FRCH SEMINAR REPORT

Proceedings of the Seminar

HEALTH FOR ALL
concept and reality

BOMBAY: NOVEMBER 15-16, 1986

Edited by

Sonya Gill

Organised by

Foundation for Research in Community Health

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PROCEEDINGS OF THE SEMINAR

ON

HEALTH FOR ALL: CONCEPT AND REALITY

BOMBAY: NOVEMBER 15 - 16, 1986

(REPORTS PREPARED BY SONYA GILL)

ORGANISED BY

FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH

CO - SPONSORED BY

INDIAN COUNCIL OF SOCIAL SCIENCE RESEARCH

C O N T E N T S.

SESSION III

Alternatives for Effective Implementation

SESSION IV

Interaction between Government, Private Sector, and NGOs in Implementation of HFA Strategy

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FOREWORD

The ICSSR/ICMR report 'Health for All: An Alternative Strategy' was brought out in 1979 just prior to the formulation of the Sixth Five Year Plan. This critique of the existing health conditions, and the recommendation for a decentralized, people based health care system made by this Committee, have to a considerable extent been accepted by the Planning Commission and the Ministry of Health. These recommendations are reflected in the Sixth Plan as well as the National Health Policy Statements.

The Foundation for Research in Community Health, which had provided the research inputs and secretariat for this report, felt that it was necessary after a period of 6 years since the publication of the report, to review the progress in the implementation of the health policy. It was hoped that such an exercise with the participation of several eminent persons involved in the making and implementation of our health policies and programmes (some of whom were members of the Committee that produced the ICSSR/ICMR report) may help in overviewing the successes and shortfalls in the implementation of our health policies and programmes with the possibility of indicating midterm correction/s in achieving our national objectives.

This meeting was deliberately restricted to individuals representing various aspects of health, so that there could be free and frank exchange of information and views. Background papers were commissioned and circulated prior to the meeting in order to avoid detailed presentations, and permit utilization of most of the time for discussion and interaction. Many views, some conflicting, have been expressed on several subjects and have been included in the proceedings for

... 2.

reader to make his own interpretation and judgement.

The Seminar was co-sponsered by the Indian Council for Social Sciences Research (ICSSR). FRCH gratefully acknowledges the financial support extended to the seminar by the Ford Foundation, ICSSR and the Indian Council of Medical Research (ICMR).

We hope that the proceedings of this seminar and the background papers will be of interest and use to policy makers as well as those who implement the programmes in the field. We regret the delay in bringing out the proceedings.

FRCH, BOMBAY
APRIL 1988.

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SESSION I

CRITICAL EVALUATION OF THE HEALTH FOR ALL STRATEGY

With focus on:

*Historical and international context in which the strategy is placed.

*Alma Ata Declaration: Alip-service to socio-economic "factors" or a genuine international strategy for radical transformation of social, economic and health systems.

*Social production of illness and poverty in the under-developed countries and their reflection in the strategy.

*Social Production of sexual, racial, caste and nationality oppression, their effect on health and the HFA strategy.

DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing 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, hereby makes the following Declaration :

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically

productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care 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 the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care :

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least : education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance andparticipation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

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 health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

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RECOMMENDATIONS

1. Interrelationships between health and development :

The Conference,

Recognizing that health is dependent on social and economic development, and also contributes to it,

RECOMMENDS that governments incorporate and strengthen primary health care within their national development plans with special emphasis on rural and urban development programmes and the coordination of the health-related activities of the different sectors.

2. Community participation in primary health care:

The Conference,

Considering that national and community self-reliance and social awareness are among the key factors in human development, and acknowledging that people have the right and duty to participate in the process for the improvement and maintenance of their health,

RECOMMENDS that governments encourage and ensure full community participation through the effective propagation of relecant information, increased literacy, and the development of the necessary institutional arrangements through which individuals, families, and communities can assume responsibility for their health and wellbeing.

3. The role of national administrations in primary health care:

The Conference,

Noting the importance of appropriate administrative and financial support at all levels, for coordinated national development, including primary health care, and for translating national policies into practice,

RECOMMENDS that governments strengthen the support of their general administration to primary health care and related activities through coordination among different ministries and the delegation of appropriate responsibility and authority to intermediate and community levels, with the provision of sufficient manpower and resources to these levels.

4. Coordination of health and health-related sectors:

The Conference,

Recognizing that significant improvement in the health of all people requires the planned and effective coordination of national health services and health-related activities of other sectors,

RECOMMENDS that national health policies and plans take full account of the inputs of other sectors bearing on health; that specific and workable arrangements be made at all levels - in particular at the intermediate and community levels - for the coordination of health services with all other activities contributing to health promotion and primary health care; and that arrangements for coordination take into account the role of the sectors dealing with administration and finance.

5. Content of Primary Health Care:

The Conference,

Stressing that primary health care should focus on the main health problems in the community, but recognizing that these problems and the ways of solving them will vary from one country and community to another,

RECOMMENDS that primary health care should include at least: education concerning prevailing health problems and the methods of identifying, preventing, and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water, and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health; and provision of essential drugs.

6. Comprehensive primary health care at the local level:

The Conference,

Confirming that primary health care includes all activities that contribute to health at the interface between the community and the health system,

RECOMMENDS that, in order for primary health care to be comprehensive, all development-oriented activities should be interrelated and balanced so as to focus on problems of the highest priority as mutually perceived by the community and health system, and that culturally acceptable, technically appropriate, manageable, and appropriately selected interventions should be implemented in combinations that meet local needs. This implies that single-purpose programmes should be integrated into primary health care activities as quickly and smoothly as possible.

7. Support of primary health care within the national health system :

The Conference,

Considering that primary health care is the foundation of a comprehensive national health system and that the health system must be organized to support primary health care and

make it effective,

RECOMMENDS that governments promote primary health care and related development activities so as to enhance the capacity and determination of the people to solve their own problems. This requires a close relationship between the primary health care workers and the community and that each team be responsible for a defined area. It also necessitates reorienting the existing system to ensure that all levels of the health system support primary health care by facilitating referral of patients and consultation on health problems; by providing supportive supervision and guidance, logistic support, and supplies; and through improved use of referral hospitals.

8. Special needs of vulnerable and high-risk groups:

The Conference,

Recognizing the special needs of those who are least able, for geographical, political, social, or financial reasons, to take the initiative in seeking health care, and expressing great concern for those who are the most vulnerable or at greatest risk,

RECOMMENDS that, as part of total coverage of populations through primary health care, high priority be given to the special needs of women, children, working populations at high risk, and the under privideged segments of society, and that the necessary activities be maintained, reaching out into all homes and working places to identify systematically those at highest risk, to provide continuing care to them, and to eliminate factors contributing to ill health.

9. Roles and categories of health and health-related manpower for primary health care :

The Conference,

Recognizing that the development of primary health care depends on the attitudes and capabilities of all health workers and also on a health system that is designed to support and complement the frontline workers,

RECOMMENDS that governments give high priority to the full utilization of human resources by defining the technical role, supportive skills, and attitudes required for each category of health worker according to the functions that need to be carried out to ensure effective primary health care, and by developing teams composed of community health workers, other developmental workers, intermediate personnel, nurses, midwives, physicians, and, where applicable, traditional pratitioners and traditional birth attendants.

10. Training of health and health-related manpower for primary health care :

The Conference,

Recognizing the need for sufficient numbers of trained personnel for the support and delivery of primary health care,

RECOMMENDS that governments undertake or support reorientation and training for all levels of existing personnel and revised programmes for the training of new community health personnel; that health workers, especially physicians and nurses, should be socially and technically trained and motivated to serve the community; that all training should include field activities; that physicians and other professional health workers should be urged to work in underserved areas early in their carreer; and that due attention should be paid to continuing education, supportive supervision, the preparation of teachers of health workers, and health training for workers from other sectors.

11. Incentives for service in remote and neglected areas:

The Conference,

Recognizing that service in primary health care focused on the needs of the underserved requires special dedication and motivation, but that even then there is a crucial need to provide culturally suitable rewards and recognition for service under difficult and rigorous conditions,

RECOMMENDS that all levels of health personnel be provided with incentives scaled to the relative isolation and difficulty of the conditions under which they live and work. These incentives should be adapted to local situations and may take such forms as better living and working conditions and opportunities for further training and continuing education.

12. Appropriate technology for health :

The Conference,

Recognizing that primary health care requires the identification, development, adaptation and implementation of appropriate technology,

RECOMMENDS that governments, research and academic institutions, non-governmental organizations, and especially communities, develop technologies and methods that contribute to health, both in the health system and in associated services; are scientifically sound, adapted to local needs, and acceptable to the community; and are maintained by the people themselves, in keeping with the principle of self-reliance, with resources the community and the country can afford.

13. Logistic support and facilities for primary health care:

The Conference,

Aware that the success of primary health care depends on adequate, appropriate, and sustained logistic support in thousands of communities in many countries, raising new problems of great magnitude,

RECOMMENDS that governments ensure that efficient administrative, delivery and maintenance services be established, reaching out to all primary health care activities at the community level; that suitable and sufficient supplies and equipment be always available at all levels in the health system, in particular to community health workers; that careful attention be paid to the safe delivery and storage of perishable supplies such as vaccines; that there be appropriate strengthening of support facilities including hospitals, and that governments ensure that transport and all physical facilities for primary health care be functionally efficient and appropriate to the social and economic environment.

14. Essential drugs for primary health care :

The Conference,

Recognizing that primary health care requires a continuous supply of essential drugs; that the provision of drugs accounts for a significant proportion of expenditures in the health sector; and that the progressive extension of primary health care to ensure eventual national coverage entails a large increase in the provision of drugs,

RECOMMENDS that governments formulate national policies and regulations with respect to the import, local production, sale, and distribution of drugs and biologicals so as to ensure that essential drugs are available at the various levels of primary health care at the lowest feasible cost; that specific measures be taken to prevent the over utilization of medicines; that proved traditional remedies be incorporated; and that effective administrative and supply systems be established.

15. Administration and management for primary health care :

The conference,

Considering that the translation of the principles of primary health care into practice requires the strengthening of the administrative structure and managerial processes,

RECOMMENDS that governments should develop the administrative framework and apply at all levels appropriate managerial processes to plan for and implement primary health care, improve the allocation and distribution of resources, monitor and evaluate programmes with the help of a simple and relevant information system, share control with the commu-

nity, and provide appropriate management training of health workers of different categories.

16. Health services research and operational studies :

The Conference,

Emphasizing that enough is known about primary health care for governments to initiate or expand its implementation, but also recognizing that many long-range and complex issues need to be resolved, that the contribution of traditional systems of medicine calls for further research, and that new problems are constantly emerging as implementation proceeds,

RECOMMENDS that every national programme should set aside a percentage of its funds for continuing health services research; organize health services research and development units and field areas that operate in parallel with the general implementation process; encourage evaluation and feedback for early identification of problems; give responsibility to educational and research institutions and thus bring them into close collaboration with the health system; encourage the involvement of field workers and community members; and undertake a sustained effort to train research workers in order to promote national self-reliance.

17. Resources for primary health care :

The Conference,

Recognizing that the implementation of primary health care requires the effective mobilization of resources bearing on health,

RECOMMENDS that, as an expression of their political determination to promote the primary health care approach, governments, in progressively increasing the funds allocated for health, should give first priority to the extension of primary health care to underserved communities; encourage and support various ways of financing primary health care, including, where appropriate, such means as social insurance, cooperatives, and all available resources at the local level, through the active involvement and participation of communities; and take measures to maximize the efficiency and effectiveness of health-related activities in all sectors.

18. National commitment to primary health care :

The Conference,

Affirming that primary health care requires strong and continued political commitment at all levels of government, based upon the full understanding and support of the people,

RECOMMENDS that governments express their political will to attain health for all by making a continuing commitment to implement primary health care as an integral part of the national health system within overall socioeconomic development, with the involvement of all sectors concerned;

to adopt enabling legislation where necessary; and to stimulate, mobilize, and sustain public interest and participation in the development of primary health care.

19. National strategies for primary health care :

The Conference,

Stressing the need for national strategies to translate policies for primary health care into action,

RECOMMENDS that governments elaborate without delay national strategies withwell_defined goals and develop and implement plans of action to ensure that primary health care be made accessible to the entire population, the highest priority being given to underserved areas and groups, and reassess these policies, strategies, and plans for primary health care, in order to ensure their adaptation to evolving stages of development.

20. Technical cooperation in primary health care :

The Conference,

Recognizing that all countries can learn from each other in matters of health and development,

RECOMMENDS that countries share and exchange information, experience, and expertise in the development of primary health care as part of technical cooperation among countries, particularly among developing countries.

21. International support for primary health care :

The Conference,

Realizing that in order to promote and sustain health care and overcome obstacles to its implementation there is a need for strong, coordinated, international solidarity and support, and

Welcoming the offers of collaboration from United Nations organizations as well as from other sources of cooperation,

RECOMMENDS that international organizations, multilateral and bilateral agencies, nongovernmental organizations, funding agencies, and other partners in international health acting in a coordinated manner should encourage and support national commitment to primary health care and should channel increased technical and financial support into it, with full respect for the coordination of these resources by the countries themselves in a spirit of self-reliance and self-determination, as well as with the maximum utilization of locally available resources.

22. Role of WHO and UNICEF in supporting primary health care:

The Conference,

Recognizing the need for a world plan of action for primary health care as a cooperative effort of all countries,

RECOMMENDS that WHO and UNICEF, guided by the declaration of Alma-Ata and the recommendations of this Conference, should continue to encourage and support national strategies and plans for primary health care as part of overall development.

RECOMMENDS that WHO and UNICEF, on the basis of national strategies and plans, formulate as soon as possible concerted plans of action at the regional and global levels that promote and facilitate the mutual support of countries, particularly through the use of their national institutions, for accelerated development of primary health care.

RECOMMENDS that WHO and UNICEF continuously promote the mobilization of other international resources for primary health care.

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HEALTH FOR ALL : CONCEPT VERSUS REALITY

Dr. N. H. Antia
Dr. Ramesh Awasthi

That every human being should have the right to enjoy good health hardly needs stating; like the fundamental right to life, it is a basic human right. Further, that we have to continue to reiterate it time and again is in itself an indictment of the inability of our society to meet this basic need of the people.

History tells us that contrary to pious proclamations, basic needs of the majority rarely get priority over the extravagant wants of those few who wield power and influence. The present age is no different. Capitalism thrives on it, and throws a few crumbs to those who have fallen by the wayside. Termed 'Welfare' it helps to salve its conscience as well as prevent unrest and upheaval in the society.

Unfortunately, the vast majority of countries which gained independence from their colonial masters have fared no better. Far from liberating the masses they have created polarised society, often under the guise of democracy. Instead of using simple and cheap available technology for the betterment of the masses, the new rulers have opted for expensive sophisticated technology to meet their new life styles. In this process, they not only culturally enslave themselves but also pawn their country to the former imperial powers who lose no opportunity for economic neocolonisation. To justify their actions, they use the familiar jargon of capitalist economics which places mammon above man, and encourage urban industrialisation which produces consumer goods for the elite, while neglecting agro-economics which benefits the masses in a predominantly agricultural society.

This process of lopsided development where the benefits have been monopolised by an upper crust at the expense of the rest and which has further marginalised those with small or no assets, has directly affected the health status of the people. To expect 'Health for All' in such an invidious set-up is sheet anachronism.

The broad relationship between health and socio-economic development has been well documented by Western authors like McKeown (Health & Disease, Open University Press, England, 1984, pp:105-114) in their own countries. Almost all the major killing and maiming diseases in countries like ours are similar to those that existed there in the last century and are of a communicable nature. They were eradicated in the West long before the advent of modern preventive and curative medical technology and the decline had commenced even before the cause of the diseases was known. More recent and much more dramatic is the example of China which has demonstrated that most of these diseases can be controlled without waiting for general affluence.

Two of the earliest attempts to define a strategy for Health for All were from India; the reports of the Health sub-committee of the National Planning Committee (NPC) (1948) and the Health Survey and Development Committee (Bhore Committee, 1946)are worth reviewing for those who consider HFA as a recent concept.

Though the NPC report was published in 1948, the National Planning Committee constituted by the Indian National Congress under the chairmanship of Jawaharlal Nehru had considered the report of its sub-committee on national health as early as 1940, even before the Bhore Committee was constituted. The report indicated positive approach to primary health care - the major recommendations being:

a) India should adopt a form of health organization, in which both curative and preventive functions are suitably integrated.....

b) ... preservation and maintenance of the health of the people should be the responsibility of the state.

c) As an immediate step, in order to meet special conditions prevailing in India, we recommend the training of large number of health workers. These health workers should be given elementary training in practical, community and personal hygiene, first-aid and simple medical treatment, <u>stress being laid on the social aspects and implications of medical and public health work</u>.

d) There should be one health worker for every thousand population ...
(Source : NPC 1948:224-25, emphasis added)

The report of the Bhore Committee was also a declaration of Health for All accompanied with elaborate discussion of different aspects of public health delivery systems. The main principles being :

i) No individual should fail to secure adequate medical care because of inability to pay for it.

ii) The health programme must, from the beginning, lay special emphasis on preventive work.

iii) The health services should be placed as close to the people as possible.

iv) It is essential to secure the active co-operation of the people in the development of the health programmes. The idea must be inculcated that, ultimately, the health of the individual is his own responsibility...

(Report of the Health survey and Development Committee 1946 Vol.IV Summary p(v)).

The Alma-Ata Declaration (1978) of World Health Organization and the ICSSR/ICMR report 'Health For All : An Alternative Strategy' (1980) voice the same ideas with minor modifications. It is not surprising, for common sense dictates, that if there is a desire that health services should reach out to all in a country with a large population spread over a vast terrain, it is necessary :

a) to decentralise services to the extent possible.

b) to place emphasis on preventive measures and basic health services, and

c) to involve the people in their own health care.

India, like most other member countries of the WHO, was a signatory to the Alma-Ata declaration. Though the conference believed that, in adopting the 'Declaration of Alma-Ata', governments had made a historic collective expression of political-will in the spirit of social equity aimed at improving health for all their peoples' (WHO-UNICEF 1978: p.19), this fabled political-will however does not seem to have shown itself anywhere (beside a couple of exceptions) in terms of realising the implications of HFA which calls for a radical strategy towards social equity and at least a total reorientation of the health care system. It makes one wonder whether the signatory governments really believed in HFA or did they adopt it just to improve their international image?

Another possibility is that they found in HFA an attractive slogan to fool their people. Either of these, or a mix of these, is more likely to be the motive for adopting Alma-Ata declaration as part of the National Health Policy (1983) in India.

China took to reorganizing its medical and health services with the founding of New China in 1949 and the four cardinal principles outlined by Chairman Mao for the reorientation of health services were no different from the spirit of Alma-Ata. The principles were :

i) health work to be geared to the needs of the workers, peasants and soldiers,

ii) putting prevention first,

iii) uniting doctors of both traditional and western medicine, and

iv) combining health work with mass movement.

(China Handbook Series: Sports and Public Health, Beijing 1983, p:129).

In fact, as the following table would show, China had exceeded in 1978, the targets that we in India have set forth for 2000 AD, as part of our commitment to the HFA declaration (1978).

INDICATOR	CHINA (1978)	INDIAN HFA TARGET (FOR 2000 AD)
IMR	56	60
Avg. life span	64	64
Crude death rate	6.3	9.0
Crude birth rate	18.3	21.0

(Source : China's Population: Problems & Prospects; China Studies Series New World Press, China 1981.

: National Health Policy, Govt. of India, New Delhi, 1983).

China's accomplishments in health with a large population and without reaching a level of general affluence have long been recognised and the driving spirit of this sort of accomplishment has come to be called 'national political will' in the vocabulary that has grown up around the primary health care movement (Primary health care: The Chinese Experiences; Report of an Inter-regional Seminar, WHO, Geneva 1983, p.10).

We in India, like most other developing countries, have been paying mere lip-service to the social, cultural and economic and albeit rarely to the political factors while all strategies including those of our Planning Commission and the Ministry of Health have looked upon health as almost entirely a function of medical technology and professional skills. The medical profession which claims to be the guardian of people's health has, by and large, equated health with illness for its own benefits. The result has been that entire inputs in the private sector as well as a major part of those in the public and voluntary sector have been in curative medicine, while the more important preventive and promotive aspects have been relegated to the background. The medical profession, which had been given the pride of place by the Bhore Committee for planning as well as implementation of health care of our nation, have not only failed to perceive health in its wider perspective but also in providing the necessary leadership and direction to the health care services. Health care has by and large been converted into a lucrative business. The exponential proliferation of the medical profession and the pharmaceutical and instrument industry has inevitably led to the growth of malpractice, and exploitation of peoples' sufferings on a scale which would make those who had placed their faith in the medical profession to turn in their grave.

It is understandable why the medical profession with their blinkered education and their personal monetary interest in curative medicine have chosen this path. It is even easier to understand why the pharmaceutical industry wants to produce an excess of unnecessary and often harmful drugs, and why the medical instrument industry tries its best to promote the most expensive inappropriate technology, for their sole interest is profit. But the question remains as to why the elected representatives of the people continue to support these interests with policies that work against those very people whom they purport to represent.

The answer was aptly given by a villager:"'our' people become 'their' people once elected and sent to the capital". That this process of co-option has been a continuous one (for 40 years) indicates that those who gain power are willingly bought by the business interests or get co-opted to the ranks of those who make business by exploiting the masses.

Although many of the elected representatives who come from the grass-roots are aware of the problems of the common man, the majority of the elite whether politicians, bureaucrats, professionals and intellectuals who have the major share in power to influence decision making are largely unaware of the life and problems of those who dwell in the urban slums, leave aside the villages. Their total ignorance of grass-root issues is clearly demonstrated by their naive deductions and facile conclusions on many subjects including health. A mixture of ignorance and self-interest governs the thinking of these elite groups. Given the task of planning, even with good intentions they can plan nothing but a delivery system for the people who are supposed to offer only passive co-operation at the receiving end. Due to inherent contradictions when their implementation fails to achieve results, they can only indulge in victim blaming. To them the poor are lazy and, being illiterate, unintelligent. They have large families because they know nothing better. They are incapable of solving their own problems and over and above do not even participate in programmes for their welfare. They must, however, remain the targets of our plans since, only we are capable of planning and implementing for their welfare. That these plans often fail is due to their inability to appreciate the efforts and extend the necessary co-operation.

Let us now examine the performance of our health services - the private sector, quasi-public sector and the public sector functioning in the narrow context of illness-care, professional super-specialisations and medical technology.

The private sector is by far the largest sector and is responsible for three-quarter of all medical care whether rural or urban. Yet we have virtually no information about the operation of this sector and the extent and nature of health expenditure incurred in the private sector. Atleast three-quarters, if not more, of all doctors whether allopathic or non-allopathic are trained chiefly at government expenses but they earn their living through private practise.

As general practitioners, consultants, or running their own diagnostic clinics and nursing homes, they are mainly concerned with curative medicine and maximising earnings. There is an increasing number of private hospitals in the larger cities which offer expensive modern medical and surgical care. The lucrative nature of this sector is revealed by the extent of pressures exerted for admission to medical colleges and by the rush of corporate sector in opening 5-star super-speciality medicare centres investing several hundred crores of rupees in each such centre.

Inspite of all the talk of reorientation of medical education, fancifully called the 'ROME' strategy in our five year plans, the training that the medical students receive at public expenses is most suited to private practice of curative medicine and least suited to their role as public health doctors. In the virtual absence of any supervision or self-regulating mechanism by the profession itself, the private sector medicare system, like its ancillaries i.e. pharmaceutical and instrumentation industry, has become very much a part of the market economy imbibing all its culture, ethics (or lack of it) and rules of the game. Still 80% of our population lives in rural India whereas 80% of the doctors work in urban centres where the purchasing power is concentrated. With over-production of doctors, those who cannot succeed in urban areas migrate to the villages where they have to practise without the most elementary pathological and other facilities. The continued over-production of doctors and drugs has invariably resulted in malpractises like giving of unnecessary and dangerous injections to all and sundry who seek medical aid. The people, and especially the poor, have also been hooked on to such irrational therapy. Medicine has consequently been converted to a trade in human suffering. This applies not only to the lowly general practitioner in rural areas or slums but equally to the ultra-sophisticated private hospitals in the larger cities which often set the pace. Many of them gain tax relief under the guise of research centres.

Besides the private sector, there are quasi-government health services in the form of Employees State Insurance Schemes or dispensaries and hospitals run by the industry itself. This sector however is quite small and caters to employees of private as well as public sector industries. The idea of health insurance for general public is still a far cry.

The public sector is the most well-known sector for we have some data, however unreliable, about manpower employed, expenditure incurred and its targets and achievements in terms of various health indicators. In a dual economy the aim of the public sector is to ensure basic health services to those who need it and especially who cannot afford expensive private services, as also to undertake preventive measures chiefly for the control of communicable diseases.

Inspite of these being the obvious aims of the public sector a major portion of its budget is diverted into high technology instruments and medicines especially in running expensive medical colleges and their hospitals which produce a surfeit of doctors who cannot be absorbed in the public sector and are gifted to the private sector. Consequently, the public health sector, responsible for primary health care and for running of the district and taluka hospitals in the rural areas, suffers not only from lack of funds but also fails to attract the most talented of the medical graduates. This together with low priority to the teaching of preventive and social medicine and of communicable diseases as well as a complete absence of practical training of working conditions in the field (the rural training being only symbolic) ensures that the key personnel of the rural health programme are incapable of providing the leadership or direction to the vast paramedical manpower working under their supervision. The chief interest of the medical officers manning the primary health centres, the keystone of our public sector services, remains curative medicine at the Static Health Centre and that too of a very poor nature due to insufficient supply of essential medicines and lack of elementary laboratory facilities and total absence of contact with recent advances in medicine. Many use these postings as a stepping stone to start private practice. The leaderless paramedical staff harassed from above by impossible family planning targets and pressurised by the demands of local politicians find little joy in their work. They carry out their duties perfunctorily and there is almost total lack of accountability to the people who are deliberately kept uninformed of the health services designed for them.

Consequent to continued failure of this system to meet the health requirements of the people and the targets of the bureaucracy, an attempt was made to clutch to a new straw viz. the 'community health worker' (CHW). This worker was supposed to be a functionary of the people responsible to her own community with the Primary Health Centre only providing training and support.

A good scheme seeking the much talked about peoples' participation was once again derailed by political and bureaucratic manoeuvering and bunglings.

1,25,000 (92% male) CHWs were appointed, post haste, by a Health Minister who saw in it a populist vote-catching measure, and a bureaucracy which perceived it as a further extension of its own empire. Large scale evaluation was undertaken within nine months of the commencement of the programme which showed it to be eminently successful.

Better sense prevailed only after several years with the realisation that it was not possible for a male in our culture to look after the health problems which predominantly affect women and children, they being more vulnerable even among the poor. Changing the name to Community Health Volunteers and then to Health Guides, without increasing the 'honorarium' of those who are supposed to bear the burden of most basic health problems of the community, has had little effect. It must be realised that another good scheme has gone astray because the community was kept unaware of its worker and her role and moreover, she has now been co-opted into the lowest ring of the bureaucratic system.

What are the prospects of HFA being achieved in our country in the next 14 years? If experience so far shows any trend it is that we have been going from one solution to the other as if trying to clutch at the last straw. In the process we have multiplied the manpower manifold vertically as well as horizontally, increased the drug companies and drug production, introduced 5 star health care industry with the expensive sophistication that only a privileged few can have access to, and to cap it all we have produced bountiful reports.

In the name of HFA we have been doing everything that is inimical to HFA. All the time talking of HFA more or less as a slogan, we have moved farther away from the spirit and approach of HFA. Rather than tackling social, economic, and political issues involved in ensuring health for all, we have converted it into a question of managerial skills - taking it away from the people, and medical technology - making it inaccessible to the people. We have used HFA slogan for further exploitation of the people.

HFA in reality is the collective will of the people to be supported by the national political will. China accomplished it without talking of HFA because it had the political as well as the collective peoples' will.

China achieved it when it had closed itself from the outside world. Economic conditions and the level of technology were much worse than what we have today. The underlying approach was of self-reliance at the national as well as the people's level. Self-reliance is probably more important than high technology.

We, in India to-day, have enough resources and technology to achieve health for all. What we lack is peoples' will, the national political will and the spirit of self-reliance; and for these we do not require international intervention or collaboration. International agencies cannot play any role in achieving HFA. They can only give packages of advice or experiences which are taken up by the governments only in their phraseology which is used to divert the issues. On the other hand, international collaboration takes away the will to follow the path of self-reliance, The policy makers and the intellectuals keep looking for policy packages from these agencies to comment upon, or to adopt in their writings. International collaboration, coming as it does as a package deal in all spheres, results in cultural enslavement. Moreover, it takes away a few good people from the apex of national public bodies for international assignments on attractive salaries. As a result of this, the top people in decision making positions keep their eyes on the next international assignment rather than looking into the problems of the people. International collaboration also opens up the country to multinational exploitation under the pretext of supplying modern technology, instruments and drugs. International collaboration, therefore, can only play a negative role in the achievement of HFA and there can be no substitute to national effort. For our own failings, we probably do not wish to face the causes and therefore, call for international collaboration; the elites, of course, stand to gain from such collaboration. And for the failures, the international agencies join the local elites in blaming the people who are the victims.

In order to off-load some of the burden of its failures, the government is looking towards voluntary agencies as intermediaries to reach out to the people. Or probably it is an effort of co-opting the voluntary sector which has been its strongest critic in the recent years. The Indian government has been professing a policy of collaboration with the voluntary sector even to the extent of handing over primary health centres to the voluntary groups.

Handing over services is running away from its own responsibility but the question remains whether the voluntary sector can deliver what the government has failed to do.

In the voluntary sector there are a variety of voluntary agencies. Inspite of considerable expansion in the last decade, they are still a miniscule part of the health system. Most of them, even with good intentions, are, in practice, dependence creating. They run hospitals, organise diagnostic, clinical or surgical camps and distribute free samples/medicines and at the most, in some small areas, they are doing what the public health department should have been doing in its normal run. There is a very small section of voluntary agencies which wants to create self-reliance. Under the limitations of its size, resources and coverage, it cannot have but a limited impact on the national scene. It can only devise experimental models, enhance understanding and formulate alternative models and in this respect the voluntary sector has played a commendable role.

One of such experiments at Mandwa (Alibagh, Maharashtra) demonstrated that semi-literate and even illiterate but motivated village women, properly trained and with a little support, could use existing knowledge and technology and achieve remarkable results (in 1982) not far from the HFA targets set for the end of the century. This was possible because, for majority of health problems in the country to-day, there exists simple knowledge and technology. For putting this to use, what is required is a high cultural affinity of the health worker with the people and her accountability to the village community.

The table below shows the achievements of 30 women CHWs, over a period of 5 years, covering a population of 30,000.

TABLE 1

Mandwa Achievements* & HFA Targets

		Mandwa Results 1982	National figures 1981	HFA Target
1.	Birth rate	15	33	21
2.	Crude death rate	8	12.5	9
3.	Infant Mortality	74	127	Below 60
4.	Immunisation %			
	Triple antigen	92	28	100
	Polio	67	32	100
	Tetanus	78	NA	100

* (Source: Mandwa Story - FRCH, Bombay, 1983)

This was achieved without any inputs in nutrition, water supply or environmental improvement and despite opposition from the public and private health sector as well as (at a later stage) from the local politicians.

Projects like Mandwa have demonstrated that it is possible to improve the health of the people, even under the prevailing socio-economic conditions, if the community is encouraged to undertake the health functions which are within their ambit and adequate supportive services are provided to them. It should, however, not be misunderstood that we are talking of field level changes without any change in the system. Minor adaptations within the system are bound to get adopted by the system like the CHW scheme which was supposedly based upon the experiences of four such community based projects. The answer lies not merely in the CHWs nor in their training, motivation or skills. It lies in the will for equal opportunities of life to all, and basic faith in the people.

Left to themselves, free from local exploiters and oppressive power structure, the people can do remarkable things themselves. The village of 'Ralegan Shindi' (Tal. Parner, Dist. Ahmednagar) located about 75 km North-East of Pune, is an example. People of this village, motivated by a local resident Anna Hazare, have been able to achieve remarkable all round development in a short period of ten years. The leadership of Anna Hazare and the local tarun mandal were successful in rooting out local exploiters and in warding the oppressive power structure and bureaucracy at the taluka and district level. What followed is to be seen to be believed i.e. profound social and economic progress, and as a result, without any special health inputs, the health status of the people has improved tremendously. An impoverished liquor brewing village in a drought prone area now presents a model of relative general affluence and that too by utilising the public resources available to all other villages.

In all our national programmes, we virtually look down upon the 'peoples' sector' since we do not have faith in the people and in their capabilities. Having tried everything at the top i.e. producing more doctors, more drugs, multiplying paramedics, everything to 'deliver' health care to the people, we have now finally come down to peoples' participation, since nothing has succeeded so far. The usual perception of peoples' participation is in terms of 'their' participation in 'our' programmes. The government and its bureaucracy talk of peoples' participation without having faith in the intelligence and the ability of the people. All talk of peoples' participation without having faith in the people is bound to fail, reducing itself to a farce of nominated health committees with only the local vested interests and political power groups being represented on these committees. With little respect for our poor, even health education has been reduced to bombarding the people with messages of do's and don'ts, without really understanding whether it is in their interest or not.

The private sector and the public sector health services have proliferated and grown out of proportion in selected centres of prosperity but have not succeeded in ensuring health for all. Now at least, we should give a fair trial to a truly peoples' sector.

Health should, in fact, become a peoples' programme with the participation of the government, bureaucracy, medical profession and the elites. Health education in such a programme should include education of the poor in their rights and basic education for helping them to understand their own ability. Instead of oppressing the poor, if we only let them mobilize their own resources and help them with simple knowledge and tools together with necessary supportive services, the potential of peoples' sector will unfold itself. This cannot happen in the health sector alone in isolation. The change has to come in every field including health.

To-day, peoples' participation is nothing but another ploy used to achieve family planning targets. If we truly believe in peoples' participation, let us ask a question - when the poor demand their rights, on which side shall we stand? Can we ensure that when their rights are being eroded, they will be supported? If they are crused, how can there be peoples' participation? And, how can there be HFA without their participation?

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A CRITIQUE OF THE IDEOLOGICAL AND POLITICAL POSITIONS OF THE WILLY BRANDT ERPORT AND THE WHO ALMA ATA DECLARATION.

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ABSTRACT-This article (1) analyses the Willy Brandt Commission Report and the WHO Alma Ata Declaration within the socio-economic and political context that determined them, and (2) makes a critique of the ideological and political assumptions that both documents make. Through an assumingly a political and technological- administrative discourse both documents reproduce the major positions upheld by the hegemonic development establishments of the western world. The article analysis (through a study of what is being said and not said) how those positions appear in the documents. It is indicated that (1) their understanding of the causes of underdevelopment and its major health and disease problems and (2) their suggestions for change based on moral calls for social justice' and 'enlightened self-interest' are faulty and insufficient. Alternative explanations and solutions are presented.

BACKGROUND OF THE ALMA ATA DECLARATION: WORLD HEALTH DURING THE SIXTIES AND SEVENTIES

Discussion of any social event has to take place within the historical and social context explaining that event. Thus, we cannot understand the 1978 WHO ALMA ATA Declaration |I| without understanding the context and social forces that determined it. The stated aim of the Declaration, 'health for all people by the year 2000, clearly establishes the intent of its intervention. A brief analysis of the current health situation of the world population shows the enormous magnitude of the proposed task. The year that the Declaration document was published (1978), the following situation existed:

(1) Over 800 million people in the world lived in absolute poverty, with one-third of all deaths occuring in children under 5|2|. Then and now, in the less developed countries approx. 11 million children under 5 years of age die every year of hunger, malnutrition.

and infectious diseases [3]. To put the number of preventable deaths another way, the equivalent of 20 nuclear bombs explode every year in the world of underdevelopment without making a sound.

(2) Approximately 80% of the population in the less developed capitalist countries did not have access to personal health services [4], and the situation has since worsened for many of these and other types of services. For example, the percentage of the population covered by sanitation services in less developed countries (LDC) declined from 33% in 1975 (3 years before the Declaration's appearance) to 25% in 1980 [5].

This already alarming situation has rapidly deteriorated during the current worldwide crisis, worsening some trends existent during the sixties and seventies. Individual and collective consumption in large numbers of capitalist underdeveloped countries, for example, declined most substantially during these decades.

The consequences of these developments for the health of the underdeveloped world's populations have not yet been studied in detail. Some studies, however, do exist. One that merits distinction is Wood's study [6] on infant mortality in Sao Paulo. Brazil, a study that is specifically meaningful because it analyzes the evolution of that infant mortality during the period of the so-called 'Brazilian economic miracle'. The period following the 1964 military coup that deposed the constitutionally elected Goulard government was characterized by a large increase in economic growth, dubbed by the World Bank, the IMF and the main academic departments of international health as the 'economic miracle'. The large growth of GNP per capita that took place in the late 60s and early 70s was put forth as the best proof of that 'miracle'. But what enthusiasts of the miracle did not realize or consider was that GNP per capita is not an indicator of individual consumption or wealth. Rather, the GNP is an indicator of the aggregate amount of goods and services provided by the economy in a specific period of time. The GNP per capita is obtained by dividing the GNP by the total population of the country, assuming that everyone gets the same amount of goods and services-an assumption that is obviously incorrect. It is assumed that producing a larger pie means that everyone gets more of

the pie. Again, this assumption is incorrect. The GNP can increase in a society and the majority of the population still consumes less. Wood shows that this is precisely what happened in Sao Paulo, Brazil, during the so-called 'miracle'. As with many others assumed divine interventions, that 'miracle' was based on an overwhelming rate of exploitation of the working class which determined a most substantial decline of the standard of living of the majority of the population. This exploitation took place through the following three processes:

(1) An increase in the intensity of labour, lowering individual wages and lengthening the hours worked. Workers had to work longer periods of time to buy the same amount of food than before the coup. In 1975, a worker and his family needed to work 154 hours, 18 minutes for the same amount of food (6 kg. of meat, 7.51 of milk, 4.5 kg. of rice and others for a family of four for one month) that it took only 87 hours. 20 minutes of work to buy 10 years earlier. Moreover, in a situation of widespread unemployment, work-even for these low wages - was not easily available. Thus, per capita meat consumption declined and consumption of less nutritive foodstuffs increased.

(2) A decline in collective consumption (i.e.state benefits and services used by individuals). The percentage of state health expenditures declined from 4.6% of total state expenditures in 1969 to 2.4% in 1977|7|.

(3) A redistribution of income away from the working class and peasantry and towards the bourgeoisie. Analysis of income distribution between 1960 and 1970 indicates that the high annual growth rates were associated with an increase in the concentration of income. As Wood points out |6|.

Although estimates of the magnitude of the change vary according to method and data, a number of studies conclude that the Ginicofficient for Brazil, already among the highest in Latin America in the 1950s, rose substantially during this period of economic expansion.

These three developments were the outcome of political interventions that outlawed free unions and strikes and repressed most brutally the working class and peasantry Consequently, while the GNP grew enormosly (the 'miracle'), the standard of living for the

majority of the population declined markedly, determining an increase in infant mortality. A similar situation has occured and is occurring in many other developing capitalist countries, although those declines in the majority's standard of living are not always reflected in an increase in the infant mortality rate [8].

These figures encapsulate a reality that is clear for all to see: the situation for large sectors of today's world population is getting worse rather than better.

THE DEVELOPMENT ESTABLISHMENTS RESPONSE

In the face of this reality, let us ask what the Development Establishment-that body of internationally minded individuals who are active in major Western and agencies or who are their champions within Western political circles -- has proposed*. In the sixties and early seventies, a great emphasis was placed on population control. Population growth was considered to be either the cause or a major contributing cause of world poverty. The two sides of the coin of poverty were too many people on the one hand and too few resources on the other. The theoretical framework sustaining this position was remarkably simple. Looking at the GNP rate per capita, it seemed obvious that the fewer the 'capitas', the more GNP for the existing ones. The poor countries were assumed to be poor because they did not have resources or, at least, not enough resources. Thus, the answer was to control the size of their populations.

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* I am aware, of course, that the Development Establishment is not uniform. Many development establishments do exist. But they all share the basic positions outlined here.

The 'Oil and other raw materials crisis' of the developed countries in the early seventies showed, however, that if those LDCs were poor, it was not because they lacked resources. Actually, a great deal of the key materials used in the rich countries came from the poor ones. Thus, it could no longer be said that poor countries were poor because they did not have resources. They did have them, and in large quantities. But the resources were consumed by the rich and not by the poor countries.

The new position that the development establishment took (not necessarily in substitution for but usually complementing the 'population control' position) was that although the poor countries have material resources, they do not have the intellectual resources (i.e. the know-how or technology) to exploit them. Technological transfer from the developed to the less developed countries became the name of the game. Scientific and technological assistance became important instruments of intervention to resolve world poverty. Variants of this position soon appeared. One, represented by Shumacher [9], among others, included a concern about the type of technological transfer. 'Appropriate technology' was a term frequently used to voice the claim that not all technological transfer was positive; only the appropriate form was helpful. The meaning of 'appropriate' however, varied quite considerably. For some, appropriate meant small (of the 'small is beautiful' variety). For others, it meant 'labor intensive'. And so on.

Still another variant was the anti-technology position represented by Illich [10]. (This position appeared side by side with the anti-institutional positions, e.g. anti-medicine and anti-psychiatry, voiced in the developed countries.) Its proponents opposed technological transfer, since they perceived such transfer as a process whereby a dependency on that technology would be created, thereby hindering the possibility for individual and collective development. The alternative offered was the development of autonomous spaces outside formal institutions, placing great emphasis on self-care and self-reliance -- terms that were used almost interchangeably. Self-reliance was supposed to be for the community what self-care was for the individual.

All these ideological and political positions population control, technological transfer, self-care and self-reliance-- were elaborated by the Development Establishment not independently of but, rather, in response to, events occurring in the underdeveloped countries during that period. It was during those years that there appeared within the political and intellectual centres of the underdeveloped capitalist countries an increased awareness that their poverty was an outcome not of too many people, nor of the use of the right (or wrong) type of technology, but, rather, of a pattern of worldwide relations in which the few control quite a lot and the many control very little. The problem was perceived in those centres to be structural, not conjunctural. It required changes, not in the variables and factors of the developmental equation, but in the equation itself. It required and demanded a New Economic Order with a redistribution of worldwide resources. Moreover, an increased number of LDCs were breaking with that old order through confrontation and revolutionary transformation.

The Development Establishment's response to this new situation was to agree that some changes needed to be made in the world wide distribution of resources, but to insist that change should be based on cooperation rather than confrontation. This cooperation would be triggered by moral calls to the worldwide community, appealing to their humanitarianism and sense of social justice, side by side with calls for the capitalist developed countries to be better aware of their self-interest. Indeed, it is assumed in this new position that it is in the developed countries interests that poverty in the less developed countries be eradicated. Thus, it is proposed that developed countries share some of their riches with the less developed ones. Otherwise, the world order will collapse or explode. Moreover, less poverty in LDCs will mean more capacity to consume and thus more markets for the products of the developed countries.

A typical example of those positions appears in the Willy Brandt Commision Report (1980) [11], defined by Elson [12] as the brainchild of MacNamara, the President of the World Bank, and prepared by representatives of the development establishments of developed (referred to in the Commission as 'Northern') and underdeveloped (referred to as 'Southern')

countries*. Characteristic of that report are the following assumptions:

(1) The World is divided, not into capitalist and socialist systems and subsystems, but, rather, into the North (the 'haves') and the South (the 'have-nots'). The U.S.S.R. and the U.S. are primarily defined as northern countries, while Cuba and EL Salvador are southern countries. The report avoids using terms such as capitalism, socialism, imperialism or class struggle - all dismissed, one assumes, as too 'rhetorical' and 'ideological'. These terms are replaced by supposedly non-ideological and unrhetorical ones such as 'global solidarity', 'mutual interests', and the like.

(2) There is not an intrinsic conflict based on capitalist and imperialist exploitation within the capitalist world order. Instead, the report is intended to provide a framework within which future conciltation and dialogue can take place.

(3) Change has to occur within an unchangeable set of national and international power relations. The Willy Brandt Report refers to the development goals of the less developed countries, encouraging higher growth and greater productivity, without "wishing to suggest that changes in domestic policy must be a prior condition for reforms in the global system" |13| (emphasis added).

(4) At the international level, change is supposed to take place as a result of awareness among developed countries that it is in their own interest to eradicate poverty in the underdeveloped ones. In a remarkable twist, the intelligent realization of one's own interest is seen as the basis for everyone's interest. "Mutual interest (are) rooted in the hard-headed self-interests of all countries and

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* The Commission included members from developed and less developed capitalist countries. Among those coming from LDCs was former Chilean President Eduardo Fret, a main opponent of Allende's government.

people" [14]. Thus, the task of the Commission is to make both 'haves' and 'have-nots' aware of the mutuality of their interests. Once these mutual interests are recognized, "then both emotional and practical reasons will guide the powerful as well as the powerless in the direction of joint economic activity and reform" [15]. Within this scenario, equity, social justice and humanitarianism appear as abstract, moral categories: their meaning in programmatic terms is a better distribution of resources within a mutually beneficial sharing process.

In summary, in this ideological and political position, conflict, exploitation and expropriation do not exist. Instead, cooperation, sharing and collaboration are put forward as the solutions to today's world poverty. Needless to say, within this theoretical scenario, the concepts of class and class struggle do not appear. An alternative position, however, is that there is a basic conflict underlying the current world system, a conflict that takes place within a pattern of class power relations that explain it. It could be postulated that there is intrinsic and structural conflict in today's world, and not only between the 'have' and 'have-not' countries but also (and primarily) between the 'haves' and 'have-nots' within each country. These conflicts are mutually dependent and reinforceable. Indeed, a key place in that world system is the one occupied by the capitalist class of both developed and underdeveloped countries, and it is this class for whom the development establishments speak. The capitalist classes of the core capitalist countries play a key role in organizing the world capitalist system to defend their own interests. The capitalist classes of the LDCs are, for the most part, collaborator classes.

Whose function is to organize the state and economy in accordance with the core definitions of the international division of labor. The creation of an international political economic order based on the inequalities of nations is rooted in the existance of an expanding center of capitalism and a set of classes within the periphery whose own expansion and position is enhanced in the process. The insertion of particular social formations within the world capitalist market and division of labor is largely the product of classes which combine an

double role - exploitation within the society and exchange outside the society. This dual process leads to the expansion of production relations and antagonistic class relations within peripheral society growing exchange relations, and competition with the core [16]".

Thus, the real gap is not between North and South, but between the capitalist metropoles and the dominant classes of the capitalist periphery on the one side and the impoverished population of the capitalist periphery on the other. It is these class relations and exploitation that are at the root of underdevelopment, poverty and the disease of the majority of the world's population.

SOME NEEDED CLARIFICATIONS

Let me clarify here some points that need to be made. The proposed solutions, 'population control' and 'technological transfer' first, and a 'cooperative and mutually beneficial new economic order' afterwards - put forward by the development establishments during the last two decades as answers to the enormous problems in today's world do not represent a conspiracy by those establishments to keep the poor poor. Nor are they lies put forward to obfuscate the truth. We have to remember that to tell a lie, one needs to know the truth. And those establishments do not know it. These positions respond to a vision of reality (or ideology) that makes sense for the class which holds it. In other words, in the sixties when USAID and the Rockefeller Foundation put forward programs for population control in Latin America as a solution for Latin American poverty, they were bearers of a class-based vision of reality - the U.S. capitalist class' vision of reality - that led them to believe that the cause of poverty is not capitalist and imperialist exploitation but, rather, population explosion. As Marx indicated, every class has its own ideology-vision of reality - that serves consciously or unconsciously, to reproduce its own interests [17]. It is also characteristic of every dominant class to see its own specific class interest as universal interests. This point bears repeating in view of the overabundance of references that see history as an outcome not of structure but of personalities, conspiracies and individual motivations.

Individuals may be unconscious bearers of ideologies and practices that serve quite different purposes from the ones individually and consciously desired. The international health field is crowded with such contradictions between intentions and effects.

WHO AND THE DEVELOPMENT ESTABLISHMENT

All these ideologies and positions put forward by the Development Establishment have appeared in and are being reproduced through the WHO apparatuses. 'Population control' programs, 'technological transfer', 'Self-care and self-reliance' and 'cooperative and mutually beneficial new economic order' have been sequentially presented as the solutions to the overwhelming problems of disease and poverty in the underdeveloped world, Indeed, for many years, WHO has functioned as a 'transmission belt' of positions and ideologies generated for the most part in those development establishments. Here, it is important to stress several points:

There is a great need to question two dichotomies: Politics/technology and ideology/science. I have previously argued that science and technology are not neutral; they carry with them a set of values and ideologies that reflect and reproduce power relations [18]. In that respect, WHO, while being a technical agency of the United Nations, is also a political agency which reproduces and distributes political positions through its technological discourse and practices. Thus, it is important to question the prevalent vision of WHO as merely a technical agency committed to the eradication of disease in today's world. This vision belongs to the realm of appearance rather than reality. Like any other international apparatus. WHO is the synthesis of power relations (each with its own ideology, discourse, and practice) in which one set of relations is dominant. The dominant powers are the dominant classes in developed capitalist countries.

Let me stress that I am aware, of course, of the argument that the top decision-making body of WHO is the World Health Assembly, in which each country has one vote. But to believe that the Assembly is the top decision-making body would be as wrong as to believe that the British Parliament is the top decision-making body in Great Britain, or

that the U.S. Congress rules the United States. As Gramsei said, a vote gives the right but not the power |19|. The power of the dominant capitalist classes in those parliamentarian countries is exercised not only through elective bodies but, to a large degree, through the administrative, technical and professional apparatuses as well as through their hegemony over the ideological institutions (such as universities) that feed those apparatuses. The same occures in WHO, The power of those classes is not diminished by changing the composition of the personnel who represent their interests. In the same way that the addition of some blacks and women to the state personnel in the U.S. has not changed the overall pattern of class dominance in the U.S. state apparatuses, similarly, to have individuals of LDC origin in those apparatuses does not change the existing pattern of control in the slightest. As Poulantzas has clearly shown, what counts in Western democracies is not the gender, race, class or national origin of the state personnel but, rather, their class position |20|. The class position of state personnel appears in their technological discourse, specifically in 1) what is presented, 2) what is not presented and 3) how it is presented. And here, again, the same occurs in WHO. Any analysis of the articles and references in PAHO publications (the Latin American branch of WHO), for example, will show 1) a consistent presentation of empirical and functionalist positions, i.e. the dominant ideologies in Western academic circles, 2) an exclusion of alternate e.g. Marxist, Positions and 3) a presentation of the former positions as merely technological and apolitical, while the latter positions are portrayed as political and non-technological.

This situation is not unique to PAHO. It appears in most WHO branches. In all their discourse, there is a 'depoliticization' of political interventions, recycling them into technological ones. Witness, for example, the great promotion 10 years ago by WHO of the concept of 'barefoot doctors'. This profoundly political experience was stripped of its political significance (an outcome of a set of political forces that were occuring in people's Republic of China at that time) and presented as a wise and intelligent use

of paramedical personnel worthy of imitation in other political environments. It soon became clear that experiment could not work in other settings. The WHO reports did not seem to have understood that the barefoot doctor was a political event and an outcome of specific political forces. One could not be understood without the other. The depoliticization of that event, however, was in itself political.

In summary, there is within WHO 1) a continuous presentation of political positions through its technological reports with 2) a continuous repression of alternate positions. The extreme form of repression, of course, is the exclusion of alternate positions from the realm of debate. Let us now analyze how the Alma Ata Declaration fits within this interpretation of WHO.

THE ALMA ATA DECLARATION

First we have to realize that the major recommendations put forward by the Alma Ata report were not new. In 1972 the Office of Health Economics |21| (the intellectual center of the British pharmaceutical industry) and in 1975, The World Bank |22| produced reports on the state of health and medicine in the underdeveloped world that closely resemble the Alma Ata recommendations. Indeed, they are part of the conventional wisdom within the development establishments. These recommendations include the following: 1) a change of priorities within health care services with more emphasis to be placed on the allocation of resources to (a) primary health care services, (b) water control and sanitation services and (c) nutrition ; 2) a transfer of medical technology, shifting from highly sophisticated to less sophisticated technology; 3) an emphasis on self-care and self-reliance; and 4) encouragement of community participation in the planning and implementation of health programs.

How are the above changes to be implemented? The Alma Ata report stressed the message (repeated again in the Willy Brandt report) that these changes should take place through cooperation among nations and interest groups within nations, calling on both their morality (the call for social justice) and their self-interest (the mutual

interests of 'haves and 'have-nots' in a better economic order) |23|.

Because of the enormous importance of these points, let me further expand on what the report does say, what it does not say, and how it says it:

(1) The report speaks of a world divided between 'have' and 'have-not' nations (and within each nation, of 'have' and 'have-not' individuals) (24). Nowhere do categories such as capitalism and socialism appear. Thus, capitalist development is redefined as 'development', a process perceived to be so intrinsically good that it 'undoubtedly brings about improvment in health' |25|. Evidence exists, however, that development (of the capitalist variety) may not bring about improvements in health. I already mentioned the negative impact of the Brazilian economic miracle on infant mortality in Sao Paulo, Brazil. Many others have also shown how some forms and dimensions of capitalist development may indeed be more harmful than helpful for the improvement of the level of health of a population |26|.

(2) The report's suggestions focus on the need to introduce organizational and technological change within the framework of current power relations. These relations are considered as given and unchangable. For example, in speaking about "the need for women as well as men to enjoy the benefits of agricultural development", the report, after indicating that "women are engaged simultaneously in agriculture, household management, and the care of infants and children" |27| recommends that "(Women)" need appropriate technology to lighten their work load and increase their work productivity. They also require knowledge about nutrition which they can apply with the resources available, in particular concerning the proper feeding of children and their own nutrition during pregnancy and lactation".

In brief, the report is saying that in order to liberate women, there is a need for more technology (appropriate technology) and more education of women. The report does not mention that what is needed for the liberation of women is a redefinition of the power of women and men within the context of a profound redefinition of all power (including class power) relations in the society. Maxine Molyneux has eloquently shown how, within the world

of underdevelopment, an economic, political and social revolution has been a necessary requirement for the liberation of the majority of women and men [29].

(3) Besides the technological changes, the report calls for the collaboration of those who may oppose the shift of priorities whihin the health care sector, e.g. the medical professions and the multinational drug industries. The report suggests that governments make these interest groups aware of the commonality of interest they have with the reformers. These interest groups need to be convinced that the proposed changes will be to their benefit as well. For example, the report notes that "physicians and other professionals will need to be persuaded that they are not relinguishing medical functions but gaining health responsibilities" [30]. Similarly, the drug and medical industries need to be made aware of the enormous benefits that they can obtain from the changes.

"Opposition from the medical industries can be directed into positive channels by interesting them in the production of equipment for appropriate technology to be used in primary health care. Any losses from reduced sales of limited amounts of expensive equipment could well be more than counterbalanced by the sale to large untapped markets of greater amounts of less expensive equipment and supplies for primary health care" [31].

In other words, there is a lot of profit to be made from those changes. An assumption is made here, of course, that the powerful groups and the powerless ones (for whose benefit the reforms are supposed to take place) can share the same interests. This is in essence what is being said. What is not said, of course, is that the medical profession holds a class, gender and professional position and reproduces an ideology and practice aimed at optimizing its class interests, which are inconflict with the interests of the working class and popular masses. This explains why the instruments of the medical profession have always - from the Bolshevik Revolution to Allende's Chile - opposed the socialization programes put forward by the working class [32,33]. Similar arguments can be made about the drug and medical industries. It is to their advantage to reproduce the current relations of forces within the outside medicine. Witness the current opposition of the multinational pharmaceutical industries to the establishment of

National Health Services in the LCDs [34]. Let us not forget that the drug industry paid for the fascist Pinocher coup in Chile, and that the Chilean Medical Association sent the first telegram of congratulations to Pinochet! [35].

(4) The Alma Ata Declaration also calls for community participation. By community, the report means an aggregate of individuals having common interests and aspirations (including Health). Thus, community participation is defined as "the process by which individuals (and families) assume responsibility for their own health and welfare and for those in the community who develop the capacity to contribute to their and the community's development" [36]. Community, then, is seen as an aggregate of individuals: it is more than that. A community is a set of power relations in which individuals are grouped into different categories, of which classes are the key ones. And power is distributed according to those categories.

A physician, for example, is not merely an individual. He/she is a member of a class (as well as a race and gender) whose power comes not only from his/her medical position but also from the position he/she occupies within the class and gender and race relations in that society. It is primarily one's class position that determines one's interests. The primary commitment of the medical profession, for example, is not the health of the people. The primary commitment of those in the medical profession is to the optimization of the interests of their class (as well as their race and gender).

These four positions are clear ideological and political positions, and all of them appear in the Alma Ata Declaration. These positions need to be critized, not because they are limited (i.e. they do not go far enough) but because they are wrong. But let's continue our analysis of the WHO Alma Ata positions and see what other ideologies appear in them.

THE HEALTH CARE SYSTEM AS THE HEALTH SYSTEM

(5) The Alma Ata report uses the expressions 'health', 'health care', 'health care sector', 'medical care' and 'health systems' interchangeably. On deeper analysis, it appears that what the report

actually means by health system is basically a health care system built upon and organized around the medical care system, i.e. health care goods and services provided to individuals and families by health professions and health workers. The report's main recommendation is to shift the emphasis more toward primary care. That shift is supposed to take place within a medical care system in which primary health care should be at the center [37]:

"Primary health care is the hub of the health system. Around it are arranged the other levels of the system whose actions converge on primary health care in order to support it and to permit it to provide essential health care on a continuing basis. At the intermediate level more complex problems can be dealt with, and more skilled and specialized care as well as logistic support provided. At this level, more highly trained staff provide support through training and through guidence on practical problems that arise in connection with all aspects of primary health care. The central level provides planning and managerial expertise, highly specialized care, teaching for specialist staff, the expertise of such institutions as central health laboratories, and central logistic and financial support" [38].

It is clear from this quotation that the report is basically referring to regionalized and modified medical care system which includes primary, secondary and tertiary care services, giving major emphasis to primary care. Primary care is to include preventive as well as curative services, environmental as well as personal health services. The report is aware, of course, that health cannot be attained by the health sector alone [39]. It indicates that other interventions, such as anti-poverty programs, water, sanitation, housing and education, contribute to health. Later on, the report refers to these interventions as "supportive of the primary care sector" [40]. Agricultural, water, housing, public works and communication interventions need to be designed to support the tasks of the primary health care sector, which is considered to be at the center of those endeavors.

In summary, the report uses health and health care interchangebly. Thus, when the report speaks about health for all by the year 2000, the report is actually promoting accessibility to health services for all by the year 2000. Moreover, by considering the primary

health services as "the key to achieving an acceptable level of health throughout the world", the report singles out health services as the most important intervention to attain health |41|. The central role that accessibility and availability to health services plays in this strategy for health needs to be challenged. It represents an ideological and political position that indeed, should be questioned.

I do not want to minimize the importance of a shift of priorities within the health care sector. Nor do I want to diminish the value of expanding the responsibilities of the health care sector. These are very important tasks. But to consider them as the most important interventions to achieve health for all is profoundly incorrect. Most improvements in health have been due to changes in economic, social and political structures rather than in the health sector. Indeed, abundant empirical evidence exists to show that the most important changes in the health of the underdeveloped countries' populations during the last 20 years have occurred in revolutionary socialist underdeveloped countries via changes in their economic, political and social structures, independently of and outside the health care sector. It is worth mentioning that even the British pharmaceutical industry recognizes that the major changes in health have taken place in revolutionary socialist countries, referred to in its report as 'command economies'|42|. Those revolutionary changes have also enables changes in the health sector that have assisted in the further improvement of health. But most of the changes have taken place because of interventions coming from outside the health care sector.

EMPIRICISM OR ATHEORETICAL PRAGMATISM IN THE ALMA ATA DECLARATION: THE WAY OF INTERPRETING NON-HEALTH-SECTOR-RELATED INTERVENTIONS

(6) The Alma Ata document recommends a series of interventions outside the health sector, such as food production and education plus changes in public works and communications, housing, water etc. |43|. All of these changes are needed to improve the health of the population. This listing of activities is presented in apolitical terms. However, this type of presentation is itself political. It assumes that each of these interventions has a autonomy of its own. In sociological discourse this is called empiricism or atheoretical pragmation, i.e. the analysis of the

variables without reference to their structural determinants. A system, society or community, however, is defined not by the individual elements and/or interventions that exist within it but, rather, by the structural relationships among these elements and the powers they reproduce. Linear atheoretical pragmatism and empiricist thinking view interventions as independent of the structure and the power relations that determine them. For example, the discussion on whether 'population control' or 'technical transfer' or 'the New Economic Order' is the solution to underdevelopment carries with it this type of thinking. The ways in which the questions are posed predefine the answers. The reality (which is dialectical rather than linear) shows, however, that to know whether population size is a problem or not, we have to understand the variable (size of the population) within its historical and political context. In other words, the size of the population may or may not be a problem, depending on the social, economic and political structure in which that population is articulated.

In summary, what defines the effectiveness of an intervention (e.g. housing) is not that variable per se but, rather, 1) how the different interventions are structurally related; and 2) who and what are the agents of change, conflict, and resistance within those structures (both within and outside medicine). A specific intervention may be successful in Cuba but ineffective in El Salvador. Its analysis needs to be seen politically and historically. Empiricism and atheoretical pragmatism fail to do this; by not relating the parts to the totality, the totality remains unchanged. The Alma Ata Declaration fails in the same way. Its assumed 'pragmatism' is only an indicator of its ideological function.

Here, again, we find that the Alma Ata recommendations are not so much limited but, rather, incorrect. The mere listing of different types of interventions (both outside and within the health care system) is misleading, since the key question (whether they are or are not to be effective) depends on how these interventions are related within a structure and a set of power relations that give their meaning and importance. The avoidance of recognition of these structures and power relations is thus the main weakness of the report.

CONCLUDING REMARKS

Contrary to widely held belief, health is a profoundly political issue. I have tried to show in this part of the article how the Alma Ata Declaration is not apolitical but rather profoundly political. WHO, through its technological-administrative reports, reproduces ideologies and political positions as well. The WHO Alma Ata Declaration is not an exception.

Let me quickly add that it is not my intention to castigate but, rather, to critique that report. It does contain, after all, a good major recommendation, i.e. the shifting of priorities within health care toward primary care and away from secondary and tertiary care. But its interpretation of the major health problems in today's world, as well as its proposed solutions for them, is wrong. Its recommendations reproduce, for the most part, the point of view of the development establishments. These views are part of the problems and not of the solutions; they represent the perspective of the dominant classes in today's world.

The changes in the world structures and the power relations that explain them (greatly stimulated by the new liberation forces that are breaking with the Old Economic Order) will determine changes in the United Nations and in the 'technical' agencies within it - including WHO. A sign of that change will be for WHO to 1) break with the medical ideology (the Flexnerian model) that sees health as an outcome of medical care, however that care may be redefined and expanded as health care and primary health care: and 2) embrace the systemic view of health that explicitly sees health in the world of underdevelopment today as primarily an outcome of politically determined structural economic and social changes.

This new understanding of what health and health struggles are should lead the WHO of the future to focus on 1) concrete assistance to the liberation movements in their struggles against institutionalized violence and disease*; 2) analysis of the structural constraints to health and the class and other forms of resistance to basic change; 3) change of all existing staff and consultant structures to better reflect the huge diversity of views on health, breaking with the

*Foot-note on next page

dominant medical ideology; and 4) research and storage of information on the international mobility of capital and labor and its possible implications for health. Let me add that today, for example, there is no international agency that gathers information on the flow of capital (including toxic industries) among countries and continents, nor about the movement of workers (migrations) between countries and the health consequences of both. Similarly, there is no international agency which collects systematic information about structural economic changes and health, nor about employment (or lack of it) and health.

These are mere examples of areas and problems that need to be faced and that have not been faced, because they are seen as too 'controversial' or 'political'. They are controversial because they threaten the interests of the dominant powers that define the acceptable items in the social agenda. They are not more political, however, than the current 'technological' discourse that dominates WHO positions. They do respond to different interests than the dominant ones, the ones that establish the permissible boundaries of current discourse. Still, demands for change are increasing, augmented by the largest crisis that the world capitalist system has faced since the 1930s. New, bold and daring solutions need to be put forward that will transcend and leave behind the Alma Ata report. This new discourse will not be the one of the development establishments of the Western world, but will come from the authentic representatives of the majorities in the underdeveloped world who will justly proclaim their right to a place under the sun in their magnificent lands which could, under different system, give to all what is now denied to most.

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* Although I am aware of the structural constraints under which WHO operates, still the reality is that other U.N. agencies are providing such assistance already.

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THE POLITICS OF PRIMARY HEALTH CARE*

by
Malcolm Segall

When primary health care (PHC) made its somewhat glittering debut on the world stage in the 1970s, it took on the ambitious role of the agency by which a decent level of health for all peoples would be achieved by the year 2000. Now, well into the penultimate decade of the century, PHC seems to be losing momentum and may be in danger of going the way of its predecessor - basic health services (BHS) - in starting as a good idea at the time, but becoming one that is more spoken about than acted upon.

In this article I want to review the politics of this situation, and try to make the case that political factors underlie past failures and may be the key to future successes. To simplify the exposition the discussion will be limited to developing countries, although many of the issues apply also to the developed world. Similarly the argument will be couched mainly in terms of the typical need in developing countries to improve the health of the impoverished rural majority of the population, on the understanding that many of the principles apply also to the urban poor.

PRIMARY HEALTH CARE: ITS RISE AND FALL

The PHC approach may be characterised as embodying three basic ideas (Segall 1983a):

- That the promotion of health depends fundamentally on improving socioeconomic conditions and, in most parts of the world, on the alleviation of poverty and underdevelopment;
- That in this process the mass of the people should be both major activists and the main beneficiaries;
- That the health care system should be restructured to support priority activities at the primary level, because these respond to the most urgent health needs of the people.

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The third of these elements is essentially the same as the BHS strategy, although with the knowledge of how inadequately the latter was implemented, there is now a greater concentration on the need to mould the whole health system to support the development of the primary level. While controlling expenditures on large urban hospitals was a recognised corollary of BHS thinking, there was still the tendency to treat the BHS as a seperate programme, With PHC came more coherent statements about the need for integrated health sector planning and development, including even consideration of the private sector (Djukanovic and Mach 1975: 21-2; WHO/UNICEF 1978:40). This was an important change of emphasis.

Nevertheless, it was the addition of the two ideas listed first above - asserting the importance of poverty and community participation - as major elements of international thinking on health policy that constituted the qualitative departure of PHC from BHS (Djukanovic and Mach 1975:10-16; WHO/UNICEF 1978: 44-52). These new elements did have their forerunners during the BHS period, and some versions of that model acknowledged more than others the importance of poverty in disease and of seeking community co-operation with health service personnel (see for example King 1966:ch 1). Yet these factors were never operationalised as central features of the strategy, and the BHS approach was essentially technocratic and indeed often paternalistic: health was something to be 'delivered' to the population by health professionals and their assistants.

In this sense PHC represented a breakthrough in official policy formulation. In international circles, health was now distinguished more clearly as a separate, if related entity from health care: the former was the product of many factors of which health care was only one, if an important one. What prompted this ideological shift at the beginning of the 1970s? The scientific basis for ascribing importance to socio-economic factors in health had been established for a long time. Two main reasons for the change may be identified.

One was the evident failure of the BHS strategy to materialise. While there was much talk of extending rural health services through health centres, auxiliary personnel and low-cost technology, practical progress was painfully slow, and resources continued to be channelled disproportionately to expensive hospital and medical care for urban minorities, especially the well-off. Meanwhile earlier improvements in life expectancy at birth were slowing down (Gwatkin 1980), and health and nutritional status in the developing world remained very poor, with high morbidity and mortality rates due to largely preventable diseases (for a review of the situation at the time see Office of Health Economics 1972). There was a growing crisis of confidence in the conventional wisdom about health, and strategists were looking around for 'alternative approaches' to solving the problems.

The second main factor prompting the appearance of PHC was the recognition of the successes of certain practical experiences. Some of these were in capitalist countries, often involving non-government projects that were adopting progressive approaches, particularly with regard to community participation. Yet it would mean a rewriting of the history of that period not to acknowledge that the main demonstration effect came from the national experiences of the developing socialist countries, notably China and Cuba, and especially the former (see for example Djukanovic and Mach 1975; Newell 1975). In these countries poverty had been greatly alleviated, access to health services had markedly increased, and health and nutritional status had substantially improved. One new feature of these experiences was the organisation of the people through political and social structures. Though some of the account at the time may have painted a somewhat idealised picture, descriptions of the health movement in China particularly after 1965 (see for example Horn 1969; Akhtar 1975; Wilenski 1979), and especially the mass campaigns and the barefoot doctors, caught the imagination of world health circles looking for a way out of the apparent impasse.

Primary health care was born as a synthesis of these negative and positive experiences. As a statement of the then 'state of the art' it

was positive contribution, and PHC provided a basis for a fresh attack on the world's mass health problems. Some years on, however, it is all once again proving to be very difficult. To quote an international study which was a follow-up to the original 'Alternative Approaches' study (Djukanovic and Mach 1975) that launched PHC on to the world stage:

> .... there is often a large gap between PHC plans and implementation: words abound, but concrete results are frequently thin on the ground. What progress there is seems often to be along conventional basic health service lines, sometimes extended in a cheaper version in the form of village-based health workers. The scope and depth of community involvement are often doubtful. The co-ordication of health and development planning if often poor and intersectoral health-related activities are frequently rudimentary. Vertical single disease programmes are often not yet integrated with PHC in practice.
> (WHO/UNICEF 1981:48)

Meanwhile the recession is slowing down, wiping out or even reversing per capita economic growth in many parts of the Third World, especially in the poorest countries, with bleak prospects and possibly increasing poverty in the 1980s (World Bank 1980a). Overall per capita food production in developing countries (excluding China and the other Asian socialist countries) scarcely grew during the 1970s and in many areas (notably in Africa) actually decreased (FAO 1977:4,1980:79-80). Earlier increases in life expectancy are slowing do down substantially, and in some areas have ceased or have even been reversed (Gwatkin 1980). According to the latest WHO report on the world health situation: 'As regards the many diseases that plague the less developed countries, there appears to have been little or no progress in recent years in reducing either their incidence or their prevalence'; some communicable diseases appear to be on the increase, and nutritional deficiencies are widespread and serious (WHO 1980:46).

The reality must be faced that the PHC movement is not yet fulfilling its promise to bring health to the world's peoples, and that the year 2000, by when 'Health for All' is meant to be

achieved,[1] is approaching fast. What are the obstacles to better progress?

A POLITICAL OVERVIEW OF PHC

I will now review in turn the three basic PHC themes itemised earlier in order to bring out their political quality. This will not be debated in depth since it is assumed that the experienced reader will be familiar with the issues referred to; my purpose is only to survey the broad political topography of the area.

THE POLITICAL ECONOMY OF HEALTH

The importance of socioeconomic conditions for health is now well established (see for example McKeown 1979; WHO 1980). Many health indicators are related to social class or reflection of class (like occupation, income, literacy and housing) at all levels of development (Stewart 1971; Cochrane et al 1978; Preston 1976, 1980:291-3; WHO 1980; Townsend and Davidson 1982). Life expectancy at birth, for example, correlates closely with per capita income,[2] a relationship that holds bothebetween countries and within countries.

There have been suggestions that the advent of modern health technology has weakened the relationship between income and life expectancy, in the sense that many health problems which previously had to await socioeconomic development can now be dealt with technically (see for example Golladay 1980:1825). In fact, if anything, the evidence is that mortality reductions in lower income countries became more responsive to rising per capita national income in the 1960s than they had been in the 1930s (Preston 1976). Two plausible explanations for this are that modern health care is more effective in synergism

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[1] Resolution WHA 30.43 of the 30th World Health Assembly, 1977.

[2] The relationship is approximately logarithmic with an upper limit to the effect of income above which no further gain in life expectancy is seen (Preston 1976).

with higher living standards, and/or that greater national wealth allows the provision of better health care.[3] Modern health technology has simply meant that greater life expectancies are achieved now for any given level of income, but the relationship between income and life expectancy continues to hold strongly. An estimate has been made that about half the gain in life expectancy achieved by the developing countries between the late 1930s and the late 1960s cannot be explained statistically by increases in per capita income, dietary calorie availability and literacy rates, and it is reasonable to assume that this part of the gain is the result of specific health measures (Preston 1980:304-13). However, whatever has been the empirical apportionment of responsibility between social and technical factors in health improvements in the past, there is no reason whatsoever to doubt that greater socioeconomic advances would have resulted in greater health improvements or that they would do so in the feature. No amount of technical advance is an argument for underplaying the importance of acting on social conditions to improve health.

Also it is necessary to compare like with like in assessing the relative importance of different health determinants. The increases in life expectancy as a result of modern health technology will have been due, to a considerable degree, to curative measures, especially to the use of anti-infective drugs. While the latter may reduce the transmission of some communicable diseases, the predominant effect of curative care is to aid recovery and prevent deaths from specific disease episodes, rather than decrease the occurrence of ill health. To the extent that health care is curative, its effect in increasing life expectancy does not have the same implications for improved health status as increases in life expectancy resulting from improved socioeconomic

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[3] The association of higher average per capita national income with better health does not contradict the argument that in most countries a more equitable distribution of income and health care would produce better results still.

circumstances. The latter constitute the ultimate means of primary prevention and reduce the incidence and severity of a range of important nutritional, infective and obstetric conditions, among others. In improved social circumstances people are altogether healthier and that is why they are not dying prematurely.

The struggle against poverty must therefore remain in the forefront of the PHC approach: but what does this amount to? Poverty rarely results mainly from an absolute lack of resources. Its principal causes are social structures that prevent people from working productively, reaping the benefits of their labour, and raising their living standards. The problem is less poverty as such than the structural causes of poverty.

Landless labourers represent a large proportion of the population in many developing countries: in India a third of the population is landless, and several African Countries witnessed a considerable growth of landlessness during the 1970s (WHO 1980--27). In 1975, a third of the urban labour force and 40 percent of the total labour force in developing countries (excluding China and the other Asian socialist countries) were unemployed or underemployed (ILO 1976:18). The international economic situation has greatly worsened for the developing countries. As an illustration, the import of a lorry to Mozambique could be covered in 1975(the year of the country's independence) by the export of 5.3 tons of cotton, whereas the figure in 1981 was 12.9 tons; between the same two years, the amount of sugar that had to be exported to cover the import of a ton of crude oil rose from 174kg to 639Kg (Frelimo 1983:32). Facts like these- far removed from those that are usually taught in medical schools - cannot be separated from the quest for better health.

The struggle for health may thus involve a range of actions in the economic, social and political field, as diverse as for example: the structure of ownership of productive resources; the control of markets and prices; the stimulation of economic and social cooperation among direct producers; the provision to the latter of adequate government resources, credit on favourable terms, and access to productive inputs and appropriate technology; and the structure of international economic relations. Does this mean

that PHC is synonymous with the whole development process? In a way the answer must indeed be yes, but for practical purposes it needs to have a sharper focus. I believe the PHC approach must involve that (substantial) part of the development process which relates directly to the alleviation of (at least the worst aspects of) poverty in the short term.

Overcoming poverty implies economic growth; yet this is now well recognised to be a necessary but insufficient condition. In the context of (at least a reasonable measure of) growth, the alleviation of poverty means in the first instance a more equitable distribution of income, especially if the latter is understood broadly to include both cash and subsistence income and the 'social wage' (education, health care, and other public services). However, income distribution - so often the focus of attention in reforming development strategies - is an insufficient characterisation of the problem, because it does not draw enough attention to the determinants of income. More fundamental is the distribution of the means to generate income: the distribution of productive wealth; and more fundamental still is the distribution of the means to decide on the distribution of wealth and income: the distribution of political power.

It is to cover these basic structural questions that I use the term, 'the political economy of health'. It should be noted that this embraces social issues much more far-reaching than those of 'intersectoral coordination' (involving mainly co-operation among government extension services) that often passes for the socioeconomic or development component of the PHC approach. Important as intersectoral coordination is, it does not begin to cope with the fundamental questions of income, wealth and power, which must be faced if the goal to achieve 'Health for All' during the next 17 years is taken at all seriously.

THE SCOPE FOR POPULAR INITIATIVES

Community participation has become one of the shiboleths of PHC, which is not surprising given the power of popular involvement in health promotion. One of the attractions of the idea for many governments - and for some international agencies - is

the notion that rural communities can be expected to raise their own resources for health care. Even in China, it is pointed out the commune health system is mainly financed cooperatively. It is important to recognise, however, the context in which that system operates. The economic and social situation of the communes is such that the annual membership contribution to a cooperative medical scheme amounts to only some 0.6-3 per cent of disposable personal income, and there are also collective welfare funds to cover a proportion of the health expenditures, including the payment of the barefoot doctors and other public health workers (Teh-wei Hu 1976), Also the central government now allocates a majority of the national health expenditure to the rural areas (preferentially to the poorer ones), subsidising the commune clinics and the county health services that support the commune health system. This is quite different from the typical Third World situation where impoverished rural communities are expected to raise their own health resources, while government (and private) health funds continue to flow disproportionately to provide sophisticated care for the care for the city populations. This is a case of self-reliance and village health workers for the rural poor, and hospitals and medical specialists for the urban rich- all in the name of primary health care. It is not that, in fair circumstances and in proper proportion, communities should not contribute health care resources; doing so is indeed one aspect of their assuming respomsibility in this field. But this fact should not let governments 'off the hook' with regard to reshaping the pattern of resource allocation in the health sector to give priority to those in greatest need.

This excessive preoccupation with raising community resources has often displaced attention from the central aspect of popular involvement in health, namely, the people's organised involvement in planning and decision-making on health-related activities. This may be less attractive to governments because it implies a degree of devolution of power, but it is one of the main features distinguishing the PHC from the BHS approach.

Before dealing with the question of power, it should be noted first that deprivation itself exerts a great constraint on popular initiative. There is often the lack of the material means to implement plans, and insufficient education hampers planning and management. Yet beyond these more obvious

constraints, one of the most scarce resources in situation of poverty is time, which must be devoted in the first place to the struggle for survival; but time is needed for the planning, decision-making and implementation of communal activities. One may ask how, for example, women - such important agents for health or disease in a community - carrying the responsibilities for household management and child rearing, and often doing much of the farming, can become effective in the participants health development process in these circumstances.

However, the crux of the problem of popular participation lies in the nature of social relations. This does not refer here to subjective interpersonal relations at the individual level, but to the relationships that develop within the community as a result of the objective positions different people hold in relation to the prevailing power structure. In official mythologies of community participation, communities are portrayed as harmonious homogenous entities, existing in an unproblematic relationship with governments and even sometimes with the wider economy. But communities are divided and stratified socially, and they exist within the social class structure of the national society.

Tenant farmers and landless labourers on the one hand, and landlords on the other, do not have a community of interest such that they can be characterised meaningfully as members of the same community, who happen to perform different roles. Poor homesteaders may well have different community interests from those who hold some capital, and both are very likely to have different interests from the owners or managers of large scale commercial farms or plantations. Differential ownership of productive resources creates different class interests, and it confers great influence in community decision-making on those holding economic power. Often overlapping or articulating with these economic power relations is the traditional social structure with its various stratifications. The 'community' is a different place to the mass of local inhabitants than it is to the unelected leaders of this traditional system, with its related social divisions on the bases of age, sex, tribe, region, caste, ethnic origin, and so on.

Not unconnected with these social divisions within communities are the problems in the relationship between such 'communities' and the government. These problems are usually ascribed to the bureaucratic nature of the government machinery and the arbitrary attitudes of local administrators. These can certainly cause real difficulties, but they are an insufficient characterisation of the problem area. The local bureaucrat or policman, respectively administering and enforcing, for example, the laws on land tenure and wage labour, have an objectively different relationship with tenant farmers and the landless than they do with landlords and landowners, and a different relationship with farm workers than they do with rural employers. These are social relations conditioned by the national political structure. The economic and political relationships in the wider society are present at the community level, mediated by representatives of the dominant national classes and the political machinery, and often articulated with local dominant classes or strata.

Unequal economic and political power are the bases for the divisions in the community, and they are maintained by means of the law and the enforcement agencies. But peaceful social life implies that these coercive means are invoked as rarely as possible, and clothing the iron fist of force is the softer velvet glove of supportive ideologies. These add the cultural dimension to the power nexus, and by mystifying life promote a passive acceptance of the status quo by those on the receiving end of power. In rural communities traditional ideologies are particularly strong and they can exert a highly conservative influence, sometimes even in the face of crude exploitation and oppression. No better example of this can be found than their role in the almost omnipresent subordination of women.

In such circumstances 'community participation' may mean little more than the government obtaining local compliance with its own predetermined plans (including possibly the extraction of community resources) or it might involve allowing the community a voice which is in fact articulated mainly by the local holders of power, who could well be among the main beneficiaries of participatory exercises (see for example Ahmed 1978:88). Local leadership of an undemocratic kind can succeed in mobilising populations up to a point, especially for defined projects with a limited time

frame (like clinic building or well digging), but it tends to suppress the active and creative involvement of the people in the ongoing planning and implementation of health and development activities (see for example Segall and White 1981).

The struggle for popular participation is basically the struggle for democratisation of decision-making and economic power. To achieve this goal it is usually necessary to have specific social structures - new in most parts of the world - that will provide for the democratic debate and management of community affairs, and will supply the ideological inputs necessary to support the involvement of the presently weaker community members. This is an eminently political process, involving a transfer of power and influence from a minority to the majority at the community level, and it will require a national political process to initiate and foster its development.

RESTRUCTURING THE HEALTH CARE SECTOR

Much has been written already about the typical maldistribution of health care in developing countries, with minority urban populations - usually already enjoying better health as a result of higher living standards - benefiting from health care resources per capita very many times greater than the rural poor, who carry a much heavier burden of disease. This maldistribution is usually characterised in simple urban/rural terms, but it should be emphasised that many of the health and health care problems of the rural areas are shared (if generally in lesser measure) by the town poor.

The urban health care takes the form mainly of a combination of government services and the private medical sub-sector[4]. Health care is available

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[4] The discussion here of private medicine will exclude voluntary agencies, traditional practitioners and household self-care. The more complex situation of compulsory health insurance and social security schemes for wage earners, which in many developing countries have some effects similar to those of private medicine, will also be excluded.

generally to the urban population, and even the private market at its cheaper end may be patronised by the poorer social classes. Nevertheless, the main beneficiaries of the private sub-sector are obviously those who - in the national context and in simple terms - may be said to constitute the urban rich, and they also often have privileged access to the best government facilities and personnel, sometimes by paying (often relatively small) fees. The principal pressure to maintain and develop the level of urban health care thus comes from these main beneficiaries, who also wield the greatest political clout. One mechanism for achieving their goal is political influence on the allocation of government resources; another is pressure in favour of private medicine.

The private medical sub-sector may be substantial in developing countries, in expenditure terms being often as large as, or larger than the government health services (World Bank 1980b; Preston 1980:340). The private sub-sector is inherently maldistributive, in that it directs health care resources to those who can pay rather than to those with the greatest need. Nevertheless, a defence commonly put forward by the protagonists of private medicine is that it takes a middle-class load off the government health services, which can then concetrate their efforts on the poor. This argument overlooks, however, the extent to which the private and public sub-sectors intermesh to the detriment of the latter (Segall 1983a). To itemise some of the effects, the private sub-sector: absorbs scarce government-trained health personnel; practises excessive and expensive curative care, inflating medical costs and drawing on the country's limited foreign exchange for pharmaceuticals and equipment; reinforces the technocratic clinical bias in medical education and influences students' attitudes towards profit-making private practice, thus undermining attempts to orientate health workers towards the PHC approach; and constitutes the independent economic base from which the conservative fraction of the medical profession can oppose structural reforms in the health sector. In addition, the private sub-sector is often not completely financed privately, but receives substantial direct and indirect public subsidies, ranging from the use of health service facilities and personnel at no or below cost, to tax concessions on private health insurance contributions.

The reshaping of the health sector in the direction of PHC inevitably encounters opposition from the main beneficiaries of the existing situation. On the consumer side these comprise, as mentioned, the urban rich, who benefit from superior health care both as individuals and as employers wanting to provide private medical insurance schemes for their workforce.[5] On the producer side are the health care professionals, especially the doctors, and private capital in the form of the pharmaceutical and medical equipment industries, and those private hospitals and health insurance companies that are profit-making. This is a formidable enough alliance.

Reshaping the health sector for PHC rarely takes the form of the actual redistribution of existing health care resources from urban to rural areas. Even where this would be appropriate and there is a legitimate case for rationalisations in urban care, it is usually resisted vigorously and openly, and the political scope for reductions in existing levels of urban service is strictly limited. Reshaping the sector's resource pattern is achieved usually by allocating the bulk of new expenditures to the expansion of rural health care, and here the opposition manifests itself indirectly. Primary health care is never opposed as such: in these days of its orthodoxy is must indeed be supported in theory- and there is no reason why it cannot be supported in theory. The practical struggle is over the slicing of the limited 'Cake' of new resources. It is the making of competitive demands on these resources to meet other 'urgent needs' in the urban areas, typically of a high technology character, that is the most common form of opposition to PHC reform in the health sector. Unless there is adequate resistance to these demands, a national situation easily develops that PHC is promoted in words, while urban high technology care is supported in deeds. This contradiction is greatly facilitated by the common absence of an accounting and planning system that surveys and organises the health sector as a whole. If the private and public sub-sectors, and the different levels of care are treated essentially separately - as is still usually the case - the proportional divisions of the total health resource 'Cake' are never made apparent, and the contradiction between words and deeds can

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5. There are often tax concessions on employers' insurance contributions, which may also be passed on to the general public in higher prices.

continue with relative ease (Segall 1983a). This is surely the story in most countries today, as it was in the days of the BHS strategy.

The success of PHC requires the strictest control on resource allocations both within the health service and - for the reasons given - in any private medical sub-sector as well. With regard to the latter, at least all direct and indirect public subsidies should be removed, and strict limitations will also need to be placed on the sub-sector's growth; indeed some countries have opted for its contraction or abolition. Ownership and control in the health care sector[6] are thus vital political issues for PHC implementation. Control, however, is not merely a question of public versus private ownership - though it begins with this. A highly bureaucratised government service may be almost as antithetical to PHC as private medicine itself. The issue of control involves also the question of democratisation of decision-making: within the health service generally; between the professionals (especially the doctors) and the so-called subprofessionals (ie the health team approach); and between health service workers and communities and patients. This democratisation will entail struggles against both bureaucracy and elite professionalism. It will also often be necessary to increase the obligations of health workers to government service and to institute major reforms in medical education. No less than in the areas of political economy and popular involvement, health sector reform for PHC is fraught with a wide variety of conflicting social interests - the stuff of politics.

THE NATURE OF PHC POLITICS

From the beginning official international documents identified PHC as a political issue, that required to be backed by political 'will' or 'commitment' (Djukanovic and Mach 1975:96; WHO/UNICEF 1978:5, 42).

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[6] The related pharmaceutical sector is dealt with in other articles in this Bulletin.

This entailed a far more explicit political stance than was ever the case with the BHS strategy, both in the discussion of health problems and in the choice of the national experience used for their demonstration effect. International political formulations have been in effect exhortations to governments to pursue PHC policies. The UN agencies like WHO are international - not supranational - organisations, and they are subject to the collective decisions of the constituent national governments through their respective governing bodies like the World Health Assembly. Hence UN statements on PHC must be directed towards governments and must ultimately be acceptable to them.

The UN secretariats, however, do have considerable scope for initiative, and they used it to good effect in launching the PHC movement. However, what were progressive political formulations in the 1970s when PHC was still emerging and struggling for international acceptance, may be less so in the 1980s when it is now part of the conventional wisdom of the international community. The present task in hand is to convert the formal support of the Alma Ata Declaration into actual deeds, and to show results before the end of the century: and that may require a further turn of the political screw.

Primary health care is basically a distributive policy. Not surprisingly, the developing socialist countries have a good record in this respect. This is especially so with regard to the alleviation of poverty (which has been achieved mainly by changes in ownership structure that created opportunities for gainful employment) and to improving access to health services.[7] They have also notably succeeded in mobilising populations for health, though decision making has often remained too centralised and bureaucratised (while being nevertheless usually a lot more democratic than in the historically preceding

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7. [7] This does not mean that health systems in socialist countries are without their problems (see for example Segall 1983b), but the social system is clearly a major determinant of health system development.

situations). At the other extreme, there are some countries with right-wing regimes that will almost certainly block significant progress in a PHC direction. However, there are also non-sociolist countries in which more distributive policies are pursued and in which PHC progress may be possible; but in many of them this will depend greatly on the outcome of the contention of social forces for and against.[8]

Primary health care is thus not a painless process, but one that requires persistent pressure to overcome the inevitable opposition forces. This fact should now be made explicit, because the problems will not go away by pretending they do not exist. It is no longer sufficient to limit political formulations to appeals to governments to have a voluntaristic change of heart, as though - even if this happened - it is all that is needed. The more that the necessity for continuing political action against opposition becomes common currency, the more will the struggles of those, both inside and outside governments, who are promoting PHC be legitimated and supported.

SIX AREAS FOR POLITICAL ACTION

It is impossible to generalise about who are, or may come to be, among the main protagonists of PHC in a given situation. This will vary enormously according to political circumstances. They may be the national political leadership, groups within the government, opposition political parties or groups, trade unions, peasants' associations, women's organisations, other non-government organisations, academics, UN agencies, or whoever. The following are some possible lines of action that these protagonists may individually or severally pursue. The selection is not intended to be exhaustive but is only indicative, and priority actions are likely to change over time.

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[8] On some PHC issues this principle may apply also to socialist countries.

1. DEVELOP THE SCIENCE AND PRACTICE OF SOCIAL EPIDEMIOLOGY

The key issue here is the demonstration and quantification of social inequalities in health and health care.

Epidemiology concerns the population aspects of ill health. Classically its point of departure is a disease or health problem (like tuberculosis or coronary heart disease or infant mortality). The tasks of epidemiology are then to analyse its frequency and distribution in the population, to identify associated factors (biological, environmental, social or other) that may be important in the causation with a view to discovering means of control, and to evaluate the impact of interventions on the rates of occurrence. Epidemiology is the basic science of public health, yet in this most common classical form it is (necessary but) insufficient for PHC purposes. Starting as it does with the individual condition, it does not identify adequately how a range of different health problems may be concentrated in certain social classes or groups. Though collectively individual epidemiological studies may point to a social clustering of disease, they do not characterise the clustering or the full range of links between the different problems systematically. This is the role of social epidemiology. Its point of departure is not the disease but the social group. It establishes the group's broad health experiences and analyses their association with various facets of social experience, thus identifying the problems in a way that calls for social interventions. Social epidemiology is thus the basic science to underpin the distributive goals of the PHC approach. Classical epidemiology remains the science of the individual PHC component programmes (like those for communicable disease control), but social epidemiology provides the data base for the structural PHC reforms that will create the conditions for those programmes to be implemented.

The basic task of social epidemiology is to demonstrate and quantify social inqualities in health. This is now an established procedure in some developed countries (see for example WHO 1980:47-50). In Britain, for example, it has been shown that mortality experience generally deteriorates with falling social class ranking, and that such a class 'gradient' can be observed for the majority of causes of death; morbidity tends to show a similar class distribution, especially with chronic illnesses (Townsend and Davidson 1982:ch 2).

Very few quantified data of this kind are available for developing countries, and there is a pressing need to close this information gap. One problem naturally lies in the generally deficient health information systems, but possibly more critical are the simple lack of awareness of the social epidemiological approach and its uses, and the consequent lack of familiarity with its methods and data needs. In fact the inequalities in health in developing countries are very great, and this allows the broad picture to be painted with relative ease. For practical purposes it may be that, at least in the first instance, only three main social groupings are required: the urban rich, the urban poor, and the rural poor, and there are often enough data (or they can be compiled without an impossible effort) to characterise the health experiences of these groups (or proxies for them) with reasonable accuracy (see for example Segall 1983a). Epidemiology can also be applied to health services, and social epidemiology is the basic method to demonstrate and quantify the social maldistribution of health care, showing also how this often compounds the social inequalities in health.

Social epidemiology can be powerful instrument in support both of political action for PHC and of the technical planning and programming necessary to implement the distributional aspects of the approach (see 2 and 5 below). The science and practice of social epidemiology should be greatly expanded in developing countries. It should be adapted to their conditions and resource constraints, and health information systems should be developed to serve its data needs.

2. POPULARISE SOCIAL EPIDEMIOLOGICAL FINDINGS AND THE PHC APPROACH

Continuing political support for PHC implies that knowledge of the relevant issues should not remain the elite preserve of government officials, academics and UN representatives; behind closed doors opposition forces are likely to wield more persuasive influence and to prevail. The more the facts about the inequalities in health and health care, and the principles of PHC, are shared with the mass of the people who stand to benefit - the more the issues become part of the popular consciousness - the easier it will be to build up the head of political pressure to see the policy through. Every effort

should be made to propagate PHC facts and issues in a simple form, and to use all the means of mass communication (for the literate and illiterate) to mount a sustained campaign of popular education.

The quantified findings (crude as they may be) of social epidemiological studies will be valuable in this context. For example, to know for your country the incomes of the urban rich and the rural poor (which might work out to be in a ratio of, say, 40 to 1), their respective child mortality rates (which could be in a ratio of, say, 1 to 40), and the per capita health care expenditure from which the two groups benefit (which might again be in a ratio of 40 to 1), has much more impact than general statements such as that poverty is a cause of disease and the rich get better health care than the poor - observations made by most people.

A special education campaign should be mounted for health workers, especially for the professionals, and most especially for the doctors. A classical medical education (perhaps with a few more token hours of 'community medicine') is still the norm in most countries. This type of training, together with the reality that curative practice is what most health personnel presently do most of the time, tends to narrow the vision of health workers to the traditional clinical relationship, and this can make it more difficult for them to open their minds to the broader aspects of the PHC approach, notably to the question of community and patient involvement in decision making. It is true that many professionals cannot 'understand' PHC because (at whatever level of their consciousness may be involved) they do not want to understand. Their present bread and butter with not a little jam - depends on the existing medical system. These are the fraction of the health professionals who constitute part of the opposition. However, there are also a growing number of professionals especially among the younger generations, who are coming to see the relevance of PHC to the social value of their work, and who are prepared to respond to the career consequences of the approach. It is important to provide these professionals, and all health workers, with the information they need for the development of their social consciousness and for their own work in the propagation of PHC ideas. The battle for a PHC consciousness should be carried into the ranks of the health professions; their voice carries political weight and their co-operation is needed for the technical implementation of PHC.

3. FEED PHC POLICY INTO THE ORGANISATION OF THE COMMON PEOPLE

Popular consciousness is one thing, and political clout is another. It is important that organisations representing the interests of the mass of ordinary people - be these political parties (in power or in opposition), trade unions, peasants' associations, women's organisations, or religious groups - should take up the cause of PHC. The spontaneous popular demands about health are usually for more doctors and hospitals, and this is normally reflected in the political demands of mass-based organisations. While these demands for better medical care are likely to be quite justified, they should be located in the broader context of the PHC approach. The leadership of mass organisations should be convinced about the correctness of the approach, so they can use their influence to get this message across to their members and constituencies, and use the weight of their organisations in the political arena to support struggles for PHC. They are likely to be particularly supportive of the PHC elements relating to the alleviation of poverty and to the democratisation of decision-making. As this point is illustrated so well in the article by Macedo and Vieira on Brazil included in this Bulletin, no further discussion need be undertakne here;

4. LEGISLATE WHEREVER POSSIBLE

Political pressure for change is one thing, and the force of law is another. As and when a government is persuaded to undertake a particular PHC reform, it is good practice to get it on the statute book wherever possible. A law is not automatically implemented, and it can always be revoked. It is not therefore a substitute for continuing pressure to turn PHC policy into reality, but it does strengthen the base from which such pressure is applied. In addition, the opposition may lose some support once the apparent fait accompli of legislation is effected. Thus legislative measures are among the means by which political PHC gains can be given an element of stability.

Without prejudging at this point how tough any particular law may be, the following are some areas where PHC-related legislation may be called for:

- Economic and fiscal reform relating to the distribution of wealth and income;
- establishment of social structures and processes for the democratisation of decision-making;
- establishment of a national health service;
- definition of the scope of any private medical sub-sector(s);
- educational definitions of health professionals, bonding of graduates to government service, and criteria for career advancement;
- pharmaceuticals and medical equipment.

5. ESTABLISH HEALTH PLANNING MEANS TO SERVE DISTRIBUTIONAL ENDS

The key issue here is planning on the criterion of social equity.

Health planning procedures should support the distributional aims of PHC. Given the inertia of entrenched planning methodologies, the establishment of appropriate methods may itself be a political task. While the distributional principles apply to all the health-related sectors, the discussion will be limited here to the health care sector itself.

The conventional public health planning prevalent in developing countries is based on the traditional medical approach of classical epidemiology. It identifies individual or grouped health problems and designs specific health care programmes to resolve them, like those for communicable disease control, immunisation, or mother and child health. While this is a perfectly necessary activity it is insufficient for PHC purposes; it is health care programming, which should not be confused with PHC planning in the strategic sense.

Where health care programming is the predominant planning methodology, it tends to 'verticalise' health care activities into distinct national programmes which can become complex and unwieldy. Despite being nominally PHC components, these programmes tend to develop a life of their own and reproduce many of the problems of the vertical campaigns that characterised the period before the BHS strategy. Integration of component programmes into a coherent PHC structure is a continuing problem in many countries. This is one symptom of the general

problem that health care programming does not deal adequately with the restructuring of the health sector necessary for PHC and therefore for the success of the health care programmes themselves. Without that restructuring and the concomitant allocation of resources to priority areas, the programmes will remain chronically short of funds - the common situation at present. Health care programming does not relate to a high enough level of decision-making, and does not service the political process with the information and proposals necessary for strategic PHC policy formation; indeed it does not have the planning 'vocabulary' to do so.

Primary health care requires a planning method that has - like social epidemiology - its point of departure in deprived social classes; it can then have 'horizontal' distributional goals built into it as an inherent characteristic. The key task is to restructure the health sector so that resources are channelled preferentially to those with the greatest need, that is, according to the principle of social equity; and the key instrument to achieve this is therefore the control and planning of resource allocation. Resource planning must be the leading planning method for PHC reform in the health sector. For the reasons discussed earlier, it should treat the sector holistically, looking not merely at the primary level itself, but at the higher levels of the government service and at any private medical sub-sector(s) as well.

Starting from the existing inequalities in health care and health status identified through social epidemiological studies, the prime task is to plan their systematic reduction through the differential allocation of resources, particularly by geographical area (notably with an urban/rural breakdown) and by level of care. Strengthening the structures and increasing the resource availability in rural districts create the conditions for the bulk of health care programming to be done on a decentralised basis, by people in contact with the local circumstances. This decentralised 'horizontal' approach also facilitates local intersectoral cooperation, and political and popular involvement. Increasingly national programming can consist of the supervision and coordination of local health care programmes, while the central planning role remains the promotion of social equity through resource allocations.

The resource approach to PHC planning represents a considerable methodological departure from the common practice in developing countries, and even from that of WHO, whose 'Managerial process for national health development' (WHO 1981) - itself derived from the earlier procedure of country health programming - is basically a systematic variant of health care programming and has not yet absorbed the full planning implications of the PHC approach. This subject, as well as how PHC resource planning should articulate with health care programming, has been discussed in detail elsewhere (Segall 1983a); only this brief outline of principle is given here.

6. PRESS FOR INTERNATIONAL ECONOMIC ACTION

The necessity for national actions to alleviate poverty - part of the PHC approach itself - cannot be separated from the need for economic change internationally, especially in this period of recession. Economic recession is not a natural phenomenon (as it is often portrayed), but arises out of a specific economic system and is conditioned by specific economic policies. It is hypocritical for the Western industrialised countries to claim to support the PHC approach in developing countries when, in the context of providing relatively small amounts of health sector aid, amounting from all sources to about 3 per cent of the total health expenditures by developing countries (Preston 1980: 315), their economic policies are wiping out development efforts in many parts of the Third World, with the consequent perpetuation or exacerbation of poverty and ill health.

A vigorous campaign affirming the deterious effects of poverty on health and stating unequivocally how they radically undermine the PHC approach, should be carried into the international fora where the world economy is debated. This campaign should be prosecuted, not merely by the developing countries themselves, but especially by the UN agencies most closely associated with PHC, namely, WHO and UNICEF. The PHC movement should not be allowed to provide a smokescreen for the grave effects of the present economic situation on world health. International agencies should staunchly support the calls for a reordering of the world economy, and for measures to counteract the recession and its effects on the Third World.

SUMMARY AND CONCLUSIONS

All three main elements of the PHC approach - the alleviation of poverty, popular involvement, and health sector reform - are fraught with issues of conflicting social interests, which explain the present slow pace of progress in most countries. The political character of PHC should now be made more explicit to legitimate and support the struggle of PHC protagonists to see official words translated into actual deeds. The year 2000 is approaching fast. Six lines of action are discussed; there will be others.

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WOMEN : BLIND SPOT IN HEALTH POLICY?

by

Padma Prakash

It is a curious fact that almost every national health policy document all but ignores nearly half the population in the country. The ideology, perspective and the programmes in health documents are such that women cease to exist, except that is, as mothers and potential mothers.

This paper attempts to make the following points for discussion:

1. The Alma Ata Declaration fails to reflect any new understanding or awareness of women's health. The Declaration came only three years after the Women's Conference of the International Women's Year and in the Women's Decade and evolved in the atmosphere of the new awareness among developing countries which gave rise to the New International Economic Order. That it does not show any new perspective on women's health, is a serious lapse.

2. The neglect of women's health in policy and programmes is not new. Women's health has always been considered as being synonymous with maternal health. This has in turn served to constrict the concept of maternal health and severely restricted the programmes which have evolved under MCH. While MCH programmes in the conventional format may have served a useful purpose at one time, they have long reached the limits of their effectiveness. Today they are merely a means to an end - population control.

3. This blinkered vision of women's health has had drastic consequences for women's health status. Firstly social, economic and medical factors which influence women's health but are not associated with pregnancy or childbirth have generally received little attention. Secondly, this invisibility of women in health policy automatically introduces a bias into the knowledge base which is reflected in the lack of information about women's health which in turn, appears to support the 'neglect' of women.

In 1975 the World Conference of the International Women's Year made a plea to governments and peoples of the world: to 'recognise the particular health needs of women in all ages and in all situations - the needs of women with many children few or more, those past child bearing age and those before... and further to" and to "introduce

effective measures for the prevention of all forms of discrimination and cruelty against the well-being of women which keep them from participating actively in the political and social development of their community and which violate their human rights"

Quite obviously the International Conference on Primary Health Care at Alma Ata in September 1978 had not heard the plea or if it had the resolution was ignored. Such are the distances in time and space to be bridged in bringing issues of women's health to the attention of the health policy makers!

It was at the women's conference that for probably the first time, a collective and comprehensive analysis of the situation of women all over the world emerged. The Conference recognised and identified their low health status relative to men (in most countries but especially more marked in poor countries) as a crucial factor in determining the disadvantage and discrimination they suffer. Women's low health status, it was acknowledged contributes and perpetuates their exploited and oppressed status. The Alma Ata Declaration nowhere reflects an awareness of this understanding of the roots of women's low social status. The Alma Ata Declaration defined primary health care in the context of the New International Economic Order, which ostensibly was directed at reducing disparities between nation and nation. It considered that while people had the right and duty to participate in the planning and implementation of their health care, governments had a responsibility towards providing health care.

Primary health care, according to the Declaration, must evolve from local socio-economic and political characteristics and endeavour to address the major problems of the community. It should include, as a minimum, at the least these components - health education, nutrition and food supply, water and sanitation maternal and child health including family planning, immunisation etc., and was to involve related sectors such as agriculture, industry, education communication etc. Primary health care required and promoted maximum "community and individual self reliance and participation in the planning and implementation of health care at all levels".

Quite clearly, the Declaration envisages health as the primary responsibility of the individual, with the government, given that it has the 'political will', providing the infrastructure to make it possible

for the individual to achieve this self-reliance in health care. That is, it assumes that individuals are in fact, in a position to exercise their rights to health care. Further there is no recognition of the social disabilities that women suffer from, - those disabilities which had been much-discussed in another international forum just three years before.

The Declaration is after all, a general statement putting forth a certain philosophy and some concepts. The fact that it does not reflect nor even acknowledgesa specific concern for women's health, especially when these issues were being debated on international fora during that period, is a serious criticism. This lack of a perspective concerning women's health has grave consequences because the problem is not identified and stated no solutions are sought. In other words, since women's health, other than what is termed maternal health, is not defined as a problem, there can be no question of incorporating special component in primary health care to resolve the problems of women's health.

This neglect of women's health in health policy is not new - at no time have women as individuals other than as reproductive beings, been of interest or consequence. So much so that it is unquestioningly taken for granted that anything to be said on women will automatically be put under maternal and child health. Why has this been the case? Why has MCH become the only programme which caters to women's health and what have been the consequences of this tunnel vision?

One of the more arguments put forward is that maternal deaths comprise a large, even a major proportion of the mortality among women. Reducing maternal mortality would automatically reduce female deaths. Moreover, morbidity associated with pregnancy and childbirth is the main cause of women's persistent ill health. Therefore policies directed at reducing maternal morbidity and at bringing down the fertility of women would improve women's health. These arguments need to be examined in the context of health programmes before and after the Alma Ata Declaration. In India maternal and child health has been an early concern - the first systematic attempt to do something in the area dates back to the late nineteenth century. Much later the first two documents which provided the basis for a health care system in independent India were the National Health Committee Report and the Bhore Report.

The Bhore Committee report published in 1946, a pioneering document in the health field, treats women's health issues almost entirely under a chapter 'Health

services for mothers and children'. The report aimed not merely at safeguarding maternity, but at providing adequate health protection to all women so that "the function of motherhood is undertaken under optimum conditions of health". Influenced no doubt by events at home and abroad, it strongly recommended the setting up of creches and introducing provisions of maternity benefits for working women. It even suggested that an adequate number of women doctors be inducted into the proposed industrial health services. It suggested the supply of 'home help' for expectant and lactating non-working mothers! The main emphasis was therefore, on protecting women's health in the workplace and the family so that they could adequately perform the socially accepted and dual role of both reproducing and sustaining the family as well as contribute towards production. All programmes were evolved towards this end. The maternity and child welfare centre was to play a crucial role in 'national reconstruction'.

The National Committee report reiterated these main aims and objectives of the Bhore Committee and was critical of the 'largely ineffective course' so far pursued in relation to maternal and child health. It particularly drew attention of a'charging India to consider motherhood as high and vital a function at least as (and ofcourse really much higher than) ruling the country or teaching or building or inventing'.

The report looked at several estimates of maternal mortality and concluded that the commonest causes are puerperal sepsis, anaemia, eclampsia and other tocaemias. Two other conclusions are also drawn from these estimates that anemia as a cause of maternal mortality is practically non-existent in England and Wales and that in Calcutta and presumably other big cities the other causes are practically the same as in England and Wales. Keeping in mind the fact that this latter situation may not obtain in the rural areas, the report concludes that "the real abnormal factor in our maternal death rate is the prevalence of anaemia'.

It was argued that the protection of motherhood and childhood was important because it was so vital to the 'economic and social reconstruction' being envisaged. It was with this same purpose in view that birth control was to be promoted as part of the 'protection of motherhood' 'children are born not as a creative evolutionary response to the vital urge, but as brittle standardised products of a tired reproductive machinery automatically set in motion by the sexual act. The reproductive system has to be kept fresh and vitalised to respond creatively and must not therefore be subjected to that strain'.

Thus, maternal health was a concern and component of health policy and programmes because it affected the health of children, - the health of a new generation who were to carry out the tasks of social reconstruction. This was the 'primary place of this (maternal and child welfare) work in Indian reconstruction'.

There is obviously no gainsaying the fact that maternal mortality was one of the major, if not the 'greatest single cause' of female mortality in the country.

Therefore, it would be quite logical to view the reduction of the high maternal mortality rates as a high-priority programme within a health policy which is aimed at improving the health status of women and increasing their expectation of life. Such a policy would recognise socio-political disadvantages that women suffer. It would also recognise the fact that maternal ill health and mortality is rooted in the ill-health and neglect of women throughout their life and met only at the point of maternity; and it would accept that the mere provision of health facilities without special measures to ensure that these programmes reach women, makes little impact on women.

Nowhere is there any evidence of this perspective in the early health documents which set the tone of health policy in the country. In the circumstances, maternal health programmes were bound to have at best, a limited impact. Even more importantly these documents set a certain precedent about what constituted health policy and they defined the components of all future health programmes, and demarcated the limits of these components. And in the process, they made women invisible to health planners except in the role of mothers and potential mothers. In other words health policies were designed to enable women to play their socially structured primary role in society within the predefined limits. If the structure and nature of maternal and child health programmes have undergone change or if its relative importance within health programmes has varied it is because these limits have been changed or redefined.

Thus, while promoting birth control measures was only a minor component of MCH programmes when it was directed towards protecting the reproductive health of mothers so that they may produce healthy children, it became a major component when the limiting of births began to be viewed as main objectives. In neither case was the health for women a priority concern.

Women have continued to be invisible in health policy even in more recent times. None of the plans and policies have reflected an awareness of the real problems in addressing the problems of women's health. Even in those documents which re-ordered health care priorities such as, for instance, the Shrivastav Committee Report, while maternal and child health continues to be one of the high priority areas, it continues to be viewed in the same conventional narrow point of view. The stereotype of woman the mother dominates and is reinforced constantly. For instance, the 1977 plan for health care Services in Rural Areas which lay great stress on the centrality of family and community welfare to the developmental process states: 'Indian mothers, like mothers elsewhere, are selfless and ready to sacrifice anything for the welfare of their family'. In other words, the image of woman as mother is not only consecrated but her sacrifices for the welfare of her family applauded. And what is the nature of her sacrifices? It hardly needs to be enumerated - that she go hungry so as to be able to feed her children and menfolk of the family; that she work long hard hours to make ends meet and to nurture the family; that she bear child after child or accept the high levels of morbidity associated with every available method of family planning in the context of current health care system; that she forgo much-needed medical care because her sons or her husband needs it more; that she be abused, beaten, bruised and burnt alive... all for the sake of her family. How can we ever hope that health policy will pay attention to women's health issues when it accepts implicitly and explicitly, without question and as unchanging, the very conditions which make for women's low social and health status?

It is necessary here to add that the above statement, in the 1977 health policy is, not, and cannot be, taken in isolation. It has to be seen in the context of the priorities, programmes and the general perspective of the entire policy. The characteristic neglect of women is quite clear in the very programmes which were formulated. Unfortunately, not only have health policies disregarded women's health issues, but most of us who have looked at health, these policies have also tended to overlook the significance of this state of affairs.

Curiously enough it was in the post Alma Ata health document the ICSSR-ICMR Report that we find for the first time a recognition of the real situation of women's ill health. The document noted the falling health ratio and enumerated some of the reasons - the greater mortality among women, the fact that women are more vulnerable to disease because of their nutritional status and yet, availed of health services much less than men. It also recognised that 'the public health services have reflected social attitudes in regarding all women primarily as mothers or potential mothers'. Unfortunately this recognition of the real situation regarding women's health was not reflected in the programmes suggested, which continued to be in the conventional MCH format.

That this new awareness was an aberration of sorts is clear from the fact that neither the Sixth Plan nor the Report of the Working Group on Health for All by 2000 AD accorded it even a passing mention. The Sixth Plan while echoing many of the recommendations of the ICSSR-ICMR document chose to emphasise those suggestions which had been formulated in a milder form in that document - MCH programmes as a means to an end i.e. population control. And the Working Group completed the turnabout that the Sixth Plan had begun after the ICSSR-ICMR report and health policy was back on old track. However, coming as it did when the women's movement in the country had already made its presence felt, it recommended, rather blandly state aid for the setting up of women's groups which could then be utilised for health and family welfare 'education'. Comically enough, it laments the importance of the mother for promotion of health within the family and through the family to the community has <u>not</u> received due recognition!

Consequences for Women's Health

Let us examine the basis for the assumption that maternal health is the single most important factor in determining the status of women's health. Maternal mortality, it is said, make up the major proportion of female mortality. How valid is this argument? Maternal mortality certainly does account for a large proportion of the deaths among women approximately 13 percent and 9.4 percent in the reproductive age groups 15-24 and 25-44 respectively. But it is not the major killer; infective and parasitic diseases and accidents violence and poisoning account for 47 percent and 42 percent of all deaths in the two age groups. About 30 percent of all women who die are in the reproductive age groups; about 26 percent of all men who die are also in this age group. (Table 1).

Table 1

Percent distribution of deaths by sex for selected causes to total deaths in each age group (1979)

Cause	Sex	Age in years 15-24	25-44
I Infective Parasitic diseases	M	28.16	30.55
	F	23.11	27.70
XI Complications of child births pregnancy and puerperium	M	-	-
	F	13.15	9.38
XVII Accidents Poisening and violence	M	25.18	16.94
	F	23.87	14.03
All cases		100	100

Source: Health Statistics of India, 1984

Even if we accept that maternal mortality is caused by specific easily identifiable and preventable factors and must therefore, be the major target of health programmes for women, what are these causes? For the last 40 years they have remained the same - toxaemias, peurperal sepsis, haemmorrhage and anaemia and these have been the years when MCH programmes have functioned. Undoubtedly maternal mortality rates have come down, peurperal sepsis is no longer as much a risk of childbirth as it used to be. But anaemia and toxaemia continue to be two primary causes of maternal deaths. And both these are rooted in health conditions which are beyond the purview of the conventional MCH programmes. Slapdash measures at the point of pregnancy have not worked. It is thus more than likely that the limits of what may be achieved by the conventional MCH approach even in the limited sphere of maternal mortality has been reached. Moreover, there is some indication that not all deaths which are recorded as being due to maternal causes are in fact so. In a recent paper Karkal (11) has quoted a study of postmortem investigations of 175 maternal deaths with clinical diagnosis. They found that although cause of death was assigned as haemorrhage toxaemia etc., at postmortem several other conditions which had probably got aggravated during pregnancy and may well have caused death were discovered.

Maternal and child health programmes today have become reduced to being mere channels for family planning work, a means of reaching women. And in fact, in the process they may be instrumental in producing additional morbidity among women.

In the last decade, ironically enough after the Alma Ata Declaration, the entire family planning effort has been directed at women. All the research in family planning being conducted is on long acting hormonal contraceptives for women. Every one of the methods being offered is associated with problems. This morbidity among women is often unrecorded unless it leads to death. And again because women have so little access to health care facilities because of various socio-economic reasons even a minor health problem can become life threatening.

In fact many of the complications arising out of the use of contraceptives aggravate the very conditions which MCH programmes are ostensibly designed to eradicate. For instance, it is well known that IUDs cause blood loss ranging from 35 percent to 146 percent and even in developed countries it is has been shown that the prevalence of anaemia increases by 3 to 16 percent. Although hormonal contraceptives are supposed to decrease blood loss, it is also known that they reduce the absorption of Vitamin B12 and folic acid. Moreover HCs are associated with a higher risk of pelvic inflammatory disease which if does not lead to sterility, may well contribute to problems of pregnancy and childbirth.

Although much has been written about the increased mortality risk for a woman with every additional birth, the fact that "a large share of maternal mortality experienced in the third world relates to wanted births (2) has often escaped attention. As the NJPH Editorial cited above, points out "Provision of contraceptives services will have little impact on the mortality risks of women whose pregnancies are wanted".

Ironically family planning activities have been introduced as components of MCH programmes gradually, but quite deliberately the ICSSR-ICMR document, in fact quite emphatically and clearly sets out to define the FP component of MCH programmes and the need to involve women. Later documents are even more conscious of this aspect.

Quite apart from the FP component, the fact that MCH programmes are badly designed and badly implemented is too well known to need elaboration. After so many years of MCH programmes, only about half the pregnant women receive antenatal care. Thus MCH programmes in their conventional format have reached the limits of what they can achieve. Improving the efficiency of these programmes is hardly likely to yield better results - what is required is a rethinking on the entire concept of MCH vis a vis other health programmes.

This neglect of women other than as mothers in health care programmes has led to a non-recognition of other causes of female morbidity and mortality. As seen in the table, a large proportion of women in the 'reproductive' age groups die because of parasitic diseases and due to or in violent circumstances. These causes also account for a large proportion of male mortality in these age groups as well. It is ofcourse a telling comment that even after so many years of the implementation of the Primary Health Care concepts these diseases continue to take such a toll of human life. It may also be conceded for the time being that comprehensive measures may reduce both male and female mortality (we have to keep in mind however, that women are socially disadvantaged and that whatever are the measures provided they will be benefited to a lesser degree than men).

The situation is however different in the case of deaths due to (accidents, poisoning etc. The so-called accidents due to which women die, we know now are hardly 'accidents' - they are deliberate acts of violence on women, variously termed as 'dowry deaths', wife battering etc. Karkal points out that deaths due to burns constitutes the single largest cause of death among women in this category in rural Maharashtra. The health system has no way of even classifying these deaths which is itself indication that for the 'health people' - be they doctors, statiscians, or policy makers, such causes simply do not exist.

This invisibility of women in health policy has also had consequences for the nature of information which is collected, and in the manner in which such data are analysed. Only recently has processed health information, say for instance morbidity statistics, been presented sex-wise. And

even now, there are crucial gaps. The very manner of data collection therefore, is biased against women, by simply not recording vital information since there is no place for such data in the records. This lack of documented information is in turn used to suggest that the problem does not exist!

Quite clearly, if women's health is at all a priority then women have to be reintroduced into health policy and health care programmes.

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DISCUSSION

The first session critically evaluated the HEALTH FOR ALL strategy in terms of its significant breakthroughs and major limitations. Presenting an overview of the four background papers, Dr. Dhruv Mankad of Medico Friend Circle, reiterated that the main contribution of the Alma Ata Declaration lay in its comprehensive perspective and focus on the socio-economic and political determinants of health. Third World poverty and the widespread mortality and morbidity resulting from preventible enviromental factors, were the historical context for the new emphasis on non-health factors. However, the strategy needed to be critically examined in order to identify and transcend the hidden lacunae and inconsistencies. Various terms used in the recommendations such as political will, self-care, self reliance, technology transfer and the new international economic order, required to be defined and assessed for their real meanings. Did the recommendations truely address the needs of the poor masses, or did they reproduce the ideological and political perspective of the dominant classes of today's world?

The presentation concluded by highlighting areas for further research that had not been covered by the papers. While class inequalities in health and in the utilisation of health care services had been discussed, there was little data regarding other forms of discrimination and inequalities. The limitations of the strategy in dealing with women's health was the theme of the paper by Padma Prakash. However, there were no studies in India on racial discrimination on the lines of the Black Report from UK, and except for a few micro studies on Muslim women, there were no studies on inequalities based on community, nor caste or nationality.

Key Role Of Non-Health Factors:

Initiating the discussion, Dr. D. Banerji questioned the commitment of the Indian HFA strategy to its own wider perspective. How far was the Indian health policy attempting to subordinate medical technology and socio-economic planning to the needs of the Indian people? The WHO's recommendations had a progressive content, in part the result of popular and democratic pressures, which however, were unlikely to be translated into people-oriented programmes by the ruling classes. The pace setters for any fundamental change were the people themselves. In this context, it was necessary for concerned health workers to empower the people with managerial, technological, epidemiological and socio cultural skills for a more effective assertion of their demands.

Dr. Deodhar pointed out that HFA referred to a strategy for promoting the level of health of the people, and therefore had as its focus the environmental, nutritional and educational determinants of health. This required a throughgoing epidimeological approach, and data, to identify the promotive and preventive factors underlying the health of the people. Instead, at the level of implementation, HFA was being wrongly equated with medical services. According to him, there were two major factors contributing to ill health in the Indian context. The most important was the chronic, long standing deprivation of large sections of the Indian people, often clubbed into an economic concept like poverty, which was sought to be projected as medical deprivation. The second factor was the very inadequate outreach and coverage of the health services themselves.

Dr. A.R. Desai, elaborating on Dr. Deodhar's point, raised the question whether economic planning in India,

including its underlying assumptions and pattern of resource allocations, was at all conducive to making health services a minor factor in the HFA strategy? Responding to Dr. Banerji's observation, he wondered whether the ruling classes were actually broadening the welfare base and that too, under pressure from the people. The emerging socio-economic order in the Third World was in no way conducive to 'HFA', and even progressive health delivery systems in the advanced market economies, such as UK's National Health Scheme, were under attack. A progressive strategy in such a context merely provided a few crumbs to the people as a means to co-opting and suppressing their participation.

Ravi Duggal also took up Dr. Banerji's observation. In his view, there were socio-economic reasons for formulating progressive policies. Firstly, increased welfarism in capitalist and backward capitalist countries was a method of managing the crisis of capitalism and the social conflicts arising out of it. Secondly, any progressive shifts in resource allocations, such as the priority given to the rural sector in the Sixth Plan, had to be seen in the context of expanding rural markets and the saturation of the urban market. Finally, many radical policies were first advocated by peoples organisations and were later taken over by the government. For instance, in the late 70's Medico Friend Circle had talked about child survival. Today, it was a Government programme advocating massive immunization campaigns. However, the question that needed to be asked was, in what fashion was the government taking up these issues, and how did its approach differ from that advocated by the people's organisations.

Dr. Ashish Bose felt it was not practicable to do a post-morten of the genesis of the WHO's Declaration. Quoting the central premise of the HFA strategy from Drs. Antia and

Awasthi's paper, namely that it was a radical policy based on social equity and the total re-orientation of the health care system, he posed the question "How do we convert this beautiful slogan into a reality?" There was no need to point out China's achievements as there were several local experiments in primary health care such as the Madwa project. More discussion was required regarding their replicability and usefulness as models for re-orienting the medical services.

Dr. Banoo Coyaji, referring to the papers by Navarro and Seagall, asked whether the aim of the seminar was to question the HFA strategy itself. She also questioned Dr. Banerji's view that pressure from below was responsible for progressive changes, such as the shift in budgetry priorities in the 6th and 7th Plans. In her experience food, water, money and jobs, and not health, were the priority areas for the people. She asked, 'Do you really think that people are interested in health?"

Dr. P.B. Desai agreed with the point made by all the papers that HFA was a political issue. He pleaded however, that it was necessary to use the verbal committments made by the Government to concepts such as 'people's participation', 'decentralisation' etc., to rouse the people and presurise the Government towards greater democratisation.

Padma Prakash felt that analysing the roots and the evolution of policies was not an intellectual exercise alone. The changes in health policy were determined by tensions between people's demands on the one hand, and the needs of the ruling class on the other. Every new policy reflected certain dominant ideas and positions. In order to identify other points of view emerging from people's pressure, it was necessary to understand the context in which a policy evolved, as

well as its dominant features. The aim should be to extend the policy so that it expressed the needs of the people.

Dr. Saroj Jha raised the issue that while the primary health care strategy enunciated by the WHO appeared to be sound, the entire emphasis from the WHO down to the implementing governments and some NGO's was on doctor centred programmes. The entire composition of the WHO was one of medical personnel, including its regional representatives. The traditional medical sciences did not equip doctors to deliver primary care with its three components of inter-sectoral co-ordination, appropriate technologies and community participation.

Dr. Haran felt that it was no point blaming either WHO or the doner agencies. The latter had their own priorities. The problem was one of Government policy, its implementation and the management of health services.

According to Dr. Dhruv Mankad, the strategy had to be viewed in terms of two aspects. The first aspect was the underlying assumptions of the strategy. 'Health for all by 2000 AD' was not an empty slogan, but a concept which projected a particular view of health to be achieved within a certain time-span. The time-span had its own dynamics which affected the concept itself. Such underlying assumptions had to be questioned, and to do this the evolution of the concept needed to be understood. The second aspect referred to the implementation of the concept, i.e. to the existing reality. The issue of implementation included the nature of administrative controls and health programmes, and the constraints-resources perspective and political - under which the HFA strategy had to operate in India. Pointing to the primary importance given to non-medical factors for the first time in health policy, Dr. Mankad focused on the example of nutrition.

Nutrition, or the availability of food, was a question of wages for most Indians, but in the implementation of HFA there was no mention of increasing wages, implementing minimum wages or land reforms. Apart from the other implementational problems, this aspect had to be discussed in greater detail.

Dr. Uma Ladiwala pointed out to Dr. Coyaji that for the rural population ill-health was the priority since it affected their capacity to work and earn a living. However, the relation of prevention to illness and health was not clear to them, and therefore, only in a limited way health became an important need.

Dr. Ramesh Awasthi made a distinction between the targets, and the spirit and content of the HFA strategy. While the targets could be achieved within the system, the spirit of HFA was nothing less than revolutionary, and would not be implemented. His plea however, was that a socially progressive legislation should be used to build people's pressure towards releasing forces of change.

Dr. Sujit Das found it difficult to accept the view that, without first analysing the genesis or purpose of committments made by the Government, these should be used to build people's pressure. There were definite committments from the Government of India outlined in the Directive Principles of State Policy embodied in the Constitution, but little had come out of them. Turning to the methodology of building people's pressure, Dr. Das asked whether it was as concrete and atraightforward as putting up a banner with a list of demands, or were there other social demands and actions which mediated people's health needs? For instance, in demanding money, food, water, etc. the people were actually asking for the determinants of health. People had always been struggling for a

better standard of living, a basic determinant of health, and for more and better health care. The state and the ruling classes in present-day society, as against feudal society, had to respond to the people's demands, but in a manner that would ensure the latter's continued exploitation. Hence, every health policy, state health care system and other welfare measures that had emerged from such contradictory or contending forces, had to be approached very carefully.

Dr. N.H.Antia felt that the WHO, like every other group in society, began with good intentions but had, inevitably, developed vested interests inimical to its social and global goals. For instance, the majority of WHO's recommendations and financial aid was concentrated on high technology, even though it was conscious that the solution lay in more social science inputs. Today, it was more of a 'Western Health Organisation' dominated by the western countries that funded it. A more serious problem was that senior administrators, interested in lucrative jobs with international agencies, were more interested in following the recommendations of bodies like the WHO than being guided by the needs of their country. The Government had accepted the HFA Declaration as it provided them an excellent, high-profile slogan. The slogan was used a potent tool for keeping people in a perpetual state of expectancy and dependency. It was being misused to inform the people about only some aspects of the HFA strategy and keeping them ignorant about other features. The health and education infrastructures were being highlighted for their vote catching potential, but not the services and inputs needed to eradicate illitracy, or raise the health status of the people. Even the ICSSR/ICMR Report which had been accepted by the Government, was not being implemented in its true spirit. The money earmarked for primary health care was benefiting the professionals, the bureacracy and the village level politicians.

Therefore, the question was, what was to be done with the HFA slogan? The people were not questioning the slogan and even most doctors were not aware of the HFA strategy. Dr. Antia felt that the most substantial contribution that professionals could make would be to popularise the strategy and inform the people about all aspects of HFA, the health infrastructure and facilities available for them, as also their health rights.

Dr. Coyaji felt that the increased allocations to rural areas in the 6th and 7th Plans indicated a definite shift in the pattern of Government planning. In her view the most important problem before the seminar was the lack of implementation of the ICSSR/ICMR report.

According to Dr. Jessani, a more clear-cut perspective on the relationship between the Government and the people was required. If the participants believed that the government was representative of the people's will and genuinely interested in solving their problems, then it was possible to talk of utilising the government's progressive commitments. On the other hand, if it was felt that the government, with all the resources and administrative apparatus at its command, had failed the people, then utilising the strategy would not achieve anything. The relationship between the people and state-power, ie. the government, had to be changed and for that the people had to be organised. It was necessary to concentrate on the people, address their needs and develop their consciousness, instead of merely attempting to pressurise the Government to make some concessions and cosmetic changes.

Dr. Mankad pointed out that although the Alma Ata Declaration spoke of the rights and duty of the people to plan and implement health care, yet its recommendations were all

directed at the participant governments. People's participation being viewed only for achieving targets for government programmes. The two major limitations with the concept of 'people's participation' were firstly, that it did not specify the organisations which represented the people's interests and secondly, that it did not define who the 'people' were. Did 'the people' refer to a homogenous entity, or to groups and classes with fundamentally conflicting interests? And by 'people's participation' did the strategy mean the participation of the oppressed and exploited groups Dr. Mankad felt that the solution did not lie in making more recommendations to the government and bureacracy alone; very small beginnings had been made through trade union activities, wage struggles of underpaid workers, women's protest against the sex determination tests etc., to build people's consciousness about health issues. In this process some elements of the strategy could be utilised for revolutionary purposes, although the Alma Ata document itself was hardly revolutionary.

Dr. P.B. Desai pointed out that at the core of the HFA slogan lay the political issue of mobilising the people for whatever they themselves could do. He asked whether the participants were prepared to take a political approach and mobilise the people. If, however, the participants and other concerned intellectuals could not fight to change the power structure, then what were the alternative ways by which the people could be approached?

According to Dr. Sanjiv Kulkarni, the discussion had identified 3 sets of actors in the HFA strategy. The first was the state and the WHO; the second were the people and the third were the professionals and intellectuals such as the participants themselves. He felt that as long as the participants continued to view themselves as a separate group from the

people, the latter would not achieve a correct perception of people's problems, nor evolve correct stands and solutions.

Dr. G.G. Parikh did not think that the participants and other professionals could appropriate the right to represent the people. They were, in fact, a part of the ruling class, and consequently with the government. He differentiated between the HFA slogan and the strategy. The latter was truely revolutionary in spirit and could not be achieved within the present framework of capitalist economic policies of the Government. Only the targets could be achieved through certain techno-managerial inputs. Within this framework, the only option for professionals was to identify those parameters of the strategy that could be implemented, and attempt to implement them outside the government. In this way, the people might get motivated and pressure from below would be generated. However, these actions and solutions had to be based on people's needs and not on intellectual considerations.

Dr. Deodhar, addressing the question raised by Dr. Sujit Das as to what was hidden in a slogan, pointed out the need to clarify the term 'Health for All'. Health, according to him, really meant 'health facilities', and the implication of the slogan was to give health facilities to all those who did not have them. Accordingly, two areas for further action emerged. Firstly, beyond doctors, primary health centres, health guides and multi-purpose workers, what were the health facilities that people required and wanted? Secondly, was people's participation possible when they lacked basic facilities? Organising the people and developing their abilities in conditions of deprivation required a long educational process. However, the burden of providing health for all was on health services, and certain specific questions had to be raised about the history of health services in India. At Independ-

ence, the objective adopted was to provide comprehensive medical care to the people. It was assumed that the satisfactory provision of curative services would give people the confidence to follow up preventive and promotive services. Instead, in the past 20 years such shabby curative services had been provided, that the people had turned away from public health care. All public health centres and sub-centres remained poorly utilised. One solution was perhaps to separate public health services from medical services. For instance, family welfare services had nothing to do with health, ie. the prevention programme. In this way, some change could be effected in the outlook and approach of doctors and the medical profession.

SESSION II

SCOPE AND PROBLEMS IN IMPLEMENTING THE STRATEGY IN INDIA

With focus on:

*Social structure and functioning of health care services in India.

*A review of India's efforts in the delivery of Primary Health Care: From Bhore committee to Health For All.

*Internal and international factors responsible for India's acceptance of Health For All strategy.

*Health Policy determinants in India.

*Gaps and constraints in health planning in India.

*Existing system and status of curative services, drugs & pharmaceuticals, preventive services and population control programmes - and what changes are needed.

INDIAN STATE PURSUING CAPITALIST PATH OF DEVELOPMENT : MAIN OBSTACLE TO HEALTH FOR ALL

A.R. Desai

1. I deem it a privilege to participate in the Seminar on "Health for All : Concept and Reality", organised by the Foundation for Research in Community Health.

I am no specialist either in Medico-health problems as a medical practitioner, or as an activist devoted exclusively as a medico-social worker. I am a student attempting to understand the socio-economic transformation that is taking place in the country since independence. I am studying the transformation that is being brought about actively by the State, which emerged after independence and has adopted a path of Development which is now clearly realized as Capitalist Path of Development. I am attempting to grasp the impact of various measures, economic, political, social, cultural, educational and health, on various classes, strata, groups in Indian society, particularly on the conditions of toiling strata who constitute the overwhelming majority of Indian Society.

In a country, which contained the world's second largest population and where overwhelming majority of people were rotting under absolute and not relative poverty, illiteracy, unemployment, underemployment, malnutrition, verging on starvation and semi-starvation for many and lack of elementary, but basic requirements for health and dignified existence like food, shelter, water, unpolluted environment, sanitary conditions, and almost near absence of disease preventing and disease causing health care services for majority of Indian people during British period, I am struggling to grasp the impact of State measures in eliminating these conditions during last forty years on the basis of the capitalist path of Development pursued by the Rulers.

I have attempted to analyse economic, political, social, class and caste stratification and other aspect of the impact of State policies in a number of my studies, which are already available and hence I will not elaborate on the same here.

2. As a part of my larger study of the impact of the State policies, I have been trying to understand the impact of the Government measures on the "Health Situation" of various strata and classes of the Indian people.

Considerable amount of studies of highly sophisticated nature as well as survey type researches of Health Care System are now available. Starting with Bhore Committee Report (if we do not take into account the National Planning Committee Report framed by Indian National Congress prior to independence) to a series of Reports by special commission and committees including the Alma Ata-Declaration and the Indian State which became a signatory to implement the programmes suggested in that Declaration, a massive literature has emerged examining the achievements, limitations and basic flaws still prevailant in the policies pursued by the Government during last forty years as well as suggestions to rectify the situation emerging out of the policies pursued upto now.

The Government, during its various five year plans, have made many changes in their health care programmes and health care system and administration. The Government has also clearly defined various categories to be included for financing what is described as Health Care system.

These categories as formulated in Five Year Plan allocation comprize of following:

1) P.H.C. & Rural Health (Hospitals and dispensaries), 2) Control of communicable diseases, 3) Education, training and research. 4) IMS (Indegenous Medical System), 5) Other. These five categories directly dealt with health care practices for curing diseases and are described as Health Programmes and 6) Water supply and sanitation 7) Family Planning as category though important has been considered as indirectly concerned with health care and diseases. Information about allocation of funds for health plan outlays are available in Five years Plan documents. Even data about the amount of resources allocated including priorities of allocation and percentage of allocation to the total plan allocations are also available.

3. The achievements and limitations of the State policies and programmes launched by the government are now analysed fairly extensively by numerous studies conducted by various agencies, including academic institutions and researchers belonging to Research Institutes or Sensitive doctors, social workers and social scientists. The participants in this Seminar, are well acquainted with the achievements and limitations of Health Care policies pursued by the Government of India during last three and half decades. The publication "Health Care for all - an Alternative strategy" a report of the study group set up jointly by Indian Council of Social Science Research and the Indian Council of Medical Research, and a small pamphlet "Health Care in India", a CSA publication authored by George Joseph, John Descrochers and Mariamma Kalathil, sum up the entire situation of the "Health Care in India during post independence period.

4. I will avoid inflicting massive data and findings on different aspects of Health situation in India as well as the nature of health care institutional structure that has been evolving in the country. I will briefly present the over all assessment as indicated by various studies.

The "Health for All" Report while surveying the present health situation, makes following alarming observations.

"The current morbidity and mortality picture shows one major variation from the past. Famines no longer take the toll they used to; smallpox has been eradicated; cholera and malaria have been curbed; and immunization has protected children from dangerous childhood disease like smallpox, whooping cough, diphtheria, tetanus and polio. But, in other respects, the overall character of morbidity has not changed much. Diseases arising from poverty, ignorance, malnutrition, bad sanitation, lack of safe water supply, drainage or adequate housing, and low levels of immunity are still the most common. These include tuberculosis, gastroenteritis, malaria, leprosy, filariasis, etc. (which rarely occur in the developed nations) and measles, tetanus, whooping cough, bronchitis and pneumonia, scabies, worms and fevers (specially among children). It appears that although the average Indian may now live longer, his morbidity is only marginally less than that of his forefathers and he continues to be largely prone to the same diseases as they were. While children are being saved from death, the problem of the surviving children with severe physical and mental retardation is one of considerable magnitude."

5. I need not provide the statistical details about the massive prevailence of the diseases, arising from poverty, ignorance, malnutrition, bad sanitation, lack of safe water supply, drainage or adequate, housing and low levels of immunity. They are given in various studies conducted upto now as well as in the information provided by Government documents. I will only sum up the situation as it prevails today in the words of the Report "Health for All" submitted by the above mentioned study groups.

1. "In both morbidity and mortality, there are larger variation from State to State, and even within State there may be variation".

2. "The differences between urban and rural areas are also very large, and on the whole, the health situation in rural areas is more dismal."

3. "What is even more important, there is a marked difference, in health status (which is found to be closely corelated with class, caste, income) between the upper and the middle classes on the one hand and the vast bulk of poor on the other. Among the latter, frequent illness and untimely death is still the lot of the average individual, and among at least some sections of the poor, there is reason to believe that morbidity has increased rather than decreased."

Before I raise some crucial issues arising out of this situation, in the context of the capitalist path of development pursued by the Indian State, I would like to draw your attention to the assessment of features of the existing model of Health Care system as it has evolved after independence.

(i) The present Health Care system is:urban biased, top-down and elite oriented, inspite of considerable expansion of the primary health centres since independence.

(ii) Bulk of the expenditure on the Health services is still incurred in urban centres, their benefits are still largely skewed in favour of the upper and middle classes.

(iii) Inspite of all the talks about programmes of improving environmental sanitation, and immunization against communicable

diseases, during the last thirty five years, and some development of promotive and preventive programmes, the basic thrust and bias of financial allocation is towards providing of curative services i.e. establishment of hospitals and dispensaries and training of doctors, nurses and other personnel needed for them.

(iv) The system is essentially based on urban based hospitals, and consume substantial proportion of funds available. The nature of a typical hospital as a large complex offering multiple services and many specialities and vast amounts for maintenance of its facilities and staff and operating as a very expensive, inefficiency providing primary health centre for the population in periphery is now highlighted by many studies.

(v) The system based on urban based hospital model has become highly centralized and bureaucratized, unable to handle the problem of distance or organize good referral services.

(vi) The Hospital based system is highly dependent on doctors, not educated by the right kind of training and mostly unwilling to reach out to poor in urban areas or unwilling to go to rural areas. The system is highly medicalized resulting in cultural alienation of medical profession, and oversophistication and mystification of these professionals. Over medicalization, has lead to heavy reliance on drugs, injections and many a times unnecessary and costly technical diagnostic instruments and practices.

(vii) Emphasis on curative health services at the cost of more important promotive, preventive and simple curative aspects of community health, has resulted in the over production of drugs, production of large varieties of unnecessary, harmful or even dangerously defective and fraudulent drugs. This creates a vast network of vested interest comprizing of drug-industries, doctors, traders and vendors in drugs and other medical commodities.

(viii) This phenomenon has created a situation wherein the drug industry and doctors have become not the curer of diseases, but agents interested in continuance or expansion of ill health.

According to the Report Health care for all, "It is not generally recognized that we are dangerously close to the explosive point."

(ix) The basic feature of the Health care system is that in this system there is no involvement of the community.

(x) Our health care system is comprized of private sector, quasi-public sector and public sector - operating in the very limited context, as indicated earlier, of sickness-care, super-specialized professionals and drug-injection-and other medical technology.

(a) In this mix, the private sector constitute the largest sector responsible for nearly three-quarter of all medical care whether rural or urban. The private sector health care system is mostly manned by doctors, operating individually by providing medical services essentially for maximising earning and selling their skills as a commodity to client patients or by giving their services on certain consideration for private hospitals, or health care agencies. They are mostly trained at government expenses. The training of the medical students, at public expense is focused on private practice of curative medicine. It is hardly appropriate for preventive approach. Rather, it immunizes these professionals from training as promoters or practitioners of preventive illnesses. The private sector medicare system, comprized of doctors, hospitals, dispensaries, diagnostic clinics, nursing homes and its ancillaries i.e. pharmaceutical and instrumentation industries works on the principle of capitalist norms of market, supply and demand in our country. It is thus infested with the same vices as other business, with all the implications of black, open, rationed, corrupt and polluted, market operations. Medicare in a market matrix is also generating sub-standard, dangerous, harmful and fraudulent commodities in the form of services and medicines. Systematic information about the extent and operation of the private sector, the major sector of medicare system is still clouded in mystery like the other businesses in the country.

(b) The quasi-public sector comprized of services in the form of ESIS schemes or dispensaries and hospitals run by industries, is very small and caters to a

limited number of employees of public and private sector industries and enterprizes. Studies of functioning of these quasi-public sector, do not provide a rosy picture of their operations and reveal the same undesirable features that prevail in private sector health care services.

The systematic information about the extent, functioning and finances of this sector of medicare system is not available.

(c) The public sector of health services is relatively more documented giving information (however incomplete) about manpower employed, expenditure incured and about the targets and achievements in terms of various categories of health services provided as well as in terms of health indicators.

The public sector, in health care system, is supposed to be operating on a slightly different principle than the private sector. It is claimed to aim at providing health services to all who need it but cannot afford it in the market. It is also supposed to undertake preventive measures to ensure certain basic services to control communicable diseases as well as create certain infrastructure for healthy living in the form of proper sanitory and other facilities.

The studies of the functioning of the public sector, health service system, however reveal some very grave alarming deformaties.

(a) Major portion of its budget is allocated to high technology instruments, and medicines and in running expensive medical colleges and public hospitals.

(b) Out of this budget a sizeable amount is spent on purchasing material from private sector suppliers - national and international, for salaries and honarariums, for maintaining outfit, constructions and other amenities, by purchasing from suppliers of services and goods belonging to private sector.

(c) Manufacturing medical practitioners and their operalized medical adjuncts, who are trained mainly for specialized curative medical treatment, and not for developing and operating preventive care.

(d) The expenses incurred in training these medical personnel is basically utilized to produce medical personnel operating in the private sector.

(e) With regard to the establishment of primary health centres, the expenses incurred are more on building infrastructural facilities and on payments of salaries and wages to the staff trained into curative medicinal approach, rather than for providing infrastructure for preventing services and personnel to manning these services. Nor are they spent on buying appropriate cheap medical services and facilities attempting to provide basic drugs and services.

(f) Even here the studies reveal that the expenses incurred on infrastructural facilities and drugs and other needs only subserve basically private sector suppliers of these commodities and services.

(g) The limited curative facilities do not reach the clients for which they are supposed to be meant.

(h) Allocation of resources on Health care system are extremely meagre compared to the allocation of resources in other fields. This prevents the extension of even this limited primary public health care system to majority of people. They do not even conform to targets laid down by the Government itself, even within the frame work of the skewed provision made by public authorities.

(i) The State has, by its own policy, transformed the public sector health care system and services as an adjunct and active facilitator of private sector health care system. It thus exhibits all the characteristics of private sector with its overall market, pro-rich, pro-profitering, upper and middle class oriented costly commodity character. The state health care public sector, exhibits all the essential features, which other public sector enterprizes and services exhibit in Indian economy and society, whose major functions is to subserve and strengthen basically private sector, and therefore, experiencing the same maladies as suffered by other public sector undertakings.

6. We have described the features of health care system as it has developed in India and so ably analysed by sensitive and concerned medico-health specialists and workers. We have also indicated how these able analysts have pointed out how "Health is a function, not only of medical care but of the overall integrated development of society - cultural, economic, educational and political". The sensitive

activists on health front have also pointed out how "an attempt to eradicate ill-health will not succeed in isolation and that it can be pursued side by side with the other two inter-dependent and mutually supportive objectives of eliminating poverty, inequality, and ignorance and against the back drop of a socio-economic transformation which will give effective political power to the poor and deprived social groups".

The Report on "Health for All: An Alternative Strategy" is to my knowledge the most exhaustive and detailed account of the pre-requisites necessary for an "Alternative Strategy" to make "Health available for all" by 2000 A.D. It also admits that "Nothing short of a radical change is called for; and that "Health for all" as defined by the Report and the objectives and targets, laid down in the document, "cannot be achieved by linear expansion of the existing system and by tinkering with it through minor reforms".

7. A few questions arise in my mind, which I want to place before the participants of this seminar.

(i) Are the maladies described in the health care system developed by the Indian Rulers after independence not the result of the Capitalist Path of Development pursued in the country?

(ii) Are the structural features of the Health Care system, which has emerged in the country, not a logical and necessary consequence of the pro-rich, pro-proprietory profit and market oriented capitalist developmental policies pursued consciously by the Rulers?

(iii) Can poverty and inequality be eliminated by the Rulers, who themselves consider poor as the greatest obstacle to pursue capitalist path of Development?

(iv) Can the State, wedded to Capitalist path of Development, and which has assumed even in the very constitution, the proprietory classes producing for profit and market as the active and main agent of development, in a labour surplus backward society, allocate sufficient resources for people without depriving the profit-chasing proprietory classes of their sources?

(v) Can a State, which is developing an economy essentially based on production for market and profit by the private owners of means of production, and which is determined to provide facilities, incentives, concessions

and even resources and necessary infrastructure to profit chasing proprietory classes, but which does not assure right to work, the only source of securing purchasing power to vast majority of people, evolve a economic-social or health care frame work which will ensure minimum, basic essentials to these people? Can this state create even minimum condition essential for health for these vast mass of people?

(vi) The developments that have taken place during last forty years, after independence, as a result of State pursuing Capitalist path of Development are now fairly well documented:

a. Unemployment and under employment are growing at an alarming rate. The number of unemployed alone, registered even in Employment Exchange Bureaus have reached nearly 20 million mark. The number of under employed have acquired such gigantic dimension that they cannot be counted.

b. Inflation, price rise has reached intolerable magnitude. All know that inflation basically helps proprietory classes seeking profits, and increases the burden on poor and middle income groups in a decisive manner.

c. Inequality is increasing, consciously engendered by the State, which systematically buttresses the rich by various means, sowell known by now. The expansion of Capitalist market and profit oriented transactions are leading to a massive pauperization and proletarianization in both urban and rural areas. During the last forty years, as a result of the Government policies to pursue capitalist path of Development, in Rural areas pauperization of small farmers, marginal farmers and artisans is taking place at alarming rate. The proletarization also is taking place at such a rapid rate that nearly 35 to 40% of population dependent on agriculture are now reduced to the status of landless labourers, desperately searching for work and purchasers of their labour power even at any cost. In urban areas, people living below that miserable inadequate and cunningly formulated poverty line are now reaching alarming proportions.

d. The health specialist and researchers on health problems have already provided a vivid picture of non-availability or polluted availability of basic amenities so essential for even survival and non-diseased existence for vast mass of poor. Can a

state, which is consciously pursing the path of "betting on the rich" provide these basic amenities to people, with the frame work of the socio-economic structure which it is purposefully erecting in the country?

e. During last two decades numerous struggles are developing at an exponential rate by various sections of the poor. They are armed to counteract the adverse impact of the path pursued by the State. In fact Government, instead of rectifying wrongs is increasingly adopting authoritarian, repressive measures to suppress these movements.

8. The document "Health for all" by A.D. 2000 admits that "The major programmes which will improve the health are thus outside the realm of health proper". According to the document, "These were comparatively neglected in the last 30 years, and that is one of the major reasons why the country has obtained such meagre results for its large investments. This error should not be repeated and during the next two decades, the three programmes of (i) integrated overall development, (ii) improvement in nutrition, environment and health education, and (iii) the provision of adequate health care services for all and especially for the poor and under privileged will have to be pursued side by side"

I would like to raise a couple of fundamental questions for serious pondering in this seminar.

(i) Is the Health Care system, as it has evolved in India a product of an error, a misjudgement by the benevolent, neutral, well-meaning, pro-poor state or a logical product of the State which is consciously pursuing a capitalist path of development in the country with its basic pro-proprietory class stance as axis of its development thrust?

(ii) Can this State radically reorient its health care policies, in the spirit of suggestions offered by the sensitive concerned scholars and activists on the health care area?

(iii) Is not the State, wedded to Capitalist Path of Development, itself the main hurdle, as it is responsible for developing the pro-rich bureaucratic top down health care system, which is so vividly analysed and exposed by the sensitive, participants and activists involved in spreading the Health care for all.

(iv) If the State, pursuing Capitalist Path of Development, in India, is the architect of the present bizzare pattern of Health care system, as well as of the larger social contours as described earlier, should not

the activists/scholars and researchers instead of placing hope, and praying the government which is itself the main cause to remedy the error, join the struggling poor in the country who are heroically launching movements under heavy odds to replace the State, which is consciously pro-rich by a state, which will place power in the hands of toiling poor which alone can usher in a path of development which will ensure right to work, and provision of essential requirements, as minimum starting point for its development trust?

I want the seminarians to discuss the following crucial question which I think is axial for proper analysis for alternative strategy for Health for all.

Is the State pursuing the Capitalist path of development in India, not the main obstacle in health care reaching out to all?

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PRIMARY HEALTH CARE APPROACH TO ACHIEVE HEALTH FOR ALL BY THE YEAR 2000 A.D. - AS IT IS UNDERSTOOD AND PRACTISED IN THE COUNTRY - A PERSPECTIVE.

by

V.N. Rao

1. Concept of Health for All:

'Health for All' in its broadest sense means that health is to be brought within reach of everyone. And by 'health' is meant a personal well being, not just the availability of health services - a state of health that enables a person to lead a socially and economically productive life. According to Dr.Halfdan Mahler, 'Health for All' is a holistic concept calling for efforts in agriculture, industry, education, housing and communications, just as much as in medicine and public health. Medical care alone cannot bring health to hungry people living in hovels. Health for such people requires a whole new way of life and fresh opportunities to provide themselves with a higher standard of living'.

2. The Strategy for 'Health for All' - Primary Health Care:

Primary Health care approach is considered to be the basis for achieving 'Health for All' especially in developing countries. The Alma-Ata Conference described primary health care as:

"essential health care 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 the community and country can afford to maintain at every state of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the Central Function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process".

Thus the pre-requisites of primary health care are multisectoral approach community involvement and appropriate technology and on this edifice that health programmes and health infrastructure has to be built.

India is a signatory of the Alma Ata Declaration. Having stated the concept and strategy for achieving 'Health for All' through primary health care approach, it needs to be examined how far the country is following these and with what results.

3. National Health Policy:

Historically health services in India have been developed on the western model. Till recently they were mainly hospital based and disease oriented, and have been heavily dependent on borrowed foreign technology leading to over-sophistication and ill-suited to the needs of the rural community. There has been a great imbalance in the provision of the services; most of the services being located in urban areas, while nearly 80% of the population resides in rural areas.

For the first time the country has adopted a National Health Policy taking into consideration all existing situation and realising the need for providing primary health care with special emphasis on the preventive, promotive and rehabilitative aspects.

4. Minimum Needs Programme:

The Minimum Needs Programme Concept was introduced during the Fifth Five Year Plan. It is the expression of the commitment of the Government for the social and economic development of the community particularly the under-served and under-priveleged segments of population. Government considers investment in health investment in human resources development and as such Primary Health Care forms an essential and integral component of Minimum Needs Programme. It is a broad intersectoral Master Plan for providing the minimum basic needs of the people. Economic development, anti-poverty measures, food production and distribution, communication, drinking water supply, sanitation, housing, environmental protection and education contribute to health and hence find a place in Minimum Needs Programme.

5. States Plans to Implement 'Health for All' :

Health is a State subject. Nevertheless in all programmes of National interest the centre has been laying down the guidelines for implementing the health policies decided and agreed upon by the Central Council of Health and Family Welfare.

The Sixth Plan had laid down the following norms :-

(i) One village health guide for every village for an average of 1,000 rural population.

(ii) One trained dai for every village by training indigenous practising dai, with ultimate objective to train all practising dais in rural areas.

(iii) One sub-centre with one female MPW for every 5,000 rural population in general and for every 3,000 population in hilly and tribal areas.

(iv) One male and one female health assistant for supervising the work of every four sub-centres.

(v) One Primary Health Centre either by conversion of existing rural dispensary or establishing new units for every 30,000 rural population in general and for every 20,000 population in tribal and hilly areas.

(vi) One community health centre for every one lakh population by providing additional inputs either in one of the existing primary health centres or in the sub-district Tehsil/Taluka/Referral Hospitals already functioning below district level.

Targets proposed for VIIth Plan

Category	Total Requirements (lakhs)	Likely in position on 31.3.85 (lakhs)	Likely to be in position on 31.3.90 (% reqd.)	Remarks
V.H.G.	4.5	3.5	100%	
Dais	4.5	5.0	-	Complete the training of all practising Dais
Sub-centres	1.30	80,000	100%	
PHC's	21,666	11,416 (incl.SHCs)	100%	
CHG's	5,417	593	50%	

Thus, it is envisaged that by the end of the VIIth Plan the States would have built up an health infrastructure to effectively establish a health pyramid for the delivery of health care. The manpower development is to run parallel to the institutional build up. The training facilities are also to be augmented to cope up with the envisaged rapid expansion of health services.

6. States efforts in establishing Primary Health Care Programme :

The Community Health Guides (CHG) Scheme was the first level of interface between the community and the regular health infrastructure. The CHG Scheme which was started in 1977 was adopted by all States and Union Territories in the country, except in Jammu and Kashmir, Kerala, Tamil Nadu and Andhra Pradesh, where an alternative scheme was adopted. Even so, the CHGs Scheme has gone through several vissicitudes. When the Scheme was 100 percent sponsored most of the States accepted it and started implementing it. But when the pattern of central assistance changed several States virtually dropped out of the Scheme. Again when the Central assistance was fully restored there was partial response. Barring a few States, the CHGs Scheme has been virtually a non starter. The Scheme suffered from such infirmities like the CHGs selected were mostly males. They were selected on the basis of political influence there was no firm linkage with the existing health infrastructure, the training was inadequate and unsatisfactory and above all there was no continuing education and supportive supervision to help them get started in their work. Thus, the CHGs Scheme which could have been an effective tool for implementing the Primary Health Care Programme has been virtually smothered.

The most peripheral health workers are the Multipurpose Workers in the health heirarchy. The male and the female multipurpose workers have been drawn from the erstwhile verticle programmes. They had to be retrained in the concepts and philosophy of primary health care approach in achieving Health for All. This has not happened. The training given to them was not adequate and satisfactory as the training centres were not sufficient in numbers and the trainers themselves were not adequately equipped to impart training in PHC approach.

Thus, a hotch-potch group of Multipurpose Workers are now functioning in the rural areas without a clear concept of their newer specific tasks and roles. The MPWs numbers is expected to increase with the reduction of population to be served by them as per the plan targets. But this increase is not taking place at the pace it was expected. Nor are the training facilities for these new recruits adequate.

The LHVs/NMs/HAs, who are in the Supervisor echelons also suffer from lack of adequate training and support. Also their numbers have not been increasing as per target.

The Medical Officers of the Primary Health Centres, although their numbers are closer to the target, have not been suitably oriented to primary health care approach and their basic training does not equip them to manage the primary health centre adequately and effectively. Consequently the leadership which they are expected to provide is conspicous by its absence.

The VIIth Plan has laid down the targets for building up infrastructural facilities like subcentres, primary health centres/ subsidiary health centres and community health centres. Again, with the exception of Maharashtra and a couple of other States rest of the States are lagging behind. Even in the States where the physical targets have been achieved, functionally they are still to go a long way to establish Primary Health Care. The physical facilities such as Primary Health Centre building, staff quarters, equipment, etc. are still far from adequate, with the result the centres are unable to work effectively.

Above all, the morale of the staff working in the primary health centres is not upto the mark. Consequently indiscipline and evasion of duties and responsibilities is surfacing more and more.

Thus, the melieu in which the primary health care programme is to be nutured and developed will need a sea change if the avowed goal of Health for All by the Year 2000 A.D. is to be achieved.

7. Need for rectifying the present priorities, strategies and approaches to realise the set goal:

While the progress in regard to operationalisation of primary health care approach throughout the length and breadth of the country has not been adequate and satisfactory as seen from the earlier review, there is certainly no need for despair. There is definitely scope for improving the situation in the remaining period of less than a decade and half, provided there is political will and a determination on the part of technocrats and bureaucrats to implement primary health care approach in the manner envisaged, successfully.

The following are a series of steps which implemented may lead us to the set goal in the limited period of time.

i) Start a movement to mobilise the community to make them realise that their health is their own responsibility. The health care, in the ultimate analysis, should be not only for the people, but also with the people and by the people. This needs a major thrust in community mobilisation in all developmental activities including health care development - a long term programme.

ii) Have a band of trained and motivated voluntary workers, not necessarily community health guides, who will be able to educate, enthuse and act effectively as interface between the community and the regular health infrastructure.

iii) Also concentrate on promoting development in health related sectors such as water supply environmental sanitation, food production and nutrition, education, communication, etc. This requires judicious mobilisation of existing resources.

iv) Develop appropriate technology, which is cost-effective suited to the needs of the community. This requires lot of experimentation in a different setting. In this connection the urgency of developing and constructing low cost buildings can be considered as an outstanding example.

v) Training of various echelons of staff in primary health care concepts and approach is of paramount importance and needs immediate attention. Apart from providing adequate number of training centres for giving basic training, orientation training, in-service training, etc., a band of competent trainers needs to be mobilised to make training more effective and meaningful. The modus operandi of training needs to be throughly revamped. Practical on-the-job training needs to be given the emphasis it deserves. Team training is yet another aspect which has been totally ignored. Last but not least continuing education is a must and should be adopted everywhere.

vi) Emphasis should be more on consolidation of existing health infrastructure and mobilising all resources to make it function effectively in providing quality services. This will automatically ensure better utilisation.

vii) There is an urgent need for each State to work out its own model/s of health care delivery through the primary health care approach. In the long run funds spent on development of such model/s by each State for a period of 3-5 years will have tremendous benefits in improving the health care delivery before the turn of the century. Such practical, not necessarily purely demonstration models, which have to be replicable, should be carefully worked out, guided, monitored and evaluated, before they can be adopted elsewhere.

viii) The development of the epidemiological services throughout the length and breadth of the country has been repeatedly stressed by various expert groups. Even so, no serious attempts have been made so far by any of the States to establish epidemiological services. The imperatives of starting such services needs no further emphasis.

ix) Health Services Research/Health Management Research has not been receiving adequate attention. Research on operational aspects of health care delivery deserves urgent attention.

The steps suggested above are by no means complete and exhaustive. But they emphasise the urgent need for re-thinking to mobilise the existing resources fully to make primary health care fully operational to achieve Health for All.

8. Conclusion :

'Health for All' is a realisable goal provided there is a political will and a firm determination to achieve it. The steps that need to be taken to achieve the set goal has to be well thought out and consistently followed and deligently implemented. Now is the time for firm action. There is no doubt that India could work towards this goal and achieve it with its available resources.

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MAIN GAPS AND CONSTRAINTS IN OUR APPROACH AND PROGRAMMES FOR PROVISION OF PRIMARY HEALTH CARE

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Introduction:

Primary Health Care has been accepted internationally as the key approach to attain the goal of "Health for All" by 2,000 A.D. Declaration of Alma-Ata, 1978, defines Primary Health Care as essential health care 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 the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

Essential Components:

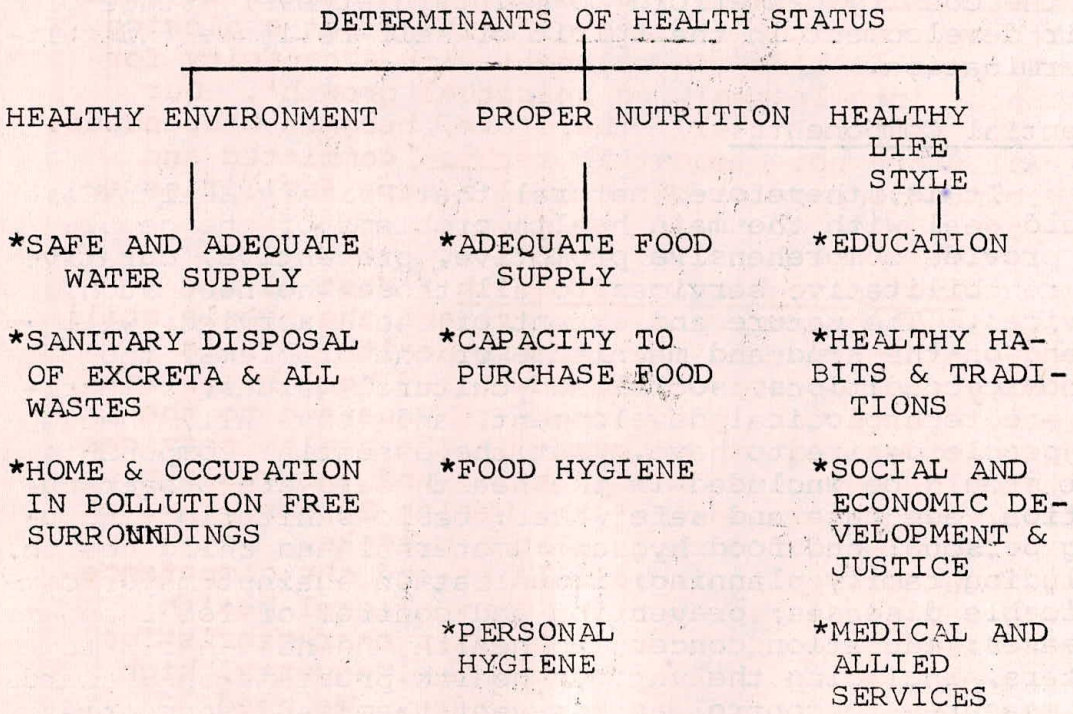
It is, therefore, natural that Primary Health Care should deal with the main health problems of the people and provide comprehensive promotive, preventive, curative and rehabilitative services to all those who need such services. The nature and extent of these services will depend on the kind and magnitude of the problems, the economic conditions, social and cultural values, scientific and technological development, and above all, what the people desire to have. But the essential components that should be included in the health care are proper nutrition; adequate and safe water; basic sanitation including personal and food hygiene; maternal and child health, including family planning; immunization against major communicable diseases; prevention and control of local endemic diseases; education concerning health and health related matters, including the various health problems and hazards and measures to control and prevent them; and appropriate and timely treatment and care for common diseases and injuries.

The Approach Vis-a-vis Epidemiology:

Health is relative, not absolute. The fundamental determinants of health ,apart from the genetic constitution, or make-up, are nutrition, environment and life style. The health of a society is directly linked to its value system, philosophical and cultural traditions, socio-economic conditions and political organisations.

Each of these aspects has a profound influence on health, which, in its turn, also affects all these factors. Consequently, health status of any community cannot be raised, nor the health for all achieved, unless all the factors shown in diagram 1 are effectively provided and all health hazards are effectively contained and countered through a programme of integrated development. Such a programme connot obviously be limited to improvements in health and medical services, but should be directed to bring about the cultural, social, economic and political transformation of the society as a whole.

Diagram 1 : Epidemiology of Health



Secondly, as health cannot be passively received or given, people must made to decide for themselves and helped to acquire it through their own effort. Therefore, active participation and involvement of the local communities and programmes, are essential in attaining self-reliance, efficiency and effectiveness in Primary Health Care. The external support that a community may need include technical knowledge and skills, training, guidance and supervision, logistic support, supplies, information, finance and referral facilities.

For success, there is no alternative to epidemiological approach. We shall have to attend to all the determinants of health care through an integrated development plan. Unless the causes of ill-health are contained, the health status of the community cannot be improved.

The Gaps :

1. The concept of primary health care for all has been aptly and beautifully expressed in an ancient Sanskrit verse: 'Sarve santu nirmayaha'. Literally it means, 'Let all be free from disease'. However, considering the colloquial meaning, the verse truly conveys, 'Let all be healthy'. Thus, culturally our concept of health is much broader and richer. In her address at the 34th World Health Assembly at Geneva, Shrimati Indira Gandhi, our Ex-Prime Minister defined health as, 'not the absence of illness but a glowing vitality, a feeling of wholeness with a capacity for continous intellectual and spiritual growth'. Our task for Health For All, therefore, becomes stupendous. We really are not adequately serious, committed and determined to provide basic health care facilities to the poor;

2. Exclusive Domain of Health : Most of the politicians, bureaucrats, doctors and the people still believe strongly that the Primary Health Care is entirely the concern of the so-called health services. Primary Health Care programmes are equatted to the modifications and improvements in the health services in terms of coverage of population and the quality. Belief that appointment of the Health Guides provides for Primary Health Care is also a mistake. The attainment of Health for all is beyond the competence of medical profession, on the conventional health system alone, to achieve. The basic characteristics of our people are rural predominance, poverty, high population growth and disease burden. We need appropriate interventions and for these epidemiological approach, community participation and organisation are inescapable.

3. Overprofessionalisation and mystification of medical and health care tend to generate dependence and lead to high and wasteful inputs, especially in drugs and equipment. We need to promote self-reliance through effective transfer of skills and knowledge to the people. The utility of whatever that is available should be maximised, eg. the traditional systems of medicine, non-governmental organisations, etc., should be fully exploited and harnessed. Physicians, as a rule, are difficult to

work with and do not always try to understand the traditional medical practitioners in whom many people place their trust. It must be realised that the needs of many will have to take precedence over the wants of the few. Mere expansion of physical facilities and staff without attention to relevance quality and effectiveness, would result in a collosal waste of resources.

4. Neglect of Public Health: In spite of the changing trends in modern medicine, growing realisation, and gradual shift of stress towards preventive and promotive health care, 'Public Health' has not been given the required professional status and high importance it deserves. In fact, nomenclature of discipline of Public Health has been changed in India to terms such as Preventive and Social Medicine, and/or Community Medicine. In medicine these are minor subdivisions in all respects, eg., prestige, number of persons, finance, political influence, etc. This has resulted not only in total elimination of earlier understanding, but has also introduced much confusion as to what these subjects contribute. Both the people and the doctors knew clearly what Public Health stood for. The concept of Public Health is that of a major governmental and social activity, multidisciplinary in nature and extending into almost all aspects of Society. The key work is 'health', not 'medicine', the Universe of concern is the health of the public, not the discipline of medicine. Medicine is a subdivision of public health and not the vice-versa. Public health needs not only the doctors, but also disciplines of epidemiology, biostatistics, health economics, sociology, anthropology, other political sciences, biological and physical sciences, public health engineering, nursing, dentistry, nutrition, health education, health administration and medical sciences.

5. Community and Community Participation: What do we mean when we talk of the people or the community? Who and where are these? There is no clarity. There are two broad categories, the 'Haves' and 'Have-Nots'. When we speak of Health for All or Primary Health Care, our target population should be the 'Have-Nots'. These are not the individuals people or communities which are rich or privileged or those in power and authority or the 'yes' type. But they are the oppressed, the poor, the exploited and the needy. They are generally not organised and should constitute the priority group or our target community or 'the people'.

Community participation is often a myth. Giving some contribution, such as labour, materials or donations cannot be considered as true participation. This is also true of utilisation of services, co-operation and other similar actions. These people can be said to be participating when they understand the situation and issues by critical consciousness, and take active part in decision making, implementation and evaluation of programme, and take responsibility of the work as well as share in the benefits. Such involvement of the local populations in the decision-making of development projects or in their implementation, is more in the nature of identification with the movement. The involvement, indeed, is a mental process as well as a physical one. Such involvement and participation would provide freedom from dependence on others, use of indigenous knowledge and expertise, and things would be done in a right way. What is needed is to encourage and help the 'Have-Nots' to get themselves organised, and to enable and strengthen them to take initiative in development work with confidence.

6. Inter Sectoral Co-ordination is of vital importance in the success of Primary Health Care which we are trying to achieve through total developmental efforts. At present, inter departmental co-ordination and co-operation at all levels from the community to the top management, are not effective. There is much scope to improve. Without personal contacts and timely follow-up actions in a well co-ordinated manner, mere co-ordination meetings, etc., may not yield anything useful. Mutual understanding, respect and determination are the key words.

7. Co-ordination within the Health Sector is also vitally important, but unfortunately it leaves much to be desired. There is fragmentation in the organisational set-up. Different programmes, projects, departments within the Health Directorates tend to form water-tight compartments with hardly any communication between them. Voluntary organisations and autonomous Institutions often run parallel programmes to that of the Government. Schemes such as the Multipurpose Health Workers Scheme and the Health Guides Scheme demand a very high degree of intra-departmental co-ordination and co-operation. Tardy progress and widespread failure of these schemes can be attributed to this weakness. Family planning programme is often run at the cost of other health programmes. Community Health Workers Scheme was originally introduced for health promotion with better

community participation and involvement but now it administered under Family Welfare Programme and the sole purpose is to bring 'cases'. Added to this retrograde step, the Health Workers, male and female, have started using the Health Guides as their substitute workers, instead of providing guidance and support to these persons who do not belong to health services. Both MPW and CHW schemes have been allowed to distort, degenerate and disintigrate because of administrative failures. They need to be scraped in the present form and reintroduced de nova in the original concept.

8. Management is another gap. For implementation of a timebound programme, with optimum, effective and efficient use of limited sources, proper use of modern management techniques, personnel management, public relations, financial, and materials management, are vitally important. But these are largely neglected fields and are often taken for granted.

We have to first realise the enormity of the task before us. Gaps between our planning and achievements are too well known. We should be clear on what we want to achieve and hown. We, in the health sector, have lagged behind in establishing subcentres, primary health centres (new), reorganising medical education, organising continuing training of various categories of staff, etc. We have not fully attained the desired norms in health manpower and infrastructure facilities needed for population of around 70 crores in 1981. By 2000 A.D., our population will be up by almost 30 percent, i.e. over 90 crores. Thus, we would need a substantial overall increase in all kinds of resources-finance, manpower and supplies.

We should have the right type of persons in management. Without adequate knowledge, skills and motivation, the services of desired quality and effectiveness cannot be given. 'Not infrequently, we find a technocrat trying to become a bureaucrat or a bureaucrat thinks that he is a better technocrat; and above all, sometimes even the public representatives (politicians) think that they are better than both'. What we need are efficient health administrators or managers. We must identify, train and use them.

9. Lack of flexibility in our programmes and approaches poses problems. Socio-cultural and other diversities and local differences demand different and varied solutions and approaches. Determinants and nature of the problems and situations vary from place to place, group to group, urban to rural, educated to uneducated, rich to poor, time to time, at different levels of development and achievements, etc. While general guidelines and objectives are essential to give proper direction and purpose, details of the programmes, activities and approaches are best left at as near local level, i.e. community level, as possible.

While it is desirable to reduce the constraints imposed by centralisation, situations of conflict are inevitable. One will have to find out the most acceptable solutions in the given cultural and social milleu. Balance between flexibility and replicability will have to be reached at satisfactorily. One should also note that there could be many solutions and approaches for achieving an objective. A single solution or formula should not be insisted upon.

10. Inadequate and Ineffective Decentralisation is another important gap. Our great exercise and programme for democractic decentralisation or Panchayat Raj has succeeded partially. In a few States like Maharashtra and Gujarat, the process is more-or-less final and the Zilla Parishads are working with fair delegation of appropriate powers and proper resources including finance, but in most of other States, there is hardly any true decentralisation.

Similarly, within the administrative Departments also, there is hardly any decentralisation with delegation of appropriate powers and proper resources. Often only responsibility is passed on to the lower levels of management. Fulfilment of local needs, effectiveness and timeliness of activities, job satisfaction, and self-reliance will be possible only after true decentralisation and accountability.

11. Passive Participation of the States in the centrally sponsored schemes and programmes is a great limitation. This is evident from the fact that although Health is a State subject, there is almost total dependance of the States on the Central Government. What is required is initiative and active partnership on the part of the States in matters of all programmes promoting health. Such an approach will facilitate decentralisation and adjusting of programmes to satisfy the local needs. It would not be wrong to state that the State Directorates of

Health Services have hardly any preventive or promotive health care programmes supported voluntarily through the State's own financial resources.

12. 'Provide approach' is still followed by the health and other services. In order to reap the full benefits, what is required for Primary Health Care, is the 'participatory approach'. The Chinese say that teach a man how to fish rather than give him a fish. There are obvious difficulties and substantial social change may be necessary. Eventually, Government should participate in the people's programme.

13. Misconcept and Lack of Faith are the important problems in the operation of Health Guide Scheme. Many people, especially the educated, and most of the doctors think of the Health Guides/ Community Health Volunteers, and the Health Workers in the field as temporary and second-best substitutes for doctors. This is not true. They are also called 'auxiliary workers'. In reality, they are the primary members of the health team. Experience gained in several research projects seeking for alternative approaches for delivery of health care, such as at Jamkhed, Mandwa, Padgha and Vadu-budruk, and also in the Health guides Scheme, proves that many villagers with minimum or no formal education are able to perform with remarkable competence, a wide variety of functions embracing both curative and preventive medicine, coperatives, community education and mobilisation. They are willing and work with interest in the community where the needs are the greatest. Their jobs are more difficult than those of an average doctor. The doctor is oriented towards disease, treatment and individual patient. He functions best when based at a hospital or in an health institution. On the other hand, these workers and volunteers are oriented towards health and the community. They have to seek a balance between cure and care. What would happen if a village has only a doctor? There would be an epidemic of gastro-enteritis, the well water would remain untreated, people would have no knowledge of the hazards of poor hygiene and sanitation. The poor villagers would wait till the children are dehydrated, and only few would have money to pay for the treatment.

The programme would succeed to the extend the community organisation gets strengthened and people have fuller awareness of the health issues.

There should be increased accountability to the community/ people. Unfortunately, in the process of utter mismanagement, we have distorted a good scheme beyond recognition and retrieval.

14. Inadequate Guidance and Technical Support to the field staff is another area of concern. Supervision on the part of medical officer is generally lacking. Problems of training, transportation, communication, logistics and supplies require quick solutions. Relationship between the Health Workers and Health Guides has not been correctly conceived and developed. Health Guides are not substitutes or alternatives to the Health Workers. Health Workers are part and parcel of the formal health services and are required to discharge their assigned duties. They are accountable to their superiors such as the Health Assistants and medical officers. They have no formal control or authority for supervision over the Health Guides. Their authority lies in their technical knowledge or skills. Health Guides are volunteers or social workers andaare not employees of the Government or the local authorities. They provide a link with the community so that utilization of health services facilities are maximised, and people co-operate. The Health Guides major task is to help the community to get better organised and become self-reliant in matters of health. The Health Guides are accountable to the villagers and speak for the people.

There is also a misconcept about the new category of health staff, the Community Health Officer. He is a non-medical staff provided specially to improve guidance and technical support for the field staff of the Primary Health Centre (Newer Type) through intensive supervision. He is not a substitute to the medical officer so as to relieve him of his responsibility of supervising the field staff under his control. Unfortunately, this corrective intervention has not received due consideration and acceptance by the State Governments.

15. Identification of the Process: Entry to the community may be through the development of health services, but this should not be interpreted as a way for developing community participation. The Primary Health Care is basically an educational process. How to get at it? A process that has high potential of success should be tested and established. There cannot be a programme to deliver Primary Health Care, it is a development process. Implementation of Primary Health Care can be ensured only if one is able to foster the

necessary political will at various policy-making levels.

16. Lack of Trust on Health Education: Knowledge and skill are the best and most potent weapons. The present programme of health education-as a part of the health services programme- cannot be expected to give us the desired impact on health and change in life-style. It has to be integrated and made a part of our educational system. Health should be taught as a compulsory subject with examination throughout the primary and middle schools. At the high school level it may remain as one of the optional subjects. Schools should provide the models of healthy environment and the temples for health promotion. It is needless to add that we have to ensure that all the children, especially the girls from the targeted communities/people attend school regularly. What we need is a massive drive to provide Information, Education and Communication (IEC) on all relevant issues and areas to the people. We should mean business.

17. Under the International Decade Programme for Drinking Water Supply and Sanitation, the targets were to provide safe water to all the cities and villages; and basic sanitation to 25% of the villages; 50% of Class II and smaller towns, and 100% of Class I cities by the year 1990. Our progress is, however, slow. Further, sanitation would give desired impact on health status, especially in reducing the gastro-intestinal infections, only if it is coupled with improved personal hygiene and food sanitation. In practice, there are instances when water is being piped and supplied from sources which are either polluted or potentially unsafe. This further strengthens the need to co-ordinate activities of the departments of health, education, public works and housing.

18. In summary, our target groups of people, viz., most of the rural population, and the slum dwellers and other under-privileged people in the urban areas, have poor levels of health because t they are under-nourished, suffer from infections and infestations, are deprived of social and economic justice, live in unhygenic conditions in unhealthy environment, are ignorant of health and other health related matter, are not aware of various health hazards they are exposed to, fail to utilize health and other services fully, have harmful habits, have large families, and generally

live in a way that is not conducive to health. Further, these people are economically poor and corrective measures are far beyond their resources in many ways. The status of women is low. It is essential to deal effectively and immediately with all the factors that are responsible for the poor state of our people. We shall have to concentrate on "Have-Nots", may be even at some disadvantage to the "Haves". For this, political will should be very strong and the health administrators should be highly efficient and determined.

Better health should lead to improved quality of life. Therefore the health indicators should include, among others, Index of Physical Quality of Life (PQLI).

This should be our Primary Health Care. Key note should be the people, for the people, with the people and to the people through self-reliance. All that we need is the will, the motivation and the commitment, to do this.

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ISSUES IN THE POLITICAL ECONOMY OF HEALTH IN INDIA

by

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The political economy of health care provides a necessary backdrop to an understanding of the nature and process of health policy-making in India. This context provides the possibility of answering questions such as why different numbers of different cadres of medical personnel are trained; why some areas of health provision are well-funded while others get little more than a pittance; why some health facilities are under-used while others are swamped with demand; and why some systems of health care financing are used and not others. In this paper I intend to discuss this context, rather than the details of outcomes, for which other sources are available (cf.Jeffery, 1985, 1986, forthcoming).

The political economy of health care is an attempt to specify the ways in which economic interests and political processes structure the provision of health services. It can take many forms. At one extreme lie economistic models, based either on neo-classical economics or vulgar Marxism, in which the political processes are seen to follow directly from economic determinants. At the other extreme lie politicist models where political forces, either national or international, are in the driving seat (Staniland, 1985). An example of neo-classical economism would be Mahbub-ul Haq's argument for Pakistan that health provisions could be left to market forces (1963); of Marxist economism would be Djurfeldt and Lindberg's'Pills Against Poverty' (1975). Lipton's 'urban bias' arguments lie near the politicist end of the spectrum, with his argument that indigenous practitioners are supported as a way of keeping good medical services for town-dwellers (1977); so are those accounts by doctors or administrators which conclude that 'political will' is the answer, of focus on corruption.

An essential element in these different political economies is how the role of the State is understood. One politicist view is usually characterised as 'pluralist', where power is exercised through alliances forged by groups on the basis of a number of common and competing characteristics - caste, language, religion, education, for example, all providing bases for common action as well as (and often over-riding) narrow economic

interests. State bureaucracies are seen as central to an understanding of the chances of any policy being implemented (Braibanti, 1961). In some cases the analysis seems to assume that the bureaucracy is divorced from the every-day political world and just 'holds the ring'. Failures to maintain this divorce are then castigated by calling the result 'corruption', without posing questions about the interests of the bureaucrats, or the social groups favoured by these 'corrupt practices'.

The alternative view of the State draws on Marxist traditions, more or less economistic. In this view the State reflects or is an instrument of dominant classes: debate (as, for example, between the various Marxist parties in India) focusses on which classes are aligned together, and whether to collaborate with the so-called 'national bourgeoisie', seen as particularly powerful in the Congress Party (Kurien, (ed.) 1975; Hawthorn, 1983). The work of Alavi (1972) raised the level of this debate by posing the possibility that State bureaucratic structures had some limited independence of action, because the State in post-colonial societies inherited bureaucratic and military institutions designed largely with a concern to maintain order and control. Alavi suggested that these institutions are strong enough to be relatively autonomous of the propertied classes within post-Colonial societies, and of their metropolitan allies abroad. In Alavi's view, what distinguishes the colonial State from post-Colonial one was its 'alien' character, not its institutions or primary concerns.

Alavi's formulation was criticised on several grounds, most notably that he seemed to exaggerate the extent of the colonial State's control over civil society (Saul, 1974; Bayly, 1979; Washbrook, 1978; Moore, 1981). The British recognised the limits to the control which their State apparatus could wield, though of-course, the Indian Army (with the British Army in India), the Indian Police, and the Indian Civil Service, could still together forge an instrument of domination more efficient and flexible than any previously seen on the sub-continent. But since Alavi's case seemed to be based on the ability to manage everyday politics and bureaucratic matters without reliance on landed classes, the objections have considerable validity.

Secondly, Alave seemed to assume that the Imperial State was fairly directly a tool of the 'Metro-politan bourgeoisie'. However, the extent of control from London was restricted by distance and lack of knowledge. The interests of the 'Metropolitan bourgeoisie' were rarely clear, unambiguous or unchanging, and by the 1920s the overall structural constraints of Imperial interests gave few guidelines to Indian bureaucrats attempting to cope with world recession and Japanese competition (Charlesworth, 1982). Further, little can be gained from Alavi's formulation if we wish to understand not only the pressure on the State to provide for the needs of 'capital' but also social policy, such as the British suppression of sati and female infanticide, or programmes of general education, particularly female education and in the field of health. Here, elements of imperial ideology (and variations in the form this took between imperialists and at different times in different places) have to be considered seriously.

A third difficulty with Alavi's formulation is how the State changed at Independence. The Indian Congress Party wanted the levers of power but had confused and contradictory ideas of what to do with them (unlike the Chinese Communist Party) (Maddison 1970). By taking over the existing bureaucracy Congress could cope with the immediate problems of maintaining an administration in desperate times, but they were also constrained in the policy innovations they were then able to take. Congress never developed ways of overcoming bureaucratic inertia nor provided an alternative structure of power. Alavi argued that this was because the bureaucracy had developed ways of by-passing political leaders. Wood(1980) suggests that its main technique was to increase the complexity of bureaucratic routine as a way of blunting political pressures.

Alavi was, ofcourse, talking specifically about Pakistan and Bangladesh, though Wood extends the argument to India. However, ministerial office in the Indian States seems to offer several controls over the bureaucracy - for example, in the transfer and promotion of State (rather than all-Indian) civil servants, and the awarding of contracts (Wade, 1984), 'Policy' presumably emerges from processes of negotiation between politicians and bureaucrats, rather than a one-sided dictation. How do we understand the direction taken by such policies in Ministries like Health or Social Welfare?

Alavi provides some answers to these issues in a recent article (1982), which perhaps offers a way of avoiding the polar weaknesses of politicist and economistic approaches. He distinguishes four levels of analysis of the State. The first draws on the so-called 'capital-logic' school and focuses on the role of the State in creating and reproducing a social order which permits capitalism to flourish - in Alavi's terms, India is a 'peripheral capitalist' economy, so the minimal role the State must fulfil is to make it possible for capitalists to make a profit, to benefit personally, and to continue to invest. The second level relates to the questions Alavi raised in 1972, on the classes and groups who can be said to control the State: at this level issues of the actions of the State in specific spheres have to be considered. The third level is the analysis of the bureaucracy, its social origins and interests, and the extent of its autonomy, while the fourth level is that of the State as an arena for competing interests - party and pressure group politics. This approach does not solve all the issues it raises - in particular, there remain problems of specifying how the different levels relate to each other, and a lurking suspicion that it is a catch-all for very different approaches which mean very different things when they refer to the State. Nonetheless, I intend to explore the issue of health policy in its terms as far as it can go.

Alavi argues that State action (at the second level) takes place within the context of a 'structural imperative', set by the first level. The basic notions of profitability, calculation, and capital accumulation affect the consequences of State action but do not determine those actions in advance. Rather, aspects of the other two levels (the bureaucracy and the 'political') may cause deviations from what might be considered the strict logical requirements of capitalist enterprises or capital in general. In this model of political and social life, strict logic never applies but politics and society tend in this direction in the long run.

Alavi's recent position, then allows the possibility that 'mistakes' can be made, and that not everything done by the State meets the needs of dominant classes, or results from class conflict or class formation. In addition, it provides a space for sociological analysis of the ideas and interests of bureaucratic and other groups without making them seem

either hypocrites - consciously dissembling about the real reasons for policy - or idiots - unaware of the benefits to particular classes. Alavi's position allows for both economic and political elements in the development of health policy. In this respect it shares many similarities with Bardhan's analysis of the relations between three dominant 'proprietary classes' (not in a strict Marxian sense) - industrial capitalists, rich farmers, and the public sector professional bureaucrats (1984). Bardhan is basically concerned with industrial and agrarian policy, and the cause of the slow-down in economic growth. He argues that the public sector grows because it is a way of managing conflicts between these classes (not to buy off the masses), but this growth has helped to undermine the prospects for productive investment and economic development.

DETERMINANTS OF HEALTH SERVICE DEVELOPMENT

Health services respond to the demands of some groups rather than others - men's complaints rather than women's or children's, town-dwellers' rather than villagers', ruling races', classes' or parties' rather than those of the ruled. These groups experience different disease spectrums, and also interpret their experiences differently. Therefore, even if health services were to respond in a direct manner to the effective demands made on them, they would not necessarily reflect any 'real' disease pattern. However, other interests also affect health services. The State has interests in order and control. Doctors, who dominate the medical division of labour, have theories of disease causation and treatment as well as views on their own proper position in society. In a colonial situation, such as India before 1947, indigenous and colonial views may vary considerably: and many would argue that this mismatch continues in the post-Independence world because of neo-colonialism. However, State interests, and those of medical occupation, cannot be assumed once a particular country has been identified as 'peripheral capitalist'. The forms taken by health services have varied from country to country, and they have changed through time.

An historical and a bureaucratic context must therefore be taken into account. Health services in India today are conditioned in important ways by the legacy of health services established under British rule. 'Incrementalism' is a major feature even of change in 'revolutionary' contexts, as Lampton's painstaking accounts of medical policy in post-Liberation China make clear (1977). Workers at all levels of a bureaucratic

hierarchy have interests in restricting changes which may mean they lose their jobs, or have them radically re-defined, or require retraining and uncertainty: those near the top have scarce skills (socially defined) which give them power to limi proposals which might reduce or change their positions. But in addition, the different elements which go into the State are often inconsistent, and policy rarely proceeds in any one direction without calling forth entrenched opposition. For example, Imperial medicine in India cannot be understood solely in terms of either social control or humanitarian concern for an ignorant and diseased populace. While social control and Imperial economic rationality set limits on possible health provisions, ideas of the civilising mission of Imperialism and the proper concerns of charity gave medical services a particular form. Medical services were chosen as part of the symbolic justification for Imperial rule, and as long as they never threatened Imperial stability, they could take a variety of forms. A successful rural health service, after all, could have contributed far more to social order than the inadequate, almost non-existent, rural health structure which was provided.

The Imperial impact on health in India was thus contradictory. On the one hand, changes in famine policy and food distribution helped to reduce mortality; increasing numbers of men (and later, women) were trained in medicine to the international standards of the time; hospitals and dispensaries attracted considerable numbers of patients; and issues of disease prevention and public health provision were addressed as never before. On the other hand, many of these measures were restricted in their impact to a relatively small sector of the population, firstly the European civil and military servants and their families, later those with access to urban facilities; if 19th century medical services were 'beneficial', then the mass of the Indian population could not have benefited. The preventive campaigns were never pushed fully through, and their impact was limited. Both vaccination and, more powerfully, plague control, demonstrated the failure of British health policy to come to terms with local society. Health measures *per se* probably had little marked influence on mortality and morbidity; but they established a framework (of personnel, ideas, institutions) which permitted more substantial post-Independence provisions, whose impact is more noticeable.

Ramasubban argues that this pattern can be defined as a 'colonial mode of health care', characterised by segregation, and by provisions for the enclave sector which kept pace with 'metropolitan' developments. The rest of the population 'missed going through the period of sanitary reform which swept through most of Europe in the nineteenth and early twentieth centurees' (198?:107). This picture seriously over-estimates a number of elements in the story. Firstly, the stress on segregation was moderated by realisation that it could never be complete, and the interests of colonialists were linked with those of the Indians who surrounded them. Thus the most substantial urban improvements (in water supply and drainage) were designed to improve the living conditions of Indians. Secondly, provisions (in terms of hospitals and dispensaries, or places in medical schools and colleges) soon out-ran the needs of the Army and the European civil population, and this was regarded with satisfaction, not alarm. Thirdly, the most effective elements of European sanitary reform were also largely urban phenomena: many rural areas in Europe are still without centralised water supply, drainage or refuse disposal, for example. To blame the colonial government for not transferring urban solutions to a largely rural India is to under-estimate the extent of the problems involved. And fourthly, the role of public health itself in Europe is overstated by this view, since rising living standards and changes in personal hygiene were largely independent contributors to the changes in the level and kind of morbidity and mortality experienced by the European population.

The failure of the colonial Government to make a substantial impact on morbidity and mortality in India, then depended on factors outside their control as well as the constraints imposed by the nature of that Government. We should not dismiss these arguments as self-interested excuses merely because they were made by the Imperialists themselves. Most prominent amongst the problems faced by health policy-makers was the poverty of the Indian population (not all caused either by the depredations of British conquest in the eighteenth century, or by commercialisation and the sustenance of landlordism in the nineteenth). Not only did this mean that the diseases which they suffered were (and are) difficult to cure, and (with the technology of the time) difficult to prevent. In addition, the tax base for raising revenue to implement public solutions was also limited. The Imperialist Government did not, ofcourse, place sanitory reform or medical services high on its list of priorities; but in some ways they were higher in India than in Britain. In Britain, the Government was inclined to leave medical provision to charitable or voluntary hospitals; medical education to independent medical schools; and sanitary reform to urban councils. All these in India were seen as the proper concern of the Imperial Government.

A further problem was provided by the radical differences in understanding the causes of disease and the consequences of some aspects of the environment, held by the rulers and the ruled. This was most marked in the case of plague, but was also true for issues of 'controversy', or water supply, or antisepsis. Some, or even all the views on these issues put forward in the nineteenth century may now appear to us to be wrong, and they might have made little difference if they had been widely followed. But one of the causes of slow implementation was the gap between the medical models of the rulers and the ruled. In addition, the proposed solutions encountered real technical problems (e.g.for water closets, or water purification). The commitment to implement such policies may have been weak; and the constraints (financial, political, or administrative) set on health policies were undoubtedly considerable; but it remains an open question how much difference would have been made by any conceivable alternative structures or commitments, given the extent of the changes in living and thinking patterns which were necessary.

Therefore, even colonialism was not totally integrated. The context (the reproduction economically and politically of the Imperial order) did not totally define political processes within the State. Other pressures with an impact on medical policy were the perceptions of medical bureaucrats, the requirements of meeting some of the political demands made by the rising political classes, demandx in the market for medical services and education and the need to defend the State from accusations of exploitation - quite apart from the brute facts of poverty and the environment.

THE IMPACT OF INDEPENDENCE

At Independence, the 'alien' rulers were replaced by Indian ones, albeit ones often rebuked as no less alien in thought, speech and action than many of the British. The extension of liberal democratic institutions, and changes in the nature of the international environment, had consequences for State structure. But the impact of Independence in 1947 was much less substantial than the political rhetoric suggested, and do not need to be rehearsed for an Indian audience.

I want to draw attention to only a few features of the political situation since Independence. Firstly, at the same time as the State has become more centralised, it has had to come to terms with an increasingly clientelistic local political structure. These potentially opposing trends provide a tension which underlies many apparent discrepancies in policy proposal and implementation. Policy-making has progressed with an eye less to ideological coherence or overall rationality than to a desire to meet interest group demands, often through an expansion in the role of the public sector. Myrdal (1968:895-900) called this a 'soft' State - one which places few demands on the mass of its citizenry, and attempts to offer services, employment and other benefits without, for example, establishing a tax system or a political structure which can systematically call upon individual resources. Another way of describing this pattern would be to say that Alavi's levels of the State in India are less tightly constrained than in many other countries. None of the policies envisaged by 'Gharibi hatao'or by the '20-point programme'involved a direct attack on class privileges or mobilised individual resources.

Secondly, in the field of health policy, Congress took over the planning framework mapped out by the Bhore Committee, established by the British as part of a campaign to win the hearts and minds of Indians during the War, rather than their own National Planning Committee's public health proposals (Jeffery, 1976). By comparison with the Bhore Report, the N.P.C. report on Public Health (N.P.C. 1946) was shorter, less well argued and costed, and drew on far less detailed analysis of the existing situation.

In many areas the two reports overlapped. Both looked towards a socialised system of health services, dominated by the public sphere, with no financial barrier to equal access to all, and the eventual elimination of private medical practice. Both supported the development of insurance-based services for industrial workers, but accepted that this was impractical for the mass of the Indian population in the foreseeable future. Both reports pointed to nutrition and general living standards as the major determinants of health, and gave preventive measures highest priority. Both saw the integration of preventive and curative services, provided by a full-time salaried cadre of workers, as the way to achieve this, and they also called for Government doctors to lose their rights to private practice.

The crucial position of rural provision was also common ground: in Bhore's words, "it is the tiller of the soil on whom the economic structure of the country eventually rests" (G.O.I., 1946:4), and health services should be as close to the people as possible. Both drew on the models for health provision developed between the World Wars by the League of Nations Health Organisation, and implemented in Yugoslavia and parts of Nationalist China (Lucas, 1983). These involved health centres in nodal villages, linked to larger units at district level. The Bhore report specified in much more detail not just desirable staffing levels over a 30-40 year period, but also suggested a strategy for the first 10 years. Both reports called for a substantial increase in the amount of public money allocated to health matters, but stressed that a shortage of trained personnel would be a major constraint. Finally, both reports saw the need for health education - to change the habits of mind and ways of life of the mass of the population - and the need to engage the co-operation of the villagers in the work which was needed. The Bhore report cited an article by Henry Sigerist on Soviet health committees, and suggested that pioneer work at Singur, in Bengal, was proof that they could work in India.

The difference appear in three main ways. Firstly, Bhore urged the establishment of special campaigns against specified diseases, in particular malaria, tuberculosis, V.D. and leprosy, whereas the N.P.C. report was silent on this issue. Secondly, clear difference emerged over the priority categories of personnel for training, and the proper role of semi-trained villagers and indigenous medical practitioners. Although Bhore was willing to float the idea of 'health assistants' to relieve medical men (sic) of some of their curative and preventive duties, he saw no role for part-time health workers, who were the 'cornerstone' of the N.P.C. proposals. The third difference was the N.P.C.'s willingness to include indigenous practitioners in a reformed health service, whereas Bhore excluded them.

In sum, both reports went well beyond a 'medical' model of health services. In Rifkin's terms, these are examples of 'health planning'; but the N.P.C. Report included elements of 'community health', missing from the Bhore Report (Rifkin, 1985). However, without the support of a secretariat, or any political powerbase within the Congress Party, the N.P.C. Public Health report disappeared with very few traces, and the Bhore report provided the framework for most health decision-

making. Perhaps the most important point to note about both these reports, however, is that they legitimised in a powerful way the views of those who espoused a 'health planning' view of India's public health needs. But the new health policy had to be implemented by a health system still dominated by a 'medical' model.

In the rest of this paper I will analyse the outcomes of health policy since 1947 in terms of the 'levels' which Alavi distinguished in his 1982 article.

THE STRUCTURAL CONTEXT

How far has India's position as a peripheral capitalist economy determined the course of her health policy? It is not possible to do more than suggest a few possible themes here. In the first place, health policy could not undermine principles of private property, personal profit, or the reliability of contractual agreements; but this does not take us very far. Secondly, in the post-War period, India has never been seen as short of people, so pressure to reduce the death rate has been small; India's slow but now evident success in doing so accounts in part for the alternative pressure (much stronger) to reduce the birth rate. Thirdly, issues of population quality have almost all focussed on education, not nutrition or good health. Although industrial workers have been provided with subsidised medical services much better than those of the rest of the population, no concern has been shown to improve environmental factors in urban areas nor to implement Factory Acts to reduce industrial pollution, diseases and accidents. Most of the industrial labour force has been easily replaceable. Finally, in the maintenance of a docile labour force, factory doctors or the employees' health service generally have played a minor role.

All these points are even more true for the agricultural sector. Labour productivity in agriculture is low, and the agricultural sector remains largely outside the direct control of corporations. On plantations, a surplus labour force is maintained through concessional granting of small plots of land for self-cultivation, and by the relative isolation of planatation populations, geographically and socially. Health services provided by plantations companies do little more than meet the letter of the law. Improved health services are not demanded by trade unions nor are they offered by management.

It is, then, difficult to make the case that good health is needed for the reproduction of India's economy; the alternative argument - that bad health is necessary instead - seems to underplay the significance of the malaria control programmes in dramatically improving the state of health after the War. Ofcourse illness can weaken organised movements of the downtrodden, just as do illiteracy and the fanning of ethnic and caste divisions, but I do not think this adds up to a sustained case.

The limits set by the structural context relate mostly to the financial limits on investment in health. Establishing and maintaining a healthy environment, adequate disease control programmes and promotive health measures, and a medical service accessible to all would be enormously expensive. In this sense, the preferred policy would be 'indifference', keeping the cost of the social wage as low as possible. At current levels of economic surplus, the Indian economy cannot seriously contemplate more than palliative measures, whatever the long-run economic benefits that might accrue.

CLASS INTERESTS IN HEALTH POLICY

Narrow class interests have a clear impact on several aspects of health policy. The urban professional, bureaucratic and commercial classes have a direct interest in the expansion of medical education in order to provide career paths for their sons (and to a lesser extent, daughters). Medical college places were expanded through the 1950s and 1960s, mostly by Government but latterly by the growth of private medical colleges, run as combined political and commercial ventures in a number of States (Kothari, 1986). The same groups have supported doctors in campaigns to ease the import of high technology medical equipment (so as to avoid the 'need' to go abroad for advanced treatment), and to permit the establishment of specialist hospitals in the major cities. These urban classes also expect basic sanitary arrangements for their parts of the cities.

Quite different interests activate the rural 'proprietary' classes. For their own medical care they share the demands for private medical facilities in the towns - none of the proprietary classes would use Government hospitals except in emergency, or if (as with some urban teaching hospitals) they have facilities unavailable elsewhere. Some of them may also have

interests in the growth of medical education. But their direct political concerns focus on the expansion of the Governmental rural infrastructure. Their political stock-in-trade is the allocation of resources and the influencing of appointments to jobs or access to Government facilities. On occasion their concerns may even extend to the proper carrying out of official duties, and ensuring that disease epidemics or notorious causes of illness are dealt with. Thus they are interested in the provision of clean water supply through handpumps (though not in ensuring that all villages get them or that the programme functions properly everywhere) as well as in the supply of insecticides for malaria control - in fact anything which is regarded by villagers as an asset. They also are interested in services which are unofficial, or break the law in some respects, such as unregistered medical practice: such people require a patron in order to avoid trouble with the police.

Finally, the proprietary classes perceive an interest in population control of 'them', the masses. Family size amongst the urban classes is already small, one or two child families being common. The spectre of untrammelled population growth destroying urban cohesion, denying employment to their children, and undermining their own long-term economic security, is a potent force affecting Government policy. These fears may be unjustified; after all, the growth in white-collar employment in much of the public sector is based on growing demand from a growing population rather than growing wealth. Nonetheless, in large measure, the family planning programme dominates the public image of the main task of the health services.

At this second level of the State, therefore, class interests do not produce a straightforward drive for the application of a 'medical model' to health services development. However, they support tendencies which undermine the application of health planning models - such as the growth of private sector medicine which is ever more sophisticated and expensive, and which sets the standards for the public sector to aspire to; the creation of a bureaucratic ethos which differentiates sharply between the treatment of those with 'pull' and those without it; and a pressure for increasingly coercive measures of population control which further alienates most people from the idea of involvement in community health activities.

GOVERNMENTAL STRUCTURE AND HEALTH POLICY-MAKING

Under the 1950 constitution the primary responsibility for health matters was given to the States. The Centre kept control over international aspects - quarantine etc. - and over a limited range of all-India matters, including the regulation of standards of medical education (to permit medical personnel to practise throughout the country) and the control of communicable diseases.

The abolition of the I.M.S. deprived the Central Government of a cadre of medical bureaucrats whose careers it could control and who had played a major role in influencing and co-ordinating health policy throughout the country. Since 1950 co-ordination of health policy has largely been handled through the financial incentives offered by Plan funding, and by persuasion through informal channels and through annual meetings of the Central Council of Health (C.C.H.). These have established that the conclusions or motions passed by the C.C.H. were only advisory and the states would not regard them as binding. This exposure of the weakness of Central control has led to calls for an All-India cadre of medical administrators to replace the I.M.S. (G.O.I. 1962:46-7 & 463-476, but without success.

The Planning Commission has provided the Central Government with a powerful agency for affecting health (and other) policy because it has controlled the most substantial part of uncommitted funds. In addition, the Planning Commission has provided a counter-weight to the Ministry of Health in health policy-making. Economists and administrators have dominated the Planning Commission. If the Ministry of Health has been vulnerable to takeover by doctors' interests, the Planning Commission has had a powerful veto on their proposals (Jeffery, 1986).

Most discussions of the planning process in India have focussed on the overall context, and on the dramatised by the crises of planning (see, for example, Streeten & Lipton, 1968; Bhagwati & Desai, 1970; Cassen, 1978; Frankel, 1982). The catalogue of criticisms is almost endless. One with specific relevance to health sector planning is that prior to the Fifth Plan the distributional aspects of development were ignored. This assumption has come under increasing attack (eg. Chenery et al, 1974), and

alternative planning strategies have been proposed. Of these, a concerted attack through land reform on those institutions which generate poverty in rural India has not been seriously considered. Instead, the response has been a 'basic needs' strategy; that is, to emphasise programmes to provide basic services to the mass of the population. The so-called Minimum Needs Programme raised the importance of 'social expenditures (health, education, social welfare etc.) in contrast to the earlier Plans when the 'core' sectors were always heavy industry, power and minerals.

In this setting, several policies have been introduced and implemented, apparently within the framework established by the Bhore committee. Prior to 1970 these were particularly the disease control programmes, most notably that against malaria and smallpox; the creation of a health centre network covering the whole country; establishing a public-sector basic drug production capability; and the training of paramedical personnel in large numbers. Since 1970 the emphasis has shifted to integrating specialist paramedical cadres into categories with multiple functions; creating sub-centre clinics for every 8-10 villages; introducing village level health volunteers and training traditional birth attendants; and trying to provide protected water supplies to the majority of India's villages. None of these achievements are unproblematic, but here I want to focus on the fact that they have been introduced at all. By comparison with many other 'peripheral capitalist' countries, these policies were outstandingly successful. The numerical balance of health personnel has shifted steadily away from the doctors, the balance of health expenditures have favoured primary care and the public sector health facilities have retained a dominant position (Jeffery, 1986 and forthcoming).

Three factors help to explain this success, as well as many of the weaknesses. The first is the position of the Planning Commission, providing a base for the 'health planning' perspective largely immune to doctors' pressures. The second is the presence in the Indian medical elite of highly trained medical scientists open to the international development of ideas of appropriate health care. The third is the support of foreign aid, unusually willing to fund the technical aspects of several major policies (Jeffery, 1985). The weaknesses of these policies derive from the same sources. The Planning Commission had no mechanisms to ensure that the policies were implemented in spirit as well as in

form. Elite medical scientists never worked in primary health centres, district hospitals, or in State Ministries of Health, and so they could ignore the realities of those situations. Foreign donors' influence ended when their funding ran out, and much of their effort (willingly or not) has been amenable to transfer to use for family planning of an increasingly coercive kind.

THE 'NEW' HEALTH POLICIES

How far has this picture been modified by the health policies which have been introduced since 1977? Key features of the new approach are its concern with 'people's participation', 'integration', and the use of auxiliary health workers.

The 'people' were supposed to 'participate' in developing the work of primary health centres under the Community Development Programme of the 1950's and 1960's, but the new thinking was more sophisticated. However, Government programmes assume that non-Governmental personnel can only participate in implementing a programme, with no say in raising the resources for it nor in deciding what it should be. In addition, no changes have been made to the Government structures themselves, which in many States work to maintain the existing inequalities, and are closely aligned with conservative political forces. In fact, participation receives no more than a cursory mention. Participation in the selection of village health workers rarely gained any meaning in practice. Further proposals for village health committees to oversee the work of the C.H.V. and to carry out environmental improvements are part of the received orthodoxy, but examples of their successful introduction through Government schemes are lacking. Villagers perceive a health committee as part of normal political activity, in which leadership is arrogated as of right by dominant factions; or as a means of increasing the assistance the village might receive from Government services. Village political processes are rarely able to deliver village-level resources (labour, in kind, or cash) for health improvements. No plausible proposals exist to generate such support for major improvements such as environmental sanitation or collective rural insurance.

Neither Congress nor the regional parties make great claims for trying to change local social structures; and practice is even less reformist. The Congress Party is closely tied into local structures of power, economic and social, and tends to draw in the institutions of Government (the police, the civil service) to support local partymen. Where Congress dominates, the political orientation is at best reformist, but more usually conservative; if Congress politicians control health committees, 'participation' is unlikely to progress very far.

'Integration' has also been a key word in discussions of health policy. The discussions in the 1950s and the 1960s related to the integration of curative and preventive care, at the level of the doctors, or the administrative structure; in the 1970s the integration of the different preventive health campaigns with separate cadres of paramedical workers was a central issue. In both cases, however, integration was restricted to health workers. In the 1950's health work was made part of rural development but little was carried out, perhaps because most people do not place health high on their lists of priorities (Taylor et al, 1965). The new voluntary sector health projects are much more adventurous in attempting to integrate with non-health development as an opening into the village by addressing the 'felt needs' of its members or on the grounds that water supply or poverty are the main causes of ill-health (Antia, 1985).

Government health services are only integrated within the health sector. Health Assistants and Health Workers are now expected to turn their hands to whatever work, curative or preventive, which is required of them, though the Multi-purpose programme is still not fully implemented in all States. In some measure, integration can be seen as a way to bring more workers (especially men) into family planning work, and family planning is the only programme regarded as sufficiently important that the health services can require support or involvement from other Government agencies - revenue, rural development or police. Can this really be regarded as 'integration'? During the Emergency, and to a lesser extent since 1981, it has been perceived by the public at large as using coercive agencies to meet sterilisation targets (Vicziany, 1983). At the level of day-to-day dovetailing of programmes so that they reinforce one another,

integration is conspicuous by its absence. Even in the I.C.D.S., where the resources are available and both Health and Education Ministries have overt health goals in common, integration is at best partial and inadequate. Integration of plans in New Delhi or at the State Capital is so diluted by the time it reaches the District or the Block that integration where it really counts - where services are delivered - is almost indiscernible.

The expanded use of auxiliary health workers is a final element. In general, village level workers are drawn from the villages where they work. But projects have varied according to the minimum education they demanded, from none at all to several years of schooling. Ideological differences occur between using untrained personnel as a way of demystifying medicine, or accepting auxiliaries only in the context of shortages of trained personnel.

The experience of Governmental approaches to participation, integration and the use of auxiliary workers support the argument that these innovations cannot be applied as if they were techniques, divorced from a social, economic and political context. The two lessons of local flexibility and committed leaders cannot be transferred to a Government structure which allows initiative to be exercised only by those at the top, and in which communications are transferred down the hierarchy but almost never up.

CONCLUSION

It would be easy to conclude that health policy in India is so closely dominated by national and international class interests that little scope remains for major change. However, this analysis would be too simplistic. In the first place, it ignores the very real achievements of Indian health policy. Health planning has shifted resources towards preventive medicine, rural areas and paramedical workers. Substantial preventive campaigns have been waged against malaria and smallpox. Large numbers of P.H.C.s and subcentres have been built and equipped, and staff have been appointed. In some parts of the country, admittedly areas relatively favoured on other counts, many workers are conscientious,

and beneficiaries have not been restricted to the higher classes and castes. Paramedical staff may be trained and employed on the cheap, but their numbers have continued to rise, and they are sufficient to supply most of the population with something approaching a reasonable health service. Some of these services probably have helped to support the decline in levels of mortality, halting and uncertain though this has been.

Secondly, amongst the various legs which support class domination, health policies, health sector assistance, and even the operations of pharmaceuticals companies, do not have high priorities. More radical health sector proposals (like the nationalisation of drug production) are ofcourse fought hard by those whose interests would be directly affected. Further, changes in the local distribution of resources which might be needed if inequalities in health are to be overcome, or diseases of poverty are to be significantly reduced, will also be fiercely resisted. But very few health proposals come at all close to such radical ideas. The more notable features of Indian health policy are the extent to which it has shifted towards more appropriate models; and the role of factors internal to the Government and political party structure which have limited the implementation of even these relatively modest proposals.

Further, the Indian Government has been relatively successful in what it has achieved, measured against its near neighbour, Pakistan, with which it shared its historical legacy (Jeffery, 1974; A.D.B., 1981; Shepperdson, 1981). As always, the frame of reference is crucial: compared to Pakistan, India's achievements are considerable; compared to the ideals of the planners and proponents of the 'new perspectives', India comes off much less well. The explanations for these patterns derives from features of the social organisation which are well captured by Alavi's discussion of levels of the State and the degree of their integration. 'Tight' States have consistencies among the different levels of the State, and integration is close. In these States, whether conservative (Iran, perhaps) or radical (China) the class interests which dominate the State are closely in accordance with the structural constraints in which they are set, and have a bureaucratic and political party system which responds to those interests. 'Loose' States are those where integration is much less clear, and contrasting pressures are able to operate with some effect.

In India, the tightness of relationships between the levels is less than in many other countries. This results from the nature of the Indian nationalist movement, from decisions made by the Indian political elite soon after Independence - the creation of powerful Planning mechanisms, the retention of State control over aspects of the economy, the elimination of zamindari - and from features of Indian class structure, such as the greater size and sophistication of the Indian capitalist class, and the more secure base of the Indian civil service. This has made possible a political party structure more democratic in its organisation than many others, with a diversity of parties and competition for local political resources.

Thus, Indian decision-making has been centralised in the hands of a bureaucratic and political elite which has given rural provisions a priority, based firstly on socialist and Gandhian perspectives and latterly on a populist strategy. The shift from 'top-down' socialism, to a populist, potentially authoritarian regime, emerges between 1965 and 1975. In health policy terms, the Planning Commission has lost much of its centrality, and control over key aspects of policy (such as the numbers and 'quality' of medical colleges) has become much more difficult to assert. The socialism remained 'top-down' because it involved no party structure at the village or ward level which could either transmit its demands up the political or bureaucratic structure, or act as the channel for ensuring that higher-level decisions were taken. Some have derided this as 'Fabian', on the grounds that it was largely a matter of the intellectual classes, with no popular roots. The absence of these roots made it vulnerable to the populist takeover, which lies most clearly behind the final implementation of the C.H.V. scheme. But the new populism also has no strong village roots, which limits its potential for improving health almost as much (Jobert, 1985).

The thread which links these levels of the State is a clientelist political structure. The State has what coherence it receives from the flows of resources (usually called 'black' money) which move between capitalists, landlords and their dependents, political parties (especially Congress) and members of the Government machinery. These

flows are essential for the maintenance of the party structure, but they are also the flows which ensure the protection of propertied classes. The C.H.V. who gains his job through patronage has to repay that patronage; the paramedical worker who wishes to get a favourable transfer must please local elites and accumulate financial resources which will eventually end up recycled through the political machinery; and the creation of rural resources is part of the currency of local politics, not the implementation of clear-sighted solutions to underlying problems.

The balance of these forces varies throughout the country. The contrasts between Bihar, where the levels seem most tightly linked, West Bengal and Kerala, where most separation is discernible, or Punjab and Haryana, where the situation seems most fluid, have been noted (eg. by Nag, 1983). Kerala and West Bengal have the makings of a localised party structure, based on ideological party commitments and drawing support from the poor and landless as well as the landed, though the effect on health services organisation and achievements is more marked in Kerala than in Bengal. Local niches can be exploited by voluntary sector organisations, and occasionally by mass-based political movements, but the wider structure will not disappear.

No-one can be very optimistic about the health of Indians and the prospects for the implementation of community health services. Conversely, however, nonne should write off the possibility of improvement. The grounds for hope in the Indian experience lie with those who are building on local social forces to employ the health resources which are finally arriving at village level.

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HEALTH POLICIES IN INDIA: COMPARISONS WITH THE CHINA EXPERIENCE

by

Lincoln C.Chen

INTRODUCTION

A close professional colleague once confided to me that he would have very much enjoyed undertaking a comparison of health in India and China, two of the world's most populous countries. Despite his firsthand experience and academic expertise on the topic, he had never pursued the study because, as he said, "India's health situation would come out so poorly in comparison that I might lose my Indian friends!"

I am an expert on neither India nor China, although I was born in the latter and have had the unique privilege of living and working in the former for the past five years. Moreover, I certainly value the many close relationships that I have formed with Indian friends and colleagues over the recent past. Nevertheless, I have consistently felt that a comparison of the India and China health experiences would be enormously stimulating - not so much for the answers that would be generated, but for the many questions that would be provoked.

It is thus with considerable anticipation and trepidation that I undertook the analysis presented in this paper. I began with admittedly imperfect statistics describing the health situations in these two societies at the beginning of the 1980s. Moving from this empirical comparison, I developed a conceptual framework describing how various socioeconomic and health care system factors could be hypothesized to impact upon the health of the Indian and Chinese populations. The paper then underscores a set of policy issues relevant to the theme of this conference, "Health for All: Concept and Reality". The gaps between concept and reality are illustrated in two health policy arenas - vertical campaigns and village-level worker performance. The paper concludes with a discussion of the political economy of health in India and China.

INDIA AND CHINA

The 1982 populations of India (733 million) and China (1,019 million) combined constitute nearly 40 percent of the world's population or 75 percent of people residing in low-income countries with per capita annual incomes below US $400 (37,38). In addition to their demographic size, these two Asian societies share other features. Both are ancient cultures which attained their current political governance structures about four decades ago. Both have low per capita income, modest levels of urbanisation, and a predominance of agriculture in the economy.

Table 1

Selected Development Indicators: India and China (1983)

	India	China
Demographic		
Population (millions)	733	1,019
Urbanisation (%)	24	21
Labor force in agriculture (%)[a]	71	74
Economic		
GNP per capita (US$)	260	300
Absolute poverty (million)	300	100
Cereal availability per capita (gms/day)	414[b]	533[c]
Social		
Adult literacy[d] (%)	34	77
Enrollment primary school[e] (%)	79	100+

a. 1981
b. 1982
c. 1979
d. 1977
e. 1982

Source: D.T.Jamison, 1985; World Development Report 1985; C. Gopalan, 1985.

Differences between these two giants, however, are also noteworthy. Politically, China is a centrally-controlled communist state, while India is a federated democracy operating a mixed economy.

While the Chinese people are relatively homogeneous ethnically (93 percent Han), India's people are highly diverse with multiple languages, many religions, and diverse caste, tribal, and cultural affiliations. The Chinese have achieved nearly universal literacy within a reasonably egalitarian social structure. By contrast, the majority of India's people remain illiterate and deeply imbedded in rigid social stratifications. Interestingly, both India and China may be classified as "superior health achievers" since their national mortality levels are lower than would be predicted by their respective national incomes (6,18).

Data in Table 2 show that India and China experience markedly different health situations. India has moderately high fertility and mortality, while China's births and deaths are very close to those of economically-advanced countries. China has been able to achieve these dramatic health advances over the past three decades (Figure 1) (8,22).* In India, reasonably steady health improvements have been observed throughout most of this century, but India's contemporary health situation continues to remain relatively inferior (15,35).

Table 2

Health Indicators: India and China(1983)

	India	China
Crude Rates (per 1,000 population)		
Births	34	19
Deaths	13	7
Natural increase	21	12
Fertility Rates		
Total fertility (per woman)	4.8	2.3
Mortality Rates		
Infant(per 1,000 livebirths)	93	38
Child 1-4 yrs (per 1,000 population)	11	2
Life expectancy (years)		
Male	56	65
Female	54	69

Source: World Development Report, 1985

*Because these data are 5 or 10 year averages, the dramatic mortality peaks of the Great Bengal Famine(1943) in India and the Great Leap Forward (1959-61) in China are not depicted.

A most interesting comparison between India and China is health disparities within societies. Despite high overall life expectancy, China experiences health differentials that are primarily geographic in character (23). Infant mortality in rural China is 70 percent higher than urban levels, and the rate in backward Yangsu County is nearly threefold that of more advanced Shanghai County (39). Mortality rates in the minority regions of China involving nearly 100 million people may be considerably worse than generally reported. In India, health differentials are also marked, and the disparities are evident not only geographically but across many socioeconomic characteristics (Table 3) (15,21,35). Indian rural infant mortality is nearly twice that of the level in urban areas, and the likelihood of infant death in the backward state of Uttar Pradesh is five-fold that of socially-advanced Kerala State (14). Differentials are also pronounced between religious, caste, and class groups, and socioeconomic characteristics such as literacy and mother's education (4,21,35). India is one of the few societies in the world where female life expectancy is briefer than male (7,10).

Table 3

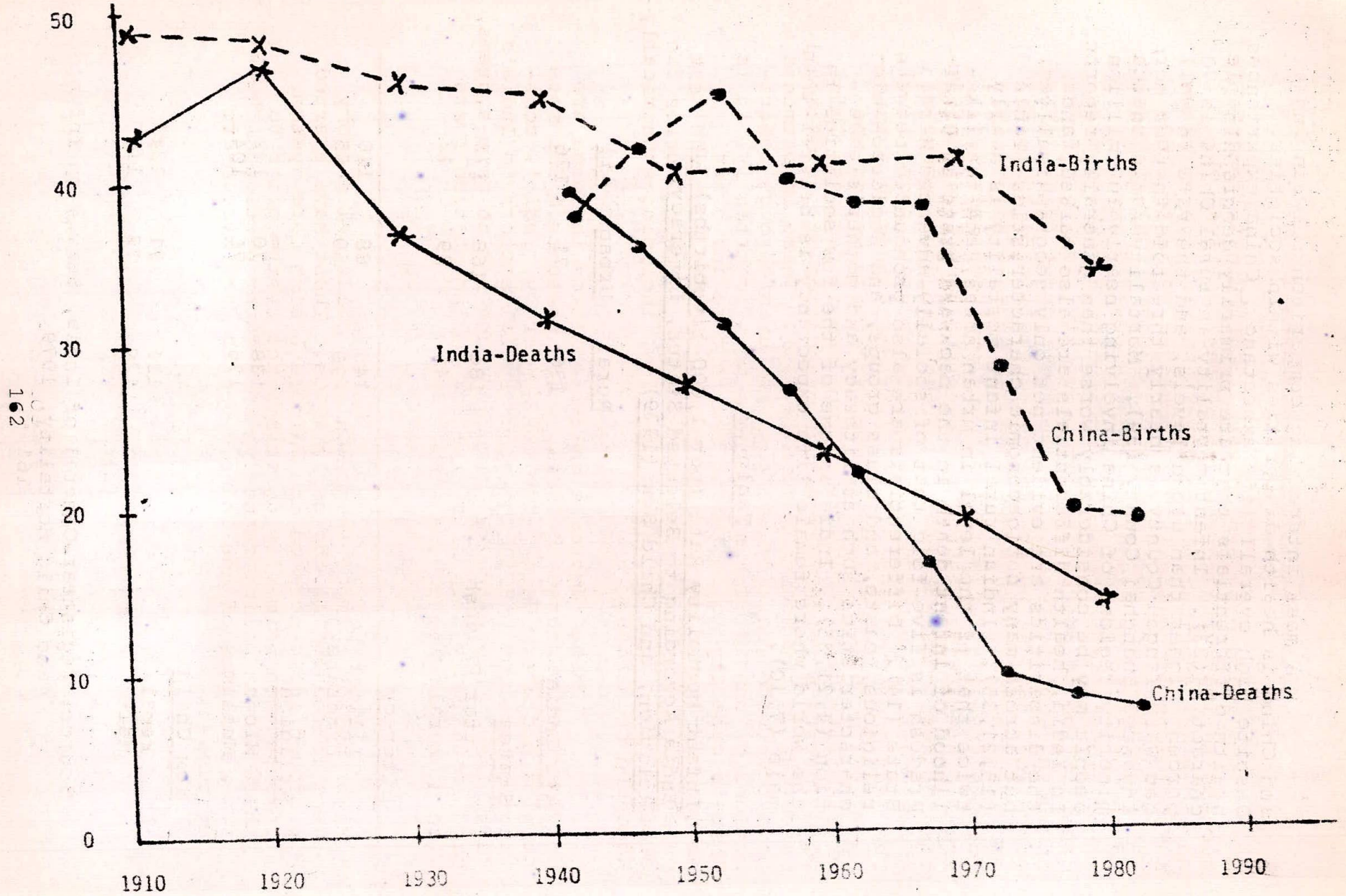
Infant Mortality Rate (per 1,000 livebirths) in India According to Selected States, Literacy, Religion, and Child Sex (1979)

	Rural	Urban	All
All India	136	71	126
States			
Jttar Pradesh	184	168	172
Kerala	45	29	42
Literacy			
Illiterate	145	88	140
Literate	90	50	55
Religion			
Hindu	138	70	132
Muslim	126	76	104
Sex Child			
Female	131	71	121
Male	129	73	119

Source: Registrar-General of India, Survey on Infant and Child Mortality, 1979.

Figure 1

Crude Birth and Death Rates in China (1940-1980) and India (1911-1981)



Much has been written about China's remarkable success in improving the health of its people.* The advances are attributable to China's health system as well as socioeconomic gains in the provision of basic needs - water, sanitation, and food (11,18,23,32). China's health system prior to the 1980s has been marked by several innovations. Among the more significant have been mass mobilisation of the people for preventive health efforts, including campaigns against the 'four pests' (rats, flies, mosquitos, and bed bugs), sexually-transmitted diseases, mass vaccination, and control of the vectors responsible for the transmission of malaria and schistosomiasis. Another noteworthy feature has been the deprofessionalisation of health care providers through the development of a mass cadre of barefoot doctors at the grass roots level. The mass application of paraprofessionals through a three-tier health care delivery system has helped extend the availability of basic services into remote regions. China also invests a relatively larger proportion of its national resources in the health sector (23,31). These investments have been both monetary, as well as human through contributions of unpaid labour. Perhaps most importantly, it is China's capacity to implement health care and other programmes at the grass roots level that has been the most outstanding feature of its success (33). Few countries can claim similar implementation capacity, including economically-advanced countries.

These favorable characteristics in China are only partially shared in India, which presents a far more complex picture. As a federated democracy, India's constitution assigns health and other social sectors to India's 22 states. The centre may plan and fund health care systems, but the ultimate responsibility for implementation rests with diverse state governments (12).

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* Major policy changes in the Chinese political economy were introduced in the early 1980s. These have exerted profound influences on the Chinese health care system. This section primarily describes the system prior to these recent policy changes. In a later section, recent changes of the Chinese health care system are discussed.

The health departments at the state level mirrors the bifurcation of health and family planning at the center. The health department is responsible for health services, medical education, hospitals and vertical disease control programmes. The family welfare department is primarily responsible for family planning, and secondarily for maternal-child health services. Other health-related fields are assigned to other ministries: nutrition to social welfare; water and sanitation to housing and public works; and pharmaceuticals to industries and chemicals. Urban health services are provided through a network of state or municipal hospitals and dispensaries. The overwhelming bulk of India's people are in 576,000 rural villages, covered by a three-tier primary health care system. At the district level (population about 1 million) are medical and family planning officers responsible for the entire district, including dispensaries and hospitals. At the block level (population about 100,000) are primary health centres. These, in turn, supervise and back-up the work of subcenters, which optimally cover about 10,000 people through multipurpose workers. The bulk of basic services are provided by part-time community health workers based at the village level.

The density of health personnel in India and China are, at senior levels, rather similar(15,22).

Table 4

Health Personnel & Facilities in India & China

	India		China	
	No. (000's)	Per 100000 pop.	No. (000's)	Per 100000 pop.
PERSONNEL				
Senior				
Doctors(western)	271.6	37	516.5	52
Doctors(traditional)	382.5	52	289.5	29
Pharmacist (all)	155.6	23	162.7	16
Middle				
Assist doc/Med pract.	250.0	44	436.2	44
Nurses	160.9	22	525.3	53
Midwives	247.4	34	70.9	7
Primary				
Aides/Workers	140.8	19	769.5	78
Village Workers	313.2	42	1839.6	185
FACILITIES				
Hospitals(all)	7.2	1	65.9	7
Beds (all)	500.6	67	2017.0	203
Beds (Rural)	93.5	16	1097.1	138

Source: China:The Health Sector, World Bank,1984.
Health Statistics of India,Ministry Health Family Welfare,1984.

Both have large numbers of western-trained allopathic doctors, and both have nurtured and subsidized traditional health practitioners.* At the middle - and primary-levels, differences become noteworthy. The density of Chinese assistant doctors is similar to India's rural medical practitioners. There is considerable difference, however, between Chinese para-professionals trained and supervised as assistant doctors in comparison to unqualified, unregistered, commercially-motivated rural medical practitioners in India. At the grassroots level, China's health aides and barefoot doctors are four-fold more dense than India's village aides and community health workers. Moreover, in-depth observational studies in India have demonstrated high rates of absenteeism, diversion into private practice, and low work output among Indian health personnel (2,4).

China's health facilities situation is also superior. China's hospital to population density is seven-fold that of India's, and it has four-fold the density of beds per population (15,22). China's bed availability for rural people, furthermore, is eight-fold more than India's. Much of India's primary health care infrastructure is still in the planning stage and not yet functional. In 1984, less than 30 percent of primary health centres were actually operational, and less than half of the subcenters were staffed with trained multipurpose workers (2).

Although their 1982 per capita GNPs are roughly similar (China US $ 265, and India US $ 229), the share of national income invested in health differs (49). I estimated that India's per capita health investment is $ 2.7 or 1.2 percent of GNP (2,9,15,17,25,31). This level is only one-third that estimated for China's at $ 8.8 per capita or 3.3 percent of GNP (22,37,38). **

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* The Chinese traditional medical systems are Han,Mongol, Tibetan, Udyour, and others. The Indian traditional systems include Ayurveda, Unani, Homeopathy, Siddha, Tibetan and others.

** Indian resource investments in nutrition, water, and sanitation are excluded from these financial analyses.

Health sector resource mobilisation patterns in India and China are compared in Figure 2.* Private sources constitute two-thirds of India's health finances; one-quarter is from government; and only 8 percent from insurance schemes. China, by contrast, has tripartite financing structure with about equal shares coming from state, private and rural cooperative insurance sources.

Resource flows through various health care delivery systems follow the pattern of financing. In India, two-thirds of the flow goes through the private commercial systems. Only one-quarter goes through government health services. Very small portions flow through private non-profit voluntary organisations and enterprise-related health systems. In China, the flow through rural collective systems predominates (40 percent), with smaller portions through government and enterprise systems.

Interesting is the similarity of Chinese and Indian resource allocations in health. In both cases, half or more of the resources are invested in pharmaceuticals, and nearly all of these expenditures are for modern, not traditional, drugs. About a quarter is allocated for personnel salaries. China's investment in hospitals is proportionately half that of India's.

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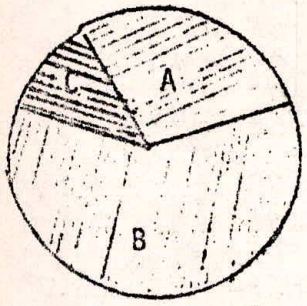
* Health financing and resource allocation data for China were obtained from the World Bank (22,23). Data for India are extraordinarily difficult to compile and analyse. Considerable information was obtained from many disparate sources (2,3,4,9,12,17, 19,25,31). Government expenditure patterns are complex because Five Year Plan allocations relate only to central government allocations; yet approximately two-thirds of public health sector expenditures are from the diverse recurring budgets of state governments. Moreover, the available data are often broadly categorised, precluding detailed analysis. The most difficult estimate relates to the size and pattern of India's vast and complex private sector. Isolated health care expenditure surveys are available, but these show expenditure patterns ranging from Rs.3 to Rs.108 per capita annually. Crude averages were estimated through validation of these scattered estimates with more reliable financial data on turnovers in the pharmaceutical industry. (3).

Figure 2

Health Resource Mobilization and Allocation: India and China

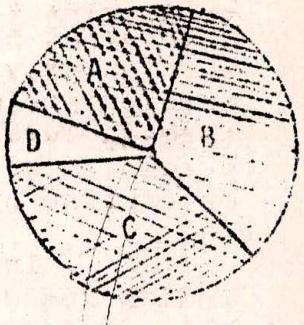
India

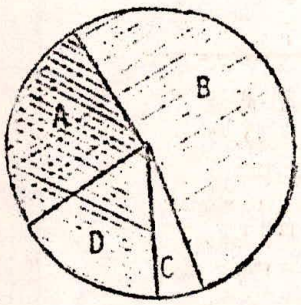
China



SOURCE OF FINANCE

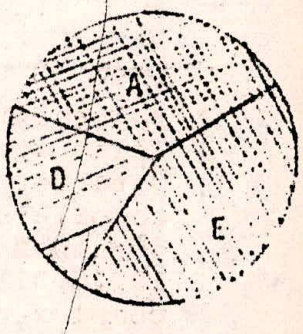
India		China
26%	A. State	30%
66%	B. Private	32%
8%	C. Insurance	31%
0%	D. Rural Cooperatives	7%

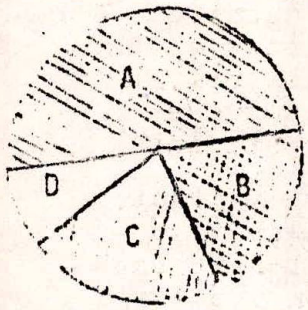




DELIVERY SYSTEMS

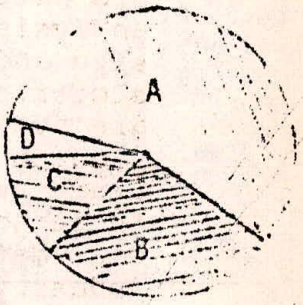
India		China
24%	A. Government	32%
62%	B. Private (market)	0%
4%	C. Private (non-profit)	0%
10%	D. Enterprise	25%
0%	E. Rural Collectives	40%





RESOURCE INVESTMENTS

India		China
50%	A. Pharmaceuticals	58%
21%	B. Salaries	24%
21%	C. Hospitals	13%
8%	D. Others	5%



Source: China data (27)
India data compiled by another.

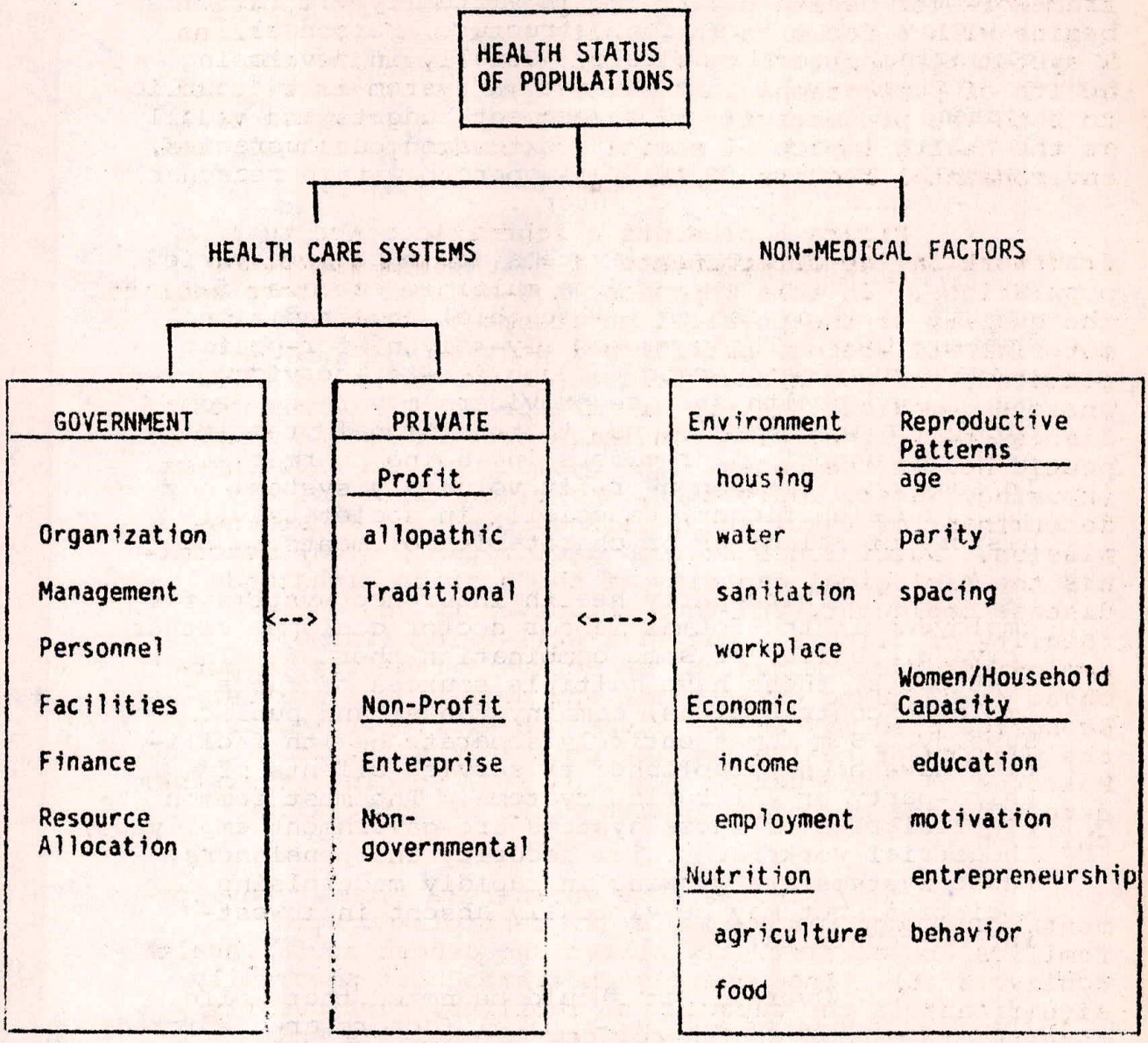
CONCEPTUAL FRAMEWORK

The comparison between China and India provides an empirical base for formulating a conceptual framework for health policy analysis. Such an approach begins with a focus on the health status of populations. A systematic approach to factors that determine the health of populations introduces considerations related to both the productivity of health care systems as well as the health impact of social, economic, political, and environmental factors (6,18,30).

Figure 3 presents a schematic conceptual framework on the determinants of the health status of populations. In this approach, non-medical factors include the quality of the physical environment, economic or material well-being, nutritional status, reproductive patterns, and women/household capacity variables (30). These non-medical factors are the primary determinants of disease risk; they also condition preventive and therapeutic health responses. The quality of the environment (housing, water, sanitation, workplace) is a primary determinant of the risk of disease exposure and transmission. Nutritional status (agriculture, food) determines the biological capacity of the host to withstand disease onslaught, and thus the severity and case-fatality of illness. Material well-being (income, employment) determines the capacity of families to purchase an adequate environment and nutritional status. Economics also may shape client behavior, particularly the pattern of health service utilisation (24,26). Patterns of reproduction (age, parity, spacing of births) determine the biosocial health risks of mothers and children.

Many studies have shown that even if environmental and economic variable are controlled, some families are consistently better and others poorer, health achievers (6). Inadequately understood but powerfully significant is the capacity of families, particularly mothers, to manage health-related investments and behavior within households. One measurable indicator reflective of this capacity is maternal education (5,36). But the health capacity of a household probably relates to a host of additional, poorly-measured factors such as motivation, enterprise, and behavior(36). These household-capacity factors probably exert their effects through both health care and non-medical factors - such as disease prevention, improved nutrition and more timely and effective prevention and management of illness.

Figure 3


HEALTH STATUS OF POPULATIONS
HEALTH CARE SYSTEMS
NON-MEDICAL FACTORS
GOVERNMENT
Organization
Management
Personnel
Facilities
Finance
Resource Allocation
<-->
PRIVATE
Profit
allopathic
Traditional
Non-Profit
Enterprise
Non-governmental
<----->
Environment
housing
water
sanitation
workplace
Economic
income
employment
Nutrition
agriculture
food
Reproductive Patterns
age
parity
spacing
Women/Household Capacity
education
motivation
entrepreneurship
behavior

The other major determinant of the health status of a population is the health system. One useful classification for health systems is public versus private. Such a dichotomy usefully classifies systems that are different in virtually all respects - objectives, organisation, structure, personnel, financing, and client role. Usually in developing countries, the better understood system is the public system. Subsidised by government budgets and usually directly operated by public extension bureaucracies, public sector health systems operate within reasonably well-defined policy parameters.

The private systems are much more varied and difficult to map. Often multiple schools of health, modern western (allopathic) and traditional, are involved. The commercially-driven, for-profit private systems operate through fee-for-service payments, and health service providers may range from highly-trained physicians, to traditional practitioners, to untrained providers including pharmacists. In some countries, non-profit voluntary systems may also be significant, especially in societies with a history of religious or charitable movements.

Third-party health insurance systems for employees in the formal labour sector could be either private, public, or some combination thereof. In most cases, these have multiple sources of funds - employee contributions, company funds, and public subsidy. Sometimes entirely separate health facilities have been established to service clients of third-party or enterprise systems. The most common beneficiaries of these systems are government employees, industrial workers, social security and pensioners. These systems are growing in rapidly modernising societies, but may be virtually absent in lowest-income countries.

Overall, it should be noted that while the health system and non-medical factors are depicted separately in Figure 3, they are in reality highly interactive and interdependent. In other words, non-medical factors can influence the shape and performance of health systems/* can influence non-medical factors. The reduction of debilitating disease could facilitate the exploitation of previously inaccessible agricultural lands and a reduction of malnutrition and morbidity could improve work performance. There

/* and conversely, the performance of health systems

may also be interactive processes between governmental and private sectors within the health system - such as the private production of pharmaceuticals for distribution in public systems or the part-time private practice of full-time government-employed doctors. Thus, processes and outputs of health systems (public and private) and non-medical factors are highly dynamic, interactive and interdependent.

CONCEPT VERSUS REALITY

At least on the surface, there are conceptual similarities between the Chinese and Indian health systems - in organisation, management, facilities, personnel, and technology policy. Both China and India have three-tier horizontal health care systems with outreach to the village level. These countries have invested heavily in modern hospitals and doctors, while simultaneously subsidising the traditional health systems. At the grassroots level, both have para-professionals providing basic services to the population. In both countries, about half of all health expenditures are for drugs. Hospitals and personnel salaries command most of the remaining resources.

Deeper analyses demonstrate critical differences, however. One reality is the organisational controversy regarding the relative merits of vertical versus integrated programme structures and the relative emphasis between preventive versus curative services. Curiously, in both countries, prevention receives less than 10 percent of health resources (22). Disease prevention in China, however, has achieved outstanding results through mass mobilisation of peasants for health campaigns. These preventive health actions did not overtax the health budget in a poor society since monetary resources were supplemented by compulsory mobilisation of surplus labor during slack agricultural seasons (30,32,33). China's success with vertical programmes, however, is probably unique to the sociopolitical conditions of the society (33). Effective implementation depended upon China's strong political-administrative capacities at the grassroots level.

India, by contrast, has experienced mixed results with vertical programmes. In the past 40 years, India has introduced many preventive campaigns - in family planning, malaria, filariasis, leprosy, blindness, goitre, smallpox, tuberculosis, kala azar, Japanese encephalitis, and more recently an expanded programme in immunisations

(EPI) and oral rehydration therapy (ORT) (2). Of these health problems, only smallpox has been eradicated. The remaining have persisted, and in some instances resurged (such as malaria). India's health system is increasingly burdened by budgetary obligations and staff from defunct vertical programmes in which permanently employed field staff have been left behind as priorities have shifted (2,4).* India's vertical campaigns also depended entirely on a full-time extension bureaucracy, not voluntary labor, and pressures from the top could not generate indefinitely high productivity in the health sector.

A similar contrast of reality is noteworthy in personnel and facilities policies. China's barefoot doctors were a creation of and their functioning depended upon the Chinese political-administrative system at the commune and brigade levels. In other words, the barefoot doctor fitted into the local organisational structures of rural China (33). The community health worker in India operates in an administrative vacuum. The community development movement in India, begun in the 1950s, is based upon an extension model orginally transplanted from the United States. Parallel sectoral extension workers function within traditional village power configurations, which are hierarchical and socially stratified. India's extension approach has yet to overcome weaknesses in motivation, supervision, and training.**

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* Foreign donor resources often play stimulate the establishment of vertical programmes in India.High priority problems are identified, Five Year Plan resources are targetted (usually involving foreign aid), and specialised vertical programmes are launched. The cost of these special programmes, after the start-up phase, must be absorbed by the recurring regular budgets of state governments.

** Functional time allocation studies in India have found that community health workers spend 44 percent of their work time on family planning and less than 25 percent on health or maternal-child health services. (3).

In neither China nor India has there been broad recognition and concern over the health consequences of drug use patterns and the proportion of health resources invested in modern pharmaceuticals. In China, drug production is by a state corporation. There appears to be large-scale abuse of modern pharmaceuticals. In India, only recently have there been public efforts made to promote rationalisation of drug production and consumption which are predominately in the private sector (3). The problem in India is grossly complicated by the fact that pharmaceuticals are not considered primarily within the domain of health. Rather, drug production and marketing are under the purview of the Ministry of Industries and Chemicals (2, 3).

POLITICAL ECONOMY OF HEALTH

While understanding of health policy concepts and reality can be advanced through any specific lens (eg. organisation, technology, finances), such comparisons are only useful to the extent that they are geoculturally specific and incorporate considerations of the broader context of the political economy shaping health care and non-health care factors. Historical, political, and economic forces operate both directly on the healty system, as well as non-medical factors.

Health systems do not exist in a time vacuum. Rather, they have histories which shape their present and constrain their future.* For China, the communist revolution may be identified as a central determinant of China's performance in health. A newly-formed government without a colonial past, China was able to introduce a health care structure integrating local financing and implementation to its own unique political-administrative

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* Abel-Smith noted that Bismark developed the German employee/employer health insurance fund (2). While risk sharing was introduced, physician fees were determined by the market beyond government control. The cost structure of the German health system ever since has been locked into a high cost trajectory. The German system, moreover, was transferred to Austria, Belgium, Italy, and Japan. Japan, furthermore, transplanted the system into Korea during Korea's colonial period. All of these systems today are plagued by problems of high physician costs. In contrast, Scandanavia earlier selected a system to pay physicians from government budgets, which today accounts in part for Scandanvia's relatively lower-cost health care system.

structures. In India, British colonialism introduced western medicine and medical structures well before the time of the peaceful transition to independence. The famous Indian Bhore Committee in 1946 recommended a national health strategy that contained all of the elements of what we today call primary health care(13). A more recent report by the Indian Medical Research Council and the Indian Council for Social Science Research reaffirmed the Bhore recommendations (19). Neither, however, have been able to overcome historical momentum nor constraints imposed by the political economy.

In both China and India, the broader political context of health is important. China's communist government has consistently ranked health a high ideological, and thus budgetary, priority. China's repressive political system, however, has also generated health problems. Political opposition is not tolerated and public debate is non-existent. Thus, 16-20 million Chinese died quietly of famine during the Great Leap Forward in 1959-61 (1). India, by contrast, is a socially-stratified democracy with an open political process and a relatively free press. Food self-sufficiency has been recently achieved, but 30 percent of Indians continue to be deprived of an adequate diet. Lack of response by the Indian Government to an acute famine would trigger public outcry and could perhaps bring down a government. But the Indian elite and political system, nevertheless, are able to diffuse criticism of persistent mass hunger among nearly half of its people (34).

The linkage between politics and the health system is well illustrated by recent developments. The new Chinese 'household responsibility system' has reintroduced the concept of economic incentives according to individual productivity (32). Peasants and workers are now encouraged to produce privately for individual reward. This fundamental political change has had dramatic, perhaps unintentional, consequences for the Chinese health care system. With a population in pursuit of private gains, decision-making has shifted from groups to families, previous operating structures have weakened, and health motivation can no longer be mandated but must be achieved through mass education.

The network of barefoot doctors has nearly collapsed, rural health care coverage has declined, county hospitals and rural clinics are in financial distress, and private medical practice has re-emerged. Well-to-do clients are now bypassing lower paramedical staff to present themselves directly at more-advanced facilities (20, 32). In India, interestingly, recently policies liberalising the economy may generate a similar trend towards capping of the public sector and stimulation of private enterprise.

History and politics are important, but economics also counts. Health policy thus inevitably confronts the fundamental question: how binding are economic constraints on health? Here we are not dealing with fiscal issues in the health sector, but the significance of economics as one of the non-medical factors determining the health of populations. At the simplest level, the relationship between per capita national product and life expectancy of populations is tight - more wealth, better health (14,18,38). The role of socioeconomic development (versus medical technologies) in the historical decline of mortality in the now industrialised countries has never gained full scientific consensus (6,16,29). Moreover, there are many contemporary exceptions to the direct income-health relationship. Some countries (such as China, India, Sri Lanka, and Costa Rica) are clearly superior health achievers as predicted by their income levels, while others (such as Saudi Arabia, Iran, Libya, Iraq, and Algeria) are clearly inferior health achiervers (6,18). The explanation for these cases of positive and negative deviance from economic prediction is not entirely clear. *

Economic binds are also imperfect at the household level. Some poor families are able to bear and rear healthy children, and conversely some well-to-do households cope poorly. Indepth field investigations have delineated some of the factors responsible, including

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* Caldwell noted that common features among the superior health achieving countries were religion (Hinduism or Buddhism), history of British colonialism, women's autonomy and education, higher relative investments in health, education, and social services, and a political environment fostering egalitarianism and social justice (6).

female education, family entrepreneurship, and health behavior. Female education appears to be a powerful indicator of improved family health, even when income levels are controlled (5,36). Many hypotheses have been advanced to explain the power of women-related or household capacity factors. Some have argued that education imparts knowledge regarding the scientific basis of disease transmission (germ theory), while others have proposed that educated women are more likely to utilise effectively preventive and curative health services (6). Others argue that it is not the knowledge imparted by education, but the socialisation which promotes adoption of an entire set of modern values and practices. Enhanced status of women in the family, some propose, shifts the distribution of power in the family and thus the distribution of intra-household resources towards women and children, the subgroups at highest health risk (36).

The significant conclusion here is that the family is the central production unit for health. Economic constraints may be important, but they are not insurmountable. Educational, behavioral, entrepreneurial, and other factors clearly play critical roles in the production of health. In a recent review, Caldwell boldly concluded that 'good health is within the reach of all' rich and poor nations alike (6). He concluded that necessary was high levels of government investments in the health sector, * broad societal consensus that health is a high political priority, and enhanced status, education, and autonomy of women. The issues were less technical or bureaucratic and more ideological and cultural in which people perceived health and social equality as fundamental rights.

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* There is often substantial co-variation in government expenditures for health and other social services. Commonly, high levels of investments in the health sector is accompanied by high levels of investments in education, nutrition services, and other social welfare activities.

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HFA AND NRRU BY 2000

by

P.B. Desai

It has been a long and as yet unmitigated travail from 1940 resolution of the National Planning Committee of the Indian National Congress on the report of its sub-committee on health to the 1982 adoption of the National Health Policy statement by the Parliament. In this, the fourtieth year of political independence, the evidence has accumulated to show that the dependence of our people remains to be liquidated. This is true of the different sectors of national life to a varying degree. It has been truer in the fields of health and population. What we have accomplished in the course of the period of independence is a long string of prescriptions by a succession of commissions, committees, working groups and the like official bodies. These august bodies often chose to produce prescriptions without any aid from adequate diagnosis. The definitions, concepts, models and the like constructs emanating from the affluent west remains unabated to grip the minds of those who wield the destiny of the second largest population in the world, which grew from around 300 million to more than 700 million in the course of these 40 years. The alienation of the power base from the evolving realities has been the dismal cause of the nation's poor performance in health and population control. It is possible that the failure to control population has compounded the health situation. Yet, the admission of close interaction between health and population growth, that is between mortality and morbidity on the one hand and fertility and mortality on the other, has not been reflected in social action which the government has chosen to operate.

2. The recognition of the mutuality of mortality and fertility trends has been of long standing. It was more pointedly enunciated by the Planning Commission's working Group on Population Policy in their report in 1980. The ICSSR-ICMR Report too had drawn attention to these relationships and the 1982 National Health Policy statement has put it on record. The thrust of the contention has been that the two goals of 'health for all' (HFA) and 'net reproduction rate of unity' (NRRU) to be achieved by 2000 are entirely synergetic. The implied synergism can, however, be seen as limited to the common target date adopted for the simultaneous achievement of the two goals. Beyond that, it is difficult to see if a common strategy has been evolved to maximise the operational interphase between the deter-

minants of mortality and morbidity and those of fertility and family planning.

3. Indeed, HFA and NRRU belong to different conceptual categories. Health for all, whatever its contents may be, is easy to grasp. It symbolises universal aspiration and the causes of its absence are easily identified. NRRU is a fiction in so far as the common man is concerned. It is a variable which has caused enough mischief in formal or technical demography. It can be grasped by statisticians, demographers and other social scientists specialising in quantitative analysis. But it fails to impart clarity even to well-informed planners and policy makers. They, therefore, cling to it as a catch-word or a slogan without being able to spell out its implications as a goal. The variable is synthetic in the sense that it rests on specious assumptions about the continuation of a set of fertility and mortality patterns. It can, however be translated into a much simpler notion of a couple leaving behind them no more than another couple. If we do so, it involves an assumption that it would be possible to pursuade as many as over 150 million couples of the year 2000 to have not more than 2 children each. While we do not contest the veracity of those who desire to define the national goal in this manner, we are concerned about confused thinking that it may generate among policy makers and ultimately amongst the people who must abide by the implied prescription on family size. We are inclined to the view that the close interrelationships between positive health and individual behaviour pattern including reproductive behaviour should make it unnecessary to complicate the straightforward goal setting in terms of progress in the health field without invoking the so-called synergism between mortality and fertility trends.

4. It is now universally recognised that health is conditioned by social, economic, cultural, environmental, genetic, biological and physiological factors. Progress in health is, in the ultimate analysis, a function of the social organisation which in varied ways deals with these factors. Fertility and family size too are conditioned by the same set of factors that determine the health and mortality situation. But in operational terms there is a basic difference.

Individual behaviour patterns, as conditioned by these varied factors, play a role in the determination of health. But their role is partial and it often gets overwhelmed by the broader social setting. Fertility is again a product of the social setting. But here individual behaviour patterns appear to play a major role. Changes in the social setting often appear too distant and take considerable time to enter into the perceptions of individual couples so forcefully as to make them change their reproductive behaviour.

5. In respect of mortality, manipulation of social setting is undertaken to reduce mortality levels over a comparatively much shorter time horizons. Improved mortality patterns then become a part of the social setting conditioning reproductive behaviour of individuals. This is precisely the reason why in the course of demographic transition there has been a time lag between mortality decline and the subsequent fertility decline. It is possible that the common social setting carries a cultural load that facilitates mortality decline but delays fertility decline. The imputed synergism between mortality and fertility goal is tenuous; to claim any synergism between the strategies for reaching the two goals is entirely unfounded. This does not, however, invalidate the thesis that health improvement is a necessary precondition for fertility decline. It is, however not a sufficient condition and many more changes in the social setting are needed to strengthen the negative impact of reduced mortality on fertility. We can go on deploring high fertility, but if we do not wish to impose fertility reduction on couples, it is imperative that we carry forward the process of establishing a new social order within which the people begin to cherish this quality human life at the expense of its quantity. Against this background we may reflect a little more on what we have achieved in the fields of health and population control keeping in view that we have in this country surrendered the entire responsibility to the same ministry.

6. With regard to health, the tortuous development of approaches to the problem of the critical health situation in the country has never been informed in the past by the concept of positive health. The major concern throughout has been with the construction of a nation-wide infrastructure for the provision of medical care. Health care, as distinguished from medical care, has received only lip service and it continues to do so. A limited approach by way of mounting a separate vertical programme for each of the major communicable diseases has yielded success for which the government does not fail

to take credit. Death rate has come down substantially. Correspondingly, expectation of life at birth has increased. But reduction in infant mortality has been entirely modest. Even maternal mortality has made unsatisfactory progress. We have little evidence about the prevailing morbidity levels. But an overview of the current situation suggests that reduction in the mortality has not been accompanied by a corresponding reduction in morbidity. It is in fact possible that we have bargained reduced mortality for increased morbidity. If a comparative view of the health standards of our people is taken, it is one of the lowest in the world. Another glaring aspect of the health situation is that it is characterised by wide disparities between income classes, between rural and urban populations and between different regions of the country. Health for all is a concept based on equity of opportunities for the attainment of reasonable health standards by all people. That equity has remained jeopardised and is in fact tending to be increasingly compromised.

7. The proliferation of the so-called health services in the country drew inspiration from the oft-cited Bhore Committee Report of 1946. But the inconsistencies and the contradictions between the principles enunciated in the report and its more elaborate operative recommendations have never been taken into account. Health is a state subject, but the central government has from the beginning assumed the leadership role. This role had been performed by health officials under the circumstances, the bureaucrats often assumed a professional stance and the professionals aspired to exercise power that the bureaucrats enjoyed. Both were, in principle, subject to the control of the politicians. Unfortunately, as it almost invariably happens in our parliamentary democracy, alienation of the politicians in power from the masses in need of health services, exercised an overriding influence on the course of development in this field as in most other fields of national endeavour. In the result, ad-hocism, trial and error, and piece meal palliatives have been the characteristic features of this process. These were further compounded by the gross inadequacies of the financial outlays that were made available for the health sector. It is not surprising, therefore, that we readily accept the denunciation of the health services as predominated by bureaucratic approaches and professional dominance leading to their urban orientation and over emphasis on technocratic, hospital-based, superspeciality clinical medical care aspects. In the process the people have been treated only as beneficiaries, even when most of the benefits bypassed most of the people.

8. In the course of this period, the health establishment has claimed credit for several milestones including, to begin with, the success of vertical programmes, the creation of national infrastructure comprising primary health centres and sub-centres, impressive enlargement of the complement of para professionals, the introduction of the multi-purpose workers' scheme in the middle of 1970s and the Rural Health Scheme in the late 1970s. They may also take credit for internalising into the system the family welfare programme. We may admit that these have occurred. Yet the cost it has involved in terms of the lag in the improvement in people's health remains a matter of speculation though it has apparently been tremendous. For those who explore this development strategy, it will not be difficult to realise that the so-called family welfare component has been more of an obstacle than of help in the progress of health. The situation has remained so complex that it is no more possible to expect the operationalisation of its replacement by an alternative model of the kind suggested by the ICSSR-ICMR study group. We may denounce this course of development as a neo-colonial aberration, but this is not at all helpful for a viable constructive approach. To drastically change the situation in favour of people's health is nowhere in the offing.

9. The HFA through primary health care has been implanted in this situation. Besides equity, it calls for inter-sectoral collaboration, decentralisation and community participation. These concepts are easy to advocate, but they are difficult to operationalise in a social situation in which the forces of polarisation between the rich and the poor or between the rulers and the ruled are forcing the pace of nation's progress or regression. There has been a tendency on the part of the scholars exploring this field of primary health care to draw pointed attention to the political nature of the whole undertaking. Politics indeed is in-built into this concept of HFA through primary health care. Equity, decentralisation and community participation are essentially concepts resting squarely in the political field of social action. They are as much necessary in other vital fields of social action like education, welfare, productive utilisation of human potential as in health. The only significance we can attach to their articulation in the field of health is that the concern for health is the most universally shared concern and we may have a chance, therefore, to develop political approaches of the kind needed in this field.

10. Yet, it must be clearly understood that pursuit of primary health care is to initiate a rather holistic process of social transformation which cannot remain confined to this particular field, but will certainly overflow into most other fields of development. At the moment, the odds are against this approach, despite the verbal commitment of the power base to operationalise it. That base may view it with concern our poor performance in the Seoul, Asiad, but it is difficult to say how the vested interests in the centralisation of political, economic and social decision making powers will entertain any percolation of that power down the line to the people at the grass roots level. For those outside the government who are committed to the primary health care approach is to take up the challenge to organise at the grass root level the poor and the deprived and the underprivileged in order to not to teach them health, but to promote political consciousness and social awareness among them. There is no other alternative than this to enable the people to give themselves essential health care which is so comprehensive as to include promotive, preventive, curative and rehabilitative services. People have been left always to rely on themselves in enduring the difficult health conditions. That passive self reliance has to be transformed into active self help for the attainment of positive health.

11. We have already commented the inadvisability of formulating the goal in the field of population in terms of a technical jargon. There is no question in our mind that it would have been better for economic progress of our country if the population had not grown as fast as it has since independence. Unfortunately, it continues to grow at the same rapid rate. A hind sight conveys the message that the reasons why we have not been able to temper the growth of population are the same as those that prevent us from securing adequate improvement in the health condition of our people. As far back as the beginning of the first plan the government had introduced a population policy limited exclusively to the official propagation of family planning. It was a technocratic approach of canvassing modern contraception to influence socially conditioned, but intensely personal, individual behavioural patterns. Adhocism, trial and error, and piece meal measures have always kept the programme of family planning in a disarry.

It is quite clear that the I Plan's saner enunciation of the approach to family planning was abandoned too soon after it was pronounced. This change can be traced to the advice, perhaps well meaning, we received from external western sources to the effect that sooner we reduce fertility, more success we would achieve in raising per capital income. This source of advice had hammered on the minds of our planners only the adverse consequences of our failure to match reduction in fertility with that in mortality. Neither they nor our planners had any notion of the great variety of socio-cultural settings which conditioned fertility patterns in a population which had millennia of civilisation behind them.

12. Since then the family planning programme has witnessed a sequence of changes in strategy without ever compromising its basic thurst centered on modern contraception. In the first plan we experimented with the Rhythm method. In the second, we started constructing family planning clinics and in the third we added extension education. Then we pined our hopes or the IUD, reverted to vasectomy and launched a strategy of time bound sterilisation targets; experimented with the so-called camp approach and put the programme on a war-footing during the Emergency. There followed a back lash which is being countered by large scale campaign of laparoscoplic tubal-ligations.

13. A national population policy was adopted in 1976 which threatened resort to legal compulsion, but it also focused attention on some measures 'beyond family planning' including female age at marriage. In the days of the backlash the Planning Commission's working group on population policy laboured the need to operationalise the linkages of fertility with social and economic development. From this thinking, there seems to have emerged the notion that the success of family planning would depend on female education, female work participation outside home and women's development in general. These notions remain to be translated into policy packages. Meanwhile, in its utter helplessness the family planning delivery proceeds in its old ways of recruiting, by hook or crook, cases mainly for women's acceptance of terminal methods. MCH is said to form an integral part of the family welfare delivery system. But it seems to suffer neglect in the bureaucratic zeal to exceed targets set for family planning performance.

14. Implied in the fixation of NRR of unity as a goal for 2000 is the reduction of the birth rate of its present level of around 33 to 21 per thousand population over the next 14 years. This is apparently a difficult task unless we strike upon an alternative strategy of transforming family planning into people's movement which the government has been unsuccessfully trying to do for the last nearly a decade. At the moment no such favourable prospect is in sight.

15. There has been a constant criticism of our population policy that it does not form an integral part of the planning process. This criticism, valid as it may sound, misreads the social situation in the country. It neglects to take into account the indifferent performance of the planning process itself. Planning may be said to have succeeded in developing certain necessary economic overheads like power, irrigation, transport etc. It has succeeded in creating a viable and deversified industrial base as well as creating a net work of national institutions for the promotion of rapid advance in science and technology, but it has remained ineffective in securing full employment, reducing regional economic and social disparities and in alleviating poverty. It has been a process of implanting economic progress on to a pervasive situation of economic want and social backwardness and led therefore to a polarisation between the small upper crust of population as the main beneficiary of development and the vast majority of the masses competing for the crumbs that may percolate down from the commanding heights of the economy. This nature of the planning process has not been able to bring about meaningful changes in the universe of fertility determination, within which individual couples carry on family building activities in the overall context of the age-old traditional milieu.

17. A special feature of the Indian planning profession is to rearticulate the inexceptionable goals, that any planning may have, every five years. The latest seventh plan accordingly emphasises social justice and employment generation together with the increase in national income. It goes on, however, to spell out an apparently new element under the rubric of 'human resources development'. In fact a Human Resources Development ministry has replaced the Ministry of Education and Social Welfare. It is not as yet clear of what is the operational content of Human Resources Development Ministry. As of today it is in charge of a high ranking cabinet minister who carries

the responsibility also of the Ministry of Health & Family Welfare. The government is thus in a position to operate an integrated programme dealing with all the different aspects directly related to the development of vast human potential. The new health policy has been followed up by the announcement of a new education policy, which can be coordinated with the existing child development and youth policies and a prospective policy of the women's development. Primary health care, women's education, maternal mortality, integrated child development programmes, universalisation of primary and secondary education, female education, women's participation in economic activity and improvement of the status of women in society are some of the more important elements of social development that have a crucial bearing on the fertility decline. If this articulation can be transformed into practice, we will need no family planning propagation, but only an assured access of all people to family planning information, advice and services. This is in the realm of hope, however fondly one may cherish it.

18. The concept of primary health care has taken care to cover family planning services as well. But the intrusion of family planning as one element in the whole gamut of services to be provided at the grass roots level is not very helpful. It is possible to argue that given the existing and adversely changing political and social situation, family planning may overshadow the more important elements of health care that deserve priority attention. The question is not so much to create clinical services for facilitating adoption of contraception, but of bringing to surface the latent demand for family planning services or generate new demand for it. This imperative imposes the need of invoking manipulation of social and economic conditions such that the couples find reduction in family size beneficial to themselves.

19. Here again it is a question of transforming social organisation which conditions the living and life styles of the individual members of the society. It is a question of creating an atmosphere that leads to the generalisation of human motivations for limiting births with or without artificial means of contraceptions. If the motivations are created, marriages will be delayed and within marriage abstinence, the Rhythm method and coitus interruption, that were the most effective means that reduced the European fertility levels in the late 19th century, will surely be used widely. In a society which puts some store on the spiritual aspects of human existence, resort to technological innovations in

contraception may not make that much of a difference. In the ultimate analysis, the strategy to be developed for the achievement of NRRU will rest more on 'non-medical, non health care' aspects of social change which has not hitherto been attempted by the planning process in this country.

20. Yet conceptually, the notion of positive health retains its captivating quality. Positive health defined as a state of physical, mental and social well being necessarily implies a development of a rational approach on the part of couples towards their fertility behaviour. But the achievement of positive health invokes equity, intersectoral collaboration, decentralisation and community participation. That cannot be realised without fundamental social transformation in its broadest sense. We admit the primacy of social transformation and therefore the primacy of positive health. But social transformation is a political process, apparently easy to achieve through revolution than through evolution. Since the possibility of a revolution, social or political is remote, at the moment, we are left with the only alternative to continue our endeavour to secure a viable health care system and social changes of the kind that promote motivations favouring smaller families. We must simultaneously continue to work actively for democratisation of health services that would necessarily involve its debureaucratisation, deprofessionalisation and depoliticisation. That means we must put complete faith on the people at the grass roots level and help them to take care of their own health themselves. Unfortunately, there are few in the vastness of people to take up this challenge.

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LOGISTIC SUPPORT AND FACILITIES FOR PRIMARY HEALTH CARE: THE CRUCIAL ROLE OF PHYSICAL ACCESSIBILITY

by

Ashish Bose

In the rhetorical discussions on the Alma Ata Declaration of Health For All By 2000, not enough attention has been paid to the crucial role of physical accessibility. The Alma Ata Declaration (1978) does show awareness of the fact that "the success of primary health care depends on adequate, appropriate and sustained logistic support..." and recommends that "government ensures that efficient administrative delivery and maintenance services be established reaching out to all primary health care activities at the community level... That the government ensures that transport and physical facilities for primary health care be functionally efficient..."

"The global strategy for health for all by 2000" adopted by the World Health Assembly in 1979 indicates that "the main thrusts of the strategy are the development of the health system infrastructure starting with primary health care for the delivery of countrywide programmes that reach the whole population". (WHO, 1981: 12).

The object of this paper is to draw attention to the impact of the human settlement pattern on physical accessibility and consequently, on the delivery of primary health care services at the local level. We shall present here very briefly the preliminary results of the statistical exercise which we have done on the basis of 1981 Census and 1977 Economic Census data.*

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* The computational work in connection with this project was done at the Computer Unit of the Institute of Economic Growth.

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In the international literature much is made of the Kerala model. Several sophisticated statistical exercises have also been made on the impact of literacy, education, status of women, higher age at marriage and related factors on the fertility pattern. However, there is no evidence that these exercises have taken adequate note of the human settlement pattern and the access to health and education which the state of Kerala has, by virtue of its unique settlement pattern where one can hardly distinguish a rural area from an urban area. This is partly a function of density of population. But a number of historical, geographical, political, economic and other considerations have influenced the settlement pattern of Kerala. For example, according to the 1981 Census, in Kerala, 90.3 per cent of the rural population was enumerated in villages with population of 10,000 and over. The comparable figure for Bihar was 4.2 per cent; Madhya Pradesh 0.1 per cent; Rajasthan 0.9 per cent; and U.P. 0.7 per cent. The terms of the number of villages (in Kerala) 74.3 per cent of the total number of rural settlements belong to villages with population of 10,000 and over. The comparable figure for Bihar is 0.3 per cent; madhya Pradesh negligible; Rajasthan 0.1 per cent and U.P. 0.1 per cent. These figures bring out the sharp contrast between Kerala on the one hand and large states like, Bihar, Madhya Pradesh, Rajasthan and U.P. (which will be referred to subsequently as BIMARU states) on the other.

As is well-known, in our strategy for primary health care, we have more or less adopted a blanket approach through-

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out the country (though there are some minor modifications in tribal and hill areas) by laying down norms for the establishment of primary health centres, sub-centres, etc. Inherent in our primary health policy is the weightage given to population In other words, if the majority of the villages in Kerala have a population of over 5,000, it is obvious that there will be sub-centres located in these villages and the access of the people to primary health care will be greater in Kerala than in U.P. because of the combined effect of the settlement pattern and the weightage given to population in our health policy. When we consider the physical accessibility on the basis of data on transportation, the contrasts are even sharper. For example, in Kerala, for every 100 sq kms, the length of roads was 275 kms. The comparable figure for Bihar is 48; for Madhya Pradesh 24; for Rajasthan 21; and for U.P. 52. Another index of road transportation is the length of roads per one lakh population. In Kerala, for every one lakh population, the length of roads is 421 kms. The comparable figure for Bihar is 120; for Madhya Pradesh 205; for Rajasthan 213; and for U.P. 129.

Another question one may ask in the context of physical accessibility is: how many villages are linked with roads? The road statistics give such data for only two categories of villages: namely (a) villages with population 1000-1500 and (b) villages with population 1500 and above. In Kerala, 100 per cent of the villages are linked with roads in category (a) The comparable figure for Bihar is 39 per cent; for Madhya Pradesh 40 per cent; for Rajasthan 40 per cent; and for U.P. 25 per cent. For category (b) villages, the figures are as follows: Kerala 100 per cent; Bihar 52 per cent; Madhya Pradesh 65 per cent; Rajasthan 56 per cent and U.P. 52 per cent. Thus, the human settlement pattern, the size of villages, the distribution of villages, and the road transpor-

tation system all favour Kerala in terms of the delivery of health services. What is true of health is also true of education.

According to the 1977 Economic Census, in Kerala 96.3 per cent of the villages had a primary school right in the village The comparable figure for Bihar was 60.0 per cent; for Madhya Pradesh 65.5 per cent; for Rajasthan 55.8 per cent; and for U.P. 45.5 per cent.

In the case of middle schools, the position was as follows: in Kerala 92.3 per cent of the villages had a middle school located in the village. The comparable figure for Bihar was 14.5 per cent; for Madhya Pradesh 10.5 per cent; for Rajasthan 14.6 per cent and for U.P. 9.3 per cent.

Next we come to high/higher secondary schools. In Kerala, the figure was 76.5 per cent while in Bihar it was 4.8 per cent; in Madhya Pradesh 1.8 per cent; in Rajasthan 3.6 per cent and in U.P. 3.5 per cent.

These figures speak for themselves. Both in terms of health and education, the settlement pattern favours Kerala. If the literacy rate is high for Kerala, one could ask why is it high? It is obvious that the settlement pattern in Kerala make access to schools and primary health centres easy, compared to the situation in BIMARU states. Before we look into the so-called cultural and other factors while explaining the diversity in India, we feel that we should have a good look at the human settlement pattern, transport linkages, and the communication network.

The 1981 Census (and also earlier censuses) classified rural settlement into the following seven categories:

Category	Population
I	Less than 200
II	200-499
III	500-999
IV	1000-1999
V	2000-4999
VI	5000-9999
VII	10,000 and above

In our statistical exercise, we have worked out the settlement pattern with reference to villages as well as population in all the districts of all the states in India. We have defined a small village as a village with population of less than 1000. Our hypothesis is that these small settlements, barring a few exceptions, are by and large, inaccessible. We have calculated two indices:

(1) Population Accessibility Index (PAI)
(2) Village Accessibility Index (VAI)

If, in a district, the population of villages in categories I to III (i.e. less than 1000) is more than 50 per cent of the total population of the district, the district will be designated as a low population accessibility district. Similarly, if in a district more than 50 per cent of the villages are in the categories I to III (i.e. less than 1000 population) then the district will be designated as a low village accessibility district.

We shall present a few figures here. In India as a whole our Population Accessibility Index (PAI) was 60. In Kerala it was 98; in Bihar 59; in Madhya Pradesh 47; in Rajasthan 55; and in U.P. 55.

As regards the village accessibility index (VAI), the figure was 38 for India. It was 95 for Kerala, 38 for Bihar, 34 for Madhya Pradesh, 37 for Rajasthan, and 38 for U.P.

The average size of a village in India in 1981 was 911. It was 16,967 in Kerala; 966 in Bihar; 583 in Madhya Pradesh, 774, in Rajasthan; and 808 in Uttar Pradesh. In India as a whole, 29.8 per cent of the population was in LAP districts (i.e. low accessibility in terms of population). In Kerala, the figure for LAP districts was 0; in Bihar 19.4; in Madhya Pradesh 80.0; in Rajasthan 23.1; and in U.P. 16.1.

In terms of the low accessibility districts in terms of villages, (LAV districts) the overall position was as follows: In India, 75.3 per cent of the districts were LAV districts. The figure for Bihar was 74,2 per cent; for Madhya Pradesh 100 per cent; for Rajasthan 92.3 per cent; and for U.P. 91.1 per cent. In Kerala, the value was zero.

Before we conclude, we would like to mention that in our initial exercise, we had assumed that the size of the settlement had a direct relationship with the accessibility to health services. In other words, smaller the village, lower the accessibility and vice-versa. Subsequently, we found enough support for our assumption in the District Census Handbooks. Unfortunately, all the 1981 District Census Handbooks are yet to be published. However, we shall quote the data from the Jhunjhunun District of Rajasthan in support of our contention (Census of India 1981, Series 18, DCH Jhunjhunun: lxiv).

Population Range	Percentage of Villages with some medical facilities available in the village, 1981
Upto 499	7.5
500-1999	28.8
2000-4999	82.2
5000 and above	90.9
All rural settlements	34.1

We hope to do this analysis for all the districts of India, as and when all the district census handbooks are available.

We shall conclude by pointing out that our preliminary analysis shows that our primary health care policy has not taken note of problems of physical accessibility and logistic support which are absolutely crucial for any strategy for health for all by the year 2000. We would recommend that the status should be asked to prepare district health plans on the basis of available data and each state should have the flexibility to devise alternative strategies to meet the local and sub-regional requirements, keeping in mind physical accessibility as a crucial factor. In fact, our analysis raises serious doubts about the strategy of multiplying sub-centres only on the basis of population size, as spelt out in all our five year plans. It is unlikely that this strategy would succeed in delivering health care services to rural people, particularly in the small villages of the large states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. Alternative models based on increasing mobility rather than multiplying sub-centres should be seriously considered, along with other criteria for logistic support and facilities for primary healthcare.

Paradoxically enough, a large population has helped and not hindered individual rural settlements in having access to health services because our health policy has an inbuilt bias in favour of population size. Our plea is for the fullest consideration of physical accessibility as an important factor in planning for primary health care. This is an obvious point. Nevertheless, our planners have innocently ignored it.

DISCUSSION

Ravi Duggal began his presentation of the background papers by identifying the twin questions that defined the scope of Session II. Firstly, why had health programmes failed? Secondly, was the present strategy capable of providing health for all? He divided the papers into two categories on the basis of the explanation and insights offered on these questions. The first category of papers (by Dr. A.R. Desai, Dr. Lincoln Chen and Dr. Roger Jeffrey) emphasised structural constraints to the implementation of the strategy. The social structure itself, i.e. class relation within the society, inhibited or set limits to radical policies. The structural factors highlighted were the capitalist path of development, the political economy and the private medical sector. The other category of papers (by Dr. N.S. Deodhar, Dr. V.N. Rao, Dr. P.B. Desai and Dr. Ashish Bose) highlighted the problems with the functioning and delivery of health care services. Factors such as health management, epidemiology, community participation, health education, the wrong priorities of high technology, urban bias and emphasis on family planning and the physical accessibility of health services were the many functional problems that could not be ignored until such time that the structure was transformed.

The presentation also sought to point out further areas for research not covered by the papers. One such area was centre-state relations in the field of health. Whereas policy making was vested in the Centre, the responsibility for implementing the programmes lay with the states. As a consequence many important schemes suffered. Even the community health workers scheme was not being implemented in some states such as Tamil Nadu and Kashmir. Another problem area was the over-

whelming urban-rural disparities in the availability of health care facilities and delivery of services. Data gathered by FRCH had shown that the hospitalisation facilities in urban areas were 21 times more than in rural areas. The role of foreign funding agencies also needed to be reassessed. Although foreign aid constituted a low 2 per cent of the entire health sector outlay, the significance of foreign agencies lay in their ability to influence and focus national policy. These agencies were often linked up with foreign multinational corporations. For instance, the importance accorded to measles in the immunization campaign was partly due to the fact that India, which did not manufacture the vaccine, was a potential market for the multinational drug companies. Finally, there was the whole question of decentralisation in the context of the local power structure and politics of the community.

In conclusion, Ravi Duggal pointed out the need to expose the myth that health sector plans and programmes were free of problems, whereas the whole issue was one of negligent and inadequate implementation by the lower level bureaucracy. He questioned the policy framework that formulated concepts such as 'participation' , 'self - reliance', 'political will', 'people taking care of their own health', etc., in isolation from the social and political structures.

Dr. A.R. Desai initiated the discussion with a short summary of his paper. He asked whether the government policies addressed the pressures from below, or were they mere crumbs to the people. Also, there was a need for greater clarity about the term 'people'. Did it cover both the beneficiary and the oppressed classes? Given the capitalist framework of development being followed by the Government, Dr. Desai pointed out that the main question was what position

should the medicos take?

Even if the ICSSR/ICMR HFA document was implemented both in spirit and content, Dr. Ashish Bose wondered whether health for all could be achieved.

According to Dr. Antia, the operational word in the strategy was 'radical'. In the process of interacting with the Government, the Study Group had to some extent influenced the 6th and 7th Plans. But in implementation, only those elements were being given priority that suited the Government. Infrastructure was being developed, but there was no devolution of financial and administrative power to the people. He did not think that radical change was possible in the present political economy.

Dr. Coyaji agreed with Dr. Bose that there were many discrepancies in the recommendations of the Study Group of which its authors were aware, and which meant that some elements of the strategy would not succeed even if it was implemented faithfully. She felt that though there had been a change since 1978 in the accessibility and availability of health services in rural areas, yet the primary level staff had not become oriented to the primary health care approach. They still believed in taking health care to the people.

Dr. V.N. Rao, while agreeing with Dr. Coyaji that the adequacy and accessibility of health services had improved, pointed out that only 40% of the available public health facilities were being utilised. Poor utilisation was a major failure in implementation. He attributed this problem to the lack of community awareness about their own health needs and about the available health services.

Padma Prakash, who along with Dr. Amar Jesani was a research staff for the ICSSR/ICMR Study Group, pointed out that the members of the Group were well aware that all reports and recommendations, including the Bhore Committee report, had been implemented selectively. She wondered why, inspite of this history of policy recommendations, the Group had expected its recommendations to be implemented faithfully.

Dr. Rao felt that the Government had accepted the Group's report and was implementing the infrastructural aspect of it. It was, however, failing in its task of mobilising the people to utilise the services and facilities. Dr. Coyaji added that other Governmental schemes for rural areas and poverty allievation, such as the Integrated Rural Development Programme (IRDP), were also not reaching the people. The implementational problem lay in people's lack of awareness of the existing facilities available to them, and it suited the bureaucracy to keep information from the people.

According to Dr. Amar Jesani, the minutes of the initial meetings showed that the members well aware that their recommendations would not be implemented, wished to formulate a radical plan that would be useful in a new society. At a later stage this perspective was modified and something inbetween was proposed. Consequently, the Group's recommendations were neither a plan for a new society, nor suited to the present one. Another problem was posed by the 'pillars of health'. The report had categorically asserted that these were absolutely important to achieve health for all. Yet Government policy was only addressing the health sector and certain social services, without transforming and focussing the planning process and the Industrial policy towards achieving these determinants or 'pillars' of health.

Vimal Balasubrahmanyam raised the question as to whether the committee members had made efforts towards putting pressure on the Government to implement their recommendations. She cited the pressure exerted by the intellectual community on the Bangladesh Government to implement a rational drug policy, and wondered whether the Indian professional community felt it was their duty to also adopt such action.

Dr. Antia pointed out that the Study Group was not a Government body, but was set up by concerned professionals and academics. Its achievement was in getting the Government to consider its report, endorse the strong indictment of previous health policy, debate it in Parliament and incorporate elements of the recommendations in the National Health Policy. Now that it was Government policy, and not just a private report, the recommendations could be further used to question and expose Public health policy and programmes, and thereby raise the people's consciousness about failures in the health sector. He hoped that Session III would throw light on the ways and means of communicating with, and mobilising, the people.

Dr. Jeffrey explained that his paper took for granted Dr. A.R. Desai's framework of constraints for Indian health policy. His aim was to show the scope for changes within the health planning model adopted by India for providing health services. Since no radical change was possible in a bureaucratic system, the question was whether it was possible to push, even slightly, the existing system in the desired direction. What were the small scale programmes that needed to be pursued within the existing Government structure? One of the drawbacks of the Ramalingaswamy Committee (ICSSR/ICMR Study Group) report was that it did not provide assertive, tangible, potentially achievable short-term goals and

programmes for the government, as for instance with regard to a rational drug policy. He also felt that Seagall's proposal about social epidemiology was a starting point for giving people information about health issues in their own enviroment

Dr. A. Bose, referring to the paragraph on page 16 of Dr. Jeffrey's paper, asked for information regarding the agencies that had run out of funds and withdrawn from India. According to him, foreign were always ready to provide funds for the family planning programme and, historically, had been responsible for introducing the coercive element in family planning.

Dr. Jeffrey clarified that his reference was to the fact that all foreign aided projects had a limited time span and a limited budget, and in the long run, the local Government was expected to take them over. He also felt that foreign aid to India had been directed towards public health measures, rather than towards high technology medicine and hospitals. Dr. Bose was, however, of the opinion that foreign aid and agencies had been responsible for the coercive family planning programme, and no agency was withdrawing its fund from the family planning sector in India.

Dr. Haran felt that the recipient Governments often failed to take firm policy decisions regarding the relevance of ideas and priorities put forward by the donor agencies. There was also a time lag in the priorities of donors and Governments. In recent times the donors were giving priority to low technology, community based programmes, such as home based ORS (oral rehydration syrup) and community based cold chain. The Government, however, was still emphasing the expansion of infrastructure.

Manisha Gupte asked Dr. Haran how the perceptions and priorities of donor agencies had changed from a high technology to a low technology, people oriented approach? Was it a recognition of the failure of earlier approches? She felt that in the absence of basic facilities such as clean drinking water and sanitation, the emphasis on home-based ORS relieved the Government of its task of meeting basic needs, and put the entire responsibility of child survival on the people themselves.

Dr. Haran agreed that donors perceptions changed as new themes and ideas became fashionable in their own countries. However, foreign aid, including that of the World Bank, constituted a mere two per cent of India's budget, and therefore, the Indian Government was in a position to formulate its own priorities and policies.

Dr. Ashish Bose intervened to point out that two per cent of money was accompanied by 98 per cent of the ideas. The bureaucracy was influenced by these ideas emanating from such respectable sources as the World Bank, USAID, UNFPA etc. However, the projects that were formulated on the basis of these ideas, could not stand scrutiny in terms of either their conceptual framework, or their implementation approach.

Dr. Jesani pointed out the need to assess the impact of foreign agencies on Government policy-making as a whole. At a time when the Government was going in for large-scale technological and financial collaboration in the field of industry and agriculture, the health bureaucracy could not be expected to have a different policy.

Dr. Dhruv Mankad emphasised the need to focus on non-traditional health inputs, such as food, water supply, sanita-

tion and nutrition, in implementing the Health for All Strategy. The implementation of the strategy was dependent not just on bureaucratic - legislative (i.e. Governmental) action, but would be determined by the nature of the state as a whole, including the media and the politically vocal intellectuals.

Dr. V.N. Rao explained that the failures in implementing the strategy were due to the neglect of 3 important factors. These were the neglect of community participation, appropriate technology and intersectoral co-operation and co-ordination. He cited the example of the small health project with which he was associated. The project had been successful in adapting technology to the local situation, mobilising the existing resources and providing information to the people about their health needs. It had, however, reached a plateau as it was unable to arouse the community to self-care, and to achieve co-operation between all health-related sectors such as water supply, housing, nutrition etc. These needed to be brought within the health services sector for better implementation.

Another major problem with the Indian health services, according to Dr. Rao, was the lack of proper training and orientation of the multi-purpose workers (MPWs) and community health volunteers (CHVs). These Schemes were conceptually good, but their implementation was very poor. Finally, the development of the epidemiological services was absolutely necessary to understand the nature of health problems in India. He suggested that several experimental health care delivery models be developed in different regions of the country, which could be replicated widely in order to improve the health services.

Next Dr. Deodhar read out the main points in his paper

regarding the problems of implementation.

Dr. P.B. Desai pointed out that the family planning programme was leading to the coercion of para-medical workers and the neglect of primary health care services. The improvement of health conditions was a pre-condition for family planning acceptance, whereas the Indian Health for all strategy was attempting to achieve the precondition and the outcome simultaneously.

Padma Prakash pointed out the fundamental biases in the National Health Policy regarding women. The latter were only viewed as reproducers, and pre-determined solutions had been put forward.

According to Dr. Ashok Dyal Chand, the voluntary sector had been primarily responsible for formulating the white paper on HFA (i.e. the ICMR/ICSSR Study Group's report). However, in the absence of clearly defined concepts and operational guidelines, it had turned the HFA slogan into a myth. Taking the example of community health workers, he pointed out that no cost-benefit analysis had been done, and the unstated costs of the scheme had been hidden from the policy makers. The scheme had been rendered unimplementable. Similarly, no steps had been taken to operationalise concepts such as 'health for all' and 'community participation'. He suggested that the participants undertake to operationalise the HFA concept by clearly stating who was to implement it, what needed to be done and how it was to be carried out.

Dr. Amar Jesani, responding to Dr. Dyal Chand, felt that the non-operational character of the HFA concept was its real strength. It could be used to mobilise and educate the people. Intellectuals, in his opinion, were not responsible

for merely formulating acceptable prescriptions but had a duty towards raising fundamental issues. He asked how was it possible to mobilise the people in order to fight the system.

Dr. Sujit Das asked, "What constitutes participation?" One way of defining participation was in terms of the utilisation of health services. However, real participation meant control and that, in turn, was based on power. Since power was rarely given, participation in this sense could not be implemented. Even the term 'empowering' was inadequate as it required an agent to delegate power, but not relinguish it.

Dr. Antia pointed out that the non-functioning of primary health centres was mainly due to the emphasis on expanding infrastructure without developing the services. The voluntary sector, too, had its problems. Many excellent projects were non-replicable. These projects were dependency creating and did not activate the people. In this context the role of professionals was to create awareness and give graded information and knowledge about the available services. Professionals had to be the catalysts in making the people question the basis of their unequal and discriminated situation.

SESSION III

ALTERNATIVES FOR EFFECTIVE IMPLEMENTATION

With focus on:

*Relevance of people's participation.

*Management & people's participation: Are they mutually exclusive.

*People's participation growing over to people's control.

*Relevance of high technology in our needs.

*Appropriate technology for implementing strategy - machines, equipments, drugs etc.

*Prevention of disease: a techno-managerial solution.

*Communication strategy for achieving Health For All.

*Role of education in people's participation.

THE MEDIA, THE MESSAGE AND HEALTH FOR ALL

by

Vimal Bala ubrahmanyan

"Communications" is such a fashionable word today in the Rajiv Gandhi era, that there is no need for me to elaborate on the importance of using different forms of media for conveying information on health issues to the public. However, this paper will not cover the use of audio-visual and print media by health educators to convey specific messages to specific targets e.g. slide-and-tape shows, flip charts, pamphlets etc on topics such as immunisation, birth control, ORT and the like. The object of this paper is to examine how the general mass media can be used by the rational health movement to influence people's attitude understanding and behaviour on health matters.

A brief account of my involvement in health action may be relevant here. As a freelance journalist some of the topics I have written about since 1981 are: drug trials being conducted on disadvantaged sections of the population; campaigns against various harmful drugs; promotion of ORT; the baby food issue; misuse of anabolic steroids and irrational antidiarrhoeals; the politics of family planning; occupational health issues; the health aspects of the nuclear industry; the medicalisation of pregnancy and childbirth; and the campaign for a rational drugs policy.

In the course of my search for information and data, I have become closely associated with health action groups and have gained access to a whole body of research and analysis which has not only given me facts on the specific topics I have written about but also insights into the larger politics of health and the social, economic and cultural roots of ill-health.

If the public at large is to begin to understand these deeper and broader aspects, then the public too must have exposure to all this information which has so far been confined within the "alternative" media of the health activist and progressive social scientists, and has remained circulating among the already 'converted'

I am not referring here to specific information , on, say, the side-effects of clioquinol and oxyphenbutazone. These have been figuring fairly prominently in the general media (though I have doubts whether the adverse

publicity has had any impact on the prescription and over-the-counter sale of hese drugs). What I mean is, even though there have been media exposures on various health issues, there has not been much basic education of the public on issues like environmental health, preventive medicine etc. which are integral to the Health-For-All concept. The public still equates 'Health For All' with 'Medical Care For All'. And not just medical care, but the most sophisticated medical care possible in terms of costly equipment, diagnostics facilities and surgical procedures. For example, the inauguration of a nuclear medicine unit in a postgraduate institute of medicine is seen by the public, the media, (and also described as such by the Health ministry) as one more step towards achieving Health-For-All--without anyone pausing to wonder why, despite all this technological advancement, our people continue to suffer from, and die of, the ordinary communicable diseases which have long ago been eradicated in the developed countries even before the modern medical discoveries were made. In the public mind, athe low health status of the people is seen as the result of inadequate medical facilities and hence the clamour for more doctors, more hospitals and CAT-Scan units.

Thus one finds that despite fairly intensive coverage in the media during recent years on specific health issues, this has not been accompanied by fundamental enlightenment of the public on what health really means, how Health-For-All can be achieved, what people must do to change their own outlook and lifestyle, and what kind of economic and social measures the government should introduce as part of its health policy.

A lot of writing and analysis on these basic aspects of the politics of health does appear constantly in the serious, progressive journals, but these have a limited readership and do not reach the general public. So, the question facing the health movement is: Can a sustained consciousness-raising health education campaign be directed towards the lay public through the mass media?

One must begin by acknowledging that this kind of health education must necessarily explode a lot of myths and this will inevitably mean that powerful vested interests are not going to like it one bit. For the sake of credibility and in order to convince the public, this task should not therefore be left to journalists alone--for two reasons:

a) General articles on health issues (as opposed to reportage on, say, harmful drugs which have both news-value and sensation value) carry greater conviction when the information and advice comes from qualified health personnel. Readers are far more receptive to health advice from columns where the by-line is a 'Dr Somebody'. (See for example the popularity of the weekly medical column published in the Sunday magazine section of the Hindu.)

B) The medical profession is itself hostile when a non-medical person exposes malpractices by the health-care profession. (e.g. Padma Prakash's column Medisense which appears once a month in the Express Sunday section. The most vocal opponents to Padma's plain-speaking on overprescription of drugs and vitamins have been doctors.) Health columns which seek to enlighten the public on the politics of health will necessary tread on Establishment toes. And when such articles are attacked by 'qualified' medical personnel, the public doesn't know whom to believe--the doctor or the journalist.

It is worth mentioning here that health education of a radical kind is also bound to offend the drug industry, especially when specific brand-names are mentioned. Journalists as well as doctors writing on harmful drugs face different kinds of pressure--subtle as well as blatant-- and since the media controllers are anxious not to lose the support of their advertisers, this is a major problem and we have to get together to think of appropriate strategies to fight this phenomenon.

On the basis of some of my experiences while writing on health issues, I would like to offer some suggestions on how the health action movement can more actively use the media as an instrument to further its own cause.

1) Health activists, especially those with medical degrees and designations, must acquire media skills, establish contact with editors, and introduce regular health columns in the print media. The help and guidence of sympathetic media people can be enlisted to ensure that these columns are written in appropriate language and style. The column on 'Harmful Drugs' by Dr P.K. Sarkar in the Telegraph and the Education Service started by LOCOST (published in the Express Magazine) are good examples of the kind of initiative needed.

2) Constant and tactical use of the Letters-to-Editor columns should be made to: initiate debates; get across information on crucial issues; refute distorted information planted in the media by vested interests. (The example of ORT which I shall describe later illustrates this point.)

3) Qualified medical people, especially those in high positions who may not be 'activists' but who are progressive in outlook, should come out in vocal support of any health action campaign launched by the activist groups. This could be in the form of a press release, a formal statement or even a letter-to-the editor. Such endorsement greatly enhances the credibility of the activists. For example, media coverage of the rational drug policy campaign has helped in getting the government's pro-industry proposals stalled. However, it has not occurred to the 'eminent' members of various government-appointed committees, who have in the past called for an essential drugs policy, to issue statements supporting the demands of the All India Drug Action Network.

4) Health activists must feed information more effectively to committed journalists so that timely coverage of important issues is ensured. Often it is necessary not only to brief the media on the pertinent facts but also to explain the perspective lucidly so that the emphasis is on the right aspects and the message is not distorted. The health movement should actively seek out and identify sympathetic media people and keep up a steady flow of information to these contacts so that consistent media coverage on health matters is maintained. (This is something that the KSSP has been successful in doing in Kerala)

5) It is sometimes more useful to feed information to a news agency rather than to a freelancer or a staffer whose report will appear in only one paper or journal. An agency report is likely to be carried by newspapers all over the country. For example, when the Medico Friend Circle published a critique of painkillers on the market, I realised that any article I might write would only appear in one of the weekly journals I contribute to, I therefore passed it on to a friend in PTI, persuaded him to do a short news item on it and this subsequently appeared in many newspapers in different parts of the country.

6) Specific health actions should be appropriately planned with an eye to factors like 'news value' and

'topicality'--two holy criteria for the media people. For example, if a letter is written to the Drug Controller calling for a ban on a certain in class of drugs, the news is more likely to be printed if released to the Press simultaneously rather than two weeks later--as often happens.

7) If an issue needs coverage in the press, a suitable and timely write-up should be released to the media which is short, and which straight-away mentions the highlights in the first two paragraphs. A long research-type report, often polemical in language, may be all right for publishing in the alternative media but very difficult for use by the general media. Most media people won't even have the patience to go through the stream of words and sift out othe relevant 'newsworthy' facts. It is my impression that health activists do not realise the nature of this problem and feel disappointed by what they see as the media's indifference, when reports they send to newspapers don't get published.

In this matter, much can be learnt from the UNICEF style of preparing a well-designed 'Press Kit' every year, consisting of terse and snappy pieces summarising its longer and more verbose yearly report on the State of the World's Children. Most of this material gets published in the newspapers mainly because it comes in the 'predigested' and 'instant' form which readily appeals to the hardpressed newspaper staff.

8) If you turn media-watcher for a while, you will notice how cleverly vested interests use the media for their own purpose. The PR departments of the drug firms work overtime to present a favourable picture of some of the worst culprits--and the public swallows it all. When a drug gets a great deal of adverse publicity, the industry manages to get spokesmen from the medical profession to defend its product and these statements are reported prominently with big headings. This has happened repeatedly in the case of the E.P. Forte drugs, clioquinol, anabolic steroids and injectable contraceptives. Unless these statements are challenged and refuted by the progressives, the public will continue to receive only distorted information. The media has to be <u>used</u> by the health action people in as dynamic a manner as it is currently being used by the Establishment.

9) The potential of radio and television in serving the cause of the health movement remains almost totally untapped. Recent programmes on health issues in Janvani, Panorama, Sach ki Parchayen and Focus Indicate the immense possibilities that exist. We have become so obsessed with the notion that radio and television, being government-controlled media, are not 'free' that we have overlooked the fact that it is precisely because these media are government-controlled that they can be harnessed even better to serve the Health-For-All purpose. The government claims to be committed to achieving Health For All and so the most logical thing would be for the government to agree to use the media under its control for this purpose. Talks, interviews, feature programmes, even serials, could be planned as vehicles for getting across health education messages to the public, using the most potent of audio-visual media. And this could be extended to the area of the UGC television programmes as an excellent way of getting basic health information to the student community. Since the initiative to do all this won't come from the government, its upto the health movement to 'persuade' the controllers of government media to act.

The fact is that the different forms of media have been generally thought of as areas of expertise beyond the purview of those not specifically trained to handle them. It is time that all of us, working for various progressive movements and causes, realised that the media are only tools for getting messages across and if we have something important and worthwhile to say, all we need to do is to collaborate with those trained in the media and disseminate our ideas effectively. But to do this, we have to go to the media instead of writing in the media people to come to us.

The ORT Example: Some of the points I have raised in this paper may be illustrated by a specific instance.

Thanks to UNICEF's consistent PR work on ORT, there has been a steady media focus since 1983 on the salt-and-sugar remedy for diabrhoea. The image which has been built up in the process is that ORT is a miracle solution for preventing Third World diarrhoeal deaths. Inevitably, the word ORT has become associated with 'children' and with 'poverty'.

Nowhere does the ORT message in the mass clarify that this is a therapy for all people, rich and poor, adults as well as children. (Nor does the media image of ORT acknowledge tnat ORT may prevent dehydration deaths but it doesn't prevent repeated diarrhoeal attacks and that the ultimate solution lies in sanitation, hygiene and safe drinking water. This however is a separate and important aspect which I won't go into just now for lack of space.)

Going back to the media coverage on ORT, a crucial omission is a statement to the effect that ORT is the only therapy needed for the common Viral diarrhoeas and that most of the antidiarrhoeals prescribed or soldover-the-counter are unnecessary and that some are positively harmful. Besides this, evaluation of ORT promotion has revealed that a major obstacle to ORT acceptance is the fact that senior health personnel are themselves unconvinced and continue to recommend drugs rather than ORT. In the eyes of the literate middle-class public, even today, three years after a veritable media blitz on the ORT miracle, the salt-and-sugar remedy is seen as something meant for the very poor--those who cannot afford to buy anti-diarrhoeal drugs.

This critique of the ORT issue is something I have written about in serious progressive forums, but I felt that this aspect needs to be focussed also in a typical Establishment paper, whose readership is unlikely to have been exposed to such an understanding of the issue. I have already mentioned that both readers and editors are suspicious of health information coming from non-medical writers. So, instead of an 'opinion and advice' piece, I did a short 'news' report quoting the information compiled by Health Action International in their Diarrhoea File and released last December for use by the health movement. This I sent to the Open Page of the Hindu which I felt was an appropriate choice as a conservative newspaper and mouthpiece of the Establishment. The Open Page is a weekly forum for the expression of diverse views but the Hindu declined to use my item on this page (probably because I am not a doctor and therefore not competent to write on matters medical), and placed it instead in the Letters-to-the-Editor column. Anyway, my purpose was served.

My piece specifically mentioned that many doctors themselves do not promote ORT but prescribe irrational drugs. Not surprisingly, there was an immediate response from a Madras doctor asserting that "doctors

know best and also defending some of the commonly consumed irrational preparations (which one assumes he was in the habit of prescribing). This was immediately followed by a letter from an 'eminent' Madras doctor, one who is well-known to the readers of the Hindu, defending the statement of his younger colleague, and condemning the misinformed sensationalism indulged in by "journalists and politicians".

I now stood thoroughly discredited in the eyes of the Hindu readership and all because I tried to share with them the information I had been regularly receiving from the health groups and from no less a journal than the WHO supported Diarrhoea Dialogue published from London.

I realised that in addition to my own rejoinder, it was necessary (for carrying conviction) to get doctors to support my stand. I therefore sent photocopies of my original letter and the two responses to doctors in health groups all over the country (members of AIDAN), and requested them to send their responses to the newspaper. Of about 16 letters sent by these health activists, the Hindu published about eight, all deploring the attitude of the Madras doctors, welcoming the kind of critique I had offered, and endorsing the statement regarding irrational antidiarrhoeals. Some of the letters also used this as an occasion to explain why a rational drugs policy is an essential component of health policy and that this alone will prevent the misuse and overconsumption of harmful and unnecessary drugs. There was no response to any of these letters from the Madras doctors and one assumes that as far as the Hindu readership at least was concerned, the point about ORT was adequately made.

This little episode shows that: 1) It is not easy to get radical health information into the Establishment media. 2) Even when one 'smuggles' it in there is opposition from the medical profession itself. 3) When a doctor contradicts a journalist on a health issue, it is the former's words which carry weight regardless of how well-informed, factual and scientifically sound the latter's argument may be. 4) In spite of these handicaps it is still possible to save the situation if the movement as a whole mounts an orchestrated attack on the views being propagated by the vested interests. 5) In such a strategy the role of 'qualified' people with medical degrees is crucial.

6) The letters pages of the Establishment papers are an ideal forum to introduce information which may not readily be accepted in the news columns or feature pages. This fact should be exploited more consistently and these columns used for raising consciousness and for creating an informed public.

All of us in the health movement must be vigilant media-watchers and media-critics if we are to become effective media-users. And every time an opportunity presents itself, however trival it may seem at the moment, a 'counter-message' should immediately be sent out to point out the distortion. For example, when a sophisticated diagnostic service meant for the elite displays a full-page ad. using the slogan 'Health For All' and announces that the Health minister will inaugurate the building, a strong letter-to-the-editor from activist doctors should set right the picture in public eyes: that Health-For-All does not mean costly medical services for the affluent and that it is scandalous for the Health minister to be a party to this perpetuation of falsehood.

However, this type of alert action has so far not come naturally to the health movement because they haven't really thought about it seriously. Taking the ORT issue for instance, many progressives who read the Hindu may have silently criticised the Madras doctors' statements but did not realise that in public interest they should sit down and write rejoinders. The activists who did write had to be contacted and briefed, and their subsequent use of the media to put across the viewpoint of the movement was part of an organised strategy. For, this issue of using the media more actively was something we had discussed earlier during a conference last December on 'Pharmaceuticals and the Poor', and when the Hindu incident cropped up, everyone was conscious of the need to "swing into action".

What we need therefore is to draw up a sort of 'media strategy' by which activists in the health movement in different parts of the country agree upon a regular programme for using the different forms of media, in different ways to suit different occasions and subjects, consistently and imaginatively--from features, columns, articles and news reports to sponsored programmes, cartoon films and even public-interest advertising.

I put it to the participants in this seminar that they should see this as an important component of the action programme for achieving 'Health For All' and for stimulating the 'Peoples participation' which is crucial to the achievement of this goal.

ROLE OF CURATIVE MEDICINE IN HEALTH FOR ALL

Dr. Sujit Das

The social practice of arranging for medical care is as archaic as any other social activity. Individuals, community, religious & voluntary institutions, and the State - all play their party. Modern societies, however, enriched by advanced scientific knowledge, have turned their attention to basic health care which determines the health status of a community. Socio-economic-cultural roots of ill health have been identified and the determinant role of food-water-sanitation, economic security, education, women's liberation etc. has been emphasized. Accordingly, in the strategy of Health For All, priority is given to universal availability of the provisions non-medical health care and the prevailing dominance of curative medicine in the practice of health care has frequently been decried.

Concerned people betray an ambivalent attitude towards medical care or for that matter, curative medicine. Since the Bhore Committee's (1946) observation, "If the nation's health is to be built, the health programme should be developed on a foundation of preventive health Work", to the latest proclamation of national health policy (1982), the Government of India persistently emphasized the necessity of prioritisation of non-medical health care, but the Government practice of steadily expanding medical care service to its highest sophistication has never been decelerated. For some considerable period lately, medical education has been according due importance to the training in preventive and social medicine, but medical practice continues to deal with curative medicine almost to its entirety. Political and sociological commentators have incessantly been talking about socio-economic roots of ill health but political activists demand only medicare for the people. People on their part, consistently seek curative medicine which is not only the urgently felt need but often held synonymous with health care.

Concept and Reality:

Role of curative medicine though underplayed in policy-making, is not ignored in practice. This apparent paradox is resolved if the relationship between concept and reality is reviewed. Healers are venerated and honoured since the infancy of the human society for the

essential vital function they perform both at the individual and social levels; they respond to human distress. Most of the minor illnesses heal themselves; man learns to tackle a good number of every day physical distress himself; when he seeks a healer, it is more than the mere physical but includes added factors of apprehension, fear and helplessness which compoind the distress. The healer offers an explanation of the causation of the ailment (however weird), takes charge of the battle, relieves the patient of helplessness, applies his technology (however primitive and absurdly ritualistic) of diagnostication and therapy and emerges triumphant when the self-healing ailment heals itself. The entire episode restores confidence and balance to the sufferer and his kinfolk, enabling them to again face the adverse world with renewed courage - the unknown enemy is now known and conquered, and the weapon to tackle the enemy, the healer, is there. Even when the healer fails, he allays distress, offers comfort and finally legitimises death. This is one of the most vital psycho-social function to the mankind - to adjust to environmental adversity in the strive for survival and progress. Modern doctors also perform the same psycho-social function, only immensely more successful owing to remarkable development of potent, life-saving, preventing, curing, relief-producing technology of medical science.

Curative medicine has long been an integral element of tradition and culture, while preventive medicine, a recent concept born out of recent knowledge, is yet to attain such position. Even preventive medical intervention e.g. vaccination which also saves lives, took a long time to gain acceptance from a section of the people. Various efforts in health education have so far failed to make any positive impact in people's concept wherein the determinant role of non-medical health care is yet to gain entry. Protection of health, it is believed, is essentially dependant on curative medicine.

In health care, the dominance of the felt need of medical care is as strong as ever. The agony of the body in distress and relief in the removal of that distress or for that matter, the dramatic episode of life-saving carries such an overwhelming emotive force that it transcends all cold reasons and arguments. This reality explains the emergence of certain apparently irrational but culturally compatible practices. In India,

we have created a large number of institutions where a citizen, dying from a physical ailment, may legitimately claim free life-saving high cost medical aid. But there is no such institution to provide life-saving food to a citizen dying from starvation or for that matter, cloth-shelter etc. to the similarly deprived. Neither is there any demand on the State from any corner for such provisions. In fact, it is still conceptually repugnant to the present society that there should be some provision for the routine free supply of food etc. to the deprived, though it is not disputed that without food there cannot be any health.

It is not suggested that this ambivalence has no objective basis. The parent of a child dying from diarrhoeal dehydration cannot be expected to be interested in safe water supply; his/her instant need is medical care to save the child. The need of curative medicine is so enormous in India that in popular concept, no health care service is worth its name if it does not offer curative medicine. On the other hand, it would perhaps be unwise to hold that people have no conception about the determinant role of the provisions of non-medical health care. Social and political workers, providers of medical care, the ailing people - all are quite aware that persons with higher living standard suffer less from ill health and the linkage between affluence and health is there for all to see and draw conclusions. And it is also known that people all over the world have been struggling for food-cloth-shelter long before their determinant role on health has been formally theorised.

Medical Care : The Key approach

The contradiction between the concept and reality of H.F.A. needs to be reviewed in this perspective. It is apparent that the W.H.O. slogan of H.F.A. has not so far been able to obtain a significant place in people's struggles. Primary health care has been prescribed to be the key to attain H.F.A. Elements of primary health care were not unknown earlier and the health centres established in post-independence India were supposed to provide almost all of these elements. But eventually, the health centres have been turned into agencies to provide medical care and even this cannot be adequately provided. It is quite clear that conventional health institutions are not suitable to provide for non-medical health care.

Food-water-sanitation-employment-education cannot be achieved by the people in minimum necessary measure without establishing political control over the State, Social wealth and Means of production. Primary health care approach may be sound in concept but is not implementable in practice in the present Indian socio-economic reality. People's participation is sound in concept but in real life, only those participate who wield power and exercise control. That is why in the prevailing health care service only the providers participate, not the recipients. People's participation is a myth if delinked from authority and control. In this context, it is suggested that medical care could be a key approach to attain the goals of H.F.A.

Present situation:

Medicare service is catered to the people through three broad systems:-

(a) Free medicare; through State health care service and non-governmental voluntary & philanthropic agencies.

(b) Indirectly purchased medicare: through various schemes e.g. E.S.I.(M.B.) Scheme. institutional schemes of Government and non-government employees, rudimentary insurance schemes etc.

(c) Commodity medicare: through the large market of private practitioners, nursing homes, laboratories etc. Private practitioners include those belonging to various systems of medicine as also quacks.

State authorities never tire of proclaiming for umpteen times that the State service is free and is meant for the poor. In reality, both the principle and practice are far from true. In principle - legal, constitutional and otherwise - State medicare is not meant for the poor only. By policy, the access is universal. State service is available to the residents of the province - millionaire and pauper alike; to the visitors from other provinces; to the visitors from other countries; to the people who enjoy guaranteed indirectly purchased medicare e.g. C.G.H.S., E.S.I. etc.; one and all. Needless to say, the state service is not equipped - neither it is so expected - to cater to such large clientele. Expectedly the service is far short of need. The demand for free State medicare has been fast increasing mainly for three reasons - steady development of more and better technology;

steady price escalation of commodity medicare; and concentration of up-to-date intervention technology and better skilled medical personnel in the State institutions. For emergency patients, the universal trend is towards State hospitals. Affluent people, who in the earlier days, used to shun Government hospitals, now increasingly invade them and corner the better and costlier part of the State Care employing economic, social and political power they enjoy. The topographic distribution pattern is also stacked against the poor. Both quantitatively and qualitatively, State service is overwhelmingly concentrated in the urban areas while the poor mostly reside in the villages. The eventual result is that the poor is deprived of its only available source while the affluent enjoys the option to choose from all sources. Then again, the State service is far from free for the poor. Conceptually, the State service is still run on the old philanthropic principle - as a matter of charity or welfare. While the recipients approach the State institution as if seeking alms and feel obliged for whatever they receive, the providers, i.e. the doctors and hospital workers are imbibed with reciprocal concept - they hand out doles. Such basis has expectedly given rise to all sorts of corrupt practices similar to what are found in the relief programmes. The practice of some form of payment as premium to the doctor or hospital workers for the privilege of admission in a free bed is still rampant in most of the provinces. Quite frequently such premiums are obligatory for investigative, surgical and similar services. In the urban and semi-urban hospital wards, it is now customary to engage an additional care-taker at the patient's own cost in order to obtain minimum necessary caring services. It should however be kept in mind that the affluent can avoid paying these premiums on account of higher social status and when pays, the service is far too cheaper than the market commodity.

Rational Medical Care Scheme:

A rational medicare service is expected to be based on social justice and provide for essential need of all people regardless of their ability to pay. Under the existing socio-economic reality a drastic restructuring of the medicare service is therefore called for.

(a) State free medicare should be exclusively reserved for the larger section of the people living below a predetermined level of income.

(b) Rest of the population be divided into two broad categories, again on the basis of income and wealth. The upper richer section should be left to fend for themselves - to build up their own medicare service in the private market.

(c) Medicare for the remaining middle group be organised through insurance system. Among them, sections of people belonging to 'indirectly purchased medicare schemes' should be kept confined within their respective schemes.

A host of problems will come up in the way of implementation of this scheme. It has been argued that such a scheme is discriminatory, is not feasible and works against humanitarian principles. Surely it is discriminatory but it is a reverse discrimination in favour of the poor aimed at abolishing the present discrimination and introducing equitable distribution. As regards feasibility, the problem does not appear to be insurmountable. The scheme envisages a compartmentalised medicare service and already a few such schemes are being operated in the country e.g. E.S.I., Railway, Armed Forces etc.; it is only a question of extension and coverage of the entire population. Division of the population into economic categories already exists in some form or other - the food rationing system in Andhra Pradesh being an example. There may occur some interpolation and that could be ignored. The humanitarian argues that it is cruel to bar the hospital door to a dying person just because he is rich. This argument hardly holds water as under the present system the hospital doors are virtually closed to the poor millions. Closing the door to a few and opening the door to many actually reduces cruelty and the rich has means to gain entry to his own category of medicare institution. In any case, in extreme cases emergency services may be rendered in the State hospitals to the unentitled but at a price, not free.

Implementation of the above scheme will require restructuring and rationalisation of various related enterprises. For example, State financing of medical education, uniformity in the standard of medicare, decentralisation of and accountability in local administration etc. There will be many other related issues demanding attention e.g. private investment in commodity medicare, State policy on preventive and rehabilitative health intervention, Centre-State

relationship etc. But these are issues that can be and should be tackled only after the adoption of the scheme is decided upon.

Implications:

It is not suggested that the above scheme will be readily implemented by the authorities, if only its rationality and feasibility are established. The State, in an exploitative society, does not undertake social welfare for innocent benevolent purposes. Social welfare measures e.g. education, health care, and public distribution system are actually outcome of class struggle. The State is obliged to concede these and at the same time, uses these to project a benevolent, friend-of-the-underprivileged image for itself. Such a process perforce has a limitation within the constraints of the exploitative system. Financial allocation to social welfare cannot be allowed to climb to such proportions as to make a substantial dent in profit rate of the economy. This unwritten law is causing a crisis in the State medicare service. Demand for modern curative medicine has been increasing steadily and the state, under the restraint of the unwritten law, finds it difficult to provide such costly service universally. But it is imperative to maintain the benevolent image in order to contain social unrest and legitimise and sustain the existing social order. Hence, sprouted a number of prescriptions as the way out. Barefoot doctors, glorious indigenous medicine, people's health in people's hands, healthy life style etc. are being propagated in order to explain, justify and perpetuate denial of effective medicare to the underprivileged. It is noteworthy that the proponents of all these alternative remedies never propose dismantling of sophisticated modern medicare system serving the affluent. Theaffluent will be allowed to enjoy alien western curative medicine. Alternative prescriptions are meant only for the poor.

The proposed scheme under discussion will not only expose the deprivation of the poor in the current discriminatory medicare service practised under cover of universal eligibility, but at the same time disturb the legitimization process. The deprived people will now have a concrete slogan to counterpose against the apparently benign slogan of H.F.A. The slogan of exclusive guaranteed medicare service carries no amount of mystification around it. The effects of medicare on health, life and limbs are obvious, pointed and clear

to them. They now have a clear circumscribed demand to struggle for and organise. They may leave no avenues unexplored to achieve an exclusive right for themselves and if achieved, will be equally zealous to guard it. If achieved, they are apt to exercise control over it through their own democratic means in order to see that it functions effectively for them. The demand is culturally compatible, emotionally moving and meets urgently felt need.

Will this scheme be realised? Will the State concede this demand to the deprived and exploited classes? The prudent answer is No. Indian reality enjoins that social justice and equitable distribution cannot be expected to materialise in an exploitative class divided society. A few sporadic benefits may be realised from time to time through class struggle to produce some palliative effect. But a scheme of exclusive control by the lower echelon of the society is apt to face strong opposition and resistance. The present beneficiaries of the State service will oppose it as they are to loose an existing privilege. The controllers of the State exchequer will oppose it as it not only entails increased allocation to the poor but setting up a framework for accountability of the providers to the recipients. Such opposition will instantly expose real beneficiaries and utter inadequancy of the present system; will pierce through the humanitarian camouflage undermining the benevolent friend-of-the-poor image of the State; and make a dent in the legitimacy of the present social order. It will breed conflict and facilitate polarisation of the contending forces. It may act as a nidus for class struggle.

There is, on the other hand, the question of legitimacy of the scheme itself. The illusion that the deprived people may obtain effective primary health care for themselves through the good-will & philanthropy of well-meaning liberals and humanitarian international community should be abandoned once and for all. India has a long tradition of voluntary welfare activity in the field of medical care producing, so far, little result. The illusion that technological (alternative medicine etc.) and managerial (H.F.A. : an alternative strategy - I.C.S.S.R./I.C.M.R.) innovations may do the trick, should also be seen through. The deprived will have to demand for their legitimate due and struggle for control. But then the demand itself

should not only be legitimate but should also be rational and conform to political reality. The labouring masses should not act only as a pressure group for themselves but should emerge as the future leaders of the ensuing just social order. They will have to take the need of entire people into consideration in order to earn legitimacy for the scheme. The scheme therefore provides for feasible effective medicare for the other strata of the society.

If the control over the medicare service is ever achieved it will soon be apparent that without overall political and economic control neither effective medicare could be sustained nor the basic health care provisions e.g. food - water etc. could be obtained. The fundamental problem is political and economic. This situation is not peculiar to health. State allocation on education, housing, relief etc. does not reach the poor but is substantially appropriated by the socially dominant classes. Only successful struggle and eventual assumption of control over the State by the overwhelming majority of the organised labouring people could reverse the trend. It may begin in the field of medical care.

HEALTH FOR ALL NEED FOR A PEOPLE'S DRUG POLICY

by

B. Ekbal

India has become one of the few developing countries whose pharmaceutical manufacture has reached a high level of self-sufficiency, oriented towards full integration at least for the main sectors of the economy. For example, India produces 45 thousand formulations in different forms like tablets, liquids, injectables using about 400 bulk drugs being manufactured in the country. In its classification of pharmaceutical industries of less developed countries, UNIDO placed India in group 5, representing the most advanced stage. Some of the characteristics of this stage as defined by UNIDO are near self-sufficiency in raw-materials for the production of drugs from basic stages, a wide variety of therapeutic groups of drugs produced etc.

The total investment in the pharmaceutical sector expanded from Rs.24 crores in 1952 to Rs.200 crores in 1972 and further to 600 crores by 1983. The value of output which was only Rs.10 crores in 1948 rose to 300 crores in 1971-72. By 1974, the value of production of drugs and pharmaceutical products reached the level of Rs.377 crores and further Rs.1870 by 1982-83.

Table I

India's Pharmaceutical Growth 1952-53 to 1982-83

Sl.No.	Item	1952-53	1982-83	% Increase
1	Number of units	1643	6631	300
2	Investment	24 crores	600 crore	2400
3	Bulk drug production	27 crores (64-65)	325 crore	1800
4	Formulation	35 crores	1545 crore	4300
5	Imports	16 crores	141 crore	780
6	Exports	0.08 crores	111 crore	13700

Source: Charpure Y.H. 'Drugs for Masses', Eastern Pharmacist, 26 Feb.1985 pp. 35-38.

The evidence presented above on the growth of pharmaceuticals industry in India suggests an impressive picture. But a closer look, however, reveals a somewhat different picture of extremely disquieting features. Though the total number of licensed drug units of nearly 5200 are among the highest in the world the share of Indian pharmaceutical industry in the world production is as low as 1.2 percent. Per capita drug consumption is one of the lowest in the world, embracing only 20% of the total population.

Since independence, the government of India permitted the Multinational Corporations to set up units in India so that India may get access to new discoveries of the West. The liberal approach to foreign collaboration in the pharmaceutical industry was highly detrimental to the development of initiatives already taken by the then existing research institutes in India. The 'Pro foreign' attitudes of government of India enabled Multinational with ready access to the sophisticated technical knowhow as well as modern managerial talent, to establish production facilities. A closer look on the history of the development of this industry will instruct us about the weak chemical base over which it is erected. While, the pharmaceutical sector in developed countries came to be established as a result of diversification of basic chemicals, the growth process in India was characterised by a 'reverse process' of backward integration which has the adverse effect of making the industry dependent on Multinational Corporations for the supply of raw materials and other inputs. The liberalisation of major instruments of controls like licensing, foreign collaboration guidelines etc. facilitated the growth of foreign companies.

At present there are 48 firms in the foreign sector of which 35 firms are those in which foreign share holding is 40 percent and above. The number of foreign companies operating in India will only show the outward manifestations of foreign control. Foreign control defined in terms of control of output is of staggering proportions. Foreign companies control about 78% of total sales turnover of drugs in the country while the shares of Indian private and Public sector are 16% and 6% respectively.

A study of the market shares of foreign companies in India vis-a-vis their shares in a few developed and developing countries yielded interesting insights into the concentrations of Multinational Corporations in the Indian Pharmaceutical industry. The concentration is found highest in the case of Indian pharmaceutical industry than in both developed and developing countries.

The proportion of bulk drugs produced by Multinational Corporations have been coming down over the years. If it was 36.17% in 1974-75, it declined to 21.8% in 1980-81. Whereas the share of Indian sector including public sector increased from 62.82% in 1974-75 to 68.2% in 1980-81. The thrust of Multinational Corporations continue to be, as Hathi Committee has observed long back, 'towards capitalising over drug formulations and nondrug items like cosmetics and luxury goods where technology and capital inputs are much lower and which permits promotion and aggressive salesmanship and brings in much higher returns on investment'. What is more tragic has been the breach by the Multinational Corporations of the important National Drug Policy directive stipulating that the ratio of bulk drug to formulations production by them must not be lower than 1:5 but atleast statistics indicate that they are nowhere near the official guidelines.

Table II

Ratio of Bulk Drugs to Formulations

Sectors	Ratio as on 1974-75	Ratio as on 1980-1981	Ratio as on 1982-83
I Foreign Sector	1:6	1:12.53	1:12
II Indian Sector	1:8	1: 2.6	1:3.44
III Public sector	1:0.8	1: 1.26	1:1.12

Source: Ministry of Petroleum and Chemicals, various reports quoted by Mohanan Pillai in paper presented in KSSP Seminar 'A Decade After Hathi Committee' Nov.24-27 at Trivandrum.

Instances of over pricing through transfer pricing in India have been reported. Librium was introduced into the Indian market at more than Rs.5,555 per kg. While local firms could import it for Rs.312 per kg. A foreign subsidiary was charging Rs.60,000 for a kg. of dexanethasone which was reduced to Rs.16,000 on threats and pressures by the controller of imports. The international price of a particular bulk drug used in the treatment of heart disease, is approximately 530 per kilogram. A multinational was producing it in India in the early 1970s by importing the basic raw materials from its parent company and price paid for this import was $ 871 per kilogram. Such examples can be multiplied. (Table III)

Table III

Over-pricing of Imports of selected bulk drugs by the TNCs in India

Name of the bulk drugs	Unit	The price at which the TNCs imported in India (Rs)	Inter-national market price(Rs)	Over-pricing
Chlordiazepo-xide	Kg	5555	312	1680.4
Vitamin B 12	Gram	230	90-100	130-155.5
Indomethacin	Kg.	3400	360	844.4
Prenylamine lactate	Kg.	1900	470	304.2
Erythromycin	Kg.	1200	780	53.8
Fursam ide	Kg.	1650	520	217.3

Source: Towards a Rational Drug Policy
All India Drug Action Network 20 March 1986.

A recent systematic study on the incidence of transfer pricing by multinational subsidiaries revealed that outflow of resources on this account alone amounts to Rs.550 lakh an year. According to Kafauver Committee of U.S.A. drug prices in India were the highest in the world and were in inverse proportion to the per capita income (Table IV). Drug price indices in developed countries have been falling when static groups of drug price index calculated on the basic prices of eight age old static drugs showed a rise by 41.9% during 1961 and 1970.

Table IV

Some common drugs	Price at which bought (per kg.)	International price(per kg.)	Percentage of profit
Doxycycline	5,890	1,377	340.5
Ethambutol	620	320	93.8
Frusemide	1,426	450	216.9
Gentamycin	35,670	3,500	919.1
Vitamin B 12	494	132	274.3
Ampicillin	1,392	743	87.3
Librium	5,555	312	1680.4

Source:Quoted from paper presented by Dr.Naresh Bannerjee in KSSP organised Drugs Seminar,Trivandrum,Nov.24, Also see Sudip Chaudhuri's Making Drugs without TNC's EPW Annual Number 1984.

In India, pharmaceutical industry controlled by Multinational Corporations is notorious for its use of high pressure sales techniques. When new products which are only 'molecular manipulations' (with no therapeutic gains and is by-product of marketing oriented research than genuinely innovational research) are introduced in the market, they are backed up with a barrage of high-powered promotion. The success depends much on branding them and impressing the doctors of the virtue of particular brandnames. The 'merit' of brands are proved to be of a dubious kind. They promote a product differentiation under which the same basic drug is marketed under different brandnames. There are around 40 to 45 thousand brand names circulating in India for some 700 basic drug. The amount of promotion expenditures on brand names is just stupendous, around 23 percent of the value of sales in the case of some foreign companies. Some companies like Pfizer spend even more. No wonder than that as many as 406, 308, 155 and 115 formulations under different names are marketed for vitamin B complex, Multi-vitamin tablets, chlorophenical, Vitamin B12 respectively. What is more disturbing in this context is that Multinational Corporations market in India drugs which are not authorised for sale in the country of origin. The U.S. food and drug administration has circulated among federal agencies a comprehensive list of 369 drug products that it considers either ineffective or unduly hazardous. It is not precisely known how many of these are being currently sold in India.

Table V

Drugs marketed by MNCs in India but not in their home countries

Name of the Drug	Company	Country of origin	Indications for which the drugs are promoted
Avil Expectorant	Hoechst	F.R.G.	Cough Expectorant
Soventol Expectorant	Boehirnger Knoll	F.R.G.	-do-
Piriton Expectorant	Glaxo	U.K.	-do-
Periactin	Merind(MSD)	U.S.A.	Appetite Stimulant
Os tocalcium B12	Glaxo	U.K.	Growth Tonic
Amebiotic	Pfizer	U.S.A.	Anti Diarrhoeal
Novalgin	Hoechst	F.R.G.	Pain Killer
Baralgan	Hoechst	F.R.G.	Anti Spasmodic
Suganril	S.G.Chemical (CIBA Giegy)	SWISS	Anti inflamatory containing phenyl or oxyphenylebutazone.

Source: Towards a rational drug policy.
All India Drug Action Network, 20th March, 1986.

Is the higher levels of production in the pharmaceutical industry in confirmity with the pattern of prevalent diseases? The industry is bestowed with the responsibility of protecting the health of the nation by orienting its product structure to the prevailing disease pattern. All studies done so far indicate the inappropriateness of the drugs produced in India for catering to the needs of the people. Infections and parastic disease (e.g. dysentry, Malaria and Cholera) and respiratory diseases (general respiratory illness and tuberculosis) are the major classes of illness prevalent in India. Drugs for these major illness should be available in India for indigenous production but paradoxically most of the required drugs are not produced and if at all produced, it is in such a small quantity that requirements have to be met by imports. (Table VI). Whereas sales of vitamins, cough and cold preparations tonics and health restorators which are used for no ailment in particular, constitute 22% of the total sales of pharmaceuticals in the country and essential medicines such as anti-tuberculous drugs are always under produced. (Table VII).

Table VI

Decreasing Production of Essential Drugs

Drugs (in tonnes)	1980 Apr.to Sept.	1981 Apr.to Sept.
Chloramphenicol	46.41	36.16
PAS (For tuberculosis)	215.16	122.22
INH (For tuberculosis)	69.18	53.70
Piperazine (for worms)	6.30	4.20
Dapsone (For Leprosy)	10.28	10.17
D.E.C.Citrate(for filariasis)	10.58	8.42

Source: Issues involved in Drug Policy
Chermai Books, Madvas 1986

Table VII

Sale of vitamins formulations and tonics

Product	Company	Sales 1979	Sales 1984	Growth %
Santevini	Sandoz	1.83	3.05	66.67
Neogadin	Raptakos	1.46	3.05	108.90
Bayer's tonic	Bayer	1.45	2.54	74.17
Waterbury's	Warner	1.40	2.15	53.57
B.G.Phos	Merind (MSD)	1.40	2.06	47.14
Phosphomin	Sarabhai	1.19	2.00	68.06

Source: Amitava Guha 'Cycle of Profit' paper presented in Seminar 'Drugging of Asia' Madras 6 to 9th December 1985.

One of the dynamic effects postulated with regard to the activities of Multinational Corporations is that their operations in developing countries like India will lead to research-intensive technological advancement. But the pharmaceutical industry dominated by Multinational corporations showed an extremely poor record of research and development. The R & D expenditure of all Indian companies as percentage to sales is calculated to be around 1.5 whereas in advanced countries it is as high as 10 to 11 percent of total sales. Studies in the past indicated that there is no serious attempt on the part of foreign companies to adopt and assimilate imported technology and to make further process on it. In particular they have shown no interest in tropical drug research, such as antimalarials, anti-tuberculosis etc. With 40 to 50 years existence they have yet to come out with a drug the knowhow of which has been developed entirely in India. What research and development studies are undertaken is generally confined to and relevant for the parent companies' research efforts. Instances have been quoted in the case of few companies where, in the name of experimentation, human trials were carried out first in India even before trials were carried out in the West. It is also alleged that some subsidiaries of Multinationals do research on processes which is forbidden for experimentation in advanced countries. May be India is a preferred area for multinationals because of the absence of any strict rules of safety against genetic engineering research. Such examples of Multinational companies doing irrelevant research in the Indian context can be multiplied. In areas of essential drug research the Indian companies had made rapid success. But such successful efforts could not be carried forward due to the opposition from drug multinationals and also due to the charry attitudes of government of India.

The official statistics is replete with evidences that shows higher profitability of foreign firms vis-a-vis Indian companies. In particular, the profitability of foreign firms in sectors such as perfumes and cosmetics, medical and pharmaceutical products and beverages, are the highest. The data for 72-73, 73-74 showed that when the average profitability of all foreign subsidiaries operating in India was only 9.5, 9.3 percent respectively that of foreign subsidiaries in pharmaceuticals were to the order of 15.6 and 15.1 percent. It is to be remembered in this connection that this represents profits on book values and does not include the remittance through other channels such as, transfer pricing etc.

The banning of irrational and dangerous drugs in India or even their control is a tedious and often impossible task because of the plethora of control measures. Some of the drugs that have been banned with a great deal of procrastination over the years is still furtively available in the market as are some drugs banned or rigorously controlled abroad. Recently the Drugs Consultative Committee recommended the weeding out of 22 drug formulations. The firms were asked to stop production by September 1982 and marketing and sales by March 1983. The Government's procrastination in stopping the sales of drugs obviously to help the manufacturers to clear the stocks, has come in for severe criticism in a recent judgement on drug issue by the Hon'ble High Court of Kerala (Annexure 1).

But the banning of 22 formulations itself was so much diluted. For example, hydroxyquinoline groups of drugs are permitted to be administered for diarrhoeal disease. The drugs have been known to cause SMON (Sub Acute Myelo Optic Neuropathy) in 28 countries of which Japan reported 10,000 cases. They suffer numbness and weakness in the legs and eye damage. A large number became blind. One firm had to pay out millions of dollars as compensation and the drug was subsequently banned in U.S.A. and U.K.

The absence of a national stability forum like the British Safety Committee of medicine in U.K. or FDA in U.S.A., is one of the reasons for this sorry state of affairs. Only three out of twentytwo States in India(Maharashtra, Gujarat and West Bengal) have machinery to regulate the manufacture, distribution and sale of pharmaceuticals. A lot of drug analysis is done at private laboratories barely equipped for the job.

Some vital measures like the introduction of essential drugs in mass scale as advocated by the Hathi Committee and WHO, centralised bulk purchasing of these essential drugs by national agencies, introduction of generic names in preference to brand names, cheap standardised packaging of a limited but sufficient number of products need to be implemented rigourously in poor countries in order to provide essential drugs at low prices to a much larger proportion of their people. But in almost all countries the large pharmaceutical firms have consistently opposed such policies. It is a measure of the enormous power and influence they weild that they have generally been successful in getting rid of all progressive measures taken by some third world countries like Sri Lanka and Bangladesh.

The use of drugs has in any case to be put in its proper perspective. In the developing countries like India, ill health is mostly caused by a vicious combination of malnutrition and infectious diseases. Drugs cannot help unless the very sources of diseases, nutritional and environmental conditions are improved. Latrines to carry away excreta, improved housing, draining stagnant water and pipes for clean water are much a part of a programme to bring health to people as drugs and hospitals. A People's Drug Policy linked to health strategy which meet the real health needs of the people should be formulated.

It becomes an urgent need therefore to have a people oriented drug policy, which is based on sound scientific principles and not on the drug industry's profit motives. The Government of India has already in principle accepted the need for formulating such a People's Drug Policy. In the Fifth Non-Aligned Summit Conference held in August 1976 in Colombo a resolution (resolution No.25) was unanimously passed by the Heads of States present, asking for the preparation, with assistance of UN agencies, of a detailed drug policy and programme suitable for these countries. Accordingly in 1978 with the help of 4 UN agencies (UNAPEC, UNCTAD, UNIDO and WHO) a Joint Task Force was set up which after detailed discussion with governments and the industry submitted its report titled 'Pharmaceuticals for the Third World. Policy for Health, Trade and Production'. This report, which contains a detailed description of an integral national drug policy was accepted unanimously by the Sixth Non-Aligned Summit conference held in Havana in September 1979 (Resolution No.8).

The Kerala Sastra Sahithya Parishad has already initiated a big campaign exposing the anti-people and exploitative tactics of the multi-national drug companies. The questions of essential versus non-essential and dangerous drugs, the inadequacy of the drug safety control measures, the rising prices of life saving drugs, the non-implementation of the Hathi Committee recommendations (Annexure II) are being highlighted during the campaign. The aims of the campaign will be to sensitise the medical profession on these issues and to launch a people's Movement for the formulation of a People's Drug Policy. KSSP is organising seminars, street meetings, exhibitions, signature campaigns, slide shows, art items, publication of pamphlets, books etc. during the campaign period. The campaign was launched on April 7th, 1984, the World Health Day. KSSP along with other voluntary groups in India has already formed the 'All India Drug Action Network' to take the campaign to the all India level.

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ANNEXURES

Annexure - I

"As between the lives of the citizens of this country on the one hand and the loss that may result to the manufacturers and traders by the immediate ban on the manufacture and sale on the other, Government has chosen to view the latter as of more concern".

Justice Subramanian Potti,
Chief Justice,
Kerala High Court,
Judgement on the ban of
Harmful Drugs,
May, 1983.

Annexure - II

The Main Recommendations of the Hathi Committee were:

1. Nationalisation of multinational drug companies.
2. Establishment of a National Drug Authority.
3. Priority production of 116 essential drugs.
4. Abolition of brand names and introduction of generic names.
5. Revision and updating of the Indian National formulary.
6. Strengthening of quality control.
7. Elimination of irrational drug combinations.

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Conceptual Basis:

There are at present two major trends in public health practice. One trend is to move away from the very wide and almost all-embracing definition of public health given by pioneer public health scholars like C.E.A. Winslow(1920). In many instances, the term, public health, has often been replaced by the term, Community Medicine. As has been rightly pointed out in an Editorial (1985) in the Journal of Public Health Policy, the term Community Medicine is used to underline its subordinate position to tertiary care - as one of the many subdisciplines of the overall discipline of medicine. Many medical schools have even dispensed with their departments of community medicine and in some cases, schools of public health have been merged with medical schools. The emphasis is on technology - high technology.

The other trend is to make a fundamental departure even from the concepts developed by the pioneers by shifting the focus of public health practice from technology to the people. It is this trend of starting from the people, rather than from technology, which has formed the foundations for concepts and methods for a new approach to public health practice - New Public Health. This approach situates the health of a population in its social, economical and ecological setting. Actions in social and economic fields, in their turn, are considered as parts of a political process. Again, a political process is an articulation of the socio-cultural aspirations of the people, which emerge from the existing modes of production and production relations. Going further still, socio-cultural aspirations have their roots in the history and in the dynamics of human ecology. Correspondingly, this approach also underlines the fact that the very social and political forces, which determine the health status of a population, also determine the growth and development of its health services. Thus, developments both in health and in a health service system should be basically considered as components of socio-cultural and political processes. In effect, it leads to the rediscovery of what Rudolf Virchow had advocated in the middle of the nineteenth century - that medicine is essentially a social science (Rosen 1958:86).

In terms of formulation of a health service system, these social and political parameters of New Public Health impart a sociological and epidemiological perspective to the managerial and technological processes in public health practice. In other words, health problems are considered

not only in terms of the factors determining the dynamics of their prevalence and incidence in the entire population, but also in terms of the response of the people involved to these problems. It places emphasis on social meaning of epidemiological parameters of a health problem (Banerji 1986 a:95-105). These epidemiological and sociological data are then used to determine the choice of technology and type of the administrative system needed to make the chosen technology accessible to the people. As against the conventional approach of subordinating people to a predetermined package of technology, here it is the technology which is subordinated to meet the needs of the people: the approach of New Public Health requires a social orientation of technology. These basic postulates of practice of New Public Health have been included in the Alma Ata Declaration (World Health Organization 1978): inter sectoral action for health; promotion of community self-reliance by strengthening people's capacity to cope with their health problems; social control over health services; use of technology which is appropriate to the prevailing social, cultural and economic conditions; integration of promotive, preventive, curative and rehabilitative services; and ensuring coverage of the entire population.

The body of knowledge of New Public Health has thus been generated at two different planes. One plane concerns analysis of the wider ecological, historical, socio-cultural and political forces which determine the status of health and health services of a population. This plane of knowledge includes what is now called political economy of health and health services (Mckinlay 1984). In a sociological framework, this would be called sociology of health and health services (Banerji 1986a:11). It is significant that studies at this plane have led to the crucial understanding of the elements which form the foundation of the superstructure which is seen as health and health services of a population (Banerji 1985a). The modes of production and production relations, social and ecomomic structure, ecological and epidemiological conditions and health culture are examples of the major elements which form the foundation. The foundation places a constraint on the architecture of the edifice that can be built on it. In that sense, it is deterministic in nature. Any grafted health programme, which is not aligned to the foundational structure, is not allowed to thrive.

The foundation thus sets limits for health service development. The challenge, then, is to build a sound edifice within the limits set by the foundational structure. Meeting of this challenge forms the other plane of generation of knowledge for New Public Health : how, within the existing constraints, a health service system can be formed which most effectively deals with the health problems confronted by the people? It may, however, be noted that neither the foundational structure nor the more effective ways of dealing with health problems are static entities. They undergo changes as a result of changes in the objective conditions. Therefore, the body of knowledge also undergoes changes in both the planes.

New Public Health in the South : The Case of India:

Under real life conditions, practice of New Public Health should be seen as a process of shift of focus from technology to the people. In this sense, history and political economy of conventional public health and of community medicine with its high degree of technocentric orientation form integral components of the political economy of New Public Health. The case of India is taken here for analysis to elaborate on these and other aspects of practice of New Public Health.

Even a very brief historical analysis provides some critical insights into the political economy of contemporary health service system of India. Western Medicine was introduced in India in the wake of the British colonial conquest of the country in the eighteenth century. This led to further decay and degeneration of the pre-existing health practices. Concurrently, colonial exploitation led to further deterioration of the ecological setting, leading to further increase in disease load on the masses of the people. Furthermore, access to Western Medicine was limited to those who formed the oppressing class, namely the British rulers and a small section of the rich natives who sided with the British. Thus, advent of Western Medicine along with colonial conquest led to further strengthening of the oppressors and further weakening of the oppressed masses of people. Access to Western Medicine was thus used as a weapon for oppression.

Predictably, education and practice of Western Medicine was developed in the image of the Western or, rather, the British Model. The attempt was to produce British trained Indian physicians who conformed to Lord Macaulay's vision of a Brown Englishman. This privileged class orientation and heavy dependence of the

health services on foreign models was actively promoted by the new ruling class which came to power after India attained independence in 1947 (Myrdal 1968:291). Technocentricism continued to dominate. Availability of what had then been described as 'magic' or 'silver' bullets against widely prevailing diseases like malaria, tuberculosis, leprosy and trachoma whipped up considerable enthusiasm in WHO and among other foreign donor agencies. India undertook to launch a number of huge, technocentric mass campaigns against such diseases (Banerji 1985b:95-131). A still more massive programme on similar lines was built up to deal with the population problem. Following a Malthusian approach, people became 'targets' of an elaborate programme of coercion, victim blaming, motivational manipulation and social marketing to make them accept the contraceptive technology that is handed down to them (Banerji 1985:186-209). Here, too, there was a massive participation of foreign donor agencies of various kinds (Banerji 1985b:243).

A parallel movement for health and health service development as a component of the wider anti-colonial freedom struggle has been a remarkable feature. Rediscovery of the lost scientific and empirical elements of the indegenous systems of medicine, particularly the Ayurvedic and Unani Systems (Government of India 1948), active involvement of the medical profession in the freedom struggle (Roy 1982) and enhancing the capacity of the masses to cope with their health problems through the training of locally elected community workers (National Planning Committee 1948), are instances of the issues that had formed a part of the health movement. While attainment of independence saw considerable mellowing of the past rhetoric and there was a major swing in favour of the technocentric Western Model, the emerging forces of democratisation, impelled the political leadership, despite their class bias, to undertake major steps to bring the health services nearer to the people. Apart from rapidly increasing the number of facilities for education and training of the needed manpower, a major decision was taken to give a social orientation to that education and training (Banerji 1985b:73-91). An elaborate nation-wide network of rural health centres has been developed and now there is a provision for a sub-centre with a male and a female health worker to provide integrated, comprehensive health services to every 5000 people in rural areas (Banerji 1985b:255).

The decision in 1977 to entrust 'peoples' health in peoples' hands' through training of a health worker for every 1000 population chosen by people themselves, was a still more important milestone (Government of India 1978). The National Health Policy of 1982 (Government of India 1982) incorporated the philosophy of entrusting people's health in people's hands, with a commitment to ensure that the entire health service system to be geared to support the people by responding to their needs. By asserting that the contours of the health services are to be evolved 'within a fully integrated planning framework which seeks to provide universal, comprehensive primary health care services relevant to the actual needs and priorities of the community at a cost which people can afford, ensuring that planning and implementation of various health programmes is through organised involvement and the participation of the community', the policy document provides important directions for growth and development of knowledge for New Public Health in India.

As early as in 1959, historical and socio-cultural conditions had generated propitious political conditions in India for making systematic efforts to generate a body of knowledge for the practice of New Public Health. Showing their concern over the data which showed that more than nine-tenths of the (then prevalence of over six million) cases of pulmonary tuberculosis had no access to the very potent tools for diagnosis and treatment, the political leadership got together an interdisciplinary team of workers at the National Tuberculosis Institute at Bangalore (NTI) with the specific mandate for developing a nationally applicable, socially acceptable and epidemiologically effective National Tuberculosis Programme (NTP) for India (Chakratory 1978), (Banerji 1985:106-16). The instinctive response of a group of workers in NTI was technocentric - let thousands of mass radiography units filter the huge population of the country to 'catch' the tuberculosis patients for treatment with chemotherapy and let there be a Mass BCG Campaign. However, the NTI sociologists shifted the focus from the technology to the people: how do people respond to the problem of tuberculosis? (Banerji and Andersen 1963). By going to the people, they learnt that almost all the patients in a community are 'aware' of the disease and that, motivated by the suffering caused by the disease, more than half of them had sought treatment in rural health institutions, where most of the cases were dismissed with a bottle of cough mixture. Sociological data were also used for developing a people-oriented technology for diagnosis and treatment of the cases under the prevailing constraints and to draw up an

organisational and management system to embody the people-oriented technology (Banerji 1971). In subsequent studies, the sociologists questioned the then prevailing technocentric definition of a defaulter and offered a people-based alternative: a defaulter is one whose actions cause suffering to himself or others, presently or in the future. It was shown that by far the greatest 'defaulters' are those responsible for organisation and management of the NTP (Banerji 1970). There were also major lapses in the definition of a 'case'. Thus, by giving a technocentric twist to the definition the victims were blamed, while the main defaulters got away scot free.

Apart from making the substantial contributions in the form of providing a framework for formulating people-oriented national programme in a country like India, the approach developed in the NTI was also used for developing new approaches to such extensive areas as health education (Banerji 1985b:392-93), use of social sciences in health fields (Banerji 1986), interdisciplinary research in public health (Banerji 1972) and hospital administration (Banerji 1981). Thus, NTI has been one of the pioneering institutions for generation of knowledge for a new approach to public health practice, where the focus is on the people.

Development of people-oriented approaches for dealing with community health problems also brought into focus the powerful role of political and social forces in determining the degree of implementation of health services in the country. In a study on introduction of Western Medicine in the village Thaiyur in Tamil Nadu, conducted in 1969-70, Djurfeldt and Lindberg (1975:216) concluded that as 'the health situation in the village is a consequence of the prevailing economic and political order, both western and indigenous systems of medicine are equally impotent in dealing with the health situation; and only a profound transformation in the social and economic structure can give people of Thaiyur the means to improve their health'. Noting that making programmes for alleviation of suffering due to health problems accessible to the oppressed sections of a community can, atleast to some degree, (a) blunt the use of access to health services as a weapon of oppression, (b) can increase their fighting capacity, and (c) offer an entry point for wider social and political action, Banerji (1986a:129) has pointed out significant political

potential of health service development based on meeting the felt-needs of the oppressed people. There are many other contributions which deal with political economy of health and health services (for example, Mckinlay 1984, Navarro 1976). Work has also been done on political economy of specific areas, such as nutrition (Banerji 1978a), malaria control (Clever 1976), rural health services (Banerji 1978b), (Zurbrigg 1984) and family planning (Banerji 1980).

Because of its Malthusian overtones, technocentric orientation and active efforts to make people accept contraception, understandably, the family planning programme has been an important area of concern among those involved in giving primacy to people in programme formulation and development. In his book, Birth Control and Foreign Policy, Nicholas Demerath Sr.(1976) has given a vivid account of the very powerful foreign agencies in the USA which have been lending support to a Malthusian approach to family planning. However, from a very early stage there have also been a number of scholars who had underlined the need to shift the focus to the people - to their socio-economic development. They maintained that poverty was at the root of rapid population growth and not the result, as expounded by the exponents of the Malthusian school. Gunnar Myrdal (1968:2156-57), Asoke Mitra (1969), Ashish Bose(1974), P.B. Desai (1983), are among those who had thrown their weight on the side of the people. In their book, Population and Poverty, Lars Bondestam and Staffen Bergstrom (1980) have brought together ideas of a number of scholars to underline this point. In a separate paper, Staffen Bergstrom (1982) had pointed to the pronounced Malthusian overtones in the Model Plan, which had formed the framework for channelling foreign assistance in the fields of health and family planning. Subsequent evaluation of these programmes has strongly vindicated his assertions and premonitions (Banerji 1985b:318-20). In the wake of the powerful backlash from the intensified family planning drive during the National Emergency of 1975-77, a policy decision was made to shift the focus to the people : motivation for a small family norm was to be generated by action in social and economic fields, such as health, nutrition, water supply and sanitation, education, employment and status of women (Government of India 1980). With a perspective of political economy of family planning, it is not surprising to find that some basic social structural constraints are coming in the way of implementation of the new policy (Banerji 1985b:237-43).

Considerable amount of work has been done at the Centre of Social Medicine and Community Health of Jawaharlal Nehru University (1985) to develop a body of knowledge for health service development in India with a focus on the people, particularly the unserved and the underserved. The knowledge had become substantial enough in 1972 to launch an 18-month doctoral level course work for producing 'Managerial Physicians' for implementing concepts based on New Public Health. Additional work done in the past fourteen years have further strengthened this academic programme. Some concepts of New Public Health also find place in the curricula for training in other public health institutions in the country.

Considering the political and social implications of shifting the focus from technology to the people, it is not surprising that doubts should have been raised about the concepts of primary health care from some influential quarters in industrialised countries. They raised the issues of 'Selective Primary Health Care' (Walsh and Warren 1979) because they contented that the goals of primary health care, though highly desirable, are unrealistic. They glossed over the fact that primary health care is basically a philosophy for health service development, applicable to <u>all</u> the countries of the world. The suggested selective approach is the very antithesis of some of the basic postulates of primary health care: for example, community self-reliance, social control over technology and community involvement in policy formulation, planning and implementing of health services. The fact that certain countries, along with international agencies like UNICEF, could show such an utter disregard for the undoubtly weighty arguments against the selective approach (Institute of Tropical Medicine Antwerp 1985) and could impose a technocentric, dependence producing, vertical Universal Child Immunisation Programme (Grant 1985), provides a manifestation of the awesome power they command to be able to impose their will on others. This also explains why the Bhopal Disaster occured and why those responsible got away so lightly (Banerji1985c). Struggle for New Public Health has thus to be political struggle of the masses to wrest their democratic rights from the ruling classes and their very powerful foreign supporters; it has also to be a struggle in the field of public health research and practice, involving use of a sociological and epidemiological perspective to develop a managerial and technological system which ensures subordination of technology to the needs of the unserved and the underserved masses.

New Public Health in the North:

Countries of the North have attained remarkably low infant mortality rates and the expectation of life at birth is very high. The 'Medica Industrial Complex' has become so confident about its capacity to handle community health problems that even the much watered down departments of community medicine are being dispensed with. Winslow's comprehensive definition of public health has become as archival curiosity. It was Ivan Illich (1977) who dared to question the role of the medical establishments in the North as a threat to health of the people, because they cause iatrogenesis, they medicalise life and they promote dependence. He called medical technology addictive and disabling. The 1977 Dag Hammarskjold Seminar on Another Development in Health (Editorial 1978) had underlined these infirmities in the health services of countries of the North. There are additional moral and ethical dimensions when it is noted that the Medical/Military Industrial Complexes are nurtured by the sweat, blood and lives of numerous human beings of South, because North is able to extract from them unequal terms of trade, including trade with perpetrators of appartheid and including comtemptuous disregard for safety for hundreds of thousand of human lives, as manifested by the Bhopal Disaster. It is not surprising that the North should idolise Bob Geldofs for their missionary zeal in carrying out 'charitable' work for Africa and the South.

Ironically, a life of conspicuous consumption in the North has generated its own pattern of health problems: alcoholism, drug addiction, mental problems, for example. Then there are also problems of the poor, of the ethnic minorities, of the elderly and the rapidly rising number of the unemployed. Even after cornering the bulk of the natural resources of the planet through the use of brute force, different classes in most countries in the North are widely different in health status and in access to health resources. This certainly is not a profile of throbbing, healthy societies. There is a great deal that is sickening.

The task of shifting the focus from technology to the people in the North is even more daunting: it requires taming of the Medical/Military Industrial Complex, so that it is possible to develop healthy public policies, including policies concerning the medical establishment. This will require bearding the lion in its own den. The North has to go a long way in terms of social and political mobilisation to fulfil this important task. Hafdan Mahler (1986), the Director-General of WHO, has recently pleaded

for New Public Health to move into positive and active advocacy for health, to enable individuals and communities to develop their health potential. Illona Kickbush(1986), his colleague from the European Office of WHO, contends that New Public Health lies within three spheres - political, social and public health. Somehow, both of them seem to avoid confronting the principal problem of North : the depradations of the Military/Medical Industrial Complex. The Universal Child Immunization is but one manifestation of its capacity to impose its will on the South. Even if it turns out to be crass romanticism, exponents of New Public Health can be forgiven if they dream of a situation where the oppressed people in the South and the North get together to perform the onerous task of taming this monster!

Summary:

New Public Health embodies knowledge generated on the basis of according primacy to the people. With their roots in the dynamics of human ecology and history, health and health service development in a community is regarded as a socio-cultural process, a political process and a managerial and technological process with an epimemiological and sociological perspective. Elements such as modes of production and production relations, social and economic structure and epidemiological situation go into the formation of the foundation, which determines the architecture of the edifice of health service system. Practice of New Public Health involves development of a health service system which, within the existing constraints, most effectively deals with the health problems confronted by the people.

Considerable progress has been made in generating knowledge for New Public Health in countries of the South. The case of India is discussed. Colonial conquest and formation of the colonial pattern of health services, which continued to be perpetuated by the leadership of the post-colonial period and a parallel development of concepts and practices for people oriented health services, which culminated in the decision to entrust 'peoples' health in peoples' hands' provide a historical backdrop. Work at the National Tuberculosis Institute at Bangalore provided a framework for developing nationally applicable, socially acceptable and epidemiologically effective

health programmes of the country. Study of political economy of population control has led to a strong advocacy for generating motivation for small family norm through socio-economic development. It has been possible to generate enough knowledge to launch academic programmes based on New Public Health. Reacting to the political and social issues raised, there has also been a counter movement. The Universal Child Immunization Programme represents an effort to go back to the old approach of imposing on people technocentric, dependence promoting, vertical programmes.

New Public Health is also relevant to countries of the North. There is a need for social control over the medical establishment so that it does not cause iatrogenesis, medicalisation of life and dependence and it does not become addictive and disabling. Confronting some of the newly emerging problems, providing coverage to the unserved and the underserved and creation of more equitous health status are still major issues. On the wider plane of North-South relations, there remains the moral and ethical issue of epidemiological consequences of unequal terms of trade and social and political relationship.

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IMPACT OF COMMUNITY FINANCING ON - HEALTH AWARENESS, COMMUNITY PARTICIPATION, & UTILISATION OF PREVENTIVE HEALTH SERVICES

by

A. Dyal Chand

Primary Health Care has been defined as 'Essential health care ... made universally accessible ..... at a cost that the community and country can afford ...'. 'Such health care requires and promotes community and individual self reliance and participation ..... making fullest use of local, national and other available resources'.

The P.H.C. approach may be characterised as embodying three basic ideas:

- that the promotion of health depends fundamentally on improving socioeconomic conditions, and in most parts of the world, on the alleviation of poverty and underdevelopment;
- that in this process the mass of the people should be both major activists and the main beneficiaries;
- that the health care system should be restructed to support priority activities at the primary level, because these respond to the most urgent health needs of the people. (1).

Two other complementary issues have been emphasised in the PHC approach. One stresses mobilisation and effective application of underutilised national and local resources. The other emphasises the development of affordable and culturally appropriate delivery systems to make health care universally accessible. Both movements rely heavily on community participation, the first beacuse potential organisational, labour and cash resources are underutilised, and the second because the demand for health care - the ultimate expression of affordability and appropriateness - must come from beneficiaries rather than from outsiders. (2).

Since 1977, the Indian Government is carrying out an initiative, to train one TBA* and one community health worker for each village - a total of 580,000 TBAs and the same number of community health workers. (3).

* Traditional Birth Attendant

It was decided to pay the CHWs a stipend of Rs.50.00 a month. As early as in 1978, however, there were reports that CHWs were dissatisfied with their modest honorarium of Rs.50/- per month.

They demanded the same payment as Multi-purpose Workers (MPWs). The government responded by emphasizing that CHWs were not government employees, but representatives of the people and social workers. They were paid only a small honorarium because their health work was only part-time. Yet the CHWs continued to agitate for higher remuneration and a recognised place in the health service itself. There were reports from different parts of the country of CHWs trying to form their own unions. The Ministry of Health rose to the occasion and in 1979 produced a curious administrative solution. They simply renamed the programme the Community Health Volunteers Scheme. The change of nomenclature from 'worker' to 'volunteer' was intended to disabuse recalcitrant CHWs of any notions that they were government employees or that they deserved anything but a modest honorarium for their work. (4).

The Scheme continued to limp along until June 1981, when the government once again made a name change: the Community Health Volunteers Scheme became the Health Guides (HG) Scheme. The Ministry also issued new guidelines emphasizing and clarifying the responsibility of HGs to the community. Village Health Committees were to be established in order to better manage health activities. Mindful of the row about CHWs' honorariums and status three years earlier, the guidelines made it absolutely clear that the HGs were not government functionaries. (5).

'The Health Guides and the Village Health Committees are to be treated and honoured as representatives of the Village community, who have come forward to assist the Government in the implementation of the Primary Health Care Programme. In no sense whatsoever are they to be treated as subordinate to the Health Organisation or subject to its commands and orders' (Government of India 1981).

Evaluation of the programme reveals that despite its weaknesses it has resulted in changes in health consciousness and health status, and the Government, in the 5-Year Plan announced in 1984, re-affirmed its resolve to continue with the programmes. (6, 7, 8).

Parallel to government efforts several voluntary organisations have been experimenting with alternative strategies in implementing Primary Health Care. Community financing is one of the areas of concern where several health projects have been experimenting with various methods. Over 100 such innovative projects in 40 different countries were reviewed by the American Public Health Association in 1982. Of the 100 projects reviewed by APHA 11 were from India.

1. Attipra Dispensary - Govt. programme
2. Comprehensive Health & Development Project, Pachod, Dist. Aurangabad.
3. Barpalli village servide.
4. Christian Rural Health Programme - Orissa.
5. Co-operative Rural Dispensaries, Kerala - Govt.programme.
6. Howrah Contraceptive Depots, West Bengal - Govt.programme.
7. Comprehensive Rural Health Project, Jamkhed, Dist. Ahmednagar.
8. Kottar Social Service Society, Tamil Nadu - ICMR.
9. Lalitpur, Uttar Pradesh - ICMR.
10. Maharashtra Arogya Mandal, Pune.
11. Mallur, St.Johns Medical College Bangalore.

These projects are serving populations from 5000 in Mallur to 2,600,000 in Howrah, West Bengal. (9).

The various forms of community financing that have been experimented with by various projects are listed below:

Method		Form of payment
1. Fee for Service	-	CHW compensation, Recurrent.
2. Drug Sales	-	CHW compensation, Recurrent.
3. Personal prepayment	-	CHW compansation, sometimes Hospitalisation, recurrent.
4. Production base pre-payment	-	CHW compensation, sometimes Hospitalisation, recurrent.
5. Income generation	-	CHW compensation and drugs, recurrent or one time.
6. Community labour	-	Facility construction,one time.
7. Individual labour	-	Recurrent, labour.
8. Donations and adhoc assessments	-	Facility construction, or community project, one time.
9. Festival raffles etc.	-	Facility construction, one time.(10)

The summary conclusions of the APHA evaluation were .... 'Community financing requires great organisational and managerial spade work, and its ultimate yield may be small in relation to total primary care costs. The peoples' ability and willingness to pay must be ascertained, both in the aggregate and for individuals at differing socio-

economic levels. The Alma Ata Declaration lists eight elements of Primary Health Care, but individuals appear willing to pay only for curative services, not for prevention or community activities.

Curative services, though politically essential, have little lasting effect on health status, and expensive educational efforts may be required to convince communities to pay for prevention. The challenge is to find a balance between government and community finance - to use the former for professionally perceived priorities and the latter for locally felt needs. (11).

Whereas 'Community Financing is at best only a partial solution to the problem of health care finance, its impact on community participation, utilisation of health services, response to preventive health services has not been researched.' (12).

Studies of successful community finance must both process and outcome.

The Comprehensive Health and Development Project, Pachod, Dist. Aurangabad, has been researching various methods of community financing for primary health care since 1977.

Comprehensive Health and Development Project Pachod(CHDP)

Background:

The C.H.D.P., Pachod, is based in one of the more under-developed areas of rural Maharashtra. The project began in 1977, and is providing Primary Health Care to a population of 50,000 in 47 villages. The average size of a village is 1000 population. One traditional birth attendant and one community health worker have been trained in each village.

The project area is divided into 8 sub-centre areas, each with a population of 6000. There are 8 male multipurpose workers, one for each of these sub-centres, and 4 female multipurpose workers (A.N.Ms) one for 12,000 population. The female M.P.Ws and TBAs function as a team providing maternal and child health services and family planning. The male M.P.Ws and CHWs function as a team and provide child health and all other primary health care services including family planning. Both preventive and curative services are being financied by the community.

The study on community financing for preventive services were based on the following objectives:

1. To study if resources can be mobilised, in a rural community, for preventive health services.
2. To study the possibilities of generating community participation for a preventive service provided at the community level.
3. To study quantitatively the ability of community based health workers to generate demand for preventive services - immunisation of children under age 5.
4. To evaluate the effect of a quantified amount of health education on the changes in knowledge, attitudes and practices of a community.

The hypotheses of this study were:

1. Even the underprivileged in a rural community will be willing to pay for preventive health services if the demand can be created through appropriate health education.
2. Given the incentive of direct and immediate reimbursement for their initiative, community health workers would educate the community to create such a demand for preventive services.
3. Provided with appropriate skills, community health workers would be effective educators, not necessitating the use of expensive educational efforts.
4. Reimbursement directly from the community for services rendered would make CHWs accountable to the community rather than the Health System.

Methodology:

Immunisation services were provided by the project on a mass campaign basis. Community health workers were utilised to register children whose parents agreed to avail of the service. The CHWs were also instructed to involve their communities in the registration process and in preparing for facilities for the mass immunisation campaign. The children that had been registered were immunised on a single day. The immunisation team visited each village on 4 subsequent occasions at monthly intervals to provide the second and third doses, including mopping up operations.

In 1979 a Knowledge, Attitude, Practice (KAP) study was conducted to assess awareness regarding D.P.T. immunisation. In 1980 parents of children were contacted personally by the CHWs and given health education on DPT immunisation. Following a fixed period of healh education

described in detail later a KAP survey was conducted again to study changes in concepts of the community and comprehension of messages in the health education. Mass immunisation services were provided free of cost and the utilisation rate was monitored.

In 1982, three years later, a KAP study was conducted to assess the awareness regarding Polio immunisation. Following this parents of children under age 5 were contacted personally and given health education regarding polio immunisation. The strategy of health education used in 1979 for DPT vaccination was repeated for polio immunisation, so that comparisons could be made. This was followed by a KAP survey to study changes in concepts and assess the level of comprehension of health education messages. Mass polio immunisation was provided, but this time the parents were charged a nominal fee for this service. The method used to assess the ability and willingness of the community to pay for this service is discussed later in this paper.

The community health workers received the entire fee for services paid by parents as a reimbursement for educating and motivating parents and registering children for the immunisation programme. The response rate for polio immunisation and payment for the services were monitored as before. The same strategy of mass immunisation that was used for DPT was repeated for polio immunisation.

Health Education and Motivation of Community Quantified

The health education campaign for both the immunisation programmes began 3 months prior to the actual vaccination of children. During the first month pamphlets were distributed twice and their impact evaluated at fornightly intervals.

During the second month the CHWs gave informal education regarding immunisation by word of mouth to parents of children identified as eligible candidates for vaccination. The impact of this was evaluated through a KAP study. Finally, just before the vaccination the village announcer made announcements in the village twice.

One day prior to the immunisation programme, in each village the CHW of that village was asked to give identification slips to parents of eligible under-fives. The CHWs were also asked to collect the service fee from the parents. Even though this was not a part of the health education strategy it was felt that it had a considerable motivational impact on both the CHWs as educators and on parents to utilise the immunisation services.

It was felt that the CHWs would have put in considerable effort in educating and motivating parents because of the obvious benefit of immediate reimbursement for this service. Once the parents had paid the required fees they were motivated t bring their children for immunisation. Even though this process of education, motivation negotiation for the fees and actual transaction could not be observed and evaluated, it is believed it had an important motivational impact.

Each village was thereby exposed to the same message 6 times by three different vehicles. Twice by a printed pamphlet, twice verbally by the community health worker visiting households individually, and twice by the village announcer by means of general community contact. This way a minimal input was required of the project health staff. Distribution of pamphlets, health education during household visits, arrangement for village announcer, were all done entirely by CHWs in their own villages.

Similar procedures were adhered to during the DPT vaccination in 1980 and subsequently during the polio vaccination in 1982. In 1982 during the polio immunisation the CHWs were instructed to collect Re.1.00 per dose from each parent when they were registering children for the immunisation programme. They were allowed to retain this as a reimbursement for their services. This was the only difference in the strategies employed for the DPT and polio immunisations. Response rates for the two immunisation programmes are presented in Table II.

A fortnight after each immunisation programme had been completed a second KAP study was conducted to evaluate the health education and immunisation strategy. The findings of the final evaluation and KAP test are presented in Table III.

Community Participation Defined

Community meetings were held in 1978 to determine community response to immunisation programme.Once the community of a village decided that they wanted the immunisation programme, community representatives were requested to prepare lists of under-fives in each village and to determine the proportion immunised prior to the immunisation programme.

Community representatives chosen in each village help the CHW in registering the children for the immunisation programme. Announcements in the village are arranged by the village panchayat, and the community provides the building, sterilisation facilities and volunteers to organise the immunisation of children.

Methods used to Assess Ability and Willingness of the Community to Pay for Preventive Services.

Parents of all children under five years were told that a nominal fee would be required, and were asked what they would be willing to pay towards this service. The amount decided in the majority of villages was Re.1.00 per dose of polio vaccine. This decision was based on an informal house to house survey of landless labour families (under-privileged) by the CHW and upon group discussions organised by them in their villages.

Health Awareness Quantified

Awareness regarding diphteria, pertusis, tetanus and polio, and their immunisation was quantified as follows:

1. Diseases against which immunisation was being introduced.
2. Signs and symptoms of the disease.
3. Cause of disease.
4. Immunisation available or not for prevention.
5. Dosage schedule.

If respondents answered all 5 questions they got a score of 5 (complete positive). A score of 3 - 4 indicated partial positive response, and a score of 0 - 2 indicated a negative response.

Cost Analysis:

It cost Rs.150/- ($ 15.00) to have 10,000 pamphlets printed. This was the only additional input. In terms of paid personnel no additional time was allocated for this purpose. The cost of increased time and effort of the community health workers has not been analysed as yet.

Willingness and ability to Pay:

In 1982 when the polio immunisation service was offered for a fee for service it was felt that some very poor households may want to avail of the services but may not be able to afford it. Whereas the willingness to pay for this service had been ascertained through personal contact with all the families belonging to the landless labour class it was necessary to study the ability of these families to pay this amount. Following the polio immunisation a study of non-utilisers was conducted to determine how many had not availed of the service because of monetary reasons (Refer Table IV). Of the households interviewed 73.7% children had received oral polio vaccine and 26.7% had not. Of the 26.7% who had not received OPV 20% said it was due to moneraty reasons.

From the analysis it is seen that 1079 parents of 1800 children were interviewed (randomly selected). Out of 1800 children 1327 (73.7%) had received OPV and had paid for the service. 473 children did not avail of polio immunisation. A 50% random sample (230 parents) out of the non-beneficiary group were interviewed, and 20% (46 out of 230) responded that they did not avail of the service for monetary reasons.

It could be concluded that 4.8% (87 out of 1800) children could not be immunised because the families were financially unable to pay for the service.

These families were later covered by immunisation services offered at half the cost levied the first time. (See Table IV b).

In 1978 a base line survey was done to establish socio-economic and literacy levels, immunisation status of children prior to starting the project and proportion of the population in the age group 0-5.

Since this study was concerned with community financing, impact of health education through KAP studies and on immunisation of under-fives, the relevant tables from the base line survey are reproduced as follows:

a. Age composition of population:

11.93% of population - age 0-5.

b. Socio-economic status:

i. Land ownership

30.59 are landless labourers
21.90 own 5 or less acres of land, and are essentially labourers

Total: 52.49%.

ii. Occupation

49% households responded that they were either agricultural or construction labourers.

c. Educational status:

54.78% male and 83.70% female population were illiterate (unable to read or write).

d. Immunisation status of children 0 - 5 in 1978:

Less than 10% for DPT and Polio.

e. Awareness regarding DPT and Polio:

Less than 12% of the population.

Baseline Survey 1978

1. Project Area:

No.of villages:	45	-	No.of households:	10527
No.of hamlets:	33	-	No.of households:	1622
Total:	78			12149

2. Simple Random Sampling: 1215 houses selected randomly. Each household represented a nuclear family. Average number of persons per household: 5.4

3. Population Characteristics

a. Age Composition:

Age Group	% of total Popln.
0	2.75
1 - 4	9.18
5 - 9	15.09
10 - 14	13.92
15 - 29	24.98
30 - 44	18.64
45 - 59	10.68
60 - 64	4.25
75 - +	0.51
Total	100.00

b. Socio-economic Status

b.i.) Land Ownership

Land in Acres	% of Households
Nil	30.59
< 5	21.90
5 - 7	14.18
8 - 10	10.55
11 - 15	9.04
16 - 25	7.98
26 - 35	2.93
36 - 50	0.98
50 +	1.84

Note: 30.59% of households are full-time agriculture or construction labourers. Those with 10 acres or less work as labourers for 6 months of the year or more.

b.ii) Occupation

Name of Occupation	% of Households
a) Farming	40
b) Agricultural labour	42
c) Construction & other labour	7
d) Animal husbandry	2
e) Plantations	2
f) Trade, commerce or industry	4
g) Others (includes services)	3
Total	100

c. Educational Status of the Population age 5 and above:

Educational level	Male %	Female %	Total %
a) Nil (Illiterates)	54.78	83.70	69.17
b) Literates (Non-formal Education)	1.06	0.41	0.73
c) Primary (Upto 3 years)	9.86	4.91	7.40
d) Middle (Upto 7 years)	21.15	7.38	14.30
e) Non-matric (Upto 10 yrs)	6.83	0.70	3.78
f) S.S.C.(Upto 11 years)	3.29	0.41	1.85
g) Intermediate (Upto 12 years)	0.40	-	0.20
h) Undergraduates (Upto 14 yrs)	0.15	-	0.07
i) Graduates(Upto 16 years)	1.02	0.7	0.55
j) Post-graduates (upto 18 years)	0.11	-	0.06
k) Technically qualified	0.07	-	0.04
l) Others (not specified)	1.28	2.42	1.85
TOTAL	100.00	100.00	100.00

Literacy Rate (ages 5 and above)

1) Male : 45.22%
2) Female : 16.30%
Total : 30.83%

d. Immunisation Status of Children Under Age 5 in 1978:

Immunisation	Infants %	1-4 yrs %	5-9 yrs %	10-14 yrs %	Total for Age 0-5 only - %
a) Smallpox	93.09	96.51	99.78	99.62	98.00
b) B.C.G.	7.14	20.21	21.52	18.14	17.15
c) T.T.	0.60	1.23	0.86	0.11	1.10
d) D.P.T.					
Dose 1	7.74	11.78	6.42	2.64	10.84
2	4.76	11.78	5.67	2.41	10.15
3	2.98	9.94	4.50	2.41	8.23
e) Polio					
Dose 1	5.36	15.47	7.17	3.87	13.17
2	5.36	12.30	6.64	2.64	10.70
3	2.38	11.07	5.14	2.53	9.05

e) Awareness regarding DPT in 1979 and polio in 1982 - Response to KAP Questionnaire:

Immunisation	% Positive Response
D.P.T.(1980)	12.67
Polio (1982)	11.85

Table I

Dissemination of health education messages through the media of printed pamphlets studied by means of comprehension tests in 1980 for DPT, and in 1982 for Polio immunisation.

Response to written health education messages. Printed pamphlets without simultaneous informal verbal health education. Comprehension test done in 13 randomly selected villages in 1980. The same villages surveyed in 1982.

I. (a) Houses listed by level of literacy

Year Comprehension Test conducted	No. of families with no literate member	% illiterate families	No. of families with more than one literate member	% literate families
1980	1036	39.3%	1603	60.7%
1982	1328	45.4%	1598	54.6%

I. (b) Response to Printed Messages

Year Comprehension test conducted	No. of Households Interviewed	Positive Response to printed message	% Positive response	
1980	2639	1894	71.8	$X^2 = 71.26$ $P_2 = <.0001$
1982	2926	2230	76.2	$X^2 = 83.14$ $P == <.0001$

I. (c) Literate and Illiterate families analysed separately

Year Comprehension test conducted	No. of illiterate households interviewed	Positive response to printed message	% positive response	No. of literate families interviewed	Positive resp. to printed message	% Positive response
1980	1036	557	53.8	1603	1337	83.4
1982	1328	789	59.4	1598	1441	90.1

Table II

Utilisation rates for DPT (1980) and Polio (1982) vaccination in 13 villages of project area:

Year	No. of villages in sample	No. of house-holds in sample	Popula-tion in sample villa-ges	No. of child-ren under 5 yrs.	% of child ren immu-nised with 3 doses	Range of U-5s immuni-sed in 13 villages
1980	13	4312	22475	2639	52%	33.9 to 65.1%
1982	13	4791	25943	2926	77.2%	52.6 to 90%

$X^2 = 389.34$ $P = < .001$

Note: DPT immunisation in 1980 was provided free of cost. Polio immunisation in 1982 was provided at a fee for service of Re.1.00 per dose. This amount went to CHWs as reimbursement.

Table III

KAP test conducted one month after completion of both Immunisation programmes. DPT (1980), Polio (1982)

Year	No. of villages in sample	No. of house-holds in sample	Complete positive response	Partial positive response	Nega tive resp.	Total
1980	13	981	77(7.8%)	314(32%)	590 (60.1%)	981 (100%)
1982	13	1079	177(16.4%)	600 (55.6%)	302 (27.9%)	1079 (100%)

$X^2 = 215.8$ $P = < .0001$

Note: 5 questions asked in KAP test.
Score: 1) Complete positive response = 5 correct answers
2) Partial positive response = 3-4 correct answers
3) Negative response = 0-2 correct answers

Note: Households with children under 5 years were selected in the sample for the KAP test.

Table IV

a) Utilisation rate for OPV - 1982

No. of households interviewed	No. of children in households that were interviewed	No. of children who had received OPV	% of children who had received OPV	No. of children who had not received OPV	% of children who had not received OPV
1079	1800	1327	73.7	473	26.3

Of the 473 children who had not received OPV 230 (Approx. 50%) were sampled and interviewed to determine reasons for not taking OPV. Parents of these 230 children were interviewed with an open ended questionnaire.

b)

Village	Reasons for not taking oral polio vaccine				
Sr. No.	Monetary problems	Were not aware of service	Not present in village at the time	Child sick at time of immunisation	Total No. of families
1	7	14	12	3	36
2	6	15	11	8	40
3	2	5	9	1	17
4	5	--	--	-	5
5	7	4	5	--	16
6	5	4	5	4	18
7	-	5	4	3	12
8	6	14	6	2	28
9	4	4	-	6	14
10	-	1	-	1	2
11	1	6	-	5	12
12	2	5	2	6	15
13	1	6	5	3	15
Total	46	86	59	42	230
%	20	36.1	25.6	18.3	100

Limitations of Study:

Ideally the study design could have introduced immunisation service free of cost in one area and for a service fee in another area of the project. However, since the service fee was linked to the reimbursement of the CHWs it was felt that differentiating between CHWs with regard to reimbursement systems would be a divisive force. Since the cohesion and sense of association among these community based women is a very important factor in establishing group norms and expectations it was decided not to introduce different reimbursement systems amongst them.

The decision was taken to study the effects of community financing by holding every other factor constant and introducing two different immunisation programmes at 2 points of time - offering one free and the other for a service fee. For this reason DPT vaccination was introduced as a free of cost service in 1980, and polio vaccination was offered for a service fee 2 years later in 1982.

It is possible that the differences in community response to the two immunisation programmes could have been influenced by factors other than community financing alone.

Firstly the CHWs had two years more experience when the polio immunisation was introduced as compared to the DPT immunisation programme.

It is possible that the general health consciousness had been raised because of the routine activities of the Project and the increased response to utilisation of polio immunisation services cannot be entirely attributed to a greater initiative of CHWs and the community or to the impact of community financing. However, the KAP survey in 1982 just prior to the polio immunisation programme showed that awareness regarding polio and immunisation against polio existed only amongst 11.85% of the respondents. It was concluded that the increase in awareness (72%) following the immunisation programme was because of the health education provided by the community health workers.

Communication amongst a rural community is informal and verbal, but community health workers do need some audio-visual aids. The impact of pamphlets used as audio-visual aids has been shown in Table I.

Impact of Health Education:

There was a high degree of dissemination of knowledge by house to house distribution of printed pamphlets alone. Families with no literate member took the pamphlet to literate neighbours to have it read to them. Over 70% of the families responded positively when interviewed about the message contained in the pamphlet.

The message in the pamphlet was reinforced by verbal messages given by the traditional village announcer. Parents were able to associate the verbal messages with the printed pamphlet they had received.

The increase in utilisation rate in 1982 for the polio immunisation, it was concluded, was due to the increased awareness created by CHWs and their ability to motivate parents. It was also concluded that the impetus in their initiative was because of direct reimbursement by the beneficiaries.

The total utilisation rate increased from 52% for DPT in 1980 to 77% for polio in 1982.

The KAP study conducted after the two immunisation programmes showed that comprehension and retention after polio health education was greater than after DPT. Partial to complete positive response was obtained from 70% respondents after polio as compared to 40% respondents after DPT. It was concluded that the CHWs' increased initiative in educating and motivating the community was responsible for this.

Impact of Fee for Service Strategy:

From studying the utilisation rates and interview responses it was concluded that 95.2% of the parents of the children that were immunised had the ability and willingness to pay for the service. Only 4.8% responded that monetary reasons were primarily responsible for their children not availing of this service. This is contrary to the popular belief that the under-privileged in rural areas are incapable or unwilling to pay for health services, particularly preventive services.

The impact of community financing on the performance of CHWs was measured through general observation of their work. They showed more interest and exhibited qualities of leadership and initiative which were not apparent earlier.

Conclusions and Policy Implications:

In India CHWs are being reimbursed by the government. They receive a token amount as 'honorarium' for services they render to their communities. This reimbursement is linked to abstract activities which cannot be measured such as number of health education talks given per month, number of couples eligible for family planning motivated etc. They are neither accountable to their own community nor to the health system which reimburses them.

If the reimbursement of CHWs is linked to out-come instead of activity, and primarily to preventive services they will create a demand for these services in their communities by increasing the awareness of the community for the services introduced.

Direct financing by the community leads to an increased initiative of CHWs in providing health education and in involving the community in the organisation of these services.

Cost Implications:

Health education strategies which often require expensive educational inputs or intensive personnel involvement are not practically applicable.

By giving impetus to local community initiative through involvement of community health workers and encouraging community financing towards their reimbursement, substantial resources can be mobilised within the community, without the necessity of increasing direct government health spending.

Why Pay?

By linking the reimbursement of CHWs to community financing they can be made more accountable to their community. Further, by linking this reimbursement to preventive services it can be expected that CHWs will take increased initiative in providing health education for creating a demand for these services resulting in substantial changes in health awareness and behaviour (i.e. use of immunisation services).

Who Pays?

It would be particularly inequitable if those who can afford these services at the health centre can receive them free of cost, and those who cannot are made to pay for these services albeit at their own door step. If the policy of charging a nominal fee for services provided by CHWs is considered the same consideration should apply to services provided at the health centre.

Pay for What?

If community financing for services rendered by CHWs is encouraged it is possible that they may become dispensers of medicines for minor ailments. Curative services have little lasting effect on health status. Besides with the charges that CHWs were allowed to take only limited resources can be mobilised through curative services. For preventive services where the entire community is mobilised to pay for a service, larger resources can be mobilised. CHWs may consider such returns worth the increased effort they have to put for extending such service.

Implications of Research Findings:

Community health workers have been able to mobilise Rs.125 - 150 per month from their communities. This level of community financing has been sustained over a period of 4 years, 1982 to 1985. Several preventive PHC services have been added to the list which are being financed by the community.

1. All immunisations including measles.
2. Six monthly vitamin A supplement.
3. Growth charts for under-fives.
4. Oral contraceptives.
5. Minor ailment treatment.

The project pays workers for needs perceived by it, such as

1. Neo-natal survival.
2. Eligible couples motivated for family planning.
3. Growth monitoring of children.
4. Environmental sanitation.

The community finances those preventive and curative services which are high on their priority list.

Apart from the financial implication the rapid dissemination of health awareness, the increase in motivation of community health workers, and the increase in utilisation of preventive services as a consequence of community financing make it an attractive proposition to experiment with on a larger scale.

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DISCUSSION

Manisha Gupte introduced the session on 'Alternatives for Effective Implementation'. She pointed out the relevance of the theme in the context of the several experimental models of health care that had been developed in India, and that had influenced national policy making. To what extent had these models been able to generate alternative strategies for effective health care? Were they replicable on a large scale? What were the other broad strategies that needed to be considered in view of the developments in health policy since the ICSSR/ICMR Report?

The background papers, as well as the discussions in the preceeding sessions, had highlighted four categories of alternatives:

I. Techno-managerial strategies, including -

(i) the bifurcation of preventive and promotive from curative health care as suggested by Dr. Sujit Das' paper;

(ii) better implementation of the existing health care services and better utilisation of health resources; and,

(iii) the reallocation of resources within the health sector in the context of the on-going debate regarding the merits of rural-based, low technology, preventive and promotive health care as against urban-based, high technology medical services.

II. Political decision making and governmental action in the field of health policy. This included-

(i) rethinking the emphasis on family planning as it had over-shadowed the delivery of health care and the utilization of health services;

(ii) providing health insurance;

(iii) formulating a 3-tier health care system as suggested by Dr. Sujit Das;

(iv) formulating and implementing a rational drug policy, as highlighted by Dr. Ekbal's paper.

(v) nationalising the health services, i.e. private practice and private drug industry; and,

(vi) freezing the production of doctors and drugs.

These were all controversial issues and needed a thorough discussion.

III. Non-health actions which included-

(i) reforms ranging from female literacy and universal education to increasing public awareness through the mass media, and through more active media participation by medicos;

(ii) meeting basic needs such as food, water, sanitation and an unpolluted environment;

(iii) tackling more fundamental issues such as employment and wages;

(iv) mobilising the people to demand health as one's right, as stated in the papers by Dr. Das and Dr. Banerji. This last point was linked to the fourth set of strategies namely people's participation.

IV. People's action: Here the central point was, what was meant by people's participation?

(i) At what levels did participation take place? As vigilant consumers; as implementers and administrators; or as decision-makers. The last called for a redefinition of the relationship between the state and the people. Did community financing of primary health services, as suggested by Ashok Dyalchand constitute participation?

(ii) What did the phrase autonomy to the people mean in terms of the nature of government controls and the nature of authorities to be delegated to the people.

The presentation pointed out the variety of viewpoints on people's participation in the background papers. Dr.Sujit Das' paper stated that only the providers, and not the recipients, were participants since the latter had no control over other areas of their existence. According to Dr. Banerji's paper, there was no basis for participation within the existing structure of global inequality where the terms of trade were highly disadvantageous to the South. On the other hand, Dr. Dyal Chand's paper advocated participation in terms of community financing of village health workers. Manisha Gupte pointed out that while the fee-for-service approach gave some autonomy to the community to plan its finances, there was no guarantee that, within the present unequal structure, this would ensure better health care for the people. It also amounted to privatisation of health services, thereby absolving the Government of meeting basic health care needs.

The alternative approaches suggested in Dr. Sujit Das' paper were firstly, a 3-tier health care scheme with free services for the poorest segment of the society. This was suggested as a strategy for mobilisation of the people and for exposing the hollow liberalism of the Government as it would never be implemented within the present structure. The presentation pointed out that while the 3-tier scheme had a mobilising value, it could not be a plan for a radically new health and health care approach. Secondly, the paper advocated that in the existing Indian conditions, the public health sector had to ensure the delivery of good curative care to the people. Preventive and promotive care could be met by other non-health programmes, and should not be confused with

the activities of the health sector.

Vimal Balasubramaniam's paper highlighted the role of journalists in giving health education. Manisha Gupte commented that there was a need for journalists to move out from the medical framework of health which made them vulnerable to contradictions and criticisms from the medical profession, and to use concepts better suited to people's need and experiences

In conclusion, Manisha Gupte returned to the question "What do we mean by 'alternatives'?". Did alternatives refer to strategies to change the structure, or to better methods of deliverying health care within the existing structure? In this context, she raised questions with regard to the notion of community; the limits of participation; and the knowledge content to be imparted to the people. With regard to the term 'community' she pointed out the unequal participation in village life due to caste discriminations. Was it possible for Dalits to get clean water supply on an equal basis with upper caste people? The issue of people's participation developing into people's action was another grey area. For instance, health education activities taught people to ask questions, and if as a result their demands went beyond gaining access to primary health care, what attitudes should the professionals adopt? Finally, the presentation pointed out that alternatives ultimately referred to a change in attitudes, and asked what the content of these changed attitudes would be within the different alternative approaches. As an example, Manisha Gupte pointed out the many contradictory attitudes toward women. On the one hand, the population policy and its objective of NRR-I was acutely discriminatory towards women and had made them a target of hazardous contraceptives; the mother and child programme put the primary onus of child survival on women as also the responsibility of

regulating the size of their families; the health services system emphasised the importance of women village-level health workers, but went against the spirit of the CHV scheme by putting pressure on them to coerce the rural women into accepting family planning; and none of these programmes nor the medical profession acknowledged the oppressed condition of women and their subjection to familial and social violence. Did the elimination of biases also form part of the alternative approaches?

Perspectives on People's Participation:

Dr. Dyal Chand explained that his paper on community financing of health workers was concerned with ways and means to improve the work of community health workers and their interaction with the community, in order to increase health awareness and utilisation of services. He was not suggesting an alternative strategy to the Health for All strategy, but was addressing himself to the sense of dependency on the State which characterised rural communities. He was opposed to the view that health was solely the State's responsibility. This generated dependency. Community financing was one method of increasing the community's stakes in its health conditions, and thereby increasing participation and utilisation.

According to Prof. Mutatkar, health managers genuinely believed in technical solutions to health problems and, therefore, paid only lip-service to people's participation and health education. They perceived health education as a means to educating and informing the people rather than listening and learning from the latter.

Dr. Banerji endorsed Dr.Mutatkar's point that the health education and community participation practised in the health sector were manipulative of the people. He felt that an

optimal solution to the health problems would be reached only when the middle class activists and professionals went to the people and learnt from them about their problems and health practices. Only then would health education increase the fighting power of the oppressed sections.

Dr. A.R. Desai analysed the concept of people's participation in the context of the existing agrarian situation. He asked as to who were the people for whom health planning was required. Numerous studies on the rural areas had shown that almost 40% of the rural population was without land or had only marginal holdings. Another 30 to 33 per cent were small farmers undergoing pauperisation. Both landlessness and pauperisation were a consistent trend due to the economic policies of the Government. The middle peasants were threatened with indebtedness. It was the rich peasants, constituting 20 per cent of the agrarian population, who were the major beneficiaries of the State's economic, land, taxation, agricultural and income policies and programmes. This same section was also becoming increasingly aggressive. He also pointed out the growth of migrant agricultural labour which was controlled by contractors and found seasonal work in areas of commercialised, intensive farming. Citing the case study of migrant labour from Khandesh to Gujarat, he asked, "In this scenario, who are the people?" On one side were the rich farmers, government authorities, traders and contractors, and on the other were the small and marginal farmers and the landless agricultural population. It was the latter who were facing suppression and needed to be aroused. He felt that there was a need to use the health facilities to approach the people, expose the Government policies and awaken the people to fight the structure. Revolution did not come overnight as demonstrated by struggle for India's Independence, and several struggles and movements were required to build the momentum

for revolutionary change.

Dr. Sujit Das felt that alternative approaches had to aim at changing the restrictive socio-economic structure. He proposed the new slogan "Free medical care for the poor as an exclusive right". This would expose the hollow welfarism of the State, and arouse and mobilise the people to struggle for fundamental changes. The slogan 'Health for All' could not be achieved in the absence of people's political control, particularly control over the State. He rejected the fee-for-service approach since it was the task of the welfare state to provide the services.

Dr. P.B. Desai pointed out that in the Indian context proletarianization was occuring without polarization of the population into two major classes. Exploitation had increased which was reflected in the fact that 40% of the population was below the poverty line, but the poor had no alternative avenues for organising. In this context, the intellectuals and the medical profession had to be activists.

According to Dr. Jesani, organising the people for political struggles would lead to polarisation and the development of class consciousness. Alternative strategies for organising the people were being tried out by health activists. These activists were linking up with trade unions and political struggles in order to develop a political perspective against the system. One such example was the approach adopted by the Chhatisgarh Mineworkers Union. He emphasised that any attempt to suggest alternatives to the Government would result in those very alternatives being used against the people. This was demonstrated by the anti-women contraceptive technology and family planning programme. In this context, community self-financing could become an instrument for the

Government to privatise health workers.

Dr. Dhruv Mankad cautioned against romanticising 'the people'. It was felt that left to themselves the people had the knowledge to solve their own problems. His own experience showed that there was a felt need among the people for medical care, as well as a common sense awareness of the determinants of health, such as food, water, etc. However these demands were not taken up as the people did not foresee any liklihood of their being satisfied in the near future. In certain areas such as the growing popularity of non-essential and hazardous drugs like Vicks and Anacin, there was a need to actively educate the people. Alternatives, in his view, would emerge only through a process of working and interacting with the people on all fronts.

According to Dr. Ramesh Awasthi, there were two concepts of people's participation. The first concept referred to planning and implementation by the people, leading to their eventual control of the health services. This was possible only in conditions of equality, as otherwise it would be taken over and controlled by the dominant classes. The other concept of people's participation was guided by the free-market ethos of consumer resistance. Health was a commodity produced by some and sold to others. It was therefore necessary to provide information by way of health education to build up consumer consciousness. It was the same market ethos that resulted in strategies of community financing, since a consumer was more concerned when he had to pay. Dr. Awasthi felt that one way to develop health consumer resistance was through overproduction and free competition, i.e. that the doctors should be allowed to advertise their services and thereby give the people information about what was available to them.

Dr. Antia summed up the various possible models of people's participation under a market economy. These included

(i) creating awareness in order to build consumer resistance
(ii) allowing people to advertise; and
(iii) taking recourse to legal action and suits.

Role of the Medical Profession:

Dr. Sujit Das disagreed with the suggestions made by Drs. A.R. Desai and P.B. Desai that the medical profession should take on the role of social activists. He felt that the medical profession should limit itself to fulfilling its role sincerely and honestly.

Dr. Antia suggested there was a need to rethink the role of the medical profession. Upto the 80s, the profession had claimed public health and the promotive and preventive services as its domain. For the first time at Manipal, during a discussion of the ICSSR/ICMR Report, the doctors had voiced their desire to do only curative work.

Dr. Deodhar cautioned against limiting the role of the medical profession to curative services alone. The promotive and preventive services were absolutely necessary to reduce the disease burden in a context where poverty was the main problem and most health problems could be traced to some form of deprivation. The fee-for-service approach suggested by Dr. Dyal Chand would be counter-productive in this situation of impoverishment where the people could not even satisfy their henger. He felt that public health should be the responsibility of the PHC, and the medical services would be one part of a total approach. On the subject of community participation, he pointed out the need to help the people to translate their own experiences and knowledge into activities to help themselves. In this experience of the many health

projects in India, only one project in the Sunderbaans, Bengal had managed to achieve this.

Dr. Banerji stated that his paper was concerned with the scientific discipline of new public health, and not with the subject of health as a whole. The conventional understanding of public health was technology-based, but the new public health took the people as its starting point. The rest of the paper attempted to give substance and content to this approach based upon the work being carried out at the Centre for Community Health at the Jawaharlal Nehru University.

Role of Mass Media:

Vimal Balasubramanyam pointed out the role of the print media in providing information about drugs and other aspects of health care. Citing the mischievous OPPI (Organisation of Pharmaceutical Producers of India) advertisement carried the day before in a Bombay newspaper. ("Are harmful medicines banned elsewhere marketed in India" Times of India, Nov. 14, 1986). She felt that some sort of rejoinder by supporters of AIDAN (All India Drug Action Network) was required. This could include (i) strong rejoinders in all newspapers; (ii) lobbying with editors about the unethicality of publishing anti-public advertisements; and (iii) raising with the Press Council the issue of the industry planting wrong information in the press.

Dr. Saroj Jha felt that effective communication could utilise more relevant forms of media, especially folk media, besides the English press media. She elaborated on the importance of communication, and pointed out that even the Information, Education and Communication (IEC) approach to health education, which had replaced the earlier KAP (Knowledge, Attitude, Practice) approach, was a top-down approach.

A recent UNICEF/WHO conferenced had changed the terminology to 'Participatory Communication in Health' (PCH).

Nationalisation of Medical Services and Drug Production:

Ravi Duggal pointed out two sets of Governmental action that could be demanded from the State. The first would be to make work or employment, and the related factors of health and education, fundamental or justicable rights. The second demand, which could be met within the system, was to nationalise the health services and the drug industry.

Dr. Banerji was cautious about the demand for nationalisation as it would strengthen the powers of the medical profession and the bereaucracy. He explained that the Indian Medical Association (IMA), formed during the freedom struggle, was one of the standard bearers of the new health approach but after Independence it had come to be dominated by the emerging "medical mafia". The latter promoted the growth of medical education and the production of doctors, which had resulted in the 'brain drain', rather than giving priority to the needs of the poor. However an internal contradiction had developed between the increase in the number of doctors and the declining avenues for employment, both abroad and at home. It was at that juncture that the IMA recalled its 1935 policy resolution to nationalise the Indian health services. The medical profession had demanded nationalisation in order to ensure its employment. The demand for nationalisation according to Dr. Banerji, had to keep in mind the political economy, as well as guard against creating a "huge monstrosity of a bureaucracy" which might eat up all the resources including the little that was going to the poor.

Ravi Duggal felt that the powers of the medical profess-

ion could be checked by banning private practice, and giving doctors fixed salaries, instead of fees.

Dr. Jeffrey spoke about UK's experience with nationalised health services, though he stressed that the situations were very different. According to him, a big danger of any nationalised service was that the common people, who had in the first place demanded it and had also gained some benefits from it, lost a sense of control and involvement in its management. The service turned into a bureaucratic institution, and it was the resultant alienation among the people that had enabled Mrs. Thatcher to privatise so much that was positive in British life. He felt that a system of local control, a devolved structure, as in China, was a better alternative since the locus of power remained closer to the people.

According to Dr. Deodhar, nationalisation in India would mean that the people would receive the same inefficient services at a higher cost.

Dr. V.N. Rao felt that the Government would not be able to control private practice in a nationalised health care system, when it did not have adequate machinery to deal with the illegal private practice carried on by doctors attached to rural and tribal primary health centres (PHCs).

Ravi Duggal asserted that there was a strong case for nationalising the private pharmaceutical industry as it was being subsidised by the public sector. The public sector supplied the bulk drugs, thereby incurring losses, which were formulated by the private sector for huge profits.

Dr. Sujit Das disagreed with Dr. Banerji's interpretation of the demand for nationalisation of medical services. Accor-

ding to Dr. Das, the concept of nationalisation stood for "guaranteed medical care to all". This concept had nothing to do with the demand made by the IMA for attachment of general practitioners to hospitals. Qu stioning the viewpoint that whatever was nationalised would become inefficient, he stated that inefficiency could not be worse than the lack of ethics in the private drugs manufacturing sector. As for the problem of Governmental inefficiency in implementing nationalisation, he felt that this reflected the Government's lack of support and committment to controlling private practice. Dr. Das also clarified that there was no contradiction in simultaneously demanding Governmental intervention, such as for nationalisation, and waging struggles against the Government's policies and programmes. The former was necessary to gain certain legal rights, such as universal medical services, not available in a private medical system.

Sujata Gothoskar felt that apart from the strategies emphasising Government intervention, alternatives about autonomous action also needed to be discussed. She wondered if there had been any experiments in health co-operatives on the lines of production and self-employment co-operatives in England and Spain?

Ashwin Patel pointed out the need to regulate and socially control drug production in the private sector. Social control through nationalisation was one method, but needed further discussion.

SESSION IV

INTERACTION BETWEEN GOVERNMENT, PRIVATE SECTOR, AND NGOS IN IMPLEMENTATION OF HFA STRATEGY.

With focus on:

*Perspective of the government of India in the policy for health and socio-economic development.

*Achievements and failures of the government.

*Problems faced by government and NGOs.

*Role of NGOs and their significance.

*Private sector in Health.

NGOs, GOVERNMENT AND THE PRIVATE SECTOR

By

Ravi Duggal

This paper sets out to critically examine within a historical framework, the role that the non-governmental organizations (NGOs) have played in India's political economy. Its relationship with the private sector and government policy making will be highlighted. The health sector will be used to illustrate the issues that emerge.

WHAT ARE NGOs?

NGOs are private organizations, but their nature makes them somewhat different from what one generally refers to as the private sector. Firstly, organizations operating as NGOs are registered either as "trusts"or "societies". As a consequence, they are not supposed to make profit, unlike the private sector.

Secondly, NGOs are involved in the "development sector"; that is, running programmes such as health, nutrition, family planning, education, water supply and sanitation, urban renewal, housing, research, training and documentation, agriculture related development programmes (IRDP etc.) and employment programmes (FFW etc.), among others. These constitute what one might call service-NGOs. Another category of groups included under the banner of NGOs are activist groups who are involved in conscientisation and struggle oriented activities, but they may also undertake some services. Organizations that are usually only production oriented are normally not included under the NGO umbrella. However, some service NGOs may undertake production activities such as agriculture, household industry, etc. And there are also funding agencies which are referred to as NGOs.

Thirdly, NGOs are invariably dependent on external sources of financing their activities (including most activist groups). These sources could be government agencies, local, regional, provincial, national, bilateral and multilateral or private agencies, NGO funding agencies, private corporate foundations and trusts and religious groups. At this point, it may be noted that funds given to registered trusts and societies in India as donations are eligible tax expenditures,

therefore, for many funders, NGOs may constitute tax shelters.

And finally, a large number of NGOs, especially in rural areas, run programmes of the government on a contractual basis because of their (NGOs) supposed dedication and flexibility. This is a more recent phenomena (Fifth Plan onwards) - the government, for instance, gives its own health centre or IRDP project to be run by an NGO because the government believes that its own structure is inefficient, bureaucratic and incapable of reaching the beneficiaries.

HISTORICAL PERSPECTIVE :

NGOs, it appears to-day, have suddenly arrived. The current debate in various journals as well as at meetings and seminars generates this feeling. But it is not true. NGOs have their own history and that too a highly significant one as regards India's political economy.

Christian missionaries are generally considered as pioneers in organized activity of the kind we attribute to NGOs to-day. The non-christian response came fairly late beginning with the Brahmo and Arya Samaj and Rama Krishna Missions, among others. Much later Gandhian and Sarvodaya groups emerged and became a dominant force. The common thread among all these groups was charity and missionary zeal. The three major areas of involvement in the social service sector of these groups were education, health and rural development; and an overwhelming majority of them focussed on women and children, many of them also working with backward castes and classes and the handicapped.

These NGOs laid the foundation of the social services sector or welfare sector in India during the British rule. After independence many NGO experiments and models became replicas that the government used for formulating its own development strategy. Thus, the Community Development Projects (CDP) of the government that began in 1952 were based on the experiments of Albert Meyer in Etawah, U.P. and of the YMCA in Martandam, T.N. The First Five Year Plan notes :

"A major responsibility of organizing activities in different fields of social welfare like the welfare of women and children, social education, community organization, etc. falls naturally on private voluntary agencies. These private agencies have long been working in their own humble way and without adequate aid for the achievement of their objectives with their own leadership, organization and resources. Any plan for social and economic regeneration should take into account the services rendered by these agencies and the state should give them maximum co-operation in strengthening their efforts. Public co-operation through voluntary social service organizations is capable of yielding valuable results in channeling private efforts for the promotion of social welfare". (GOI, 1951).

To back this up, the government in 1953 set up the Central Social Welfare Board, to provide grant-in-aid to NGOs. Further, in its own development programmes, the government sought the expertise and co-operation of well-known NGOs. This was more so necessary when CDP was evaluated at the end of the First Five Year Plan by the Planning Commission : "Most of the time was spent in solving procedural/administrative wrangles making implementation of programmes inefficient, inadequate and wrongly directed". (GOI, 1958)

The government could not ignore the social services sector and the private sector was unwilling to invest in social infrastructure. The private sector, for its own expansion and profitability, pushed the government into investing vast public resources in building infrastructures and heavy industry that was essential for economic growth, but more so to facilitate the growth of private capital. As a consequence, the social sectors like health and education were totally neglected - health sector was mainly operated by private practitioners and a large number of hospitals run by NGOs, and the education sector was mainly run by NGOs (missions, public trusts and societies).

The NGOs in these early years were largely concentrated in urban areas, but many were now gradually spreading their tentacles into the countryside, the leaders being Gandhian and Christian missionaries.

In the health sector the government, though in principle had accepted the Bhore Committee recommendation, was still undecisive - even to-day, the physical targets recommended by the Bhore Committee are far from realisation. The anti-malaria and anti-smallpox campaigns were undertaken at the behest and with support of international agencies. It was not until the mid-sixties (Third Plan) that the health infrastructure for rural India got serious attention from the government. This too for two reasons - the resurgence of malaria and the government's decision to give family planning programmes a big boost through the camp approach.

This was also the time when the green revolution in India began and the countryside had suddenly come into focus (from the perspective of mainstream economics). The corporate sector showed increased interest in rural India for here was an opportunity to capture rural markets not only with the new agricultural technology but also (due to increased commercialisation of agriculture) with other goods and services.

The corporate sector, however, was unwilling to go on its own into the rural areas. It wanted crutches from the government and the latter obliged by starting massive agricultural development programmes such as IADP and later SFDA. In these programmes the inputs for modern agriculture (equipment, fertilizers, high yielding variety seeds, pesticides, etc.) were provided by the corporate sector through the government agencies to the farmers. The government paid the corporate sector for goods and services and marked the amount as loan and subsidies to the farmers. Thus, the corporate sector's profits were assured. To facilitate the government's loan programmes the corporate houses set-up NGOs who would act as middlemen between the peasantry and the government (using the same logic - government is inefficient and private sector is dedicated and effective).

This was a new kind of association for the Indian Corporate Sector with its periphery (earlier they only looked for raw materials and cheap labour in the periphery) and it promised assured returns because of the involvement and participation of the government at two levels - one as a monopoly buyer of agri-products and the other as a concession giver, in the form of tax-expenditure (with weighted deductions) and tax- holidays for venturing into agri-business and moving into the countryside (for details see Duggal, 1985).

These NGOs, floated and/or supported by the Corporate sector, invariably used medical programmes or drought relief as entry points. Though their interest was in promoting 'new agriculture' and expropriating surplus, they also added social services such as medical, education, vocational training programmes, etc. to their activities, both for legal purposes (because they were registered as 'trusts' or 'societies') as well as to show that they were socially responsible! However, their approach was significantly different from that of the existing NGOs. They broke away from the charity oriented/do-gooders approach and established a new trend.

Until the late sixties, the charity-oriented legacy of the missionaries and Gandhians constituted the dominant approach among various NGOs. Attitudes of piety and compassion towards the 'poor, down trodden and the miserable lot' motivated senior citizens to work amongst such people. It was invariably an individual's mission of charity to do 'constructive work' in a deprived and underserved community. Many 'empires' have been built in such pursuits.
Business houses too have indulged in charity, in fact, even before Gandhian groups emerged. For instance, Tatas at the turn of the present century began charitable works among the tribals in what is to-day known as Jamshedpur and by 1907 TISCO was launched, appropriating the land of the tribals of many villages to build the factory and subsequently the township.

Where the government was concerned, until the Third Five Year Plan, its official approach vis-a-vis the NGOs was mainly one of a grant giver.

After the Third Five Year Plan the country went through a prolonged and wide-spread crisis : The contradictions of the green revolution began to emerge, the fourth plan was delayed, there was widespread famine in the country, the Naxalbari uprising apread into a movement and was repressed brutally, and the Congress party split. This crisis ended with the nationalisation of banks and elimination of privy purses on the one hand and a new rural development strategy in partnership with the corporate sector on the other hand (passage of section 35(C) of the Income Tax Act in 1968 which provided 120% weighted deduction from taxable profits to the Corporate sector for undertaking agri-business).

The World Bank provided full support to this new strategy of the government and the Indian Corporate sector. McNamara categorically declared that widespread poverty in the countryside of the third world had to be stemmed otherwise the 'spectre of communism' would grip the third world. He suggested that NGOs and the private sector had an important role to play where the government had failed. He assured the World Bank's full assistance in funding anti-poverty projects in the third world.

This support of the World Bank and private US foundations, besides western government AID programmes, encouraged the Indian private sector, to directly as well as through their sponsored NGOs, to move into rural areas in a big way :

i) to promote agri-business under the umbrella of government's rural development programme (SFDA, MFAL, etc.)

ii) to set-up 'rural development projects' that would provide alternative employment opportunities as well as help in increasing agri-cultural productivity, which in turn would raise purchasing power

iii) to provide health care, assist in population projects, local resources development, and other social services, and

iv) in general to strengthen the base of capitalism.

Thus, the corporate sector paved the way for the dominance of the new approach of NGO intervention, an approach that discredited and strongly critiqued 'charity' and talked a great deal about 'self-reliance'. They professionalised the NGO sector. In contrast to the charity approach, the new approach (also referred to by many as the 'development' approach) was 'not to give anything free of charge' because -

i) whatever is given free is not seen by people to have a value

ii) it creates a 'feudal' relationship of giver-recipient

iii) it generates a dependancy among beneficiaries, and

iv) it acts as a barrier to 'peoples participation'.

In the health sector, this new approach was first demonstrated in Narangwal, Punjab, by Carl Taylor and associates but its consolidation took place only in the early seventies in Maharashtra with the Jamkhed, Mandwa and Miraj projects of different NGOs. A model for village based outreach health care delivery was demonstrated; and by mid-seventies this model had proliferated all over the country, and even before Alma-Ata it was officially incorporated by the government in its own health programmes.

By the end of the Fifth Five Year Plan, the government had realised that successive failures of all its development programmes was due to weaknesses inherent in its own structure: "Experience (CDP to IRDP) has shown that fruits of development have been mostly availed of by the better endowed areas on the one hand and the better off members of the rural society on the other'. (GOI, 1980).

THE HEALTH SECTOR :

Health programmes of the government have probably been more disastrous. After independance the government accepted the strategy outlined by the Bhore Committee. However, after 39 years of independence we are still nowhere nearer in realising the recommendations of the Bhore Committee. For instance, the Bhore Committee had suggested that for a population between 10,000 and 20,000, there should be a 75-bedded primary health centre which would provide co-ordinated preventive and curative services through doctors, public health nurses and health assistants (GOI, 1946). However, even under the 7th Five Year Plan, the target of the government still remains a 7-bedded primary health centre for a 30,000 population with less than half the personnel recommended by the Bhore Committee.

The implementation of this plan was never taken seriously because :

a) health of the people is not considered a priority area of development by the government whose power base operates through Kulaks and the bourgeoisie,

b) the private health sector and the system of private practice of medicine has prevented the government from developing the medical and health functions for the peoples' benefit. Sops such as charitable or 'voluntary' hospitals providing 'concessional' care have mushroomed to give a respectability to private medical practice,

c) the government's planning and programming has never taken into account what the actual requirements of the people are - people have always been 'given' what the government thinks people want and even the latter does not reach them,

d) the government's obsession, under the influence of international agencies, in the health sector has always been with family planning, and

e) public resources have largely been invested outside the social services sector, mainly benefiting the growth of private capital.

It is clear then that the failure of the government health and development programmes is organically linked to the manoeuvering of the private sector. How did the private sector achieve this?

The private health sector is probably one of the strongest lobbies in India. Its growth has been phenomenal after Independence, growing each year from strength to strength. Its biggest support is the pharmaceutical industry - from the late fifties onwards pharmaceutical MNCs began their entry into India and from then till to-day have monopolized control over the peoples' health.

British imperialism had cultivated a health care delivery system that served only the British and the Indian classes that owed their allegiance to them. Rural India, comprising over 80% of Indians, was left to its own means. The only contribution the British made was to leave behind a grandiose plan - the Bhore Committee report. After independence, the government accepted the Plan in principle, but since health care was not a priority area it ignored it, providing an opportunity to the private sector to monopolize it; and once the pharmaceutical MNCs came, there was no looking back away from privitization.

Thus, government's indecisiveness in the social services sector, including health, housing and education, led to the strengthening of the private sector in these areas.

The private sector was most pleased to let the government have a monopoly of infrastructure related heavy industry and general infrastructure because they (private sector) did not have the ability to muster resources required for such industry. The government accepted this task and began construction of huge public sector undertakings in the 'core' sectors from atop of which it could proclaim socialism. After getting the government busy on the heavy infrastructure front, which was in reality constructed

by the private sector under profitable contracts from government, the private sector settled down with the task of expropriating surplus from all sectors of the economy and society, including health care.

Over the years the government run programmes and projects showed heavy losses and indicated the government's inefficiency, complacency and corruptibility. On the other hand, the private sector demonstrated its efficiency, cost-effectiveness and ability to execute anything successfully. Therefore the private sector established its credibility, which the government was forced to recognise and the latter began framing policies that increasingly shifted in favour of the private sector. Even in provision of 'social services', which under the concept of the welfare state are the concern of the state, the private sector demonstrated models through its NGOs.

In the health sector today private practice is the most easily accessible and acceptable form of medical care that people have come to recognise and utilise. The public sector's rural health services are greatly discredited, both because of poor services and because their primary concern is family planning; people utilise private services most of the time. In urban areas private practice thrives because public facilities provided by local bodies are inadequate, inefficient and bureaucratic. These factors, over the years, have resulted in private practice of medicine becoming deeply entrenched in society, acquiring a credibility, that even the government has eulogised.

Thus, the private sector assured the failure of government's health programmes by :

a) monopolising and controlling pharmaceutical manufactures suited to their profitability and not necessarily to what the people's needs were, forcing the government to strain resources to acquire essential drugs through imports;

b) demonstrating that they could administer health care better and more effectively to the people than the government, which recruited mostly doctors and other health personnel who could not establish private practice or find private jobs, leading to further complacency and inefficiency of the government's health care delivery system, and

c) forcing the government's health structure to push vigorously population control, thus discrediting the government's health care delivery system.

NGOs - A NEW POLICY

The 1970s saw a great mushrooming of NGOs for various reasons. Firstly the government was encouraging them by giving grants or permitting them to receive foreign funds directly. Secondly, the Corporate sector in partnership with the government was encouraging and supporting NGOs, especially in the rural areas. Thirdly, new tax deductions to donors for providing funds for rural development and social services to NGOs were introduced in the Income Tax Act, therefore, increasing willingness to donate funds to NGOs. And finally, the Professionalisation of the NGO sector provided opportunities to committed and motivated individuals to take up careers in "development".

Further, in the fifth Plan period the government began encouraging NGOs to take over, on a contractual basis, the programmes of the government in the social services sector. This was certainly a major policy shift from being earlier only a grant-giver. In the health sector the government began giving its primary health centres to the NGOs to run them; also, certain national programmes (eg. leprosy) in a specified area would be given to NGOs to implement. Under the Sixth Five Year Plan this process was accelerated. In addition NGO representatives were made official advisors or nominated as experts in government committees and bodies, including the Planning Commission, indicating that NGO business was also official business.

During the Sixth Plan period NGO representatives lobbied the government with all its might and its impact can be seen in the National Health Policy Statement and the Seventh Five Year Plan.

The Approach Papers of the Seventh Five Year Plan calling for greater participation from NGOs states, 'voluntary organisations will have to be associated more closely and actively than hitherto with the programmes for reduction of poverty and with the efforts to make the minimum needs available to the population for improving their quality of life. This will be incorporated as part of the overall strategy for augmenting such programmes meant for the poor, as also an alternative feedback mechanism for ascertaining whether the target groups have received the benefits meant for them' (GOI 1984).

It further adds that, "Achieving active community participation and involvement in health and health related programmes should also be part of the strategy. In particular, active community participation and involvement

of non-government organisations in a massive health education effort is urgently needed ... With a view to reducing governmental expenditure and fully utilising untapped resources, planned programmes may be devised, related to the local requirements and potentials, to encourage establishment of practice by private medical professionals, increased investment by non-government agencies in establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the health field" (ibid).

The Ministry of Health and Family Welfare (MHFW) is in full agreement with the Planning Commission on the issue of greater involvement of NGOs in the field of Health Care. In a recently published document (GOI 1985) it categorically states, "The government has envisaged a very prominent role of voluntary organisation/NGOs in the implementation of these (health, family planning and 20 point) programmes. In October 1982, directives were issued that voluntary agencies be involved in the implementation of anti-poverty and minimum needs programmes which contain all the important health programmes like MCH, family planning, communicable diseases, health education, drinking water facilities, immunisation, etc. and consultative groups be formed in all the States headed by a Senior Officer of the State .... Voluntary organisations are doing a very creditable job in organising and running hospitals and dispensaries in India. India is only second to the USA in terms of number of hospitals outside the government health sectors and run by NGOs. If suitably encouraged in terms of liberal financial grants, they can contribute a great deal in filling the gap of referral hospitals at taluka level, district level and in urban slums".

Even the National Health Policy of 1983 recognised the need for greater reliance on the voluntary and private sectors for achieving the goals of 'Health for All by the year 2000 A.D.' "The policy envisages a very constructive and supportive relationship between the public and private sectors in the area of health by providing a corrective to re-establish the position of the private health sector"(ibid).

The above statements make it appear that:

a) the government has accepted its inability to provide adequate health care;

b) the active participation of the NGOs is most necessary for achieving goals of the health sector; and

c) privatisation of the health sector will result in better provision of health services.

This perspective suite both the government and the private health sector. The government succumbs to historical evidence of the failure of all its anti-poverty programmes including those of the health sector, and invites the private sector to take charge of the fight against poverty and disease. The private sector, which is mainly responsible for the poverty - poor health, nutrition, housing, sanitation, etc. - has over the years demonstrated to the government, through 'voluntary efforts', that it can do a better job even of 'development'!

Thus, a self-fulfilling prophecy is generated that:

a) the government is inefficient, complacent and too bureaucratised and therefore cannot reach the people with its development programmes, howsoever well planned; and

b) that the private sector is efficient, cost-effective, flexible and non-formal and therefore it can successfully execute the programmes of development taking it to population groups for whom they are really meant.

All this is clearly indicative of the close nexus between the private sector, NGOs and government policy making. The role played by the private sector in building up its socially more acceptable image through the NGO sector emerges clearly. How the government is used by the private sector for strengthening itself has also been established.

Today, in the health sector, as well as in other sectors of the economy, we see a great boom in privatisation both independently as well as through the NGO sector. Diagnostic centres, corporate hospitals, health insurance and the like are on the uptrend, egged on by the present government's policies to "re-establish the private sector".

Will all this lead towards "Health for All"? To answer this we need to look at the social structure. And since the purpose of the NGO is organically linked to welfarism and directed at managing inequality under capitalism, a brief description on the nature of welfarism would be in order.

A social structure that is founded on the principles of inequality is time and again forced to introduce palliative measures so as to stem the rising tide of class conflict.

Welfarism in capitalist societies (developed and backward) is one such response. It seems to make blunt both the contradictions of capitalism as well as to provide a defense system against the consequences of unequal social relations.

Historically, under capitalism in its development process, the state was delegated the responsibility to provide for welfare from public resources. The Capitalists, who facilitate unequal relations did not deem welfare as their responsibility - their sole objective being expropriation of the greatest possible amount of surplus. And whenever the capitalist did provide some welfare measures (as a consequence of workers' struggles) to workers it was only against tax expenditures - which indirectly meant a reduction in the State revenue. State welfare for capitalism was a double-edged weapon. It provided political stability which was essential for further growth of capitalism and it directed or diverted the conflict against the State which had become the main welfare agency. In other words the State more than the capitalist became the enemy of the working class. On the other hand, for the working class, welfare and not the right to employment became a legitimate and institutionalised means of attaining a better standard of living. Thus, the struggle for a change in the social order got institutionalised into a system of compromises, assuring both, a stability that would help the advance of capitalism and at the same time create an increasing dependancy of the working class on the State.

It must be noted that welfarism got established firmly only in the developed western bourgeois democracies, where today it is under great strain with the State facing a fiscal crisis. State welfare is today caught between two opposite forces - the demands of the working classes for more welfare and the pressures of capitalism to reduce state intervention in economic and social relations.

And one of the responses of the private sector to this, as discussed earlier, has been the establishment and strengthening of the NGO sector.

In this complexity of affairs where do people stand? Can we assure them health? The history of our development programmes indicates that different strategies have been tried out but have failed miserably. There have been no structural changes but only efforts at extenuating crises situations that only help postpone the crises. But for how long?

Capitalism and inequality strive with the aid of state patronage and repression. NGOs consciously

or unconsciously, are part of this system and are using ever larger amounts of public resources. The State's recent policies are supportive of this and channelise an increasing amount of funds for the NGOs.
Though the NGOs have demonstrated that they can run specific programmes limited to a specific population efficiently, including reaching out to the underserved and the underprivileged, there is no evidence that they have brought about either change or peoples' participation which they are never tired of talking about.

Thus, it is clear that NGOs serve the system rather than the people, that they preserve the status quo instead of bringing about change and that they are often only another face of the private sector.

Therefore, the question whether 'Health for All' is possible cannot be seen independent of structural changes. It is there that the answer lies.

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PARTNERS IN HEALTH - GOVERNMENT N.G.Os AND THE PEOPLE

DR. MRS. BANOO J. COYAJI

In India, voluntary agencies or N.G.Os as they are now called, have played a vital role in health, family planning, rural development, care of the sick, the maimed, the blind, the old - in fact in nurturing every significant social reform in this century. They and their contribution have been, more or less, ignored, if not viewed with suspicion. In the last few years they have become respectable, and now they are being wooed. It must mean that Government has begun to realize that the dimensions of poverty, ill-health and illiteracy have become so staggering that they cannot be tackled without the people's active participation and of the Voluntary Agencies who are close to the people.

Let us be very clear as to what we mean by Health. It was on September 12, 1978 at Alma Ata in the U.S.S.R. that 134 nations of the world affirmed that health is a state of complete physical, mental and social well being, and not merely absence of disease, and that people have the right and duty to participate individually and collectively in the planning and implementation of their own health care. The U.N. General Assembly resolution 34/58 of November 29, 1979 declared "Health For All by 2000 A.D." as its goal, with the promotion of primary health care as part of the New International Development Strategy for the 1980s and beyond. Primary Health Care is defined as essential health care based on practical, scientifically sound and socially acceptable methods, made universally accessible to individuals and families in the community, through thier full participation and at a cost the community and the country can afford to maintain, at every stage of their development, in the spirit of self reliance and self determination.

In simple words it means that such a level of health will be reached by individuals and communities by the year 2000, that it will permit them to derive social satisfaction from being able to realize whatever latent intellectual, cultural and spiritual talents they have.

"Health for All does not mean that in the year 2000 doctors and nurses will provide medical repairs

for everybody in the world for all their existing ailments; nor does it mean that in the year 2000 nobody will be sick or disabled. It does mean that health begins at home, in schools and in factories. It is there, where people live and work that health is made or broken. It does mean that people will realize that they themselves have the power to shape their lives and the lives of their families, free from the avoidable burden of disease, aware that ill-health is not inevitable. It does mean that people will use better approaches than they do now for preventing disease and alleviating unavoidable illness and disability, and better ways of growing up, growing old and dying gracefully. It does mean that there will be an even distribution among the population of whatever health resources are available. And it does mean that essential health care will be accessible to all individuals and families, in an acceptable and affordable way, and with their full involvement". (Mahler)

India is a signatory to the Alma Ata Declaration and to the U.N. pledge of Health For All by 2000 A.D. The Government of India has translated this into action by enunciating the new National Health Policy in 1983, and setting before it time bound targets.

The VIth Plan had provided resources which are considerably enhanced in the VIIth Plan. This underlines the fact that there is political will and bureaucratic planning. The million dollar question is that "Is there sincere committment to Primary Health Care and community participation or is it mere rhetoric"? Will the policy be implemented in the true spirit or will it go like the best laid plans of men and mice?

The New National Health Policy, the approach paper to and the Seventh Plan document reveal a gloomy picture of the health status of our people, after more than three decades of planned development. The National Health Policy unequivocally states that the existing situation has been largely engendered by the almost wholesale adoption of curative centres based on the western models which were inappropriate and irrelevant to our needs. It also states that the planning process was largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification

of their health needs and priorities, as well as the implementation and management of the various health and related programmes, thus unequivocally vindicating the finest blue print on health that any country could have had - the Bhore Committee report enunciated in 1946 - one year before Independence.

Undoubtedly, under the stimulus of Alma Ata, there has been considerable change in the official health policy of India. There are however many gaps, constraints and problems. One big problem, eight years after Alma Ata, is failure to understand the very basic concept of Primary Health Care. Upto date, the idea seems to be to increase the reach of the Government programmes and to "provide" services further & further into the rural areas. It is not surprising that people are reluctant to utilize such services. The main reason for this is, the failure to understand what primary health care is all about - that health services should be strongly based in the community, so that people are involved in planning and implementing programmes for their own health care, that the community will no longer be the periphery, but the heart of the system. The implication is that services do not "reach" the people but "begin" with the people and are located in their midst. It is from this strong base that they rise to district and regional levels, providing adequate supplementary referal services. It is only if this basic premise of primary health care is understood and implemented, that there will be established a close partnership between the people and the health services, which will release the tremendous capacity of the people to solve their own health problems and specially of those in greatest need - women and children.

The dimensions of the problems of bringing about Health For All are staggering. If, to this is added the fact that only fourteen years and limited resources are available to achieve this miracle, then we would be well inclined to throw up our arms in despair.

It is evident that more of the same will not do. Creative solutions to thousands of problems are needed to achieve our goals. Can Government find these solutions alone? I doubt it, if the past is any indication. Political, bureaucratic, financial and other constraints restrict the ability of Governments to design and experiment with new innovative methods

which will be needed. It is precisely because of these limitations on Government, that Voluntary agencies exist. But can the Voluntary agencies do it alone? Ofcourse not. They are a drop in the ocean. Can the people do it? Yes, but not without guidence, financial and other support and genuine democratic decentralization. What is the solution then? We can do it together. With a working partnership between Government, the Voluntary Agencies and the people founded on mutual respect, trust and shared objectives, tremendous progress can be achieved.

Thousands of Voluntary Agencies exist. They are of all sorts, shapes and sizes. Some are giants and affiliates of international agencies. Others are large and national. Some are medium, but most are small and struggling for a place in the sun. Most work in towns, but increasing numbers are working in rural areas. The most important, from the Health For All point of view are the struggling Mahila Mandals (women's groups) dotted all over the country side- estimated 70,000, albeit not equally active, with a membership of nearly 1.75 million and the thousands of youth and farmers and service groups. Here is an enormous resource to be organised, helped and guided.

What are the strengths of Voluntary Agencies? By their very nature, they are more able to design and implement innovative and creative solutions to Primary Health problems than Government. This is because they are closer to their target audiencies - the people. They are more able to be flexible and experiment. They can quickly make midcourse corrections, if things do not proceed in the right direction. They are made to, and able to work with very limited resources. They have the ability to collect funds. Philantropists can be persuaded to give them small or big donations. They must, perforce, deliver the goods. A Voluntary organisation must give excellent services to the people in order to survive. People are prepared to pay, what they can, for such services. And they are held accountable - They must demonstrate results or cease to exist - a condition that Ministries and departments of public health are not required to meet.

What are the deficiancies pf Voluntary Agencies? They mostly work in splendid isolation from Government and from each other. This results in their work being fragmented into bits and pieces. Very many depend on

the presence of a charismatic leader and therefore go under, when he disappears from the scene. They show a reluctance to work with Government and regard Government only as a funding agency. It is absolutely necessary that Voluntary Agencies show better understanding of national plans and priorities and the tremendous problems Government faces. They should be willing to be junior partners of Government in the larger task of implementing Health For All Strategies. They should use their natural strength of closeness to the community to help stimulate the development movement among the people. The Government today is interested in an indepth out reach programme to take preventive, promotive and curative health to remote villages and urban slums. Atleast in Maharashtra, Government is willing to share responsibility with N.G.Os. Let us seize this opportunity to work with Government.

Voluntary Agencies do not even work with each other. There is so much voluntary effort going to waste, just because small groups to not have managerial skills, and technical, know how, to even make proposals for financial aid. It is for this big lacunae that recently the Society for Service to Voluntary Agencies "SOSVA" has been started with the blessing of the Government of Maharashtra to identify, help and nurture these small but dedicated groups. What are the practical steps necessary to forge a meaningful partnership?

Government today is willing and ready. There are however many constraints. The procedures for registering, release of grants and rules and regulations are cumbersome. They must be simplified. For example the Mahila Mandals can get a grant of Rs. 50/- p.m. if they are registered. The hassle of getting them registered is so great, that many prefer to work without registration. Ofcourse monitoring, accounting, financial checks etc., are necessary, if Government is to give grants. But there need not be a feeling of distrust. There should be more encouragement, supportive supervision and genuine democratic decentralization. Without this there can be no "people's participation".

The raison d'etre of the whole exercise is the people - the "have nots", the oppressed, the exploited, the poor and needy living in 600,000 villages and the sprawling urban slums. "People's participation" is now

a fashionable expression in development parlance. It is still a myth - It does not mean passive acceptance of services "provided" or offered. It does not mean carrying out orders, attending clinics, or meetings, or even being persuaded to give free labour and material. The poor have been exploited from times immemorial. They view all overtures with suspicion. Community participation is a slow process and evolves through various stages from acceptance, awareness, co-operation and involvenebt to active participation. The people's own creative ability to identify problems, take decisions, gain confidence and assume control over their own lives is the central tenet of primary health philosophy - we are certainly far away from this goal. In order to help people to reach this stage a massive health and development education programme is needed - Before formulating such a programme it is wise to spend time to listen to what the community feels and thinks. A quiet talk under the trees, quiet observation and questions to know what the people's practices are, will give a wealth of knowledge. We must realize that we do not know the problems, leave alone their solution. We should forget our intellectual arrogance and be prepared to listen and learn about their concepts, beliefs and customs about health and disease. Some of these are good and should be preserved, and some are harmful and should be corrected. Patience is necessary for changing attitudes and entrenched practices. Respect the peoples' felt needs and fulfill them. The secret to win their confidence is "Serve first, service second, service last".(Taylor) In doing this, it is necessary not to allow the people to transfer their dependence from the juggernant of Government to that of a little more caring voluntary agency. That would be self defeating. Unrealistically high expectations should not be placed on the people. Community participation counts on the resources of the poor i.e. their time, energy and enthusiasm and, looked at realisticaly, these resources are limited. Community participation is not a magic solution to development and health problems, but a very critical input. Plan as if people matter. They are the most important part of this partnership.

This brings us to the role of voluntary agencies in the exciting voyage to "Health For All". It is in short :

(1) To identify and articulate the unmet needs and priorities of the people for health and development.

(2) To stimulate Government to introduce measures to meet these needs.

(3) To act as a catalyst mobilizing people for development.

(4) To be a model builder experimenting and evolving alternative approaches for health and development.

(5) To be a representative of peoples' aspirations.

(6) To act as a watchdog, ensuring the interests of the weaker sections of society, be they in urban slums, or remote tribal villages.

(7) and above all to be an active partner with Government and the people for preventive, promotive and curative health and social, economic and cultural development.

The concept of primary health care embraces the very quality of life of the people. It is an interface between the extension of essential services by Government and the vibrant, dynamic, upward struggle of the people for the betterment of the quality of their life. It is at this vital interface that Voluntary agencies have their greatest role. They are the bridges between the people and the Government. They are the pace setters, innovaters and reformers.

Ofcourse they have problems and irritants in working with Government. They have to be overcome. There are good, bad and indifferent Government officers as there are good, bad and indifferent voluntary agencies.

It is useless to blame the Government for everything that goes wrong. Let us together meet the formidable challenges of Health For All by marshalling all available resources at all levels.

Health For All is a social contract between the Governments of the member states, U.N. agencies like W.H.O. & UNICEF., Voluntary Agencies and the peoples of the world.

Only 14 years remain to redeem our pledge. The answer to health problems, as in many fields of human endeavour, does not solely lie in technology. Let us harness the tools of technology to a powerful human effort for the common good.

Let us be partners in health and development to meet our tryst with destiny.

ROLE OF THE PRIVATE PRACTITIONERS IN PROVIDING PRIMARY HEALTH CARE IN RURAL AREAS

Vasant Jalwalkar

Our country has undertaken to ensure that a minimum level of health care will be provided to every citizen by the year 2000. The progress achieved in the last nine years does not give us a great deal of hope that the level of achievement during the next 14 years will be very considerable. This paper assumes that the strategy adopted is correct and suggests some tactical changes, particularly with regards to the role of private practitioners.

When this policy (PHC approach) was announced by Government of India in 1977, in advance of the Alma Ata declaration of 1978, a certain amount of haste was discernible in the way the then Health Minister made his announcement. Although both the then ruling party as well as the main opposition party at the time had included a similar strategy in Health care in their election manifestoes for the General election of March 1977, the clumsy attempt of the Minister to hog the credit for that policy meant also that he did not stop to consider the role of private practitioners, as represented by I.M.A., in implementing such policy. The President of I.M.A. had made a suggestion to the Government about implementing such a policy and had indicated that I.M.A. would totally support any Government in this regard. This overture was disregarded. I have detailed all this an now, because impression has been created that I.M.A. the is against the P.H.C. approach. This is entirely due to some historical accidents, related more to political rivalries in the parties, rather than any basic or fundamental difference of opinion between the medical profession as represented by the official policy of the I.M.A. and the Government's position on this matter.

The P.H.C. strategy involves provision of health care to the rural population by about 100 VHWs in each Taluka (average population of 100,000) covered by one eccentrically placed Primary Health Centre manned by three doctors. I know that this ratio is now being reduced and the aim is to have 3 doctors of the P.H.C. supervise only 50 VHWs, by doubling the Centres by 2000. It is worthwhile to note that even the second centre will be eccentrically placed in the Taluka and there is no proposal to utilise even the Government

financed doctor attached to the municipal dispensary in the Taluka town. I would like to suggest that private practitioners of the Taluka town should be recruited to help in training and continued supervision of VHWs in the Taluka to achieve the aim of having one doctor supervise no more than 10 VHWs.

It is hoped that Primary Health Care will cover provision ofcataract surgery to all the population by 2000. No body quite knows the exact number of operations needed to be done in the population every year. At present about 100,000 operations are being done in the State of Maharashtra (Pop. 68 million) while 400,000 operations are being done in the entire country (683 million - 1981 census). The population is expected to age substantially by 2000 and by 2040 the number of people above the age of 55 is expected to be four times the present number, necessitating a proportional increase in the provision of services for cataract operations. I can't imagine that the Government can hope to provide anything more than a small proportion of this service through its own doctors. Provision of spectacles for myopia and hypermetropia (including reading glasses) is not even in the PHC strategy, although the demand and need for them) is enormous. The private practitioners (surgeons as well as opticians) must be recruited for this purpose.

Tubectomy (and Vasectomy) services are considered essential services and are being offered in the PHC approach by the Government. But services of a gynaecologist are not considered essential either for contraceptive advice or supervision of antenatal care of 'at-risk' pregnancies. The other glaring omission in the PHC approach is the absence of any practical plan to help those women (estimated at 5% - 10%) who have difficult labour. There is no effort to develop the provision of services of Forceps delivery, Caesarian Section and blood transfusion. Both these are perhaps due to severe shortage of trained gynaecologists, but recruitment of the services of private practitioners will go a long way in meeting the need.

The provision of surgical services for conditions like hernia, hydrocele, fistula, etc. is not included in PHC strategy, although the need for them is substantial. Private practitioners could be persuaded to help, if suitable arrangements are made to enable them to do so.

The main question is to decide whether the Government needs these private practitioners. If the answer is yes, the Government must work out suitable incentives to ensure their co-operation. I have no doubt whatsoever that enough men and women can be found in the Medical profession who will volunteer for this work, without demanding excessive compensation. I have no doubt also that the Indian Medical Association will be a strong ally of the Government if the approach is right.

Interaction Between the Government, NGOs and the Private Sector in Implementation of HFA

by

Abhay Bang

1. Ideological basis of cooperation: The Cooperation between the Government and the NGOs in the health sector was always on the basis of common ideology and interests. Thus different categories of NGOs were collaborating at different times with the then ruling governments. Christian missions were actively cooperating with the British rulers with common imperial interests. The Gandhian constructive institutions were active in collaboration with the Congress government with their common roots in the freedom movement and 'Congress' ideology. The gates were opened for the voluntary agencies with closer links with the 'opposition' parties (When these came into the power under the name of Janata Party) by allowing a major role to NGOs in the National Adult Education Programme. Now with the free market ideology of the Rajiv Gandhi's government, private sector shall have more role. The talk of social marketing, of delegating the responsibility of advertisement of the national programmes to the private agencies are the few examples.

Where do the NGOs in the health sector ideologically stand today? Inspite of their tremendous diversity and different religious or economic roots, most of them explicitly or implicitly believe in the welfare state with mixed economy. Obviously they don't find any major ideological problems in collaborating with the various governments in India. Even those who profess to have a radical ideology usually don't have problems in cooperating with the government as long as they can continue to attack the system while retaining their safe positions in the urban universities and institutions. Many other grass root workers or activists strive for limited reforms by opposing the government policies; and yet in the long run they too work with the government as their reforms are accepted.

Thus most of the NGOs today have no major ideological barriers for cooperating with the Governments in India.

2. Changing Role of the NGOs: Inspite of hundreds of failures of implementation, the National Health Policy is more progressive than most of the NGOs. At least at the conceptual level, the Primary Health Care is oriented to prevention, outreach and use of paramedics, while most of the NGOs are still curative oriented running charitable dispensaries or hospitals or diagnostic camps. Gone are the days of Albert Schweitzer or Father Demain when such individuals or NGOs outreached where no government care reached. The most important outreach agencies today are the government or the private practitioners. Thus in the Gadchiroli district which is probably the most difficult district in Maharashtra, there are:

NGOs in health	-	3
PHCs	-	34, with 230 subcentres and 700 CHVs
GPs (including RMPs)	-	About 300

A recent study by FRCH on the NGOs in health in Maharashtra concluded that the NGOs are concentrated in the developed districts rather than the backward areas.

With tremendous expansion of the Government health sector or the private practitioners, what new role the NGOs can assume, especially if they want to increase their impact by interacting with the government which alone has the political responsibility and resources to provide HFA?

Following roles may be possible
1. Research and innovation
2. Demonstration
3. Training
4. Evaluation
5. Building public opinion for change of the Government policies.

While the last one is not a cooperation with the Government in the narrow sense, this role is extremely important. The history of public health is studed with the examples as to how this role has greatly improved the Government policies and programmes. The Sanitary Movement in the Great Briton in 19th century or the work of the environmentalists today are the glaring examples. But the rest of the discussion in this paper does not include this type of role.

Issues in Government - NGO Interaction

In any working together compatibility on following points is important, and hence needs attention.

1. Ideology and Goal
2. Objectives (specific)
3. Organisational structure and culture
4. Procedures and rules
5. Personalities
6. Finances

The ideology and the goal being similar, these don't pose much problem in actual working together. But the different emphasis due to different objectives may pose a problem. Down in the field the primary health care seems to be reduced to fulfilling targets of few vertical programme objectives. The family planning tops the list with immunisation and blindness control coming next. Rest of the programmes or indicators like infant mortality count little. The NGO may have different or broader objectives and hence a tussle for priority may ensue. A NGO may not be willing to go all out for the numerical targets of FP while for the Government health officer, it is a sacred cow.

There is a contradiction in the structure and function of the Primary Health Care strategy. The National Health Policy has abandoned the unipurpose organisational structure. Now we have buildings and large number of health workers so that an organisational basis is created for continuous and comprehensive health care. And yet, the health programmes are still conducted in the form of campaigns which need a mobile structure and large scale propoganda rather than buildings and accessible workers.

In the relationship with the government organisation a NGO is likely to face what may be called the 'middle level constraint'. At the top, the officers can take broader view about cooperation. The bottom level functionary may be happy to work with NGO because of more humane and liberal treatment. It is at the middle level where the problem of rivalary and sharing of power arises and hence a great resistance or even hostility may start.

The maze of the procedures and inscrutable rules which are characteristic of the Government functioning pose two types of problems. NGOs often understand the intricacies of these and can be easily trapped into immobility while working with these. On the other hand the NGOs have the advantage of autonomy and flexibility in their own structure and their partnership with a Government institution or officer who is tied by the procedures may be like a pair of inequal bullocks resulting in strain and dissatisfaction to both.

Even in the seemingly faceless and impersonal government system the success of the cooperation may depend heavily on the personalities. A single person with vision and openness for new things can make a world of difference. Whether NGOs find cooperative government officer or an obstructive one in their path depends on their luck or on the political maneuvering. How to match compatible persons from two sides so that smooth working is possible is a major issue.

The government money should be available to NGOs in health if they too are working for HFA. And yet if NGOs take money from the government, they are either subordinated by the political decision maker who use distribution of favours as a political weapon or they are trapped and immobilised by the endless restrictions and procedures which necessarily accompany the government grants. In both the ways, NGO looses its qualities of autonomy and speed.

How can the government money be made available to NGOs and yet not have these side effects is an issue for discussion.

CHV Experiment : A case of NGO-Government Interaction:

When conceived, the CHV was to be a volunteer bringing with him/her the qualities of NGO i.e. autonomy, motivation, community participation etc. And yet during implementation he was converted into the lowest catagory of government worker with little financial remuneration. He was subordinated and internalised by the government health structure.

Except for a handful of powerful NGOs, the most will be feeble and dependent on government once they enter in cooperation. A fate similar to that of CHV must be avoided by giving attention to the various aspects of interaction discussed above. And yet, this is a new area of organisational research and innovation. Only through a process of trial and error, experimenting and learning that a feasible model will emerge. Respect for each other and openness is essential prerequisite on either side.

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'HEALTH FOR ALL' AND THE GENERAL PRACTITIONER

Mukund Uplekar

How many of practising General Practitioners know about 'Health for all by 2000 AD.'? If our telephonic survey is any indication, the answer is - 'most of the General Practitioners do not know what it is all about!

Answering three questions put to them, 4% of the responding General Practitioners confessed that they are absolutely blank about it, 36% had heard something like 'health for all' but knew nothing more than that, 54% recalled to have read a little about it but refused to give any importance to it as they considered this as just another slogan (like 'Garibi Hatao' according to a few). Only 6% could elaborate on the issue and were aware that it is a WHO declaration. They knew about Alma-Ata, the targets set for 2000 AD and also about integrated development and primary health care approach etc. The questions put were - (a) Have you heard about 'Health for all by 2000 AD (b) could you tell us more about it (c) In what way, you think you could help to achieve the goal. In most of the cases, the question of answering the third querry did not arise at all.

It is estimated that about 70% of the health care services are provided by the private practitioners. It is needless to mention that these services at present are exclusively 'curative' in nature taking care of the illnesses rather than health.

What has been the Government's efforts to involve private practioners? How many of General Practitioners are aware of our national health policy? What is precisely the role of a General Practitioner? Is it possible to achieve health for all without involving the General Practioners at all? In no other country so many systems of medicine must be practised as they are in India. How many of those trained in indiginous systems of medicine really practice what they are trained in? Why most of them ultimately land up in practising 'western' type of medicine in a haphazard fashion?

In achieving the goal of Health for all, must not the first priority go to looking after the health of health service? and particularly of those provided by private practitioners in whom people have much greater faith than they have in the Government's efforts?

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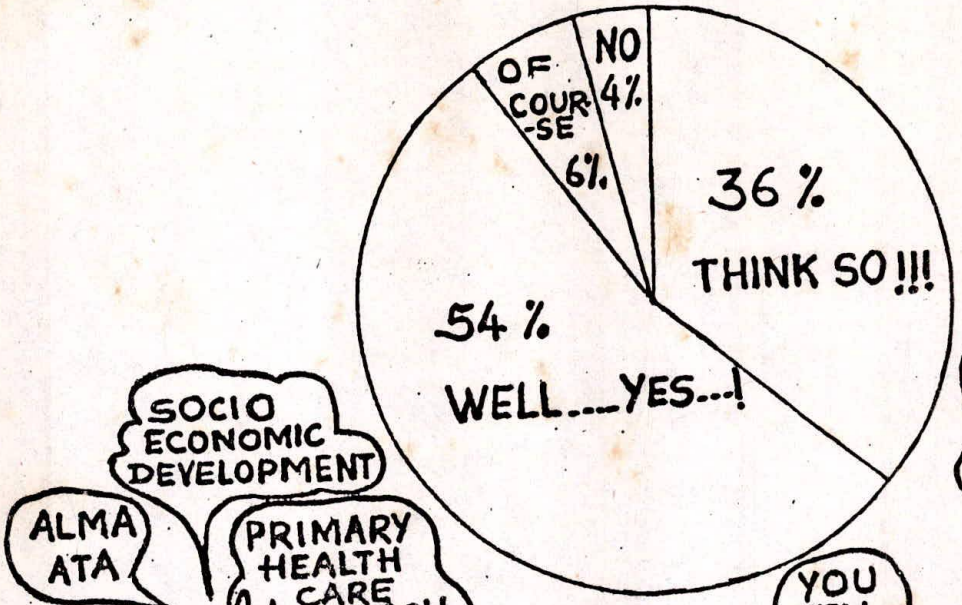
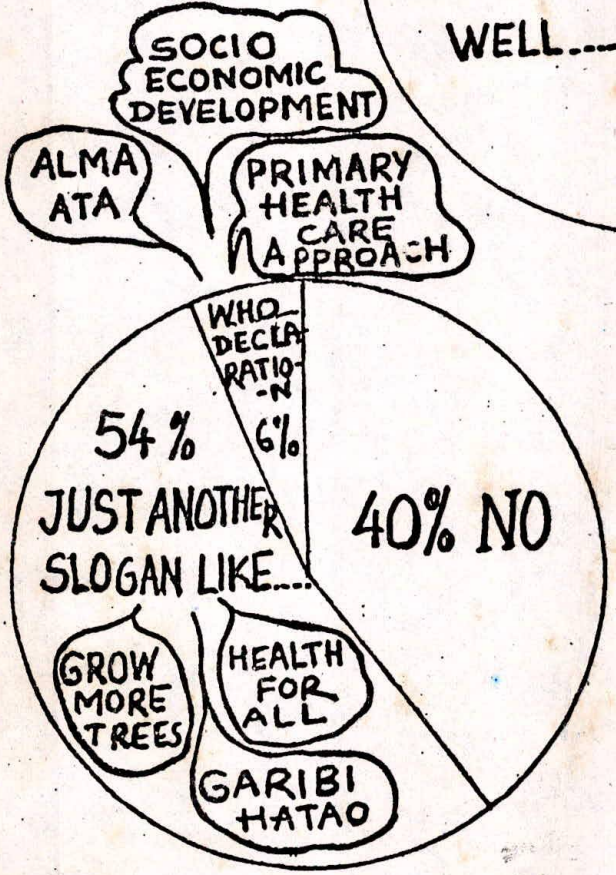
PRIVATE PRACTITIONERS' AWARENESS ABOUT "HEALTH FOR ALL BY 2000 AD."

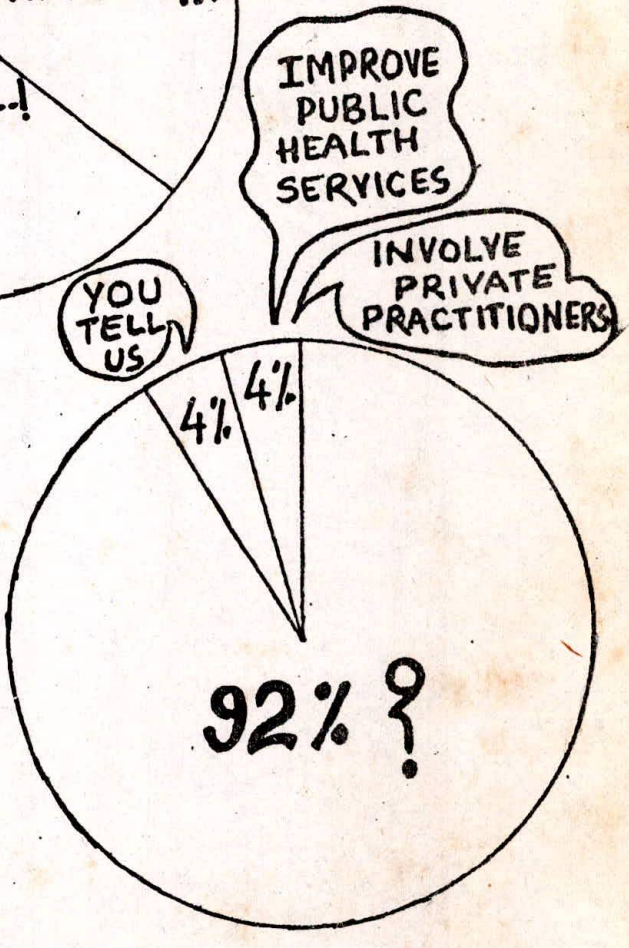
HAVE YOU HEARD ABOUT "HEALTH FOR ALL"?

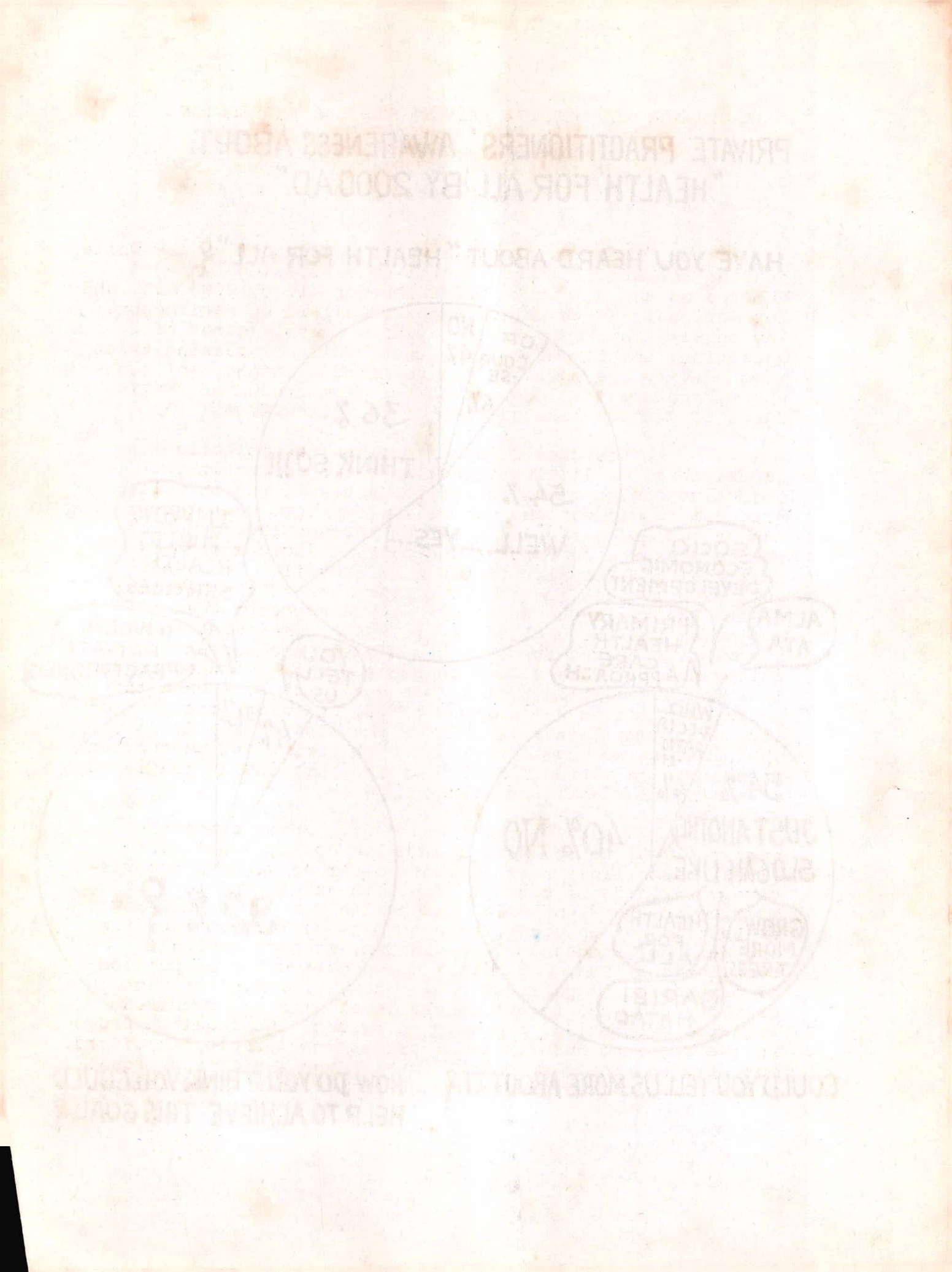


COULD YOU TELL US MORE ABOUT IT?



HOW DO YOU THINK YOU COULD HELP TO ACHIEVE THIS GOAL?





HEALTH FOR ALL AND THE PRIVATE MEDICAL PROFESSION

by

G.G. Parikh

There is always a vague feeling of unease while reading the articles and reports of discussions and debates on the objective of Health for All by 2000 A.D., and the National Health Policy adopted in 1983 by Parliament. Any enquiry into this feeling yields a whole gamut of causation; the foremost being that while discussing these almost every one moves in the rarefied atmosphere of high theory and idealism and not on the firm ground of reality. There is a dream like quality of the discussion.

This unease is not because the objective is undesirable. A little reflection tells us that the objective can be realised and the national health policy with some modifications can be implemented. But this cannot happen by the due date and through the announced policy measures as long as the current socio-economic-political philosophies continue to prevail. It is not sufficiently realised that the framework of the National Health Policy is the framework we had accepted when Socialism was the goal and there was a commitment to contain the market forces through state and societal intervention. This situation has radically changed in the last three years, in fact it was not there even when the policy resolution was being drafted, and since the date of its acceptance little is left of the old frame. It is obvious that we have accepted the objective and passed the resolution on National Health in the best Indian tradition of aiming high while practising low.

A survey of documents from Bhore committee report (1946) to the National Health Policy Resolution (1983) establishes fairly reasonably that we have progressively refined our concept of health and learnt to distinguish between health and health care. We know now that it is not enough to have so many doctors, paramedics and beds per thousand of population, so many medical institutions (PHC, DHC, etc.) for a particular proportion of population, a particular hierarchy of administration from the national to the taluka level with the required logistic support, or capacity to produce the required drugs in the required quantities at prices that people can afford, but we also need safe drinking water and sanitation, equal access to services and provision of services at doorsteps,

better nutrition, widest possible diffusion of knowledge about health and health related matters and disease and their prevention, integration of vertical services, holistic approach, integration of private voluntary effort with the state effort, more jobs, better housing, and involvement of community; in short, total economic development. What better refinement is possible! As we read through chronologically these documents we feel that a picture of Gandhian Ramrajya or a Socialist Utopia is unfolding in front of our eyes. There is no dearth of ideas or high thinking in this country and the international community comes in with a lot of high-minded suggestions to help us along, and besides, the experience of China and the pioneering work of a few of our own doctors were available to build this dream picture.

It is possible to prick holes in the policy statement from several directions, but let us limit ourselves to doing it only from just two partly related directions.

The National Health Policy adopted in December 1983 refers to the private medical profession in a few paragraphs. The reference to the profession is very scanty but mercifully it is not totally ignored. It would be worth reproducing the paragraphs where the private medical profession is referred to.

The Paragraph No.8(7) says:

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

Then there is a reference in the paragraph No.8(8)

"While the major focus of attention in restructuring the existing governmental health organisations would relate to establishing comprehensive primary health care and public health services, within an integrated referral system, planned attention would also require to be devoted to the establishment of centres equipped to provide speciality and super-speciality services, through a well dispersed

network of centres, to ensure that the present and future requirements of specialist treatment are adequately available within the country. To reduce governmental expenditure involved in the establishment of such centres, planned efforts should be made to encourage private investments in such fields so that the majority of such centres, within the governmental set-up can provide adequate care and treatment to those entitled to free care, the affluent sectors being looked after by the paying clinics. Care would also require to be taken to ensure the appropriate dispersal of such centres, to remove the existing regional imbalances and to provide services within the reach of all, whether residing in the rural or the urban areas."

There is also a reference in the paragraph 12, but it is largely in the form of a summary of the paragraph 7, which acts as an intro to certain specific measures. It says:

"Besides the recommended restructuring of the health services infrastructure, reorientation of the medical and health manpower, community involvement and exploitation of the services of private medical practitioners, specially those of the traditional and other systems, involvement and utilisation of the services of the voluntary agencies active in the health field, etc., it would be necessary to devote planned, timebound attention to some of the more important inputs required for improved health care".

A few things are clear from the above. The role of the private medical profession (75% of the doctors are in private practice in this country) in the realisation of the national objective is limited to minimising the cost of providing curative treatment by encouraging the private practitioners to establish themselves (perhaps in rural areas) and providing speciality and super-speciality services to the affluent sections of society (perhaps in urban areas).

This formulation of the role is an admission by the Government that the private professional has very limited - actually very little - role to play in the realisation of the goal of Health For All by 2000 A.D. The Government also admits that there are going to be two types of health services in the country; private for the rich and public for the poor, justified on the beguiling principle 'those who can afford should pay'.

Leaving aside the examination of this principle - it would again become a theoretical discussion, let us examine, ofcourse cursorily, what is happening to the private medical profession and what influence it can have, unless positively harnessed, on the realisation of the goal via the policy perspective and programme enumerated in the National Health Policy.

It should be kept in mind that what the medical practitioners say and do influences the rural community as much as it is influence the urban population.

(1) Since the Bhore Report, the situation in the distribution of the medical practitioners (allopaths, practitioners of Ayurved and Homeopathy - most of these practice allopathy and RMP's mostly recognised for no other reasons except that they are practising medicine for sometime) has changed to a certain extent in the last fifteen years. More and more villages are having practitioners of modern medicine (trained or not), and many of them are earning a reasonably comfortable income. Similarly, doctors have discovered that the practise in the slums can be as lucrative as in middle class areas and therefore almost every slum in most metropolitan areas has a doctor - some times more than one.

(2) There is a growing bias in favour of paid services in the country. Patients for various reasons - a few of them certainly valid - prefer to go to the private practitioners and are willing to pay for services even to those Government doctors who are not allowed to charge in the belief that they will get better services. That some Government doctors extort money and get away needs no emphasis.

(3) The general practitioner earns his income by providing services and there is a fee for each service. More service he provides more income he earns; there is little money in giving advice - excepting for the consultant. This applies not only to general practitioners but also to consultants. There is a general complaint that the number of unnecessary references, investigations, and operations have increased and this complaint is not without substance. In such a situation a private practitioner has a vested interest in over prescribing, giving injections etc.

However much the health activists talk against these, this practice will continue till either the society's mores radically change or it finds out a different way of compensating the doctor for his services. The experience of Universal Health Services as in Britain or contributory health services in other countries has not come up to the expectations of their originators. In Bombay, the ESIS is becoming more and more unpopular daily and the fault is not of doctors alone.

(4) Many patients have a preference for those doctors who give more drugs, injections and charge more. Many an idealist private practitioner discovers to his dismay that it does not pay to be idealistic.

(5) A doctor spends a lot of money on education and to start his practice. In addition, there is now the system of capitation fees and the sons and daughters of doctors queue up to get admissions. The expensive education and the high cost of starting private practice generate a desire to make money quickly. This is reinforced by the general atmosphere where every young man is talking of making a fast buck.

(6) Offering cut and extracting it from the consultants is fast becoming a normal business practice in many cities. It is not frowned upon as in the past. Young specialists plead helplessness and general practitioners argue that after all the specialists make money out of the patients they send. Barring the periodic critical notice of this practice in the lay press, there is little discussion with a view to eliminating it in the profession. Some specialists confess that they have to part with 50 percent of their fees and some general practitioners boast that they do not send patients unless they get 50 percent. Some are bold enough to extract pre-payment, the cut is earned in due course. No one talks of noble profession these days, not even for the sake of hypocrisy.

(7) No one can say that only medical profession has developed these evils. In fact it is possible to argue that it is late-comer to these practices. There is a general permissiveness in our society. Every one is busy making money. No way of making it, however unethical, is considered reprehensible. A man who makes it in a wrong way is not stigmatised. The smuggler, the corrupt politician or the bureaucrat, and the black marketeer are not shunned or boycotted. In fact, we pay our respects to

them if they are sufficiently rich, and they all move in high society. Actually, they form the high society. In such a situation, it is too much to expect the medical profession to think of the noble tradition of service to humanity or to be motivated by the example of the pioneering work of their peers who have blazed a new trail of providing low cost health care through training illiterate women, involving community etc. They cannot be expected to decry the hospital based, urban oriented, pro-rich health care system that has developed in this country and which is growing despite all efforts to the contrary. Let us not just keep bemoaning that doctors are not moving to the rural areas and keep exhorting them to settle down there. In a society where everyone is pragmatic, everyone is for himself, it is foolhardy to expect doctors to make sacrifices. An individual doctor may, but not the class.

If what is said about the prevailing practices is correct, there will be a rise in hospitals giving super-speciality services, more and more colleges to produce more doctors, and certainly even greater concentration of institutions in urban areas, specially metropolitan areas, negating the very strategy which has been accepted to achieve the objective of Health for All by 2000 A.D. No sophisticated analysis of who owns the state, or how free is the state, or whether it is a soft one is necessary to draw these simple conclusions.

The Government will not change the resolution. It will remain as a pious objective before us, useful to give us points to make impressive speeches. The International Community also will not change the Alma Ata Declaration. Only the reality on the ground will be different and now that the country is re-discovering virtues of the market economy, it might even be more difficult for our state to change course.

There are people who think in their innocence that it is possible to build at the cost of the public exchequer a health care service which is comparable to the service which the rich are giving to themselves and this public service will be free and accessible to the poor. But even a cursory glance at the fate of the welfare measures taken in behalf of the poor and the needy shows that even if money is found to do

it on the scale required (which is an impossible assumption) those who 'have' will benefit disproportionately more even from these. The better offs, the educated, the influential will preempt these services through some escape clause legitimately or through down right deception if there is no escape clause.

This is not all. If more money is spent on health care less will be available for drinking water, sanitation, nutrition supplement, employment generation, education, housing etc. And the only result of the slogan of community involvement will be that it will act as a salve to our conscience. But, if we are sensitive, it will not be very good salve. When someone from the rural areas or the slums points out to us that having given yourself a highly sophisticated medical services and solving all your economic problems, you are now giving us a second class service by making us responsible for our own health, and advising us to take recourse to the age-old 'kadhas' because they are cheap and we can afford it and also because the grandmother used to prescribe them. I am sure, we will be very much troubled, but forgive me if I assert, that this troubling feeling will not result in any action. It will only produce some debate, some discussion, one more round of seminars and taking advantage of the infinite biological capacity to adapt we will get over this feeling in no time.

But, supposing we wish to do something, supposing we are serious about achieving the slogan and are determined to persue the strategy laid down, is there anything that can be done?

There is little that can be done via the Government. We can petition it as many are doing, but a government which is convinced of the virtues of the free market economy and given the experience of more than three decades of mixed economy which has produced only a bigger and more vicious class of exploiters, there is little ground for hope to do anything via that route, unless we all decide to work for changing this government and installing a new one. While it is a task which is even more utopian than the task assigned to us by the National Health Policy, it is also a way of escaping our responsibilities. To think of changing the government without formulating a philosophical basis and popularising it and gathering the required strength to effect the change is to indulge largely in day dreaming.

Perhaps, a peoples' movement committed to the goal and convinced of the strategy can set us on the course of realising the dream. But this will involve building brick by brick an alternate social system working in a different value system, something similar to what Gandhiji did during the national movement. He visualised the ideal social system and created an army of trained and disciplined and practising people who were willing to work for it. He even made it possible for them to live in the system. We are in a very peculiar situation. We are all beneficiaries of the existing system, though we keep decrying it and trying hard to dismantle it. I am afraid, all our criticisms end up in strengthening it and not dismantling it. More than radical critique what is required is praxis. It was once a revolutionary step to offer a radical criticism of the existing society. It is no more so. Radical critics are strewn all over the landscape and a number of critiques are available and yet nothing is happening. It is time we think of acting and go beyond exploring the gap between the concept and the reality.

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DISCUSSION

Both the National Health Policy (1983) and the Seventh Five Year Plan (1985-90) envisage the active participation of the non-government (voluntary organizations) sector and the private sector in the delivery of health care services, as part of the overall strategy for achieving the goals of HFA by 2000 A.D. Session IV focussed on the interaction between the government, the private sector and the NGOs in the implementation of the HFA strategy. There were six background papers, three each on the private sector and the NGO's respectively.

The Role Of The Private Sector:

Dr. Abhay Bang, presenting the three papers specifically dealing with the private sector, (by Dr. V.C. Talwalkar, Dr. G.G. Parikh and Dr. M. Uplekar), pointed out that these had limited themselves to(i) a discussion of the features of private practice, and (ii) the potential role of private practitioners in the government's health care delivery organization. The role of the private and multinational pharmaceutical industry in the health policy was not covered by any of the papers. The papers pointed out, that while 60 to 70 per cent of the Indian medical manpower and resources were concentrated in the private sector, the latter was assigned a marginal role in the overall HFA strategy.

During the discussion, two sets of questions were raised about the potential role of the private sector in achieving HFA. The first set of questions dealth with the interactional problems between the preventive and promotive orientation of the primary health care approach, and the largely curative activity and profit motive of private practice.

Those who did not visualise a change in the curative orientation of private practice, suggested that it be integrated into the government health organisation at the point of referral services. According to Dr. Talwalkar, there was a substantial role for private practitioners in providing referral services in municipal dispensaries and taluka hospitals. These services were absolutely necessary to make a dent in the high infant mortality rate (IMR), as many infant deaths were due to difficult pregnancies in need of medical attention. Dr. Coyaji coroborated the need for referral hospitals and logistics in order to control maternal mortality which was on the increase between 1979-80. The curative component in the national programmes for diseases control could also involve private practitioners. Dr. Talwalkar felt that preventive work should be the responsibility of the government, and its para-medical workers and of the Primary Health Centres (PHC's), and not of the medical professionals. With rising educational and economic status of the population the demand for professional services, as against para-medical services, would increase, and this was already happening in China. The role of private practitioners and curative services would increase significantly in the future. A third viewpoint was provided by Dr. Sujit Das's paper (Session III) which argued for a 3-tier system within which private medicare would serve the health needs of the affluent, while free public services would be reserved for the low income groups.

Several doubts were raised regarding the above arguments for integration:

Firstly, it was emphasised by Dr. Antia that the reduction in maternal and infant mortalities in China was the outcome of preventive and promotive action in non-health areas, such as in tackling nutritional anaemia, and not of the expansion of referral services.

Secondly, the Primary Health Care (PHC) approach was a totality of nine elements, as set out in the Alma-Ata Declaration. According to Dr. Deodhar, the discussion of this approach could not be reduced to the elements of medical care and curative services, nor that of 'barefoot doctors' & Health Guides. Thesuggestions for building up the secondary level medical and hospital services were outside the scope of the present discussion and reflected a lack of understanding of the strategy is underlying philosophy. Dr. Deodhar identified a number of areas of PHC activity within which the role of the private practitioners and the service NGO's could be qualitatively expanded:-

(a) Continuing education about the national diseases control programmes;
(b) Post-treatment health care, rehabilitation and providing information about medicines, immunization etc.
(c) Cataract surveys;
(d) Registration of all births and deaths;
(e) Epidemiological information regarding morbidity and mortality in their area of practice;
(f) Conducting sterilizations & MTP's

Thirdly, accordinglto Dr. Saroj Jha, the distinction between promotive, p. eventive and curative activities was confusing, since survey and the diagnosis of illness, treatment and rehabilitation constituted a single process. A general practitioner who did not undertake epidemiological surveys and public health measures in his area and was completely clinic-oriented, could not undertake effective curative work.

Fourthly, Dr. G.G. Parikh, pointing to the experience with honoraries, felt that any integration of private practitioners in the HFA strategy would only result in the expansion of private practice. The government should (i) ensure continuing education to the GP's and (ii) develop measures to expose and

control malpractices in the private sector, before any viable interaction was possible.

Fifth, a cautious note was struck about the importance of medical professionals in the HFA strategy. According to Dr. Abhay Bang, doctors eroded the role of ANMS and grass-roots health workers, or used the latter to fulfill family planning targets. Unless power devolved to the lower-level workers, major problems such as maternal mortality could not be reduced. According to Dr. Antia, those in favour of expanding the role of the medical professionals, were under-estimating their contribution to the excessive medicalization of health problems, and the mystification of surgery and medicine.

The other set of questions were concerned with the historical trends underlying the interaction between the private sector, the NGOs and the government in health services delivery, and their implications for the future. These questions are taken up in the section on NGO's.

The Role of the NGO's.

Two broad approaches to understanding the role of the non-governmental organizations (NGO's) in the implementation of the HFA strategy were adopted during the discussion. One approach began with the assumption that the NGO sector and the Government sector were mutually dependent, and the issue was one of identifying specific areas of co-operation and conflict in their interaction. The other approach viewed this dependence in historical and structural terms, in order to pin-point the political role of NGO's and to better eveluate their claims.

The first approach was developed in the presentation by

Dr. Abhay Bang. He limited himself to a discussion of the role of "Service NGO's" (see Duggal's paper, p.1.), and elaborated on the issues set out in his own background paper. According to Dr. Bang, main interactional problems between the government and the NGO's were with regard to implementation and not ideology. To give his argument a sharper focus, he compared the interaction between the government Primary Health Centre (PHC) at Bamhragarh (Maharashtra) and a pioneering voluntary agency in the neighbourhood:

> "Just a week ago I was at Bamhragarh, probably the remotest area in Maharashtra. It requires 70 kms journey through forest to reach there, the area is totally without electricity. Some 13 years ago, a doctor-couple settled in the area and began to provide the first medical care services. According to their records, they have treated 37,000 patients in the last 13 years.
>
> To my surprise I also found a government Primary Health Centre (PHC) some 4 kms. away, staffed by a Medical Officer (an old class-mate, Dr. Maheshwar) and II ANMS. The two institutions-a pioneering voluntary agency and a government PHC-are an interesting study in contrast. Their relationship is one of mutual distrust: while the voluntary agency regards the work of the PHC as an unnecessary encroachment on its curative services, the PHC's view is that the voluntary agency's only concentrates on curative work and has no contribution to make in other areas such as family planning. In actual fact, both are only doing curative work, thereby duplicating each others efforts. The other feature of voluntary agencies, that they reach out medical services to the very remote areas not served by any one else, no longer holds. Probably the Government health services and the private practitioners are delivering curative health care far more

to remote places than the voluntary agencies. I have mentioned in my papers, and the FRCH study on NGO's has also pointed it out, that most of the voluntary agencies in Maharashtra are concentrated in the relatively developed areas.

If the original roles of voluntary agencies, such as humanitarian service and taking services where non exist, are obsolete then what are the possible new roles for them? What are the areas in which co-operation and interaction between the Government and the voluntary sector are possible?

1. Research and innovation:- Voluntary agencies have been credited with innovation, model building and undertaking pioneering projects. This role can probably provide the substance and quality in the extensive quantity of the ongoing Government programmes. As I have already pointed out, outreach is the Characteristic of the Government services, not of the voluntary sector. The former often lacks content and quality in its programmes and probably the voluntary agencies can, through innovative approaches, provide substance to the structure.
2. Training and Demonstration:- Some voluntary agencies, especially in Maharashtra such as the Wadu and Jamkhed projects, are already performing this role in relation to the government health services.
3. Creating public opinion to influence and pressurise for reforms in health policy. This will not be perceived as co-operation by the Government, but mobilising public opinion for reforms in the health policy is a very important role that the voluntary sector can play. Many agencies are doing this with regard to the drug policy, the use of amniocentesis test for sex determi-

nation and so on.

The ideological positions of the government and the voluntary agencies, and the question whether there could be any ideological harmony in their interaction, has been discussed in the papers. Although the approach to this issue differs from paper to paper, the conclusion is similiar. Ravi Duggal has argued that within a welfare state framework, voluntary agencies have functioned to provide relief and have thereby further legitimised or popularised the Capitalist Government (State). Dr. Coyaji has argued that voluntary agencies can, and should, become the partners of the Government, fulfilling those roles that the latter wants to take up but is unable to carry out. Either position leads to a statement of fact that the majority of voluntary agencies in this country have an ideology similar to the Government's-whether this is called capitalistic, mixed economy or welfare state-and that there are no major ideological barriers to their working together (interaction). Their understanding of health and health care being similiar, ideology is not the problem in their interaction.

Certain advantages and strengths have been attributed to the NGO's. There is no doubting that they are motivated. However, two other strengths claimed by the NGO's, namely that they are closer to the people than the Government agencies and that they are more efficient and cost-effective, need to be questioned and discussed.

The very structure of NGO's is undemocratic and centered around a single personality. As they work at the micro-level and their culture of working stresses humane behaviour, the illusion is created thatvoluntary agencies

are closer to the people. However, NGO's are not structurally accountable to the people. Whatever the deficiencies of the present political system, the Government is at least made accountable to the people, directly or indirectly, through the electoral and political process. With regards to cost-effectiveness, it must be remembered that voluntary agencies often have motivated people willing to work at lower remuneration. This norm is forced on the subordinate staff as well so that the functioning of NGO's is cheaper. However, what is never evaluated is the outcome or end-result of their work.

What sort of problems exist in the Government-NGO interaction? These are not ideological but problems of implementation. Although the broad goal of welfare of the people is the same, the two sectors differ sharply in their specific objectives and priorities. Let me go back to the Bamhragarh example. That particular area has the highest incidence of falciparum Malaria in the whole of India. Malaria accounts for 50 per cent of OPD attendance and hospitalization causes in the hospital run by the voluntary agency. Yet the doctor-couple, doing excellent curative work, have never stopped outside their hospital to locate (and eradicate) the source of the malaria infection. They are content to do their humanitarian, curative work! Similarly, most NGO's continue to run dispensaries, hospitals, diagnostic and treatment camps, and remain highly curative-oriented in their priorities. The pioneering model projects like Jamkhed, Vadu and some others are simply not representive of the NGO sector.

The Bamhragarh PHC on the other hand, has concentrated mainly on the Family Planning and immunization programmes. Two interesting features of the population in this area.

highlight the problems with the PHC's work. First, the tribal population is declining so that family planning is irrelevant to this area. Second, measles, diphtheria, tetanus, chicken pox are non-existent in this area. It would make an interesting epidemiological study to understand the reasons for the absence of these diseases. However, inspite of their absence, the PHC Medical Officer is vigorously implementing the national immunization programme. Thus, the main activities of the PHC are irrelevant to the area.

Irrelevance marks the work of both the NGO and the PHC, although for different reasons. In the case of the NGO this is due to a lack of epidemiological vision and the lack of prioritisation. The priorities of the NGO doctor flow from his own desire, feelings and skills rather than from what the people need. The irrelevance of the Government programmes are due to over-centralization, so that whatever the national policy, it has to be implemented in Gadhchiroli, whether relevant or irrelevant. Besides the irrelevance of their work, the problem of differing objectives has to be overcome to enable Government NGO interaction.

There are also differences in structure, rules and procedures, and the culture of work. We have been working with the Government structure for the past few months. The culture differ sharply. When I go to my office, our driver doesn't even care to stand up. When the Deputy Director of Health Services comes, our District Health Officer immediately offers him his own chair and sits, like a schoolboy, on a chair in front of the DDHS. This particular exchange of chairs is very, very symbolic. Its not a mere ritual, but is meant to indicate who the boss

is. In the Government culture it is very important to establish repeatedly, and at every step, who the boss is! The fact that I do not follow this culture has become a problem in my work with the Civil Hospital. The Civil Surgeon, the Government representative with whom I co-ordinate, is expected to follow the advise that I give him. When I go to his office, I sit in front of him and he retains his own chair. He then thinks that he is the one to advise me and tell me what I should do! So how are these two cultures to be reconciled in order to achieve interaction. Personality problems exist, but these are present within the NGO's as well. However, when the two systems come together, these problems multiply. This is more so at the middle level. At the top of the hierarchy, as for instance the Health Secretary or the Planning Commission level, no one loses anything by giving a role to the NGO's. At the grass-roots level, the PHC MO and health workers do not really mind co-operating with the NGO's. It is at the middle level where power-sharing becomes necessary, that structural and personality conflicts arise.

Most of the NGO's in the field of health, unlike in the field of education, do not depend upon the Government for their finances. This gives them autonomy in their decision-making and work. However, if the Government is committed to transferring resources to the people in the context of its goal of Health for all, then NGO's should also get a share of these resources. The problem is how to share these resources without turning the NGO's into the appendages of the Government, as has been the case with the Community Health Volunteers. Therefore, how do the NGO's maintain their autonomy, the freedom to criticise and differ with the Government, while receiving

funds from the latter?

So far we have discussed the problems and possibilities of Government-NGO interaction from the NGO standpoint What about the Government's perception of this interaction? Interaction has taken place in the past too. From time to time there is a spurt in the Government-NGO interaction. Recently, this interaction has gained momentum again. Why does the Government want to co-operate with the NGO's? Is the Government admitting to its inability to implement its tasks and programmes? Or is it an attempt by the Government to shrug off its responsibility on to other agencies? or, is it that the Government is using the NGO's to blunt the suffering of the people, and thereby, blunt their political struggles, as some of our friends here have interpreted? If the Government is willing to share responsibility, is it also ready to be an equal partner with the NGO's in sharing resources, roles and power? How is this to be implemented?"

The need to safeguard the autonomy of voluntary work was taken up by Dr. E.G.P. Haran. The evaluation of USAID funded NGO projects showed the increasing dependence of voluntary agencies on the government for finances. This jeopardised voluntarism since the government was in a position to impose its model of health services on the NGO's. Raising their own funds was one way of minimising dependence, but none of the practical schemes such as health co-operatives and health insurance had worked. The largely curative-orientation of NGO activity was also due to the scarcity of resources, since the promotive component needed additional finances. He suggested the setting up of intermediate agencies, such as SOSVA, to improve the collaboration between the Government and the NGO's.

Dr. B. Coyaji, citing the philosophy of the Vadu health project, did not accept the view that the government was attempting to control the NGO's. In her view, the NGO's were the junior partners attempting to improve the functioning of the government through certain marginal inputs.

Dr. P.V. Sathe, was critical of the view that the NGO's could provide the managerial inputs for improving the functioning of the government health organization. In his view, most NGO's required funds but worked with very small numbers. This was the basis for their success in reducing birth and death rates. Such experiments were non-replicable. They represented a parallel health system which was a waste of resources. The government should instead depend upon the resources of the government medical colleges.

A number of views were expressed regarding the political significance of the role of NGO's. Dr. G.G. Parikh, replying to Dr. Sathe's criticisms, claimed that the performance of NGO's was superior to that of the government's in every development sector. He identified the NGO's as socialist, Marxist and Gandhian grass-roots organizations which had internalised a definite radical critique of the system and were fighting on behalf of the oppressed. Progressive government policies, such as the Gandhian concept of people's participation, were substantially moulded by NGO's. They had an on-going role to play in pointing out the basic weakness in the society which needed active intervention.

Dr. A.R. Desai, however questioned the potential of NGO's, as also of the government and the private sector, in reaching out to the poor people, awakening them, and assisting them to develop movements for the solution of their problems. He posed the question, "How do these three groups handle the

three non-medical factors: food, water and shelter, which are the basic determinants of health?" Were doctors, whether private practitioners or those with the NGO's, aware of the wider problems in their environment such as the proliferation of slums and pavement dwellers and the threat of evictions, the lack of basic facilities such as laterines, water supply etc.? In his view, most middle-class doctors condemned the poor and respected those with money. They were hardly interested in wider social problems and dynamics such as the socio-economic causes underlying female suicide rates. In this context Padma Prakash pointed out that NGO's had the same limited understanding of women's health problems as the government.

According to Dr. Amar Jesani, the approach and basic philosophy of the Alma-Ata Declaration, particularly its emphasis on people's perceptions and participation, would distinguish between those NGO's who aimed at implementing the Government's development programmes, and those who sought to empower the people in their struggle against the government. The latter referred to trade unions and people's organizations and these were also a part of the NGO sector.

The trend of transferring public resources to NGO's by the Government was questioned. Ravi Duggal sought to modify the notion of ideological affinity between the Government and the NGO sector by pointing out the underlying historial trends in their interaction. NGO's had played a significant role in influencing health policy and moulding the social services sector along western models. A new type of NGO had emerged in the post Green Revolution period which was strengthening the private sector by smoothening the process of integration of rural areas into the market economy. Both he and Dr. Jesani questioned this trend towards the privatisation of the public

health sector. The issues highlighted were whether public money should be appropriated by the private sector, and whether professionals should aid this trend.

Dr. Sujit Das disagreed with Dr. A.R. Desai and Dr.Jesani about the role of the present forum. Decisions about organizing people for their basic needs could not be made in a seminar. The focus instead would have to be on.

(i) health sector allocation, and

(ii) the interaction between the private sector and the government.

A concrete discussion on what could be done within the system, and keeping in view the demand for social justice, was required.

Once again the question of people's participation was brought up. Dr. Antia, pointed out that in discussing the interaction between the Private, NGO and Government sector, the People's sector had been ignored. There were no attempts to learn from the people about the methods they used to cope with their health problems. In this context Dr. P.B. Desai asserted that the two features of HFA highlighted by Dr.Antia, namely 'democratisation' and 'd centralisation', were not realisable within the present structure, and that HFA as a strategy could not be achieved.

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