear Friends,

It's three years since this column was initiated and this is the 12th advocacy in the series. We have explored many ideas on the way...

✔ Will there be mission hospitals in 2000 AD with a preferential option for the poor and a commitment to ethical, low-cost and quality health care?

✔ Will the mission hospitals resist the medical education scam and prevent the co-option of our quality institutions by the corporate network and the 'new money bags', who propose to float questionable commercial ventures?

✔ Will the mission hospitals be willing to bring about the necessary reorientation in the current technology, organisation and management practices, to respond to the continuing and emerging health needs of the poor?

✔ Will the mission hospitals be able to offer critical collaboration to the government in the emerging Health For All strategy, and not just be co-opted by the populist rhetoric and the 'offloading of responsibility' strategy of the new government economic policy?

✔ Will the mission hospitals be willing to adopt newer and bolder options to make the 'robbing Peter to pay Paul' strategy work to the advantage of the poor ?

✔ Will the mission hospitals and their health staff recognise the new spreading virus of communalism as one of the emerging public health threats of our time, and respond creatively to build the community through all efforts?

✔ Will rational healers outnumber drug pushers and irrational drug prescribers in mission institutions in the coming years?

✔ Will mission institutions move from providing floor-mopping technologies to facilitating the more urgently required 'tap turning off' health strategies — to make 'Health For All' a reality some time in the future?

✔ Will mission institutions try to integrate different medical systems or will prejudice continue to win over science in our attitudes to the other systems of medicine and health care?

✔ Will mission hospitals invest adequately in the updating and continuing education of our health teams, to prepare them to meet the emerging health/medical challenges of the decade?

✔ Will mission hospital leadership learn from the disturbing realities, the sobering facts and the hard choices that face the leadership of similar institutions, in areas of the world from where we inherited much of our medical/health framework and thinking?

In the 1990s, the leadership of the CMAI member institutions will be confronted with some uncomfortable questions about the present or future roles of mission institutions. No one is denying that ethical, good quality, low-cost medical care, accessible to the poor and the marginalised in our society, can remain an important mission of the Healing Ministry. But the questions before us are twofold. The first, whether this itself will continue to be the 'mission' of most members of the network or will they drift away to a new mission, engendered by the market economy — that of providing the latest high-tech care to those who can afford to pay? The second, whether just providing institutional health care can remain a sufficient response of the Healing Ministry in the 1990s or are we all being collectively challenged to see the healing mission in a new light?

At the root of our problem lies the fact that most of the leaders of the 'Healing Ministry' today have failed to internalise the emerging new vision of health and health care, that is, challenging the 'medical orthodoxy' at its very foundations. Trained in the old 'biology', they are unable to fully comprehend the paradigm shift that has taken place in the emerging 'social biology' of health.

Research efforts in the last few decades, supported by behavioural science inputs and management sciences, have completely revolutionised our understanding of the concept and goals of health care. Till the 1950s, by which time a large majority of the CMAI hospitals now existing had been established, health was seen as being synonymous with medical care. In this milieu the Doctor-Drug-Dispensary-Hospital model evolved in the In-

CMJI, oct. - Dec. 1994

dian situation with the mission sector playing a pioneering role.

In 1948, the WHO defined health as physical, mental and social well-being and not the absence of disease or disability. This was a revolutionary first step in the paradigm shift from a negative concept of disease to a positive concept of health as well-being. However, the medical profession dominating the scene failed to recognise the creative challenges thrown up by this new definition. So till the 1970s, institutional drug-oriented technological responses continued to be seen as being synonymous with health care. Some more CMAI member hospitals were set up during this time as well.

Thirty years following the WHO definition, there emerged the 'Alma Ata Declaration'. Health care was described in a new framework and as a new process, where people and the community were not just beneficiaries of a professionally determined and directed system but active participants of a joint partnership. The four principles stressed in the Declaration — equitable distribution, community participation, multi-sectoral approach and appropriate technology — further emphasised the paradigm shift.

> Let us remember that two-thirds of the world's people are underprivileged, underfed, underhealthy, under educated and that many millions live in squalor and suffering. They have little to be thankful for save hope that they will be helped to escape from this misery.
>
> These [problems] are symptoms of a new evolutionary situation and these can only be successfully met in the light and with aid of a new organisation of thought and belief, a new dominant pattern of ideas relevant to the new situation.
>
> ***Julian Huxley, 1961***

Since the 1980s we have all had to grapple with this evolving, radical change in our understanding of medicine, from its 'mechanistic orthodoxy' to its more creative social metamorphosis.

This has meant that we all have slowly began to accept the paradigm shift, the key components of which are:

- moving from problems of individuals to problems of communities
- moving beyond the limited pathophysiological, intracellular understanding of disease to the more dynamic behavioural/societal context of health
- moving from the concept of illness as a disease process requiring treatment to that of ill health as a social process requiring a care system and strategy
- moving from a preoccupation with providing packages of services to a more dynamic enabling/empowering process where the individual/community exercises its rights to health and its responsibilities for its maintenance
- moving beyond the concept of patients as just beneficiaries of professional intervention to people as participants of a joint operation, where consumer control and autonomy of consumer decision-making has become more significant
- moving from the concept of the doctor/nurse being the centrestage of the process to the doctor and nurse being part of an expanding health team working together for a common social goal.

We all have slowly begun to accept the paradigm shift — moving beyond the concept of patients as just beneficiaries of professional intervention to people as participants of a joint operation, moving from the concept of the doctor/nurse being the centrestage to their being part of a team oriented towards a common social goal

The Healing Ministry of the 1990s cannot remain in the myopic bio-medical model of health. It has to respond to the emerging bio-psycho-social understanding of health and respond to the 'paradigm shift'.

I believe it will and it can — if more of us have the courage to see the new demands and the new challenges not as something that is beginning to destroy what we have built so conscientiously over the last four decades, but as a welcome stimulus and leaven for a new transformation, and a new healing of our 'missions' as well.

We are at a crucial crossroad in our common histories. Will we grasp the opportunity? ■

Finally, a Strategy to Control Malaria

◆ Dr Ravi Narayan

The resurgence of malaria as a major public health problem has posed serious concern for health policy makers and planners

THE resurgence of malaria as a major public health problem has posed serious concern for health policy makers and planners. In 1994, serious malaria outbreaks and epidemics were reported in Rajasthan, Nagaland, Andhra Pradesh, Manipur and West Bengal. A number of districts in Assam, West Bengal and Maharashtra experienced malaria outbreaks with high morbidity and reports of death in 1995.

The voluntary health sector began concerted and collective initiatives after serious epidemics in Rajasthan and the North East. VHAI had initiated a dialogue on 'rational malaria care' in 1995 by bringing together a working group to look at various aspects of malaria treatment and to review the recently evolved guidelines of the National Malaria Eradication Programme (NMEP). To take this process further, an expert group on malaria was convened in April 1995 to seek wider opinions on the malaria situation and suggestions on how to tackle the problem.

What followed was an interactive and participatory process initiated by the Society for Community Health Awareness, Research and Action on behalf of the Voluntary Health Association of India from April to January 1997.

The six-member expert group and a reference group of 44 from the voluntary/NGO sector has chalked out an alternative, community-oriented, socially-relevant malaria control strategy.

Through a review of existing policy documents and guidelines, the group has identified key issues of concern

The Public Health Crisis in India

THE re-emergence of malaria as a significant public health problem since the 1970s and the increasing occurrence of outbreaks and epidemics, especially in the 1990s, is leading to an urgent reappraisal of the country's public health policy. And also a deeper understanding of the larger public health crisis that has been evolving in the country over the last two decades. Some elements of this crisis are:

● The Socio-Epidemiological Link

Strategies to control communicable diseases have focussed primarily on techno-managerial aspects. Only analysis and solutions that link socio-economic and cultural-political contexts of the problem will help to evolve a more comprehensive, effective and sustainable malaria control strategy. The focus has been on the mosquito, the parasite, the health care delivery system, the environment and ecology. The patient and the community at risk have been neglected. The expertise of the behavioural sciences, especially the socio-anthropological and the socio-psychological dimensions at work in malaria, have been grossly neglected.

● The Political Economy of Health

Health planners and policy makers are concerned that the market economy often drives policy decisions. This also means that the approaches and priorities often promoted are at variance from the recommendations of national expert committees and technical evaluation reports.

Before evolving strategies and programmes, it is vital to understand the national and the international political economy of health.

● The Challenge of Decentralisation

To respond to regional needs and disparities in the health care situation, a concerted effort toward a framework of decentralised planning is needed.

● Primary Health Care — Beyond Rhetoric to Grassroots

Ultimately, the health infrastructure of the grassroots must be strengthened through community-based approa ches.

● The Threat of the New Economics

There is growing concern that the general health infrastructure and human power situation is continuously worsening. The culprits are the larger economic issues — the corruption, the trend towards privatisation and commercialisation, and the cutbacks in government expenditure on welfare.

The effects of the new economic policies need to be monitored carefully

CMJI, April-June 1997

India's Contribution

INDIA has an unenviable share of the global incidence of malaria... Almost 2.5 million cases are reported every year, of which the fatal falciparum or cerebral malaria claims over 1,000 lives. India contributes about 40 per cent of all malaria cases outside Africa. These figures do not reveal the entire picture though the virtual collapse of the health surveillance and information systems in India has led to gross manipulation and under-reporting of data by the authorities concerned.

which have not been adequately considered in the recent planning process — supplemented by their own field experiences and that of fellow travellers and field workers, activists, trainers, researchers and awareness builders in community health. The group has suggested some alternatives for action.

The 'Expert Group Process' has tried to move beyond just a critique to bring together the complementary initiatives and processes in the voluntary sector. Thereby collectively strengthening the emerging efforts.

Among other things, the expert group highlights the problem of underestimation of malaria; the need to strengthen the behavioural sciences dimension in planning and research; the challenges of rationalising malaria diagnosis and treatment, including the potential misuse of mefloquin; the alternatives in vector control strategies; and the need to rediscover the community dynamics and dimensions in malaria control — including community capacity building, health education, role of the voluntary sector, general practitioners and the panchayat leadership. The group recognised the urgent need to decentralise planning and to assess the role of the indigenous systems of medicine. Other areas of focus are policy issues — health, human power development and research, monitoring and forecasting, corruption and political interference, Centre-State responsibilities and international public health co-operation.

and the distortions in the planning process produced by market forces need to be countered.

- **Right to Information**

Public participation has floundered due to inertia and red-tapism linked to the absence of critical information. A process of demystification linked to the right to information can garner community participation.

- **Widening Dialogue and Participation in Planning**

By drawing on the resources of an alternative sector — a wide network of individuals and groups eager to share their experiences and perspectives — the voluntary sector, by evolving indigenously determined responses, has contributed to strategies to tackle malaria and actively supplement the efforts of the national malaria eradication programme.

LESSONS FROM HISTORY OF MALARIA CONTROL

From a review of the malaria control activities from the 1930s onwards, the most significant lessons are:

The potential for sustained public health action.

- Competence in a diversity of approaches.

Before the advent of DDT, we were competent in bio-environmental methods, anti-larval operations and other supplementary action. However, when DDT became the sheet anchor followed by other pesticides, further development of competence in other methods was disregarded with unfortunate consequences.

> "The history of malaria contains a great lesson for humanity — that we should be more scientific in our habits of thought and more practical in our habits of government. The neglect of this lesson has already cost many countries an immense loss of life and of prosperity"
>
> Ronald Ross (1911)

SYNERGY BETWEEN POLITICAL AND HEALTH LEADERSHIP

Till the mid 1960s, there was an effective synergy between the political leadership and competent and assertive public health leadership in the country so that malaria control was supported by strong political will and facilitated by crucial public health competence at all levels.

- Devise local solutions in response to local realities and constraints.
- Recognise the economic advantage of national health programmes. Effective anti-malaria operations converted the Terai in Uttar Pradesh, Wynad in Kerala and Malnad in Karnataka into the granaries of India.
- Recognise and monitor significant factors.

Drawing from these lessons of history, the malaria expert group suggests:

- Inform planners and health action initiators of the experience and strategies of the past.
- Make information and documents available to them.
- Identify and involve some of the 'veterans' of the battle against malaria to evaluate and review the current challenges. So that we do not 'reinvent the wheel' but learn from the past in our efforts to harness action for the future.

"The history of malaria contains

a great lesson for humanity — that we should be more scientific in our habits of thought and more practical in our habits of government. The neglect of this lesson has already cost many countries an immense loss of life and of prosperity." *Ronald Ross (1911).*

MALARIA SITUATION: THE PROBLEM OF UNDERESTIMATION

Malaria is grossly underestimated. The existing epidemiological information is based on inadequately validated data. Planning at all levels must be based on more reliable and valid data.

The expert group on malaria has suggested compulsory notification of malaria cases and deaths as well as improvements in the surveillance system. PHC staff and private practitioners must be motivated to provide a true picture of the local situation of malaria. Independent review and evaluations can provide further information. Among the indicators a parallel surveillance can check are: early diagnosis, prompt treatment, active case detection, passive case detection, and any other indicators.

The expert group has called for reducing duplication of data collection and record keeping. It has put forward ideas of how to integrate records to solve the 'too many registers' syndrome at the front line worker's end.

References: *VHAI, New Delhi, November 1996; Down to Earth, June 30, 1996.*

★ *Others in the expert group included Dr P.N. Sehgal, consultant, Dr Mira Shiva, head, Public Policy Unit, Voluntary Health Association of India; Prof Amitabha Nandy, Department of Parasitology, Calcutta School of Tropical Medicine, Dr Rajaratnam Abel, head, RUHSA Department of Christian Medical College and Hospital, Vellore, and Dr Sunit Kaul, Association of Voluntary Agencies for Rural Development, North East (AVARD-NE), Jorhat, Assam.*

Dr Ravi Narayan is the coordinator of the Society for Community Health Awareness, Research and Action.

The Lord's Parameters

◆ R.A. Jacob

"When I was hungry
you gave me food.
When I was thirsty
you gave me drink.
When I was a stranger
you took me in.
When I was naked
you clothed me.
When I was sick
you visited me.
When I was in prison
you came to me."

Does hunger, thirst, nakedness, sickness or someone in prison inspire us?
Or do we need funds, target groups, volunteers and resources?
In the end, only people matter. Papers matter little.
When touched by reality, plans made in air-conditioned rooms melt like ice, leaving nothing behind.
To address basic necessities, do we invite people only from the peak of the system, while people who have known such adversities watch from a comfortable distance?

Hunger, thirst, nakedness, sickness or imprisonment are the Lord's parameters of evaluating our work.

R.A. Jacob worked with the CMAI.

The People's Charter For Health
— *Does It Mean Anything To You?*

◆ Dr Ravi Narayan

People's movements across the world are working to identify and demonstrate that the path to sustainable development does not lie in neoliberal globalisation but in alternative models for people-centred and self-relevant progress

Dr Ravi Narayan

The People's Charter for Health is a rallying point around which the global health movement can gather

Nearly 24 months ago, 2500 health professionals and activists reached Kolkata in four People's Health Trains from all over India, for the first National People's Health Assembly. They brought with them perspectives, enthusiasm and inspiration from months of mobilisation for the 'Health for All Now' campaign launched by 18 national networks on 7th April 2000 (World Health Day, now People's Health Day from 2000) at Hyderabad.

The mobilisation included state, district and taluka level meetings, kalajathas, people's health enquiries, policy dialogue and the most significant of all, the publication of five consensus documents on the health situation and challenges in India.

- These booklets included a wide range of concerns brought together under five titles, (1) What Globalisation does to People's Health! (2) Whatever happened to Health for All by 2000 AD? (3) Making life worth living (meeting basic needs) (4) A world where we matter (health of women, children and the marginalised in society) (5) Confronting commercialisation of Health Care.
- These booklets are now available in most Indian languages and appreciated all over the world. These five little booklets – the distilled wisdom of decades of working on 'Health for All' issues represent a phenomenal consensus not only of health networks like Medico Friends Circle, Catholic Health Association of India, Christian Medical Association of India, All India Drug Action Network, and Voluntary Health Association of India, but also the science movements, women's movements, national alliance of people's movements and groups like the forum for creche and child care services and even the Federation of Medical Representatives Association of India and others!
- After two days of interactive workshops and solidarity-oriented plenaries, a health exhibition, a celebration of the diversity of *kalajathas* and cultural activities in health, a public march for health and a public rally, an Indian People's Health charter was evolved. Then nearly 300 Indians went across by bus and other modes of transport to Savar, Bangladesh to participate in the first global People's Health Assembly – a 5-day multicultural celebration and reflection on 'Health for All'.
- At the end of it all there evolved the People's Charter for Health – the largest consensus document in Health since the Alma Ata Declaration on Primary Health Care in 1978. The People's Charter for Health, now translated into several of the world's languages, is 'an

expression of our common concerns for health, a vision of a better and healthier world; a call for radical action, a tool for advocacy and a rallying point around which the global health movement can gather ..'

How many of you, dear readers, have heard about the People's Health Assembly? How many have seen the five little booklets? How many have read the People's Health Charter?

a. **If your answer is a definite No – then it's a time of reckoning!**

Have you been so busy and occupied with your bio-medically oriented health initiative that you missed one of the largest health obilisation of our times. Perhaps as the 'Cor Unum' document of 1976 recorded, *'the leaven is still far removed from the bread of health'*.

WCC

Marching for a cause

b. **If the answer is a qualified No – I have been too busy working with my sick and unhealthy community or my crowded OPD and wards – tackling problems with my limited resources and my overstretched capacity, then too a time of reckoning has come!**

It's time to take stock of your work, share your innovative experiments at microlevel with a larger network of ople, learn from the experience and enthusiasm of others and join the movement bringing your zeal and local experience into it.

c. **If the answer is a qualified Yes – but I was only peripherally informed and perhaps involved very little, then it's a time of reckoning as well!**

Perhaps you are still dazzled by the glamour of 'technological prescriptions' of health promoted by social marketing strategies including our medical education that are driven by market forces rather than the basic health needs of the people and the socio-economic-cultural realities of their lives. It's time to absorb the new emerging frameworks of health action from the Movement and the Charter.

d. **If the answer is a definite Yes – I have been deeply and enthusiastically involved, then too a time of reflection is at hand!**

It's time to reflect whether in line with the framework of action outlined in the People's Health Charter, your current medical/health initiative promotes health as a human rights concern; tries to tackle the broader determinants of the health problem – economic, social, political, cultural; tackles environmental challenges to health including the viruses of conflict and violence; makes your health initiatives more people-oriented, more people-determined, more people-accountable? Perhaps you are in the right direction but there are 'miles to go before you sleep!'

As you read the Charter many may say, "Of course I believe in 'Health for All' but isn't the charter too political?" Others may say, "Of course I believe in 'Health for All' but why be so against the new economic policies of globalisation, liberalisation and privatisation? Aren't they improving outreach, quality and efficiency?"

The answer to both these questions are being reiterated all the time.

☑ **Prof Geoffery Rose**, a famous epidemiologist and a committed Christian, wrote this as his last testament a decade ago after an illustrious career in epidemiology of health:

"The primary determinants of disease are mainly economic and social and therefore, its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart."

☑ **Prof D Banerjee** of the Jawaharlal Nehru University has cautioned health professionals for decades that ***'health service' is a socio-cultural process, a political process; a technological and managerial process with an epidemiological and sociological perspective."***

☑ **Dr Fidel Castro**, well-known political scientist and leader warned health leaders in a WHO Assembly speech that:

"Never before did mankind have such formidable scientific and technological potential, such extraordinary capacity to produce.... Wellbeing but never before were disparity and inequity so profound in the world....

Another 'Nuremberg' is required to put on trial the economic order imposed upon us. The current global system is killing by hunger and preventable and curable diseases, more men, women, children every three years than all those killed by world war II in six years...

ARE YOU READY FOR THE PEOPLE'S HEALTH MOVEMENT?

DOES THE PEOPLE'S HEALTH CHARTER MEAN ANYTHING TO YOU?

Is the evidence available? The perspectives are emerging as we move into the next millennium.

Dr Ravi Narayan
Community Health Adviser
CHC/PHM

War or Peace: What is Your Commitment?

◆ Dr Ravi Narayan

With the Middle East on the boil, do we as health professionals remain passive and uninvolved, thereby supporting the war through our silence?

WHO

On February 15, 2003, over a million participated in the largest rally London had seen for decades. Hundreds of thousands marched through Berlin; two lakhs marched through Damascus; thousands joined marches in Bulgaria, Romania, Hungary, Brussels, South Korea, Australia, Malaysia and Thailand; hundreds in Bosnia, Hong Kong and Moscow; and thousands in Amsterdam, Copenhagen, Johannesburg, Tokyo, Dhaka. It was the largest anti-war rally in recent decades.

Earlier many braved the cold in many American cities and many joined similar protests in Delhi and Kolkata and Kerala soon after. The protests were a significant and inspiring message by peace loving world citizens all over the globe. They were not swayed by the pro-war rhetoric of Bush and Blair; nor impressed by the machination of the armament and nuclear transnational corporations all over the world; nor provoked by the demonstration of some leaders or even stereotyping of one of the important religions of the world. Men and women, young and old, school children and college students; farmers and teachers, artists and musicians, disabled and minorities; people of all religions, class and ethnicity joined the protest in an overwhelming groundswell of public opinion. No more war; no more bombs; no more war and bombs for oil rhetoric please!

No more war;
no more bombs;
no more war and bombs
for oil rhetoric
please!

CMJI, Jan.–March 2003

RCRC

To live in peace takes a lot of commitment. To promote a world in which *Health for All Now* can be a reality, needs all of us to be as anti-war as we are anti-disease

As members of a health network; as members of an association and followers of a 'peace maker'; what was your response?

Did you join the marches?
Did you e-mail your protest?
Did you talk to your family, your friends, your colleagues, and your associates against war and stimulate them to support peace?
Did you write against the war?
Did you pray for the peace?
Or
Did you remain passive, uninvolved, disinterested, confused and supported the imminent war through your silence?

To live in peace takes a lot of commitment. To promote a world in which *Health for All Now* can be a reality, needs all of us to be as anti-war as we are anti disease; as pro-peace as we are pro-health.

Are you going to respond?
Are you going to make your small voice part of a big bang against war?
What is your commitment?
War or peace?
Peace needs You!!

Dr Ravi Narayan
Co-ordinator
PHM Secretariat
CHC- Bangalore

Twenty five years ago in 1978, the Alma Ata Declaration on *Health for All* had clearly noted that

> *"An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary healthcare, as an essential part should be allotted its proper share."*

In 1995, people from 92 countries gathered at the People's Health Assembly in GK Savar, Bangladesh and noted in the People's Charter for Health that:

> *"War, violence, conflict and natural disaster devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector."*

The Charter called on peoples of the world to:

- support campaigns and movements for peace and disarmament.
- support campaigns against aggression and the research production, testing and use of weapons of mass destruction and other arms.
- support people's initiatives to achieve a just and lasting peace.
- demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression, which can damage the health of civilian populations...

Remembering Alma Ata

◆ Dr Ravi Narayan

The 25th anniversary of the Alma Ata gives us an opportunity to ponder over the realities and the options available to us

In September 1978, an International Conference on Primary Health Care meeting in Alma Ata (then USSR), pressed the need for urgent action by all governments, all health and development workers and the world community to protect and promote the **Health of all the people of the world** through the famous '**Declaration of Alma Ata**'. This was affirmed by a large number of country delegations from all over the world and became the blueprint of a new Health and Development Philosophy around the world.

The declaration strongly reaffirmed that

- "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
- "Health is a fundamental human right."
- "The attainment of the highest possible level of health is the most important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector".

In September 2003, as we reach the twenty-fifth anniversary of this famous Declaration, it is important to reflect on some of its key recommendations and see whether the health professionals and healthcare institutions who are members of our CMAI network have been true to these exhortations.

- Have we focused our efforts on the 'gross inequality in the health status of our people which is politically, socially and economically unacceptable' and tried to reach more and more of the poor and marginalised sections of our society in our work?

Or have we allowed the 'market of health' to change our strategies, to focus not on 'Health for All' but only on 'Health for those who can pay' leading to more and more poor being left out of our institutions?

- Have we focused our efforts on 'the promotion and protection of the health of the people' as our sustained 'contribution to the economic and social development' and 'contribution to better quality of life' and 'to 'world peace'?

Or have we got enmeshed in the demands of an increasingly, costly, secondary and tertiary care oriented health system, which is pricing itself out of the poor person's options and sometime the market itself? Have we contributed to the worsening of their quality of life and to the inevitable social tensions leading to conflict and war?

- Have we recognised that 'people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare'?

Or have we continued to view them as patients and potential beneficiaries of our systems and prevented a real, informed and active lay participation in hospital / healthcare planning and management'?

- Have we recognised that 'govern-

Have we got enmeshed in the demands of an increasingly costly health system

CMJI, July-Sep. 2003

CMAI

ments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures'?

Or have we watched passively as uninterested citizens in spite of 'our so called preferential option for the poor', as governments at national and state level have reduced health budgets, cut back support to rural healthcare and allowed 'privatisation' and 'corruption' to ravage the health systems, which are supposed to be accessible to the poor?

- Have we built our community outreach and community-based healthcare programmes on the "**Principles of Primary Health Care – recognising it as essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that community and country can afford?**"

Or have we let our hospitals and health systems become the means to introduce glorified, high technology, fancy brand medicine and promoted hospital practice that has a vested interest in the 'abundance of ill health'? Have we simultaneously also become at community level, subcontractors of government and internationally inspired and supported health programmes 'socially marketing', 'magic bullets' for verticalised disease-oriented interventions, thereby destroying the spirit of Alma Ata?

- Have we encouraged our '**healthcare initiatives to move closer and closer to, where the people live and work**' – focusing on first level contact that individuals, families and communities make with our health systems.

Or have we built buildings and more buildings, ivory towered and cut off from our people by larger and larger walls of concrete, worrying more and more about our own security and the security of our machines and costly technological systems and thereby distanced ourselves from the people?

- Have our healthcare and hospital systems **evolved from the economic conditions and socio-cultural and political characteristics of our country and its communities?**

Or have we continued to transplant westernised, imported systems and ideas and a medical culture that has evolved in a different socio-economic, cultural and political milieu?

- Has this socio-cultural gap manifested particularly in our continued negligence and disregard of traditional systems of healing and the folk health traditions of our people?
- Have we '**promoted maximum community and individual self-reliance and participation in the planning, organisation, operation and control of healthcare, making fullest use of local resources and developed through a appropriate education, the ability of communities to participate?**

Or have we continued to build 'charity and dependence creating' systems funded by external resources or determined by the temptations and the marketing strategies of the growing medical industry?

CHETNA

• Have we integrated our mission hospital and dispensary network with other like-minded institutions including government institutions in **'functional and mutually supportive referral system, leading to progressive improvement of comprehensive healthcare for all and giving priority to those most in need'?**

Or have we continued to grow in splendid isolation, relating to other mission institutions and government institutions, only through cut-throat competition or 'holier than thou' or 'cleaner than thou' attitudes that have kept us all apart rather than helped us to build a collective solidarity of institutions with a mission to reach the poor and marginalised, sharing our human resources, our facilities and our experience?

• Have we relied at **'local and referral levels, on health workers including general physicians, auxiliaries, community workers and traditional practitioners, suitably trained, socially and technically to work as a health team and to respond to the expressed health needs of the community?**

Or have we begun to focus on more and more sophisticated health workers and technicians, and begun to compete with each other to participate in the increasing commercialisation and specialisation of medical and health professional education, even lending our institutions as partners to more and more of these capitation fee initiatives?

• Have we promoted through our church and lay leadership and educational resources, greater encouragement **'to genuine policies of independence, peace, détente and disarmament'** and encouraged our governments to move their resources from **'spending on armaments and military conflicts to reaching an acceptable level of health for all the people of our country?**

Or have we in our eagerness to align with the powers to be or to maintain status quo, or promote social acceptance among the elite, or even through a 'pharisaical' disregard of the increasing poverty in the lives of our people – allowed conflict – both religious, ethnic and language based, to devastate the lives of our people and destroy the bonds of communities that have kept our multi-religion and multi-cultural country together all these years?

As we ponder over the realities of our own options – and the trends in our institutions over the last twenty-five years since the call of Alma Ata, it would be important to keep in mind some reflections of health professionals, with the same motivation and inspirational history as ours:

• In 1976, the pre-Alma Ata Cor Unum document (1976) on the 'New Orientation of Health services with respect to Primary Health Care work' observed:

"The mission that we have been give is a call for a true conversion of our hearts and also of our methods..."

"We must work for the overall development of each man, and focus on the sick person more than on his sickness. Since development also means solidarity, we must necessarily turn our attention towards the human community of the patient, his family first, but also his neighbourhood or village. This means we must practise community medicine..."

"Since Christians are the leaven, we must reach out towards the masses by providing simple, accessible and promotional healthcare according to our own

To access the Alma Ata Anniversary Pack of materials from People's Health Movement, visit http://www.phmovement.org/pubsindex.html #AlmaAtaAnniversarypack

JOIN THE MILLION SIGNATURE CAMPAIGN

DO YOU BELIEVE IN 'HEALTH FOR ALL NOW'? THEN JOIN THE MILLION SIGNATURES FOR 'HEALTH FOR ALL NOW' CAMPAIGN LAUNCHED BY THE PEOPLE'S HEALTH MOVEMENT (GLOBAL) AT THE ASIA SOCIAL FORUM, IN HYDERABAD IN JANUARY 2003.

JOIN A MILLION OTHER SIGNATORIES TO AFFIRM THE PRINCIPLES OF THE ALMA ATA DECLARATION WHICH WERE REAFFIRMED IN THE PEOPLE'S HEALTH CHARTER – DECEMBER 2000, THE LARGEST CONSENSUS DOCMENT IN HEALTH SINCE THE ALMA ATA DECLARATION.

IN THE ALMA ATA ANNIVERSARY YEAR, JOIN US ALL TO SPREAD THE MESSAGE OF 'HEALTH FOR ALL, NOW.

VISIT THE WEBSITE www.TheMillionSignatureCampaign.org. AND SIGN INTO THE CAMPAIGN.

GET ALL YOUR COLLEAGUES AND STAFF MEMBERS OF YOUR HOSPITAL / INSTITUTION TO DO THE SAME.

WELCOME TO THE PEOPLE'S HEALTH MOVEMENT. HELP US IN THE STRUGGLE FOR HEALTH FOR ALL NOW.

For more information contact:

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comm.phmsec@touchtelindia.net
Website: www.phmovement.org

possibilities, modest as they are, or in conjunction with the public services, where this is allowed..."

"It sometimes happens that as a result of changes which not everyone is necessarily aware of, too many of them work in hospitals and health centres that have become too expensive for the majority of the population, and are only within reach of the pockets of certain 'elite' who can afford them. In this case, the leaven is too far removed from the loaf..."

- Twenty years later in 1996, as we were reaching the Health For All- 2000 milestone and Health for All was nowhere in sight, a group of health professionals invited by CMAI for a consultation on primary Health Care – A Christian Mandate had this to say:

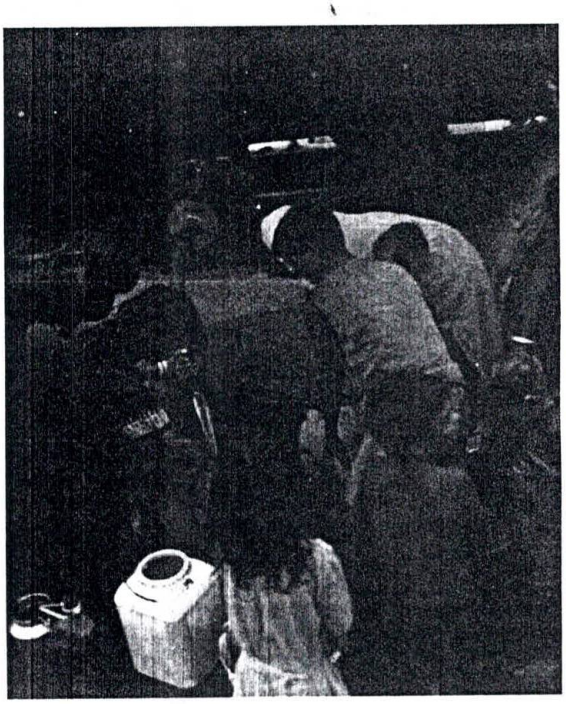
"A church has a mandate to work towards a just and health society. We believe that Primary Health Care in its widest sense would be instrumental in this work. We are conscious that as of now, the poor remain marginalised and exploited, and that we as a church have a clear bias or preferential option for them. We realise that with the change of direction in India's economic development policies with globalisation, structural reforms and marketisation of society, the poor are being sidelined and jeopardised even more. We are committed to increasing the understanding of the contextual realities of the country, within the church, its institutions, amongst health professionals and the public at large and of the urgent roles we need to take on, especially on the side of the poor." (2)

- It is time to move beyond prophecy and policy rhetoric to concrete institutional and professional change. The twenty-fifth anniversary of the Alma Ata Declaration is a time of reckoning.

- **What will be our individual option?**
- **What will be our institutional option?**
- **What will be our collective option?**
- On which side do we stand? **'Health for All Now' or 'Health for those who can pay'?**

Dr Ravi Narayan
(Co-ordinator)
People's Health Movement
(Global),
CHC, Bangalore

[Note: The quoted extracts in bold in this reflection are taken from the following source: The Alma Ata 1978, Primary Health Care, WHO/UNICEF, 1978.
The quote-marked (2) is from the handout conclusions of the Consultation on primary Health Care – A Christian Mandate, CMAI, New Delhi, February 1996, put together by Dr Thelma Narayan and Dr John Oommen].



Making a Difference

◆ Dr Ravi Narayan

Are you a floor mopper or tap turner-off?

Dr Ravi Narayan

This question has been a great stimulus to me for the last 30 years, helping me explore a new meaning for the role of the doctor and a new vision for the healing ministry

Thirty years ago, as a young post-graduate student of public health in 1973, I had the opportunity to listen to a lecture on 'Future directions and challenges in research', by late Dr Denis Burkitt. He was a famous mission hospital doctor and medical researcher from Africa, who for many years, directed the Medical Research Council of the UK and promoted a rethinking in the focus of medical research – from a preoccupation with; intracellular research' to a new commitment to 'behavioural and societal research'. The core of this lecture was an important question he presented to all of us youngsters, as a challenge in our future vocation. This question has been a great stimulus to me for the last 30 years, helping me explore a new meaning for the role of the doctor and a new vision for the healing ministry. In memory of this late medical prophet, I share this question with the readers of *CMJI*.

Imagine a room with a wash basin. On entering the room, you find that water is pouring out of the tap, the sink is overflowing and there is a mess on the floor. What would your first response be to tackle the situation? Will you be a floor-mopper or a tap turner-off?

The medical and nursing profession have long been floor-moppers, using drugs and technology to floor-mop the overflow of illnesses and disabilities in the community. With the knowledge of preventive medicine being limited, this seemed the most logical response and therefore, the clinically-oriented drug-technology-dispensary-hospital-oriented healing ministry developed.

As we reach the end of the millennium, medical knowledge has grown and our knowledge of diseases has also improved greatly. Many more of the preventable causes of illness are known and the deeper social determinants are better understood. Also newer tap-turning-off skills have been developed to varying levels of competence.

Are the healers in the ministry ready to become tap turners-off or are they going to continue to 'floor-mop' in the old tradition, getting distracted and carried away by the glistening versions of floor mops being produced by the multinational medical industry today?

For many in the ministry, this question will be a very disturbing one as it was for me 30 years ago. Brought up on the white coat, stethoscope and Pavlonian prescribing reflexology of orthodox medicine, I failed to understand what tap turning-off meant and its relevance to the medical vocation, when I first heard about this ideas. Today, three decades later, I have become a little wiser.

- The 'floor-mopper in me had stressed the relevance of coronary care units and promoted coronary bypass surgery, till the 'tap turner-off' in me took over to promote exercise, cycling, diet modification, reduction in smoking and various other lifestyle changes and social controls over advertising.

CMJI, oct.-Dec. 2003

What type of Healthworker are you?

A "Tap Turner-Off" OR A "Floor Mopper"

Rashika Dewan

- The 'floor-mopper in me had stressed trauma surgery and neurosurgical care as a response to the increasing epidemic of accidents and violence till the 'tap turner-off' in me took over to promote road safety, occupational hygiene, helmets and belts, gender sensitivity and communal harmony.
- The 'floor-mopper' in me had promoted vitamins – pills, tonics, enriched and fortified foods in response to the continuing problem of malnutrition – till the 'tap turner-off' in me took over to promote low-cost, local food mixes, vegetable gardens and efforts to make our institutions more baby-friendly and our society more nutrition security conscious.
- The 'floor mopper' in me had stressed intravenous fluids and antidiarrhoeals for the treatment of childhood diarrhea till the 'tap turner-off' in me took over to promote home-based ORT, access to clean water, and environmental sanitation and land reform.

As a medical college teacher for a decade (1973-83), and as a community health trainer in the next two-decades (1984-2003), I discovered an additional challenge in Prof. Burkitt's question. Could education of the health team geared to the floor-mopping tradition of orthodox medicine be reoriented to the tap turning-off challenges arising out of the new medical knowledge of today? Is socially relevant and community-oriented education of such a health team possible? Could health team members be sensitised to the deeper social–economic –political–cultural determinants of health?

Today, three decades after hearing that disturbing question, I can unrepentantly affirm that floor-moppers among us can become tap turners-off. But floor-moppers need a new understanding of medicine – a 'conversion' if you please.

This new vision calls for a paradigm shift in our thinking – a shift to a new people and community-centred, holistic health paradigm promoting people's empowerment, educational and societal processes, and creating autonomy and awareness-building.

The Christian Medical Commission study on 'Health and wholeness: the Christian role in health' some emphasizes the same need for conversion in a different way. Its study recognises a simple fact:

"From around the globe, the 10 regional grassroot consultations on 'Health, Healing and Wholeness' wove a tapestry depicting their understanding of health. The major recurrent thread throughout that fabric is the fact that health is not primarily medical. Although the 'health industry' is producing and using progressively sophisticated and expensive technology, the increasingly obvious fact is that more of the world's health problems cannot be best addressed in this way".

Thirty years ago, I was asked the question: Are you a 'floor-mopper' or a 'tap turner-off'? Today, the question I would like to put to you for serious reflection is: Can the healing ministers continue to be floor-moppers when they are being challenged to become tap turners-off? If so, join the People's Health Movement – a global network of 'tap turner-offs'. The People's Charter is a global consensus of around 1500 'tap turners off'.

Are we ready for this conversion?

Dr Ravi Narayan, Coordinator
People's Health Movement (Global)

(A revised and updated version of an earlier Health Advocate column that was featured in CMJI nearly a decade ago.)

(18)

CH-28

Bharat has spoken. 'Is India Listening'?

◆ Dr Ravi Narayan

Change is a way of life... but some changes herald a new epoch; and then it is time for us to take stock

Dr Ravi Narayan

They have waited over fifty years for the country to make a reality of the constitutional mandate

The results of the not-so-recent Indian elections, 'Verdict 2004' – the largest democratic exercise in the whole world, had been a joy and jubilation for some and a crushing disappointment for some others. As social scientists and social analysts identify the trends, the contradictions and the quantitative and qualitative realities of the electorates' behaviour patterns, the wisdom of Bharat becomes established.

RIGHT ACROSS THE VARIED ANALYSIS, SOME FACTS ARE CLEAR AND HARD-HITTING:

- The politics of hate has been rejected.
- Governments, who have promoted development through economic reforms that ignore or exclude the poor and the disadvantaged regions of the state have been rejected.
- Those who claim to 'feel good' when so many around us are 'not feeling good' and many decidedly feeling bad have been rejected.
- 'Origins of birth' politics have been voted out. Social sensitivity and empathy have been voted in.

AS USUAL

- The poor have voted more than rich
- The rural have voted more than the urban
- The illiterate, but wise villagers have voted more than the 'all knowing' middle class and elite.

Bharat – (whom the poor represent) has re-established again their local wisdom.

The people's wisdom has re-established through 'electronic voting machines' that India is a secular, plural, diverse, but united country which has no place for 'exclusionary models of economic reform or the homogenising politics of communal polarisation'.

Bharat has spoken dramatically, emphatically and with unexpected passion!

IS INDIA LISTENING?

Are the elite planners and decision makers of India, who have in recent years been pondering to the created needs and 'fancies' of the middle class in India, rather than the development, health and welfare needs of all, including Bharat, listening?

PEOPLE ARE SAYING LOUD AND CLEAR

- We want acknowledgment of our basic rights to food, water, shelter and employment!
- We want basic education and access to Primary health and social services, schools and the market place!
- We want freedom from hunger and disease.
- We want a state government that delivers not only promises!
- We are happy with our pluralistic society – and our multi-cultural and multi-religions ethos. We reject chauvinistic projects that destroy this ethos!

What does all this mean to us – doctors and nurses, health professionals caught up in our mission hospital, world of diseases, drugs, technology and medical care pre-occupations?

It means different things to us depending on how we voted. If you voted for a

CMJI, April-June 2004

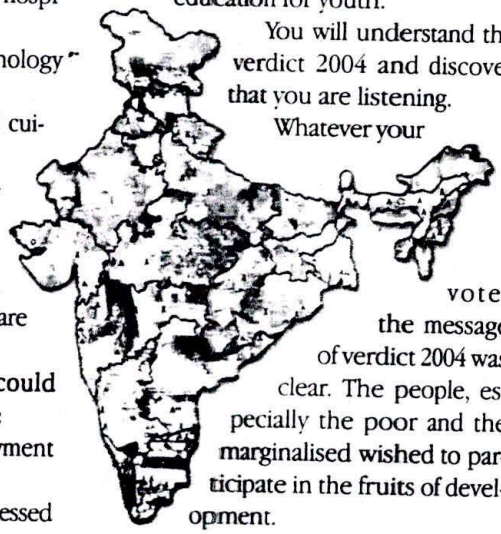
India that was shining with:

- Information technology and 'Golden Highways'
- Foreign drugs and high tech hospitals
- Latest shining medical technology and medical tourism
- Fast foods and multi-cultural cuisine
- The quest for technological solutions to our basic social and societal problems.

You may be disappointed with the result and discover that you are not listening.

If you voted for a 'India that could shine some day but not without:

- Food, water shelter and employment for all strategies
- Essential drugs which can be accessed by all people
- 'Health for All' strategies that respond to the basic needs of people wherever they are based
- The quest for low cost effective alternatives rooted in local tradition
- The quest for education and social processes including universal literacy, women's empowerment and life skill education for youth.



You will understand the verdict 2004 and discover that you are listening. Whatever your vote, the message of verdict 2004 was clear. The people, especially the poor and the marginalised wished to participate in the fruits of development.

They have no time for our preoccupation with computers; flyovers; processed foods; television channels; new temples; and fashion designs or our shiny hospitals with sophisticated gadgetry. They have waited over fifty years for the country to make a reality of the constitutional mandate to the basic rights of food, water, shelter, education health and employment. Do they want it? Will they make it happen?

ARE YOU LISTENING?

Did you vote for 'Bharat' or for India? Did you vote for 'Medical Tourism' or 'Primary Health Care'?

Did you vote for 'Health for All' or only for 'Health for Those who can pay'?

Dr Ravi Narayan
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The Global Health Watch

The Global Health Watch is a new project led by the People's Health Movement which articulates civil society's vision for global health. It is a platform for strengthening of advocacy and campaigns to promote equitable health for all.

The Watch will:

- Promote human rights as the basis for health policy
- Shift the health policy agenda to recognise the political, social and economic barriers to better health
- Suggest alternatives to market-driven approaches to health and healthcare
- Improve civil society's capacity to hold national governments, global institutions and corporations to account
- Strengthen the links between civil society organisations around the world
- Provide a forum for magnifying the voice of the poor and vulnerable.

The Global Health Watch Report

The Global Health Watch Report for 2005 will be written by NGOs, academicians and campaigners from around the world. The first report will be launched at the time of the World Health Assembly in May 2005 and at the People's Health Assembly in July 2005. The report will look at some of the most important problems, suggest solutions, and monitor the efforts of institutions and governments concerned with promoting health worldwide.

We are still looking for participation from interested individuals and organisations.

You can help us by:

- Endorsing the Watch
- Creating demand for the Global Health Watch in your region
- Launching the Watch in your region
- Initiating local national and regional health watches
- Submitting testimonies and case studies
- Volunteering to help with technical reviews.

For more details:
Visit the Global Health Watch website: www.ghwatch.org **Or**
e-mail us at ghw@medact.org