MILES TO GO.....

- A Report of the
Community health fellowship Experience

Naveen I. Thomas

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COMMUNITY HEALTH CELL
BANGALORE

CONTENTS

Acknowledgements

Before I joined this fellowship, there were many roads traversed; innumerable decisions made; many hurdles crossed; difficulties negotiated; some falls along the way; but eventual victory. Through it all, there was a constant companion and guiding light. To Him, is my first offer of gratitude.

It is almost impossible to list the number of people who have contributed to my rich experiences and learning during the fellowship. One common factor among all of them was their willingness to give without expecting anything in return. I am indeed blessed to have come across such wonderful people. A big thank you to all of them!

Dr. C.M. Francis, Dr. Thelma Narayan and Dr. Ravi Narayan, were the pillars around which this fellowship revolved. Their availability and readiness to go to any lengths to help us in our exploration of community health made the experience all the more worthwhile. The CHC team including Chander, Rajendran, Prasanna and the entire office team contributed to our learning and made our time at CHC a pleasurable one. Dr. Thelma, my mentor, requires special thanks for her complete trust in me and for helping me to work to the best of my abilities.

I would like to thank Sir Ratan Tata Trust (SRTT), who supported this fellowship programme. Supporting a semi-structured programme which aims to train young people in community health, shows the vision and orientation of this Trust. My association with the Tata Trusts began even before the fellowship, by having studied at the Tata Institute of Social Sciences (TISS) and being a recipient of the J.R.D. Tata scholarship during my student days.

My grandmother, parents and sister were very supportive of my decision in making the shift from a challenging, well-paying job to doing this fellowship. During the fellowship I also got married to somebody who was willing to marry me, in spite of the uncertainties it presented. Without all their support, I could not have made it through. Thanks to all of them.

Naveen I. Thomas

Thank you

1. Introduction

It is difficult to separate one's life experiences from a specific time period, as it is intrinsically linked to one's past. As I sit down to document my experiences during the community health fellowship, I see that it is going to make sense only when I include my past experiences, orientation and elaborate on certain decisions I took. This is even truer in the case of community health, since community health is an approach or a perspective that is linked to a person's values, beliefs and orientation in life.

I was brought up in a middle class Christian home in Bangalore. My father was a state government employee, and mother was a school teacher. My younger sister and I were brought up with the usual challenge that is thrown at kids – study well so that you can do well for yourselves. I used to read the Bible often and found it very inspiring. The life and teachings of Jesus were an inspiration and strength to me. Among other things, I believed in the concepts of grace, forgiveness, salvation, eternal life and above all, the love of God which brings about these things. One key teaching of Jesus was that we ought to love others just as He loved us. And it was not just a command to 'love others', it was also a preferential kind of 'action-oriented' love. By teaching, 'whatever you did for the least of my brethren, you did for me',[1] Jesus taught that serving the "marginalised" was serving God. There was one person whom I thought actually lived the teachings found in the Bible – Mahatma Gandhi.

Soon a time came in my life when I had to make a career choice. In Bangalore, if one completes XII standard with science as their main subject, making a career decision is often easy. Most of the students write the Common Entrance Test (CET) for admission to Medical/ Engineering colleges, and make it to either one of them, because there are numerous colleges in Karnataka offering medical and engineering courses.

The thought of doing either of those courses to make a living for myself didn't appeal to me. I wanted to do something that would help serve humankind. HIV/ AIDS was a problem which was destroying people, breaking families and ravaging countries. I wanted to work toward finding a cure for it. I enrolled for my Bachelor's degree in Science with Microbiology, Chemistry and Zoology as my main subjects.

While doing my Bachelor's degree, I became a member of a students' body called Josephs AIDS Awareness Movement (JAAM) as an HIV/AIDS trainer. We used to

[1] This portion is found in the New Testament of the Bible in Matthew 25: 40

create awareness about HIV/AIDS among college students and conduct surveys among them. During holidays we used to visit Care and Support Centres and spend our time with the people living there. This experience made me realise that the solution to HIV/AIDS, did not lie in a drug or vaccine alone, but more in tackling the larger determinants affecting the people, which are famously known in CHC as the SEPC factors (Socio-Economic-Political-Cultural factors). I went on to complete my Master's degree in Medical & Psychiatric Social Work and work in the development sector.

All through my education in social work and work in the development sphere, I have been able to relate my beliefs with my work and *vice-versa*. They have fed into each other and influenced each other deeply. My experience till now has taught me that, as social beings we have a responsibility towards each other. When we fail in that responsibility, there is disharmony, discord, misery and an increasing gap between people. This can be reduced by collectively fighting for equity and justice. The collective fight has to be based on love – a love that rises over human differences and egos. Love is the cord that binds together humankind and one can share this love only when one has experienced it themselves. For me, experiencing this love and sharing it [2] with others is true worship.

During the community health fellowship, I was able to reflect on many of these things and locate them in the sphere of community health. Community Health is an approach where the community comes together and takes responsibility for their own health in a shared manner. The coming together, doing things to maintain collective health, and demanding health as a right, is done to fulfil the basic living conditions for all, with a spirit of equity and justice. The approach is built on mutual trust and love. If these don't exist, community health does not operate in its ideal sense.

The title of this report, "Miles to go…." signifies the work that needs to be done at two levels – one, in the community itself, where the conditions for community health have to be propagated , and – two, in my own life, where much work remains to be done in building up my own personal self and in contributing to community health.

[2] Sharing this love through action is also seen as the measure against which each person will be judged, in Matthew 25: 35-36. The passage reads as follows: *For I was hungry, and you gave me something to eat, I was thirsty, and you gave me something to drink, I was a stranger, and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.'*

2. Framework of Learning

A detailed action plan (see Annexure 1) was prepared for the six-month community health fellowship, in consultation with my mentor, Dr. Thelma Narayan. The plan was prepared based on my interests along with a plan for learning from the experiences gained during the fellowship through Group learning Sessions and the Community Health Workshop. The initial plan evolved during the course of the fellowship to take advantage of the emerging practical learning opportunities such as the World Social Forum and the International Health Forum.

The modified action plan can basically be divided into three areas:

1) Understanding Health Policy and Legislations

- A booklet on Health Policy and Legislations.
- Study on Pharmaceutical Policy.

2) Closer look at Globalisation & Health

- Contribute to design, field work, write-up and analysis on 'Global–Local Partnership' Study.

3) Right to Health care

- Systematic and planned sessions in International Health Forum (IHF) 2004.
- Contribute to preparations, conducting and write-up of IHF.
- Attend meeting in Mumbai on 'Right to Healthcare'.
- Conduct meetings in South India on 'Right to Healthcare' campaign

Most of the learning during the fellowship took place by practical hands-on experience, with guidance from senior colleagues. Having previous experience in working on campaigns and policies also helped in the work done during the fellowship. Discussion on technical matters with the senior colleagues helped in better planning and understanding of issues. Regular meetings with my mentor helped in reflecting on the work done, and learning from it.

The Group Learning Sessions were also helpful in reflecting and knowing about the work of other interns/fellows. It was an opportunity for learning from their experiences and reflections. The rich experiences of senior colleagues like Dr. Sunil Kaul, Sr. (Dr.) Aquenas, Dr. Narendra Gupta, Dr. Ullhas Jajoo and others added to our learning during the Community Health Workshop.

3. Experiences

The marvellous richness of human experience would lose something of rewarding joy if there were no limitations to overcome. The hilltop hour would not be half so wonderful if there were no dark valleys to traverse.

– Helen Keller

I had a rich variety of experiences during the six months of my fellowship. But what was rewarding was that each of those experiences presented challenges, in addition to providing immense learning opportunities.

The **Right to Healthcare** campaign was something that I was involved in during my fellowship period. After attending the *National Workshop on Right to Healthcare*, organised by People's Health Movement – India [*Jan Swasthya Abhian* (JSA)] on 5th and 6th Sep 2003 at The Retreat House, Mumbai (Annexure 2), we were involved in localising the campaign in the different states of the country. Cases of denial of health care were collected from all over the country and presented before the state health officials in Pubic Hearings organised jointly by JSA and NHRC. A lot of ground work needed to be done for operationalising the campaign. I supported the efforts of JSA to conduct the public hearing in the southern region of the country.

The People's Health Movement – PHM (Global), whose secretariat happens to be in CHC at the moment, with Dr. Ravi Narayan as the Global Coordinator, organised an International Health Forum (IHF) in Defence of People's Health at Mumbai prior to the World Social Forum in January 2004. I was involved in evolving the programme for the event, with guidance from Dr. Ravi. My task included compiling suggestions for the themes from PHM members around the globe, evolving a programme for the event (see Annexure 3) and getting resource materials on the themes from resource persons and participants. This experience helped me to understand the various issues related to health, its linkages, current discussions on the topics and various perspectives on the same issues. I also came across interesting topics like Liberation Medicine; Globalisation, Poverty, Hunger and Health, etc. In the final plenary, I made a presentation on "Global Tobacco Control Campaign and suggestions for the People's Health Charter". Many of the suggestions were incorporated in a larger document called the "Mumbai Declaration". [3]

[3] The entire Mumbai Declaration document can be viewed at http://www.phmovement.org/pdf/MumbaiDeclaration.pdf

The Mumbai Declaration focuses on the key challenges that the people of the world face today in achieving health. It analyses the causes that blocks in meeting the international communities obligation in fulfilling the promise of "Health For All". The declaration highlights six key challenges and calls action at various levels.

- End Corporate-led Globalisation
- End war and occupation
- Implement Comprehensive and sustainable Primary Health Care
- Confront the HIV/AIDS epidemic with Primary Health Care and Health Systems approach
- Reverse Environmental damage caused by unsustainable development strategies
- End discrimination in the Right to Health and take measures to stop violence against women

The declaration calls for action at various levels- by the Government, WHO and other UN agencies, International agencies, International Financial Institutions, NGOs and people. The declaration calls on the people to pressure the World Bank and the International Monetary Fund to acknowledge their culpability in the current health care crisis, especially the damage caused by Structural Adjustment Programs.

While noting the ongoing health crisis in Palestine, Iraq and other places devastated by wars, conflicts and sectarian violence, the Mumbai Declaration calls to strengthen the international anti-war movement through building the global campaign: "No to War, No to WTO, Fight for People's Health".[4]

Another issue which I have worked on was **Health Policy and Legislations**. The knowledge of existing legislation is the first step in enforcing or improving the policy and legal environment. To know more, and to work effectively on the Karnataka Health Policy, I put together the health-related legislations in Karnataka. These legislations form a major part of the existing policy environment in the state (see Annexure 4). The purpose of this document was to serve a handbook for NGOs, health activists, academicians, Government functionaries, media persons and anybody who wishes to know the existing Acts as provided by the Karnataka state. It has been updated up to December 2002. A few important Acts passed in 2003 have also been included. The website of the Department of Parliamentary Affairs and Legislation, Government of Karnataka (http://dpal.kar.nic.in/), came in handy for preparing the handbook.

[4] http://www.phmovement.org/md/index.html

I enrolled for a Post Graduate Diploma in Medical Law and Ethics from National Law School of India University. The contact classes and course material helped me to learn the basics about health ethics, law and policy. As a part of the course, I also did an analytical study about the Indian Pharmaceutical Policy 2002 and gave recommendations for its improvement (see Annexure 5). Dr. C. M. Francis and Dr. Thelma Narayan helped me greatly in conducting the Study.

Another area of work was **Globalisation & Health**. In addition to reading up on globalisation-related issues, I worked on a Study of Global Public Private Initiatives (GPPIs), where we examined the impact of Global Alliance to eliminate Lymphatic Filariasis (GAELF) on the health system. The actual study and field work could happen only after the fellowship concluded. A copy of the Study is available in the CHC Library and Information Centre (CLIC). I participated in a *Panel Discussion on WTO Issues* (see Annexure 6) and subsequently had a meeting with one of the panellists Dr. Rupa Chanda, Associate Professor, Indian Institute of Management, Bangalore (see Annexure 7).

I also participated in other issues and meetings. I attended the All-India Drug Action Revival Meet Held on September 7, 2003 in Mumbai. The report is enclosed (see Annexure 8). An issue which I had worked on earlier was that of Child Law. My visit to Mumbai gave me a chance to attend a Book Release on Child Rights (see Annexure 9). An issue which I had followed since my Master's days was Budget Analysis. My work in Rajasthan prior to the Fellowship, offered me a chance to get in touch with the Budget Analysis Rajasthan Centre (BARC). They conducted a workshop on "Capacity Building for Budget Analysis". Though I could not attend the workshop, I received the report, which was studied in detail during the fellowship. I am enclosing the report of the workshop (see Annexure 10) organised by ASTHA, BARC, DISHA and Save the Children (UK).

4. Looking Outward, Inward and Ahead

The fellowship period was a time for me to experience and reflect about the community, teams with which I worked and interacted with, and different organisations and strategies. I saw many communities during the course of my fellowship, but I will reflect on two of them in this report.

The first, are the communities which I came across during my visit to Gulbarga, Koppal, Raichur, Bijapur and Bagalkot. The people in these areas were suffering from repeated drought and their vulnerability was at its peak. The struggle for survival amidst hardships had certainly influenced their coping abilities. In addition to the hardships faced by people due to drought, it was found that women bore the brunt of the burden. In cases of water shortage, women were the ones who trudged long distances to bring water.

In conversation with the people during field visits, it was found that food shortage was common and that the worst impact in nutritional shortfall of the family was buffered by the women reducing their food intake. In an interview with a family in the Lambani thanda (hamlet) of Hanumantwadi village in Gulbarga district, a woman said, “earlier we would not count out rotis and we could eat as much as we wanted, since the grains grew in our backyard. However, now we have started counting our rotis, since we have to buy the grains from the market”. When asked to quantify the reduction in her family’s food intake, she said that earlier she would take 3-4 rotis depending on how much she had worked that day. However, now she never ate more than two, while her husband continued to eat 4-5 rotis even now.

Since the number of people seeking employment is much greater than the work available, it was found that employers like landowners and brick makers preferred employing women and children, since they could be exploited and paid low wages. In Bagalkot, women were paid Rs. 20 – 30 a day, depending on the kind of work, while men were paid Rs. 40 for the same work. This increased the women’s workload, as they were the sole breadwinners of the family in addition to bringing water for the household, cooking, etc.

The prevailing drought in Karnataka has also forced many women from the economically weaker sections of North Karnataka to take up sex work in Maharashtra.

Amidst all this hardship, stories of hope and resilience among the people emerged – stories with a 'never say die' spirit. In all districts of North Karnataka, at least some kind of people's movement is visible. Newspapers in North Karnataka carry everyday reports of demonstrations, public rallies, picketing of public offices and other modes of protest by civil society groups demanding government action to help them overcome severe drought. It is heartening to note that not all of these actions are initiated by NGOs/political parties. In some places, the entire village has come together and decided that they will beat up any political party or person who dares to come to their village and ask them for votes. Nandyal village in Bagewadi taluk of Bijapur district, the disillusionment with the elected representatives was so high, that they had collectively decided to abstain from the electoral process.

Another kind of community that I came across was the development workers' community. This is a community to which I also belong. The divisions among this community are even more evident than the community with which we work. This is because, in addition to the usual divisions based on caste, class, gender, education, etc., this community also divides itself on the lines of political understanding and leaning, mode of operation, issues tackled and numerous such artificial divides. But the silver lining to this dark cloud is that campaigns and movements like People's Health Movement, Right to Food campaign, etc. have managed to bring together this community to represent people's issues with one voice. This collective strategy is the only hope for the future and is in line with the principles of community health.

While dealing with various communities, I also learnt a lot about myself. I had an initial apprehension of meeting and working with different groups. But that disappeared as soon as I began interacting with the group with an open mind. I have been experiencing this since my student days. I also learned that having a hidden agenda / orientation while dealing with a group most often misfires and spoils one's relationship with the group. In most cases, it is useful if the group knows about one's orientations and agenda, while dealing with them. I learnt that I had the ability to bring different groups together. Though I was better at one-to-one interaction, I could handle groups quite comfortably.

In the next few years, I want to focus on a few issues like primary health care, trade and health and health policy, and work intensively on them under the broad framework of 'right to health'. The community health fellowship helped me to identify these core areas on which I would like to work in the future.

Annexure 1

RIGHT TO HEALTH – A POLICY FELLOWSHIP

1) Right to Health – A Fundamental Right

- **Health Policy and Legislations** – compile, analyse, examine implementation of selected laws/ policies and examine them through the framework of 'rights perspective'; connect 'right to food', 'right to work', and other campaigns in relation to 'right to health'.

- **Globalisation and Health** – be a part of the 'Global–Local Partnership' Study team; document globalisation processes and examine them through the framework of 'rights perspective'; compile evidences of impacts and analyse them to identify areas where legislation is weak or lacking using the Global–Local Partnership Study.

- **People's Health Movement** – assist in organising the International Health Forum at the World Social Forum – 2004 in Mumbai, India.

2) Right to Health Care – A Justiciable Right

- **Support existing campaign on 'Right to Healthcare'** – to support the campaign by writing articles, collecting information, compiling reports/ documents on earlier *Right to Healthcare* workshops in India, and preparing a bibliography on the issue.

- **Campaign in South India** – work with local NGOs, academic/ political / other institutions, media persons and key persons to popularise the concept, seek support and share experiences; to document the process of the campaign in S. India.

Expected Outcomes

- A booklet on Health Policy and Legislations
- Study on implementation of selected health legislation.
- Write-up on Globalisation & Health
- Article on effectiveness of a particular policy in the context of Globalisation
- Contribute to design, field work, write-up and analysis on 'Global–Local Partnership' Study
- Systematic and planned sessions in International Health Forum (IHF) 2004
- Contribute to preparations, conducting and write-up of IHF
- Attend meeting in Mumbai on 'Right to Healthcare'.
- Conduct meetings in Kerala and Karnataka on 'Right to Healthcare'
- Annotated bibliography on 'Right to Healthcare'
- Write-up on 'Right to Healthcare'

Support Required

- Guidance in formulation of studies and analysis
- Technical and human resource support in organising meetings
- Attend training/ workshop to enhance skills in policy analysis, Rights campaign, etc.
- Conducive environment for effective functioning

Detailed Action Plan

Sl. No	Issue & Activities	Process	Expected Outcome
1.	**Health Policy and Legislations** – compile, analyse, examine implementation of selected laws/ policies and examine them through the framework of 'rights perspective'; connect 'right to food', 'right to work', and other campaigns in relation to 'right to health'.	**Sep ' 03** – Basic reading on Health Policy and Law, with special focus on Pharmaceutical Policy **Oct ' 03** – Compile information on health legislation and rights based campaigns. **Nov ' 03** – Study on implementation of selected health legislation **Dec ' 03** – Examine health policy/ selected legislations' from a rights perspective **Jan ' 04** – Analyse link between 'right to health' campaign with other rights based campaigns **Feb ' 04** – Complete the write up and design booklet on 'Health Policy and Legislations'	- Booklet on 'Health Policy & Legislations' - Study on implementation of selected health legislation.
2.	**Globalisation and Health (G&H)** – be a part of the 'Global–Local Partnership' Study (GLPS) team; document globalisation processes and examine them through framework of 'rights perspective'; compile evidences of impacts and analyse them to identify areas where legislation is weak or lacking using the GLPS.	**Sep ' 03** – Plan GLPS along with CHC team; read up on 'Global–Local Partnership' **Oct ' 03** – Field Work for Study; Compile information on G&H **Nov ' 03** – Field Work for Study; Compile information on G&H **Dec ' 03** – Field Work for Study; Compile information on G&H **Jan ' 04** – Examine legislation/ policy in respect to a particular area related to G&H to assess effectiveness based on secondary materials (linked to *Study on implementation of selected health legislation*) **Feb ' 04** – Write-up of work done on G&H	- Write-up on G&H - Contribute to design, field work, write-up and analysis on GLPS - Article on effectiveness of a particular policy in the context of Globalisation.
3.	**People's Health Movement** – assist in organising the International Health Forum (IHF) at the World Social Forum – 2004 in Mumbai, India.	(*To be decided in consultation with PHM co-ordinator*). **Dec ' 03** – Preparations for IHF. **Jan ' 04** – Participate in IH.F **Feb ' 04** – Write-up on IHF along with CHC team.	- Systematic and planned sessions in International Health Forum 2004. - Contribute to preparations, conducting and write-up of IHF
4.	**'Right to Healthcare'** – to support the campaign by writing articles, collecting information, compiling reports/ documents on earlier *Right to Healthcare* workshops in India, preparing a bibliography on the issue; work with local NGOs, academic/ political / other institutions, media persons and key persons to popularise the concept, seek support and share experiences; to document the process of the campaign in S. India.	**Sep ' 03** – Meet people involved in Right to Healthcare Campaign, Compile information, attend meeting in Mumbai on 'Right to Healthcare'. **Oct ' 03** – Read up on Right to Healthcare, compile reports/ documents on previous workshops; conduct meeting on 'Right to Healthcare' in Karnataka/ Kerala. **Nov ' 03** – Prepare an annotated bibliography on 'Right to Healthcare'; conduct meeting on 'Right to Healthcare' in Karnataka/ Kerala. **Dec ' 03** – Write-up on 'Right to Healthcare'; meeting media, academic and political institutions to enlist support for 'Right to Healthcare' campaign	- Attend meeting in Mumbai on 'Right to Healthcare'. - Conduct meetings in Kerala and Karnataka on 'Right to Healthcare' - Annotated bibliography on 'Right to Healthcare' - Write-up on 'Right to Healthcare'

- Naveen I. Thomas
26 August 2003

Annexure 2

NATIONAL WORKSHOP AND NATIONAL PUBLIC CONSULTATION ON RIGHT TO HEALTH CARE, 5 - 6 SEPTEMBER 2003, MUMBAI

Venue: The Retreat House, 6, Kane Road, Next to Mt. Mary's Basilica, Bandra (W), Mumbai – 400 050, Ph: 022 – 26416653, 26422095, 26455296

With the perspective of establishing the Right to Health Care and ensuring access to quality health care for all, JSA organized a National Workshop and National Public Consultation on the **'Right to Health Care'** on the 5th and 6th of September 2003 (the 25th anniversary of Alma Ata declaration), in Mumbai. The public consultation, which was in the nature of a public hearing, was conducted in the presence of Justice Anand, Chairperson of the National Human Rights Commission (NHRC).

Participation

The workshop was attended by over 250 delegates from 16 Indian states, representing 85 different organisations dedicated to health and rights based movements including rights for women, children, people affected by HIV, displaced people, people living in areas of conflict, as well as a number of academics, health policy analysts, social and health activists and other interested citizens

Sessions

During the workshop there were sessions on different aspects of health care as a fundamental right including sessions on right to basic (including PHC) health services, women's right to health care, right to essential drugs, health care rights of unorganized workers and urban poor, Health rights of HIV / AIDS affected persons, Health rights in situations of conflict and displacement. Similarly, there were short plenary presentations on 'Children's right to health care', 'Right to mental health care', 'Health rights related to the Private medical sector' and 'Health sector employees and the right to health care'

Testimonies

In a subsequent session with parallel groups, grass root activists narrated in their own language, their stories of denial of health care in Primary Health Centres, rural hospitals and urban public health facilities. These structural deficiencies, including lack of basic drugs or vaccines, insufficient staff and inadequate patient transport facilities had led to their relatives or people from their area to suffer or even lose their lives. In all about 50 such cases were presented, based on careful documentation by PHM-India activists from different states with the help of a standard questionnaire.

Subsequently, six testimonies and case studies were presented before Justice Anand, demonstrating how weakened public health services are denying health care to the poor. These highlighted how essential drugs and vaccines are absent in public health institutions, emergency care is not available at sterilization camps and treatment is delayed because doctors are not available and ambulances have not been deployed

NHRC Response

In the 'National Public Consultation on Right to Health Care', Justice Anand, Chairperson, National Human Rights Commission (NHRC) mentioned in his inaugural speech that the Supreme Court has taken a view that health care is a fundamental right. At the end of his speech, Justice Anand stated his clear position that "Obligation of the state to take care of primary health is paramount, total and absolute. The State cannot avoid its constitutional obligation on account of financial constraints." [5]

[5] http://www.phmovement.org/india/campaigns/rthc/nhrcmumbai_workshop.html

Annexure 3

INTERNATIONAL FORUM FOR THE DEFENCE OF PEOPLE'S HEALTH (IHF)
14 – 15th January 2004, Mumbai, India

Date/ Time/ Session	Programme
DAY ONE (IHF) **14th January 2004** **9.00 – 11.00** **Inaugural Plenary** **Part I**	<u>Overview on Confronting the Challenge of Globalisation through Health Work: Perspective, Struggles and Strategies</u> Chair: **Zafrullah Chowdhury (Bangladesh)** Moderator: **Sarojini (India)** 1) Welcome and Introduction – Amit Sengupta (India) 2) Two Keynote Presentations a) Globalization – A Macro Perspective - Walden Bello (Philippines) b) Linkages between Globalization and Health - David Legge (Australia) 3) Brief Overview of People's Health Movement and the Main Challenges before it in Response to the Threat of Globalization – Ravi Narayan (India) 4) Interactions from the floor
11.00 – 11.30	**Break**
14th January 2004 **11.30 – 13.30** **Inaugural Plenary** **Part II**	Chair: **N. H. Antia, PHM (India)** Moderator: **Maria H. Zunega, PHM /IPHC (Nicaragua)** 1) Panel: Regional Challenges, Struggles and Role of PHM (75 mins) a) Asia – Edelina De La Paz (Phillipines) b) Africa - Mwajuma Masaiganah (Tanzania) c) Americas- Arturo Quizhpe (Ecuador) d) Europe – Pamela Margaret Zinkin (UK) e) India – Abhay Shukla (India) 2) Some brief Country Case Studies (30 mins) a. Italy- AIFO representative b. Bangladesh – AHM Nouman c. Others 3) Interactions from the floor (15 mins.)
13.30 – 14.30	**Lunch**
14.30 – 16.30	**Parallel Plenaries**

14th January 2004 **14.30 – 16.30** **Parallel Plenary 1A**	**A) <u>Globalisation, Health Policies and Health Sector Reforms</u>** Chair: Moderator: **Sundararaman (India)** 1) Testimonies: Evelyne Hong (Malaysia) Cherie / Jen Cox (USA) 2) Keynotes – a) "A World without World Bank and IMF – The Cuban experience of Health for All " – Aleida Guevara March (Cuba) b) Issues & alternatives – 3) Round Table - Globalisation and Health Imrana Qadeer (India) David Sanders (South Africa) Tissa Vitarana (Sri Lanka) Julie Ancian, MDM – GATS and access to health 4) Interactions from the floor
14th January 2004 **14.30 - 16.30** **Parallel Plenary 1B**	**B) <u>Health under War, Occupation and Militarization</u>** **Chair:** Babu Matthew- NLSIU / NAPM **Moderator:** Unnikrishnan (India) 1) Welcome, Introduction 2) Key note address: Rosalie Bertell (Canada) Edgar Isch Lopez (Ecuador) 3) Voices from the field: a) Palestine – Jihad Mashal b) Gujarat, India – Renu Khanna (India) c) Vietnam: Impact of agent Orange d) Iraq – Hanna Edwards e) Iraq – Clara Kim (South Korea) f) Afghanistan g) Nepal – Mathura Shreshta h) Philippines – Reginald Pamugas i) Africa – Malachi Opule Orondo (Kenya) j) Congo – Patricia Nickson 4) Interactions from the floor
16.30 – 17.00	**Break**
17.00 – 19.00	***Parallel Workshops***

14th January 2004 **17.00 – 19.00** **Parallel Workshop 1**	**<u>Globalisation and Health Policy</u>** **Chair:** **Moderators:** Anant Phadke (India) & Edelina Delapaz (Philippines) 1) Testimonies 2) Panelists: a. Securing the Right to Health – Julio Monsalvo (Argentina) b. WHO or WTO – who determines global health priorities?– Armando de Negri Filho (Brazil) c. TRIPS and Access to Essential Medicines- Olivier Brouant, MSF (India) d. Global Equity Gauge Alliance – Alexandra Bambas (GEGA) 3) Interactions from the floor
14th January 2004 **17.00 – 19.00** **Parallel Workshop 2**	**<u>Promoting Synergy: Towards joint Anti – war action</u>** **Chair:** **Moderator:** Unnikrishnan (India) 1) Keynote: Bert Belder (Belgium) 2) Voices from the field: a) Stop the War Coalition UK b) Resistance in Palestine – Dr. Ghassan Handan (Palestine) c) Anti War effort in South Asia – Sandeep Pandey (India) d) No money for War: Boycott Bush campaign – Pol d' Huyvetter, Mother Earth (Belgium) e) Sri Lanka Peace Initiative – Vinya Ariyaratne (Sarvodaya, Sri Lanka) f) Anti war Campaign – Sarah/ Lanny (USA) g) Iraq 3) International resistance and local actions – ILPS, Philippines 4) Interactions from the floor

14th January 2004 **17.00 – 19.00** **Parallel Workshop 3**	**<u>Learning from the Global Tobacco Control Campaign – including FCTC</u>** **Chair:** Surendra Shastri **Moderators:** Carmelita C. Canila (Philippines) & Shoba John (India) 1) Testimonies: a) Community in Health Promotion – Sehra Sajjadi (Iran) b) Youth in Tobacco Control Campaign – Bobby Ramakant (India) c) Fighting Transnational Tobacco Companies – Olufemi Akinbode (Nigeria) d) The Canadian Way to Innovative Tobacco Control Policies – Atul Kapur (Canada) 2) Round Table (FCA / PATH Canada / PHM and AFTC): a) Relevance of Tobacco Control within the context of Social Development –Prakash Gupta (India) b) FCTC –Entitlements and Lessons – Shoba John (India) c) People's Health Charter & Tobacco Control – Carmelita C. Canila (Philippines) 3) Interactions from the floor
14th January 2004 **17.00 – 19.00** **Parallel Workshop 4**	**<u>Liberation Medicine</u> - Bringing together experiences of the conscious, conscientious use of health to promote social justice and human dignity** **Chair:** **Moderator:** Lanny Smith 1) Panelists include: Sayeh Dashti (Iran) Roland Bani (Albania), Chris Fritsch (US), Vinu (India) and Medico Friends Circle representative 2) Interactions from the floor
14th January 2004 **17.00 – 19.00** **Parallel Workshop 5**	**<u>Globalisation and Health Sector Reforms</u>** **Chair:** T. Walia, WHO (India) **Moderators<u>:</u>** Ravi Duggal (India), Jose Utrera (Netherlands) 1) Testimonies: a) Privatisation and Health : Edelina Delapaz (Philippines) b) A grassroots perspective - GK Health Worker (Bangladesh) 2) Panelists: a) Barriers to accessing health care in Africa - Harry Jeene (Kenya) b) Public Private Interactions and Implications – Jose Utrera (Netherlands) c) The SACHS report: Increasing the size of the crumbs from the rich man's table – Allison Katz (PHM Geneva) by Maria Zuniga (Nicaragua) d) Health Policy Reform for "Health for All"- Basic Human Needs Approach (Iran) – Md. Ali Barzgar 3) Interactions from the floor

14th January 2004 **17.00 – 19.00** **Parallel Workshop 6**	**<u>Health Teams for 'Health for All' (including CHWs)</u>** **Chair:** Qasem Chowdhury, Vice chancellor, Gono Biswbidyalay, Bangladesh **Moderator:** Prem John, ACHAN (India) 1) Testimonies: a) CHW's in Albania, Roland Bani (Albania) b) Nurses and Migration, Emma Manuel (Philippines) c) The Great Brain Robbery – Vikram Patel (Zimbabwe) d) CHW experience in Palestine (Palestine) 2) Panelists: a) CHW's an overview - Shyam Ashtekar (India) b) Health teams for HFA – R.K. Boodhun (Mauritius) c) Engendering Medical Education – Mira Shiva (India) d) Health teams for HFA- Fran Baum (Australia) 3) Interactions from the floor
14th January 2004 **17.00 – 19.00** **Parallel Workshop 7**	**<u>Traditional / Alternative Systems of Medicine and Primary Health Care</u>** **Chair:** Zafrullah Chowdhury, PHM (Bangladesh) **Moderator:** Vijayan, GK (Bangladesh) 1) Testimonies: a) Perspective of a TBA from Rajasthan – CHETNA (India) b) Understanding Folk medicine – Hari John (India) 2) Panelists: a) Integrating ASMs for Primary Health Care – The GK experience – Vijayan, GK (Bangladesh) b) Revitalisation of local health traditions – Darshan Shankar, FRLHT(India) c) Training of TBAs – Smita Bajpai, CHETNA (India) d) Integrated health policy incl. TSM – D. Bauhadoor (Mauritius) e) Promoting herbal medicines and ASMs – Fr. Sebastian, CHAI (India) f) Integrating ASMs: The GBB course – Vinod, GK (Bangladesh) 3) Responses from other countries – Guatemala, Sri Lanka 4) Interactions from the floor
19.00 –19.15	**Break**
14th January 2004 **19.15 –20.15**	**Cultural Programmes**
15th January 2004	**DAY TWO**
8.00 – 9.00	Interaction/ Fellowship

15th January 2004 **09.00 – 11.00** **Plenary 2**	**HIV/AIDS: Confronting the Crisis** **Chair:** Olle Nordberg (Sweden) **Moderator:** Thelma Narayan (India), David Sanders (South Africa) 1) Testimonies and Regional Reflections a) Ida Makuka (Zambia) b) Chiranuch Premchaipon (Thailand) c) Oblesh (India) d) Rebeca Zuniga (Central America) 2) Panelists a) HIV/ AIDS: Africa's Health Emergency- Malach Orondo (Kenya) b) HIV/ AIDS and Access to Drugs – Lawan Sarawat – MSF (Thailand) c) Health Systems approach to the AIDS challenge – David Sanders, EQUINET/IPHC (South Africa) d) HIV/ AIDS & resurgence of communicable disease- T. Sundaraman (India) e) WHO – Evolving Strategy and Overview: Craig McClure / Ian Grubb (WHO) 3) Interactions from the floor
11.00 – 11.30	**Break**
15th January 2004 **11.30 – 13.30** **Parallel Plenary 3 A**	**Women, Population policies and Violence** **Chair:** **Moderator:** Mira Shiva (India) 1) Testimonies a) MP (India) b) Narendra Gupta -Rajasthan (India) 2) Keynote Presentations a) Population Policies: Mohan Rao (India) b) Targeting Women's Bodies c) Violence as Public health issues – Manisha Gupte.(India) 3) Round Table 1) Farida Akhtar (Bangladesh) 2) Hazra (Pakistan) 3) Nadia (Netherlands) 4) Interactions from the floor

15th January 2004 **11.30 --13.30** **Parallel Plenary 3 B**	**<u>Health Care and the Marginalised</u>** **Chair:** Medha Patkar (India) **Moderator:** Enrico Pupulin (Italy) 1) Testimonies a) Adivasis and health Bijoy (India) b) Dalit Issues and health (India) 2) Panelists: a) Dalit issues and Health - Ruth Manorama (India) b) Health of indigenous people- Hugo Icu Peren (Guatemala) c) Health and people with disabilities -Anita Ghai (India) d) Health care of indigenous people – Fran Baum (Australia) e) Health care of migrant workers – Sajida Ally (Asian Migrants Organisation) 3) Interactions from the Floor
13.30 – 14.30:	**Lunch**
15th January 2004 **14.30 – 16.30** **Parallel Workshop 8**	**<u>Key Issues in Women's Health</u>** **Chair:** **Moderator:** Jaya Velankar (India) 1) Testimonies a) Mary Sandasi (Zimbabwe) b) Elvire Beleoken (Cameroon) 2) Panelists a) Women's Access to Health Care – Nadia (Netherlands) b) Reproductive Technologies: Mayhem on women's bodies– Sarojini(India) c) Trafficking, migration & labour rights – Rina Sengupta(Bangladesh) d) Sex Selective Abortion – Kalpana & Cassa T.N. (India) 3) Interactions from the floor
15th January 2004 **14.30 – 16.30** **Parallel Workshop 9**	**<u>Voices of the Unheard – Children, adolescents and people with disability</u>** **<u>Chair</u> : Pam Zinkin (UK)** **<u>Moderator</u>:** Vandana Prasad (India) 1) Testimonies a) Children's dreams through paintings – Arturo (Ecuador) b) Children's testimonies by Radio – Child to child (Ecuador) c) Mama Huaca Video – Dibujos Animados (Latin America) d) A street child's perspective (India) 2) Panelists: a) Disability and Health - Enrico Pupulin (Italy) b) Child health – The key issues – Vandana Prasad (India) c) Adolescent Health – Usha Nayar (India) d) Disability Movement in Palestine – (Palestine) 3) Interactions from the floor

15th January 2004 **14.30 – 16.30** **Parallel Workshop 10**	**HIV/AIDS and the Resurgence of Communicable Diseases** **Chair : David Sanders** **Moderator: Thelma Narayan (India), Andreas Wulf (Germany)** 1) Testimonies: a) Jennifer Atieno (Kenya) b) Parinchay Health worker, FRCH (India) c) Chiv Bunty, Cambodia d) Perspectives of PLWA,CHIN (India) 2) Panelists: a) HIV/AIDS: Confronting the Crisis - WHO Team b) Lawyers Collective, HIV / AIDS Unit c) CHIN network (India) 3) Interactions from the floor particularly focused on WHO proposed initiatives
15th January 2004 **14.30 – 16.30** **Parallel Workshop 11**	**Globalisation, Poverty, Hunger and Health** **Chair:** Thomas Kocherry, World Forum of Fisherpeople, (India) **Moderator:** Abhay Shukla, PHM (India) 1) Testimonies: a) Poverty in Germany: Gopal Dabade b) Tackling Malnutrition, Shanti, Arogya Iyakkam, Tamil Nadu (India) 2) Panelists: a) Veena Shatrugna (India) b) Sheila Zurbrigg (Canada) c) P. Sainath (India) d) Eugenio Villar (Peru)/ Alaka Singh (WHO) e) PRSP and Health – Atiur Rehman / Jobair Hassan (Bangladesh) 3) Interactions from the floor
15th January 2004 **14.30 – 17.00** **Parallel Workshop 12**	**New Economics and its Impact on Medical Practice in India** **Chair:** Sunil Pandya (India) **Co-Chair:** R. K. Anand (India) **Moderator:** Sanjay Nagral (India) 1) Testimony: a) Lessons from my crusade – P.C. Singhi (India) 2) Panelists: a) Collapse of Public Health and rise of private medicine-B. Ekbal(India) b) New players in the medical market – Ravi Duggal(India) c) Struggle for regulation of private sector –Arun Bal(India) d) Market, medicine, negligence and ethics – Sanjay Nagral (India) 3) Responses from around the world – Pakistan, Bangladesh, Philippines, Iran, UK, Germany, Egypt, South Africa and others 4) Interactions from the floor

15th January 2004 **14.30 – 16.30** **Parallel Workshop 13**	**<u>Social determinants of Mental Health and PHM</u>** "Exploring Poverty, Gender, Stigma, Globalisation and Human Rights issues in Mental Health – Linking them to the People's Charter for Health" **Chair:** **Moderators:** Vikram Patel (India) & Bhargavi Daver (India) 1) Panelists: a) Mani Kalliath – Basic Needs (India) b) Sehra Sajjadi – Iran 2) Interactions from the floor
15th January 2004 **14.30 – 16.30** **Parallel Workshops 14**	**<u>Environmental Justice and People's Health – Confronting Toxics in our Communities</u>** **Chair :** **Moderators:** Jeff Conant, Hesperian (USA) & Sarah Shannon (USA) 1) Testimonies a) Save the Abra River Movement - Anna Leung (Philippines) b) Eloor Community Study – Manu Gopalan and others (India) c) Arsenic poisoning in water – Hilal Uddin (Bangladesh) 2) Panelists: a) Environmental Justice in South Africa - Ferrial Adam (South Africa) b) Mining and human rights abuse – Sofia Bordanave (Argentina) c) Citizen's Action for Pesticides Elimination – Jayan, CHESS (India) d) Health Impacts of Oil impact in the Amazon Rain Forests - Edgar Isch Lopez (Ecuador) e) Medical tourism and toxic waste, Benny Kuruvilla - EQUATIONS (India) 3) Interactions from the floor
16.30 –17.00	**Break**
15th January 2004 **17.00 – 19.00** **Closing Plenary**	**<u>Reviving the Spirit of Alma Ata… the challenges before us</u>** **Chair :** Prof. D. Banerjee (India) **Moderator:** Pam Zinkin (UK) 1) Short inputs from six plenaries and fourteen workshops– from different regions – to lead to the Mumbai Declaration (to be decided on 14th Jan) 2) Additional responses from the floor 3) Releases a) Charters in different languages, b) Language editions of the Million Signature Campaign website c) Some Alma Ata Anniversary publications 4) Concluding overview – B. Ekbal, Convener PHM India

PHM AND HEALTH RELATED EVENTS IN WORLD SOCIAL FORUM 2004
17 – 20 January 2004, MUMBAI

PHM Events

Type of Event	Details of Event
1. **Panel** **(1000 people)** **17 Jan 2004** **1 p.m. to 4 p.m.**	**Theme: 25 years after Alma Ata Declaration on 'Health for All'** • Globalisation and primary health care • Countering the effects of globalization through campaigns and community action • Planning resistance and formulating joint action **(Organised by PHM and others)** **Chair:** **Moderator:** B. Ekbal (PHM, India) Testimonies from a few health workers and others from different countries Panelists 1) Medha Patkar – Access to Health Resources (NAPM India) 2) David Sanders – An African Perspective (PHM /IPHC, South Africa) 3) Maria Hamlin Zunega – A Latin American Perspective (PHM/ IPHC, Nicaragua) 4) Edelina de la Paz – Globalisation and PHC (Philippines) 5) Nadia van der Linde – Women's Access to Healthcare Campaign (WGNNR, Netherlands) 6) Abhay Shukla - Right to Health Campaign (PHM, India) Release of Charters and publications Concluding remarks
2. **Seminar** **(200 people)** **17 Jan 2004** **1 p.m. to 4 p.m.**	**Theme: WTO and Access to Drugs** **(Organised by PHM, BUKO Pharma – Kampagne, Lawyer's Collective and others)** **Chair:** Christian Wagner **Moderator:** Amitava Guha • Access to treatment and Right to Health • WTO and access to drugs • Social consequences of patents on medicine with ARVs as an example • TRIPS and its impact on innovation, R&D, drug prices and self reliance • Alternatives and campaign strategies • Linking campaign groups and civil society **Panelists** 1) Christian Fisher (BUKO Pharma Kampagne, Germany) 2) Dinesh Abrol (DSF, India) 3) Zafar Mirza (Consumer Network, Pakistan) 4) Zafrullah Chowdhury (GK Pharmaceuticals, Bangladesh) 5) Ellen t'Hoen (MSF) 6) Chinu Srinivasan (LOCOST, India) 7) Amit Sengupta (AIPSM, India) 8) Vinod (Lawyers Collective, India) 9) Lawan Sarogat (MSF Thailand) 10) Olivier Brouant (MSF India)

3. **Large Seminar** **(400 people)** **18 Jan 2004** **1 p.m. to 4 p.m.**	**Theme: "Wars, Conflicts, Occupation and Militarisation- the greatest threat to public health"** **(Organised by PHM and others)** 1) Key note address: a) Impacts of militarisation and sanctions – Hans Van Sponeck b) Weapons vs. People – Rosalie Bertell 2) Testimonies a) Impact of agent Orange – Vietnam b) Chemical Warfare: a present danger – Edgar Isch Lopez, Ecuador c) Palestine –Jihad Mashal, UPMRC (Palestine) d) Occupation and Landmines – Afghanistan e) Iraq – Geert Van Moorter, Medical Aid for Third World (Iraq) 3) Media - Lessons from past & building peace – Sharmini Boyle (Sri Lanka) 4) Resist Wars! The Relevance of small arms campaign – Irene Khan, Amnesty International (UK) 5) Discussions
4. **Large Seminar** **(400 people)** **18 Jan 2004** **1 p.m. to 4 p.m.**	**Theme: Population Policies and Women's Health** **(Organised by PHM, Prayas and others)** • Coercive population stabilization framework • Rajasthan: A case study • Health and psychological damage on the lives of women • ICPD policy shifts and reversal to targets • Campaigns against coercive population control action plans

Other PHM Events

5. **Seminar** **(200 people)** 17 Jan 2004 **1 p.m. to 4 p.m.**	**Theme: Gas and Natural Resources: Corporate Powers and Challenges** **(Organised by PHM – Bangladesh Circle, GK, WRF, DORP, DCI)**
6. **Testimonies** **(200 people)** 18 Jan 2004 **1 p.m. to 4 p.m.**	**Theme: Water Rights in South Asia: Options and Challenges** **(Organised by : PHM – Bangladesh Circle, Development Center International, Angikar Bangladesh, Workers Rights Forum, Development Organisation of the Rural poor)**
7. **Workshop** **(200 people)** 19 Jan 2004 **9a.m. to 12 a.m.**	**Theme: Migration, Trafficking and Labour Rights: Bangladesh Perspectives** **(Organised by : PHM – Bangladesh Circle, Workers Rights Forum, Mukta Nari –o– Shishu Unnayan Sangstha, Sammilitha Sramik Forum and others)**
8. **Workshop** **(200 people)** 20 Jan 2004 **9a.m. to 12 a.m.**	**Theme: Privatisation and Healthcare : Social Challenges in Bangladesh** **(Organised by : PHM – Bangladesh Circle, Ganosastya Kendra, Prakitatjon, DORP, HDSS)**

PHM partner related events *(This list is not conclusive. WSF Delegates are advised to look at the WSF programme schedule or website for detailed and complete information)*

9. Seminar	**Women's Access to Health' campaign – "From Rights to Actions" (WGNRR)**
10. Seminar	**Violence Against Women (CEHAT)**
11. Seminar	**Poverty in Germany (BUKO Pharma - Kampagne, Germany)**
12. Seminar	**Reproductive technologies: Implication for women's health (CWP, CGS, UBINIG, Sama)**

In addition to above programme, the IHF and WSF event will also offer opportunities for:

1. PHM Media Strategy (including media events and daily media releases during IHF and WSF

2. Health Materials Promotional Facilities (including stalls, facilities for poster exhibition, etc.)

3. Cultural Programmes

4. Testimonies

Note: Some of the speakers in the above programme are yet to be confirmed. The programme schedule is subject to modification, depending on the confirmations.

Annexure 4

HEALTH RELATED LEGISLATION IN KARNATAKA

NAVEEN I. THOMAS

September 2003

COMMUNITY HEALTH CELL
Society for Community Health Awareness, Research & Action (SOCHARA)
Bangalore, India

Introduction

If the number of laws a land possessed were an indicator of a law-abiding society, India would have been highly ranked among the nations of the world. However, the mere possession of laws and other legal instruments do not ensure a law-abiding society, instead it just adds to the notion of lawlessness (more the laws, more will be the incidents of violations). However, legislations and legal instruments provide an avenue, which could be harnessed by an aware and vigilant civil society to ensure order and social justice.

The need for a vigilant and pro-active civil society has become all the more necessary in view of legislations and decisions increasingly being taken at a global level, way beyond the reach of local communities and very often, even national governments. The World Trade Organisation (WTO) negotiations is a case in point, where nations and continents are subdued into agreeing to norms and agendas that are very often set by powerful Trans-National Corporations (TNCs). However, WTO is not the only mechanisms for remote access and control of national resources and economies. Aid and loan given by industrialized nations and multi-lateral organisations like the World Bank to less-industrialized nations, are often means of coercing them to budge to the machination of powerful vested interests. The governments of the less-industrialized nations have repeatedly failed to stand up to such devices. In such a scenario, it is important for the civil society to be pro-active and work towards strengthening the existing spaces available for people to have access and control over their resources.

Much has been written about the impact of globalization on health. Even the National Health Policy 2001 makes a note of the threats faced by people due to globalization. However sadly, the Government action has been to reduce it's spending on health, even while taking the LPG (liberalization, privatization and globalization) route. More than 80% of health spending is already in the private sector. The opening up of the health sector under the General Agreement of Trade in Services (GATS) could see further changes in the health care scenario in the country.

There is a dire need to explore different ways in which health of the people can be secured. Prioritization of health spending, increasing the health budget and strengthening the policy and legal environment are a few of the ways, in which this can be achieved. Strengthening the policy and legal environment helps people to stake a claim to health and health care as a right, if it is accompanied with proper enforcing, monitoring, redressing and mass-awareness creating mechanisms. The role of civil society in supporting the process cannot be over-emphasized here.

The knowledge of existing legislation is the first step in enforcing or improving the policy and legal environment. This document attempts to put together the legislations in Karnataka which form a major part of the existing policy environment in the state. However this has to be seen in the context of other policies and practices including the functioning of the Taskforce on Health which was set up the state Government, role of judiciary, rules framed under various Acts and regulations of local bodies like corporations, municipalities, panchayats, etc. and Government Orders (G.O.).

This purpose of this document is to serve a handbook for NGOs, health activists, academicians, Government functionaries, media persons and anybody who wishes to know the existing Acts as provided by the Karnataka state. It has been updated up to December 2002. A few important Acts passed in 2003 have also been included. The website of the Department of Parliamentary Affairs and Legislation, Government of Karnataka (http://dpal.kar.nic.in/) came in handy for preparing the handbook.

This handbook is only a preliminary document and needs to be expanded further to include laws and policies applicable at different levels. A critique of the contents of these laws and policies are also needed for an informed debate and policy refinement. That would be the next step in this journey!

24 Sep 2003

Note: The following section lists the various Acts of Karnataka state, which have a link with health. The Acts of Karnataka state have been divided into seven sections:

1) Health related Acts
2) Agriculture/ Veterinary/ Animal related Acts
3) Urban related Acts
4) Rural related Acts
5) Tobacco/ Alcohol related Acts (including industrial use)
6) General Acts

Health related Acts

Sl.	Act	Amendment(s) / Remarks
1.	Anatomy Act, 1957 (23 of 1957)	Amended by Act 15 of 1999
2.	Ayurvedic, Naturopathy, Siddha, Unani and Yoga (Registration and Medical Practitioners) Miscellaneous Provisions Act, 1961 (9 of 1962)	Amended by Act 9 of 1966, 32 of 1966, 3 of 1968, 8 of 1969, 13 of 1972, 7 of 1977, 46 of 1981, 38 of 1991 and 11 of 1992
3.	Health Cess Act, 1962 (28 of 1962)	Amended by Acts 19 of 1968, 33 of 1976
4.	Medical Registration Act, 1961 (34 of 1961)	
5.	Nurses, Midwives and Health Visitors Act, 1961 (4 of 1962)	Amended by Act 27 of 1981
6.	Private Nursing Homes (Regulation) Act, 1976 (75 of 1976)	Amended by Act 9 of 1977
7.	Rajeev Gandhi Health Sciences University Act, 1994 (44 of 1994)	Amended by Act 11 of 1998
8.	District Vaccination Act 1892 (Bombay Act I of 1892)	Act which is in force in Belgaum area
9.	Drugs (Control) Act, 1952, (Bombay Act XXIX of 1952)	Act which is in force in Belgaum area
10.	Female Infanticide Prevention (Amendment) Act, 1897 (Bombay Act III of 1897)	Act which is in force in Belgaum area
11.	Indian Lunacy (Bombay Amendment) Act, 1938 (Bombay Act XV of 1938)	Act which is in force in Belgaum area
12.	Nursing Homes Registration Act, 1949 (Bombay Act XV of 1949)	Act which is in force in Belgaum area
13.	Vaccination Act, 1877 (Bombay Act I of 1877)	Act which is in force in Belgaum area
14.	Indian Medical Degrees (Coorg Amendment) Act, 1949 (Coorg Act IV of 1949)	Act which is in force in Coorg area
15.	Public Health Act, 1943 (Coorg Act I of 1943)	Act which is in force in Coorg area
16.	Vaccination Act, 1950 (Coorg Act IV of 1950)	Act which is in force in Coorg area
17.	Infections Diseases Act, 1950 (Hyderabad Act XII of 1950)	Act which is in force in Gulbarga area
18.	Vaccination Act, 1951 (Hyderabad Act XXIV of 1951)	Act which is in force in Gulbarga area
19.	Dangerous Drugs (Madras Amendment) Act, 1950 (Madras Act XVI of 1950)	Act which is in force in Mangalore – Kollegal area
20.	Drugs (Control) Act, 1949 (Madras Act XXX of 1949)	Act which is in force in Mangalore – Kollegal area
21.	Medical Degrees (Madras Amendment) Act, 1940 (Madras Act XX of 1940)	Act which is in force in Mangalore – Kollegal area
22.	Opium and Dangerous Drugs (Madras Amendment) Act, 1947 (Madras Act XXXIV of 1947)	Act which is in force in Mangalore – Kollegal area

23.	Opium (Madras Amendment) Act, 1951 (Madras Act XXXII of 1951)	Act which is in force in Mangalore – Kollegal area
24.	Public Health Act, 1939 (Madras Act III of 1939)- Amended by Karnataka Act 13 of 1965, 83 of 1976.	Act which is in force in Mangalore – Kollegal area
25.	Tuberculosis Sanetoria (Regulation of Buildings) Act, 1947 (Madras Act XVI of 1947)	Act which is in force in Mangalore – Kollegal area
26.	Drugs Control Act 1950 (Mysore Act V of 1950)	Act which is in force in Mysore area
27.	Lepers Act, 1925 (Mysore Act IV of 1925)	- Act which is in force in Mysore area - Amended by Karnataka Act 13 of 1965
28.	Public Health Act, 1944 (Mysore Act 10 of 1944)	- Act which is in force in Mysore area - Amended by Karnataka Act 13 of 1965
29.	Vaccination Act, 1906, (Mysore Act I of 1906)	- Act which is in force in Mysore area

Agriculture/ Veterinary/ Animal related

Sl.	Act	Amendment(s) / Remarks
1.	Agricultural Pests and Diseases Act, 1968 (1 of 1969)	
2.	Animal Diseases (Control) Act, 1961 (18 of 1961)	
3.	Live-Stock Improvement Act, 1961 (30 of 1961)	
4.	Sheep and Sheep Products Development Act, 1973, (12 of 1974)	- Amended by Acts 22 of 1978 and 20 of 1980 - Proposed for Repeal
5.	Prevention of Cruelty to Animals (Bombay Amendment) Act, 1953 (Bombay Act XXII of 1953)	Act which is in force in Belgaum area
6.	Prevention of Cruelty to Animals, the Bombay District Police and the City of Bombay Police (Amendment) Act, 1946 (Bombay Act XXVIII of 1946)	Act which is in force in Belgaum area
7.	Improved Seeds and Seedling Act, 1951 (Hyderabad Act XXVIII of 1951)	Act which is in force in Gulbarga area
8.	Restriction of Cash Crops Cultivation Regulation (Repealing) Act, 1953 (Hyderabad Act XIV of 1953)	Act which is in force in Gulbarga area
9.	Slaughter of Animals Act, 1950 (Hyderabad Act VII of 1950)	Act which is in force in Gulbarga area

Urban

Sl.	Act	Amendment(s) / Remarks
1.	Bangalore Water Supply and Sewerage Act, 1964 (36 of 1964)	Amended by Acts 6 of 1966, 10 of 1966 and 18 of 1984
2.	Prohibition of Beggary Act, 1975 (27 of 1975)	Amended by Acts 7 of 1982 and 12 of 1988
3.	Karnataka Slum Areas (Improvement and Clearance) Act, 1973 and Karnataka Public Premises (Eviction of Unauthorized Occupants) Act, 1974 (33 of 1974)	Amended by Acts 19 of 1981, 34 of 1984, 26 of 1986, 7 of 1988 and 21 of 2002
4.	Urban Water Supply and Drainage Board Act, 1973 (25 of 1974)	Amended by Acts 7 of 1976, 20 of 1977, 45 of 1981 and 19 of 1993

5.	Urban Development Authorities Act, 1987 (34 of 1987)	Amended by Acts 17 of 1991, 14 of 1992 and 12 of 1996
6.	The Karnataka Slum Areas (Improvement and Clearance) and Certain Other Law (Amendment) Act, 2002 (21 of 2002)	

Rural

Sl.	Act	Amendment(s) / Remarks
1.	Panchayat Raj Act 1993 (14 of 1993)	Amended by 10 of 1995, 9 of 1996, 17 of 1996, 1 of 1997, 10 of 1997, 29 of 1997, 29 of 1998, 10 of 1999, 21 of 1999, 8 of 2000, 11 of 2000 and 30 of 2001
2.	Village Defence Parties Act, 1964 (34 of 1964)	Amended by Act 22 of 2000
3.	Village Offices Abolition Act, 1961 (14 of 1961)	Amended by Acts 8 of 1968, 13 of 1978, 27 of 1984, 47 of 1986 and 22 of 2000

Tobacco/ Alcohol Related

Sl.	Act	Amendment(s) / Remarks
1.	Excise Act, 1965 (21 of 1966)	Amended by Acts 1 of 1970, 1 of 1971, 61 of 1976, 32 of 1982 28 of 1987, 36 of 1987, 1 of 1994, 2 of 1995. 7 of 1997, 21 of 98, 12 of 1999, 21 of 2000 and 15 of 2001
2.	Prohibition Act, 1961 (1 of 1962)	Amended by Act 10 of 1967
3.	Prohibition of Smoking in Show Houses and Public Halls Act, 1963 (30 of 1963)	
4.	Toddy Worker's Welfare Fund Act, 1981 (31 of 1994)	
5.	The Karnataka Prohibition of Smoking and Protection of Health of Non-Smokers Act, 2001 (2 of 2003)	
6.	(District) Tobacco Act, 1933 (Bombay Act II of 1933)	Act which is in force in Belgaum area
7.	Opium Smoking Act, 1936 (Bombay Act XX of 1936)	Act which is in force in Belgaum area
8.	Smoke-nuisances Act, 1912 (Bombay Act VII of 1912)	Act which is in force in Belgaum area
9.	Tobacco Duty (Town of Bombay) Act, 1857 and the Bombay (District) Tobacco Act, 1933 (Suspension) Act, 1945 (Bombay Act XI of 1945)	Acts which are in force in Belgaum area
10.	Power Alcohol Act, 1350 F (Hyderabad Act XI of 1350 F)	Act which is in force in Belgaum area
11.	Cigarette- Tobacco Safeguarding Act, 1939 (Mysore Act VI of 1939)	Act which is in force in Mysore area
12.	Power Alcohol Act, 1939, (Mysore Act VIII of 1939)	Act which is in force in Mysore area

General

Sl.	Act	Amendment(s) / Remarks
1.	Civil Services (Prevention of Strikes), Act, 1966 (30 of 1966)	Amended by Act 6 of 1967
2.	Civil Services (Regulation of Promotion, Pay & Pension) Act, 1973 (11 of 1974)	Amended by Acts 40 of 1976 and 25 of 1982
3.	Co-operative Societies Act, 1959 (11 of 1959)-	Amended by Acts 40 of 1964, 27 of 1966, 16 of 1967, Presidents Act 1 of 1972, Karnataka Acts 14 of 1973, 2 of 1975, 39 of 1975, 19 of 1976, 70 of 1976, 71 of 1976, 14 of 1978, 16 of 1979, 3 of 1980, 4 of 1980, 5 of 1984, 34 of 1985, 34 of 1991, 25 of 1998, 2 of 2000, 13 of 2000, 6 of 2001 and 24 of 2001
4.	Debt Relief Act, 1976 (25 of 1976)	Amended by Act 63 of 1976
5.	Departmental Inquiries (Enforcement of attendance of Witnesses and Production of Documents) Act, 1981 (29 of 1981)	Amended by Acts 43 of 1981 and 28 of 1986
6.	Devadasis (Prohibition of Dedication) Act, 1982 (1 of 1984)	
7.	Evacuee Interest (separation) Supplementary Act, 1961 (3 of 1961)	
8.	Existing Laws (Construction of References to Values) Act, 1957 (12 of 1957)	
9.	Essential Services Maintenance Act, 1994 (21 of 1994) (for a period of 10 years from the date of commencement i.e., 16-4-1994)	
10.	Famine Relief Fund Act, 1963 (32 of 1963)	
11.	Lokayukta Act, 1984 (4 of 1985)	Amended by Act 15 of 1986, 31 of 1986, 1 of 1988 and 30 of 1991
12.	Prohibition of Admission of Students to the Un- recognised and Un-affiliated Educational Institutions Act, 1992 (7 of 1993)	
13.	Resettlement of Project Displaced Persons Act, 1987 (24 of 1994)	
14.	Repealing and Amending Act, 2000 (22 of 2000)	
15.	Right to information Act, 2000 (28 of 2000)	
16.	Societies Registration Act, 1960, (17 of 1960)	Amended by Acts 1965, 20 of 1975, 65 of 1976, 7 of 1978, 48 of 1986, 11 of 1990, 9 of 1999, 7 of 2000 and 6 of 2002
17.	State Aid to Industries Act, 1959 (9 of 1960)	Amended by Acts 3 of 1964 and 20 of 1978
18.	State Commission for Women Act, 1995 (17 of 1995)	
19.	State Universities Act, 2000 (29 of 2001)	
20.	Transparency in Public Procurement Act 1999 (29 of 2000) and 21 of 2001	
21.	The Karnataka Fiscal Responsibility Act, 2002 (16 of 2002)	

22.	Charitable Endowments Act, 1890. (Central Act 6 of 1890)	This is a Central Act which has been amended by the Karnataka Act 19 of 1973
23.	Famine Relief Fund Act, 1936 (Bombay Act XIX of 1936)	Act which is in force in Belgaum area
24.	Fodder and Grain Control Act, 1939 (Bombay Act XXVI of 1939)	Act which is in force in Belgaum area
25.	Growth of Foodcrops Act, 1944 (Bombay Act VIII of 1944)	Act which is in force in Belgaum area
26.	Hindu Women's Rights to Property (Extension to Agricultural Lands) Act, 1947 (Bombay Act XIX of 1947)	Act which is in force in Belgaum area
27.	Molasses (Control) Act, 1956 (Bombay Act XXXXVIII of 1956)	Act which is in force in Belgaum area
28.	Refugees Act, 1948 (Bombay Act XXII of 1948)	Act which is in force in Belgaum area
29.	State Guarantees Act, 1954 (Bombay Act XXII of 1954)	Act which is in force in Belgaum area
30.	Village Industries Act, 1953 (Bombay Act XLI of 1954)	Act which is in force in Belgaum area
31.	(Emergency Powers) Whipping Act, 1947 (Bombay Act XXVII of 1947)	Act which is in force in Belgaum area
32.	Abolition of Whipping Act, 1956 (Hyderabad Act XXXVI of 1956)	Act which is in force in Gulbarga area
33.	Children Protection Act, 1343 F (Hyderabad Act IX of 1343 F)	Act which is in force in Gulbarga area
34.	Famine (Stricken Pettadars Property Protection Act, 1931 F (Hyderabad Act III c.1381 F)	Act which is in force in Gulbarga area
35.	Labour Housing Act, 1952 (Hyderabad Act XXXVI of 1952)	Act which is in force in Gulbarga area
36.	Mining Settlements Act, 1956 (Hyderabad Act XLIV of 1956)	Act which is in force in Gulbarga area
37.	Poisons Act 1322 F (Hyderabad Act IV of 1322 F)	Act which is in force in Gulbarga area
38.	Protection of Flood Stricken Debtors Property Act, 1318F (Hyderabad Act I of 1318 F)	Act which is in force in Gulbarga area
39.	Protection of Houses from the Floods of Mossi River Act, 1318 F (Hyderabad Act II of 1318 F)	Act which is in force in Gulbarga area
40.	Sati Regulation, 1830 (Madras Regulation I of 1830)	Act which is in force in Mangalore – Kollegal area
41.	Essential Articles Control and Requisitioning (Temporary Powers) Act, 1949 (Madras Act XXIX of 1949)	Act which is in force in Mangalore - Kollegal area
42.	Essential Articles Control and Requisitioning (Temporary Powers Re-enacting) Act, 1956 (Madras Act VI of 1956)	Act which is in force in Mangalore - Kollegal area
43.	Famine Relief Fund Act, 1936 (Madras Act XVI of 1936)	Act which is in force in Mangalore - Kollegal area
44.	Prevention of Couching Act, 1945 (Madras Act XXI of 1945)	Act which is in force in Mangalore - Kollegal area
45.	Rivers Conservancy Act, 1884 (Madras Act VI of 1884)	Act which is in force in Mangalore - Kollegal area
46.	Abolition of Whipping Act, 1949 (Mysore Act XII of 1949)	Act which is in force in Mysore area

47.	Betting Tax Act, 1932 (Mysore Act IX of 1932)	- Act which is in force in Mysore area - Amended by Karnataka Acts 11 of 1958, 7 of 1974, 22 of 1980, 20 of 1981, 21 of 1989, 18 of 1994, 6 of 1995, of 1997, 3 of 1998, 5 of 2000
48.	Essential Service (Maintenance) Act, 1942 (Mysore Act XXIII of 1942)	Act which is in force in Mysore area
49.	Limitation (War Conditions) Act, 1947 (Mysore Act I of 1947)	Act which is in force in Mysore area
50.	Lotteries and Prize Competitions Control and Tax Act, 1951 (Mysore Act XXVII of 1951)	- Act which is in force in Mysore area - Amended by Karnataka Acts 26 of 1957, 13 of 1965)
51.	Pension Act, 1871 (Mysore Act XXII of 1871)	Act which is in force in Mysore area
52.	Poisons Act, 1910 (Mysore Act 10 of 1910)	Act which is in force in Mysore area

Annexure 5

LAW AND ETHICS IN PUBLIC HEALTH
– THE CASE OF PHARMACEUTICAL POLICY 2002

PROJECT ASSIGNMENT
POST GRADUATE DIPLOMA IN MEDICAL LAW AND ETHICS

NAVEEN I. THOMAS

May 2004

THE INSTITUTE OF LAW AND ETHICS IN MEDICINE
NATIONAL LAW SCHOOL OF INDIA UNIVERSITY
BANGALORE

...to all those people

who have been

denied access to health care ...

ACKNOWLEDGEMENTS

To be convicted can often be demoralising, but in same cases it can be challenging and lead the person to begin a new journey and reach new heights. I felt deeply troubled by the fact that all my efforts in life were aimed at making a better life for myself. The studies, the ambitions, the goal and the purpose was to have a comfortable tomorrow for myself. But the message of Christ convicted me and made me question the path that I was to take; and that has brought me to where I am today. To my Convictor and Redeemer, is my first offer of gratitude.

I am ever grateful to my parents, grandmother and sister who encouraged me to do the Medical Law and Ethics Course and persevere in it, in spite of my laziness. I thank my wife Santhy, who kept me going through the project with her prayers and encouragement.

Dr. C.M. Francis, Dr. Thelma Narayan and Dr. Ravi Narayan took a personal interest in this project, in spite of their busy schedules; they were always there to brainstorm, critique, give ideas and encourage me. This project would not have been complete without their support. Dear ma'am and sirs, I can never repay you for the valuable time and inputs you have given me, but let me promise you that I will share whatever little knowledge I have, with others, as freely as you have done. Thank you.

I thank the entire team at TILEM, including the guest faculty who contributed to this course and added to our learning. Mangala, the 'visible voice and face' of TILEM, also deserves a word of praise for all the help given to us. Special thanks to my friends, Mita and Anant, who did the course with me and encouraged me all through. Savio from Oxfam GB was very encouraging about the course. Thanks to him too.

For me, this course was a means to learn about how people could be helped to access healthcare as a right. I gratefully acknowledge all those people who have been denied access to health care for whatever reason. They have been my motivation and inspiration to do this course, and their project report is dedicated to them.

Naveen J. Thomas

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I INTRODUCTION

"At the door stood Death. She said 'I smelled your rooster
and I came along to help you eat it?
'And why not', said the man.
'Aren't you one who treats everyone alike?'
'That is so,' said Death. 'I have no favourites,
the poor, the rich, the young, the old, the sick, the well – all look alike to me.'
'That is the reason you may come in and share my food' said the man.
Death entered and the two had a grand feast."

- ***Aurora Lucero White Lea*** [6]

For death, all may be equal and may treat everyone alike, but the same cannot be said for the living. The disparity in socio-economic indicators between people of different ethnic, gender, region, religion, caste and income groups could be so marked that some groups may not even reach up to the lowest indicators of other groups. This disparity can be seen vividly in health indicators of people[7]. Some important indicators have been included in the section on Health, Healthcare and Drug Situation in India. Martin Luther King, Jr. once said, "of all the forms of inequality, injustice in healthcare is the most shocking and inhumane". [8]

METHODOLOGY

Statement of Purpose

Having completed my Master's degree in Medical and Psychiatric Social Work and working on health related issues brought me face-to-face with the interface between health issues, law and public policy. That prompted me to take up the course on Medical Law and Ethics. The purpose of joining the course was to learn about how people could be helped to access 'healthcare as a right'. This led me into the area of Ethics and Public Policy. The purpose of this paper is to examine law and ethics involved in formulating health related policy.

[6] Quoted in M. L. Kothari and L. A. Mehta, *Living, Dying* (Goa: The Other Indian Press, 1992)
[7] The World Health Report 2002, WHO, Switzerland
[8] Quoted in Down to Earth, 15 March 2003

"The health policy of a state or a nation depends on its value system'. 9 What value system does a secular state adopt – cultural, traditional, religious, a mix of all these or that of the dominant groups? A survey of literature of Health Ethics revealed two broad categories of influences – one, that is religious in origin and two ' that is 'medical profession' related. While Public Health Ethics draws from both the spheres, a more comprehensive ethics framework would extend it to include social justice and equity in health. This is not to discount the fact that religious texts or medical ethics contain values of social justice; the lacunae can be seen as a limitation in exposition of existing literature on the topic. This paper attempts to fill this gap by drawing up a framework of Public Health Ethics, which helps one to understand the process of policy formulation better and analyse it in the given context. An example of a recent policy – The Pharmaceutical Policy 2002 has been used as case-study for analysis, using the framework of Public Health Ethics.

Focus of Research

The primary questions researched in this paper are:

1) To determine the basis of Public Health Law and Ethics.
2) Policy Environment: What is the healthcare and drug situation in the country – the basis on which health related policy is formed?
3) To ascertain the link between Pharmaceutical Policy 2002, Public Health Ethics and the existing policy environment.

Research Method

A literature survey was conducted to obtain information on the above research questions. The list of books and articles surveyed are included in the Bibliography. The source of data was 'secondary', and can be broadly classified into 4 types.

1) General ethics and ethics related to health, medicine, science and technology.
2) Health reports and health policy related.
3) Drug-issues (including Pharmaceutical Policy 2002) and drug industry related.
4) Laws related to Health and Healthcare.

Due to the medicalisation of health, the analysis of health related issues is often limited to 'cause and effect' analysis. However health, being related to 'development' at one end of the spectrum and to the 'individual' at the other end, an ethical analysis

[9] C. M. Francis, *Medical Ethics* (New Delhi: Jaypee, 1993)

needs to be more comprehensive. This paper uses a reflective and dialectical discourse approach, while trying to raise questions and be non –judgemental.

The use of such approaches to ethical analysis of public health is also a step towards taking health away from the closed confines of 'medical profession' into the hands of society and the community. As Henry Sigerist, the famous medical historian said, "War against disease and for health cannot be fought by physicians alone. It is a people's war in which the entire population must be mobilized permanently".[10] The use of this analysis and the conclusions therein will also contribute to strengthen the voice of the voiceless and that of movements like the People's Health Movement who strive to work for equity and justice in health.

[10] .Quoted in Health Action, September 2003.

II PUBLIC HEALTH ETHICS, LAW AND POLICY

'If Swaraj was not meant to civilize us, and to purify and stabilize our civilization, it would be worth nothing. The very essence of our civilization is that we give a paramount place to morality in all our affaires, public or private'.

(Mahatma Gandhi, 23 January 1930, Young India, p. 26) [11]

I would like to base this paper and the analysis contained in it, on an ethical framework presented by Mahatma Gandhi during his life and struggle for India's freedom. The framework is relevant as we examine public health ethics from a perspective of health, not just begin' absence of disease', but as a 'right of every individual to enjoy and attain the highest state of well being'. Thus, 'health' transcends the realm of just being a 'medical' issue, and moves on to being on an 'existential' plane. While it would not be wrong to call it 'Gandhian Health Ethics', I would avoid usage of the term, for fear of not fully integrating the essence of his message into the analytical framework on health.

Swaraj and Public Health

Gandhi, writing in young India (19 March 1931), explained the meaning of *swaraj* (a vedic word) as meaning 'self-rule' and 'self restraint', and not freedom from all restraint which 'independence' often means! In the context of public health, *swaraj* refers to 'self rule', where the person enjoys the freedom to attain his/her highest state of well being in the manner s/he chooses. But *swaraj* is not complete without 'self restraint', where the person's way of life does not impinge of the right of others or themselves to attain the highest state of well being. Very loosely put, it can be termed as 'rights with responsibility'. A right, which can be claimed with authority, arising out of the fact that one is themselves respecting the rights of others. This is what Gandhiji called *Ramaraj* –i.e. sovereignty of the people based on pure moral authority'.[12]

[11] Young India, 23 January 1930, p. 26 quoted in M.K. Gandhi, *Village Swaraj* (H. M. Vyas ed., Ahmedabad: Navajivan Publishing House, 1962)
[12] *Harijan*, 2 January 1937, p. 374 quoted in M.K. Gandhi, *Village Swaraj* (H. M. Vyas ed., Ahmedabad: Navajivan Publishing House, 1962)

Swaraj – A Universal Concept

Swaraj in public health as in any other sphere, is an egalitarian term, and is certainly attainable, as it arises out of every human being need to be treated with respect. It does not discriminate between race or religious distinction, however it is for all, 'including the farmer, but emphatically including the maimed, the blind, the starving toiling millions'.13 In public health it translates into, all people everywhere, irrespective of their caste, gender, vocation or location being able to attain the highest state of well being, and having an environment which promotes it.

Poorna Swaraj and *Swaraj* of the Poor

Gandhiji said that his dream of *swaraj* was a 'poor person's *swaraj*', where the ordinary amenities of life that a rich person enjoyed was available to all.[14] He further added that *swaraj* was not *poorna* (complete) *swaraj* until basic amenities was guaranteed to all. In public health, the provision of accessible, affordable, and availability of quality health services is of primary importance. If *swaraj* is to be attained these services need to be given as a 'right' to all people, everywhere.

Price of *Swaraj* – Truth and *Ahimsa*

Swaraj comes at a price. As Gandhiji put it, '*Swaraj* has got to be won, worked and maintained through truth and *Ahimsa* alone'.[15] Untruth, false promises and illusions in development have become the order of the day in development; in the medical profession it has reached menacing proportions. The practise of prescribing drugs of select companies in return for monetary and other considerations is increasing.[16] To achieve *swaraj* one needs to be true to oneself as to others. Gandhiji has given the correlation between *swaraj* based on *ahimsa* and health, while writing in *Harijan*, in the issue dated 25th March 1939, 'Under *swaraj* based on *ahimsa*, nobody is anybody's enemy; everyone contributes his or her due quota to the common goal;

13 Young India, 1 May 1930 quoted in M.K. Gandhi, Village Swaraj (H. M. Vyas ed., Ahmedabad: Navajivan Publishing House, 1962)
14 Young India, 23 January 1930 quoted in M.K. Gandhi, *Village Swaraj* (H. M. Vyas ed., Ahmedabad: Navajivan Publishing House, 1962)
15 *Harijan*, 27 May 1939 quoted in M.K. Gandhi, *Village Swaraj* (H. M. Vyas ed., Ahmedabad: Navajivan Publishing House, 1962)
16 A detailed study on the nexus between doctors and pharmaceutical companies is available on www.issuesmedical.ethics.org

their knowledge keeps growing from day to day. Sickness and diseases are reduced to a minimum'. [17]

Ahimsa and Public Health

Ahimsa in healthcare is a proactive concept, where one does limit oneself to not harming others, but actively contributes to working on a common goal so that the society is benefited. *Ahimsa* values the worth of the 'other' as that of its own self, and strives to work towards its upliftment. Here, the values and worth of every individual is as important as that of the whole. Speaking of *swaraj*, Gandhiji said that, '*swaraj* of a people means the sum total of *swaraj* of individuals'.[18] *Swaraj* in healthcare will only be reality, when the self-rule is based on health rights which, arises from a due performance of one's large duties to the self, society, environment, etc. Gandhiji was speaking about such a *swaraj* when he translated an Indian song into English – the song speaks about his vision of such a land – a land where swaraj reigns.

We are the inhabitants of a country where there is no suffering and pain
Where there is no illusion or anguish, no delusion nor desire,
Where flows the Ganges of love and the whole creation is full of joy,
Where all minds flow in one direction, and where there is no occasion of sense of time,
All have their wants satisfied;
Here all barter is just, here all are cast in the same mould
No selfishness in any shape or form, no high no low, no master, no slave;
All is light, yet no burning heat,
That country is within you – It is Swaraj, Swadeshi,
The home within you –
Victory ! Victory ! Victory !
He realises it who longs for it.[19]

[17] *Harijan*, 25 March 1939 quoted in M.K. Gandhi, *Village Swaraj* (H. M. Vyas ed., Ahmedabad: Navajivan Publishing House, 1962)
[18] *Harijan*, 25 March 1939 quoted in M.K. Gandhi, *Village Swaraj* (H. M. Vyas ed., Ahmedabad: Navajivan Publishing House, 1962)
[19] Mahatma Gandhi – The Last Phase, 1956, Vol I, pp. 190 - 91 quoted in M.K. Gandhi, *Village Swaraj* (H. M. Vyas ed., Ahmedabad: Navajivan Publishing House, 1962)

Right to Life – The Indian Law and Policy

As seen in the freedom derived from the concept of *swaraj*, the constitution too guarantees the Right to Life. The Supreme Court in its rulings have interpreted the Fundamental Right to Life, as stated in Article 21 of the Indian Constitution to include right to health, as it is essential for human existence and is, therefore an integral part of the right to life. This judgement was given in Consumer Education and Resource Centre vs. Union of India case,[20] where the court also held that humane working conditions, health services and medical care are an essential part of Article 21.[21] On the issue of providing public health rights to Indian citizens, the Supreme Court judgements are in addition to the Directive Principles of the State Policy outlined in Constitution. Article 42 states "**Provision for just and humane conditions of work and maternity relief** – The state shall make provisions for securing just and humane conditions of work and for maternity relief", Article 47 states "**Duty of the State to raise the level of nutrition and the standard of living and to improve public health** – The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health".[22] The existing legislations in country are another source for citizens to claim their right to life and health.

[20] AIR 1995 SC 636
[21] PHM, *Position paper on Right to Healthcare'* (Mumbai: PHM, 2003)
[22] Part IV, Constitution of India adopted on 26th November 1949 quoted in PHM, *Position paper on Right to Healthcare'* (Mumbai: PHM, 2003)

III HEALTH, HEALTHCARE AND DRUG SITUATION IN INDIA

India's Health Situation [23]

On the basis of data received over the period from 1995 to 2000, the Human Development Report – 2002 (UNDP) states that in India—less than 50 per cent of the population has access to essential drugs, only 31 per cent is using adequate sanitation facilities, 47 per cent of children under the age of 5 years are underweight, 46 per cent of children under the age of 5 are under-height and only 42 per cent of the births are attended by skilled health staff.

A handful of states, accounting for well over half of the country's population, are performing very poorly in terms of the standard indicators. The figures bring out the wide intra-country differences at the state level; as it happens, even within states, there exist wide disparities. Thus, as the Ministry of Health and Family Welfare puts it: 'national averages of health indices hide wide disparities in public health facilities and health standards in different parts of the country.

Differential in Health Status among the States[24]

	IMR/ 1000 live births (1999 SRS)	Under 5 mortality per 1000 (NFHS II, 1998-1999)	MMR/ lakh (in 1997)[25]	Leprosy cases per 10,000 population	Malaria +ve cases in thousands (in 2000)
India	70	94.9	408	3.70	2200
Better Performing States					
Kerala	14	18.8	195	0.90	51
Maharashtra	48	58.1	135	3.10	138
Tamil Nadu	52	63.3	76	4.10	56
Low Performing States					
Orissa	97	104.4	361.0	7.05	483
Bihar	63	105.1	451.0	11.83	132
Rajasthan	81	114.9	677.0	0.80	53
Uttar Pradesh	84	122.5	707.0	4.30	99
Madhya Pradesh	90	137.6	498.0	3.83	528

Given a situation in which national averages in respect of most indices are themselves at unacceptably low levels, the wide inter-state disparities imply that, for vulnerable sections of society in several states, access to public health services is nominal and health standards are grossly inadequate.

[23] Source: Social Watch India, 2003
[24] Source: Draft National Health Policy, 2001
[25] Source: Annual Report 1999–2000, Ministry of Health and Family Welfare

A look at the Central Government's budgetary allocations under health sector, during 1992-93 to 1999-2000 shows that it rose during this period for the relatively better performing states such as Andhra Pradesh, Gujarat, Karnataka, West Bengal and Delhi, whereas those already lagging behind, viz. Bihar, Madhya Pradesh and Rajasthan were neglected in this respect, thus accentuating interstate differences.

Given the narrow reach and poor quality of the public health system in the country, the most vulnerable socio-economic groups have benefited the least from the public health system. There is indication of such an inequality as reflected through some of the major indicators of the health status among different socio economic groups in the country.

Selected Health Indicators of Marginalised People in India [26]

	Infant mortality/1000	**Under 5 mortality/1000**	**% Children underweight**
India	70.0	94.9	47.0
Scheduled-Castes	83.0	119.3	53.5
Scheduled-Tribes	84.2	126.6	55.9
Other-Disadvantaged	76.0	103.1	47.3
Others	61.8	82.6	41.1

Indian Healthcare Market

Healthcare is estimated to be a Rs 850 billion industry. The Confederation of Indian Industries (CII) anticipates a growth rate of an estimated 13 per cent per annum for the next five years in this sector.[27]

India exports health services through consumption abroad. Patients come from industrialized and developing countries (including Bangladesh, the Eastern Mediterranean, Nepal, Sri Lanka, the United Kingdom, and the USA) for surgery and specialized services in areas such as neurology, cardiology, endocrinology, nephrology, and urology.

[26] Source: Draft National Health Policy, 2001
[27] http://www.expresshealthcaremgmt.com/20020715/index.shtml (accessed on 16 April 2004)

In addition, trained health personnel migrate to other countries. A 1998 United Nations Conference on Trade and Development/WHO study estimated that 56% of all migrating physicians flow from developing countries to industrialized countries, while only 11% migrate in the opposite direction; the imbalance was even greater for nurses. The most prominent source countries for health personnel are India, the Philippines, and South Africa. [28]

Health System

As per the most recent available estimates[29],

	Hospitals per one hundred thousand of population	Dispensaries per one hundred thousand of population	Beds per one hundred thousand of population
Urban	4.48	6.16	308
Rural	0.77	1.37	44

Availability of Doctors and Hospital Beds per Lakh of Population [30]

Year	No. of doctors (Allopathic doctors registered with the Medical Council of India) per lakh of population	No. of beds (in both government and private hospitals registered with health authorities) per lakh of population
1971	27	64.0
1981	39	83.0
1991	47	95.0
1997	52	93.0
1998	52	–

Source: CSO, 'Selected Socio-Economic Statistics of India 2000'.

In the decade of the 1990s, the number of doctors per lakh of population continued to increase at a very slow rate, but the number of hospital beds per lakh of population actually decreased. This is yet another proof of the fact that in the decade of the 1990s the negligence of the health sector by the State in India became more acute than ever before.

[28] Trade in Health Services, Dr.Rupa Chanda, *Bulletin of the World Health Organization* 2002;80(2): 158-163
[29] SOURCE: Social Watch India, 2003
[30] SOURCE: Social Watch India, 2003

Health Expenditure

Currently the aggregate annual expenditure on health is 5.1 per cent of GDP. Out of this, about 18 per cent of aggregate spending is coming from the State, the rest 82 per cent being out-of-pocket expenditure borne by the citizens directly.

INDIA[31]	1997	1998	1999	2000	2001
Total expenditure on health as % of GDP	5.3	5	5.2	5.1	5.1
General government expenditure on health as % of total expenditure on health	15.7	18.4	17.9	17.6	17.9
Private expenditure on health as % of total expenditure on health	84.3	81.6	82.1	82.4	82.1
General government expenditure on health as % of total government expenditure	3.2	3.5	3.3	3.1	3.1

Health being primarily a state subject as per the Constitution, the contribution of Central Government to the overall public health funding has been limited. Moreover, the successive governments at the Centre have unfortunately shown an accelerated tendency of withdrawing from their responsibilities towards the so-called social sectors. The major squeeze on the fiscal resources of almost all the state governments in the last decade has meant that public investment in the health sector, instead of rising, has been stagnant at best in most cases. While the budgetary allocation on health sector by the Central Government over the last decade has been stagnant at 1.3 per cent of the total Central Budget, in the states it has declined from 7 per cent to 5.5 per cent.

India's Per capita Total expenditure on health at International dollar rate ($)					India's Per capita Government expenditure on health at average exchange rate (US$)				
1997	1998	1999	2000	2001	1997	1998	1999	2000	2001
64	65	71	74	80	4	4	4	4	4

Public Expenditure on Health in India which consists of recurrent and capital spending from budgets, external borrowings, grants and social (or compulsory) health insurance funds is one of the lowest in the world.

[31] Figures computed by WHO to assure comparability; and they are not necessarily the official statistics of Member States, which may use alternative rigorous methods (World Health report 2003)

Year	Public investment on health as a percentage of Gross Domestic Product (GDP)	
1990	1.3	↓
2002	0.9	

Country Public expenditure on health as a share of the GDP (1990–2003*) (in %) [32]

Germany	8.30
Cuba	8.20
France	7.10
United States	6.50
Canada	6.40
United Kingdom	5.90
Japan	5.90
Australia	5.50
Brazil	3.40
China	2.00
Thailand	1.70
Sri Lanka	1.40
Bangladesh	1.60
Pakistan	0.90
India	0.90 [33]

* Data are for the most recent year available.

Private Expenditure on Health consists of direct household (out-of-pocket) spending, private insurance, charitable donations, and direct service payments by private corporations. In 1997, an estimated 68 per cent of the hospitals, 56 per cent of dispensaries, 37 per cent of beds and 75 per cent of the allopathic doctors were in the private sector.

Comparison of the Private Expenditures on Health in Different Countries [34]

Country	Private expenditure on health as a share of the GDP (1990–1998*) (in %)
United States	7.50

[32] Source: The World Bank, 'World Development Indicators 2000'
[33] Source: Human Development Report - 2003
[34] Source: The World Bank, 'World Development Indicators 2000'.

Thailand	4.50
India	4.10
Brazil	4.00
Pakistan	3.00
Canada	2.80
Australia	2.80
China	2.60
France	2.50
Germany	2.50
Bangladesh	2.00
Japan	1.40
Sri Lanka	1.20
United Kingdom	1.00

* Data are for the most recent year available.

In the 1990s, a number of corporate hospitals sprung up on land allotted to them by the Central and state government in prime urban locations, in exchange for their promise to provide a reasonable proportion of their services free to the poor. However, there is increasing evidence of non-fulfilment of such promises by major private hospitals. Yet such policies are being pursued vigorously. The 1990s also saw the privatisation of public health institutions and specific involvement of private providers in the public health system.

India – Demographic and Health Statistics [35]

Total population (2001 census): 1,025,095,000

Annual population growth rate (1991-2001): 1.8%

Life Expectancy at birth (both sexes) 2001: 60.6 years (Male: 60.0 and Female: 61.7)

Probability of children under dying - per 1000 (2001): Male: 89 and Female: 98

Comparative Health Indicators (India):

	1961-1962	**1998-1999**
Life expectancy – Both sexes	41.2	62.9
Infant mortality	146/1000 live births	69/1000 live births
Death rate	22.8/ 1000	8.9/ 1000
Birth rate	41.7	26.4

[35] *The World Health Report 2002* (C.Murray, et.al. eds., Geneva: WHO, 2002)

	1995	1996	1997	1998	1999	2000
Total Expenditure of health as % of GDP	5	5.2	4.9	5.1	4.9	4.9
Private expenditure on health as % of total expenditure of total expenditure on health.	83.8	84.4	84.3	81.6	82.1	82.2
Government expenditure on health as % of total expenditure of total expenditure on health.	16.2	15.6	15.7	18.4	17.9	17.8

Access to Essential Medicines

The United Nations has categorized India as number 4, i.e. technologically developed enough to be totally self-reliant, with research capability for the discovery of new chemical entities. India's march to self-reliance in drugs was the result of well thought out policies to accord a leadership role to public sector, develop self-reliance in drug technology, create a suitable patent environment, achieve self-sufficiency in production of essential drugs, reduce imports, ensure reasonable price, maintain high standards of production and promote research and development.[36] The Indian Patent Act 1970, Hathi Committee Report of 1975, The National Drug Policy, 1978 and the subsequent National Drug policy in 1986 and the National Health Policy of 1983 aided the advances in the people's health and in the Indian drug scenario.

However, current policies, which are in line with international agreements and instruments, are taking India away from the self-reliance that was painstakingly built up over the years. The analysis of pharmaceutical policy 2002, in the next section will highlight the case better. The worst-hit due to these policies are the poor, who directly bear the burnt of any price hike. WHO has estimated that up to 90% of total health spending in poor countries, most of which are on medicines, are out-of-pocket payments. To highlight the need for Access to Essential Medicines, the WHO celebrated the 25th anniversary of the first WHO Model List of Essential medicines with the message that 'Access to Essential Medicines is part of the progressive fulfilment of the fundamental rights to health.' [37] WHO's Action Programme on

[36] *The World Drug Situation* (Geneva: WHO, 1988)
[37] *Essential Drugs Monitor* (Geneva: WHO, 2003)

Essential Drugs had given India a score of two on a scale of five on the issue of accessibility to essential drugs.[38]

Research and Development

Global Research and Development Expenditure on Health	**1998**	**$73.5 billion**
	Developed countries public funding	$34.5 billion
	Pharmaceutical Industry majors.	$30.5 billion
	Private not–for–profit	$6 billion
	Developing countries.	2.5%

Global spending on pharmaceuticals research and development in the private sector is $ 34 billion of which companies in the US spend invest than 70%. The top ten Multi-national companies spent $ 16.3billion. The companies are: Astra-Zeneca, Glaxo, Wellcome, Roche, Merck, Novartis, Bristol Myers-Squibb, Johnson and Johnson, Smith Kline Beecham, American Home, Products and Rhone- Poulenc-Rorer. A report by the French NGO MSF titled *'Fatal imbalance: The crisis in Research and development for Drugs in Neglected Diseases*' said that, in its study of the world's top 11 pharmaceutical companies, investment and research in diseases primarily of developing countries occurrences was minimal. Unfortunately, even countries like India with fairly advanced R&D capabilities do not invest much in R&D. The Organisation of Pharmaceutical Producers of India (OPPI) Study revealed that India spent Rs. 320 crores on research and development in the pharmaceutical sector in 1999-2000, which is 0.001% of world pharmaceutical industry. [39]

TRIPs and Intellectual Property Rights

The new TRIPs compliant policies, which will come into effect from the year 2005 have caused serious concerns in the industry and social sector. Since the topic is vast and outside the scope of this paper, the concerns will not be elaborated here. However, it is important to find the right balance between protecting Intellectual Property Rights and the basic human and life rights of the people.

In fact the TRIPs agreements itself calls for such an arrangement. Article 7 of the TRIPs Agreement states 'the protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology to the mutual advantage of producers and in a manner technological knowledge conductive to social and economic welfare, and

[38] *Comparative Analysis of National Drug Policies* (Geneva: Action Programme on Essential Drugs (APED), WHO, 1996)
[39] Source: Financial Express, Mumbai, 6 February 2001

to a balance of rights and obligations'. Furthermore, article 8.2 states 'appropriate measures provided they are consistent with the provisions of the Agreement may be needed to prevent the abuse of intellectual property rights by rights holders or the resort to practices which unreasonably transfer of technology. R. A. Mashlekar, the Director General of CSIR has said that the "Ideal intellectual property rights regime strikes a balance between private incentives for innovators and the public interest of maximising access to the fruits of innovation. The balance is reflected in article 27 of the 1948 Universal Declaration on Human Rights, which recognizes that 'Everyone has the right to protection of the moral and material interest resulting from any scientific, literary or artistic production of which s/he is the author' and that 'Everyone has the right to share in scientific advancement and its benefits'. [40]

In light of evidences coming up that that the TRIPs regime could affect Indian people and the industry, policies need to be formulated to address this concern. The Commission on Intellectual Property Rights set up by the British Government said that the global expansion of intellectual property rights unlikely to benefit developing nations. On the other hand, it was most likely to impose high cost- such as highly priced medicines and seeds making poverty reduction more difficult. The independent International Commission comprising of commissioners from developed and developing countries mostly experts in science, law, ethics, and economics also said that in addition, it would also increase in cost of access to many products and technologies. [41]

The South African case of high pricing of anti-retro viral (ARV) drugs for people living with AIDS by the patent holders, is another case in point. Most of African countries and companies (including MNCs) have approached Indian companies for buying ARV at a fraction of the cost offered by the big pharmaceutical companies.

> *Anglo, American, a South African mining giant approached Cipla for anti-AIDS drugs cocktail, which Cipla offers at $359 patient/year – which is one-thirtieth the prices charged by MNCs.*
>
> ***(The Financial Express, 20 August 2002)***

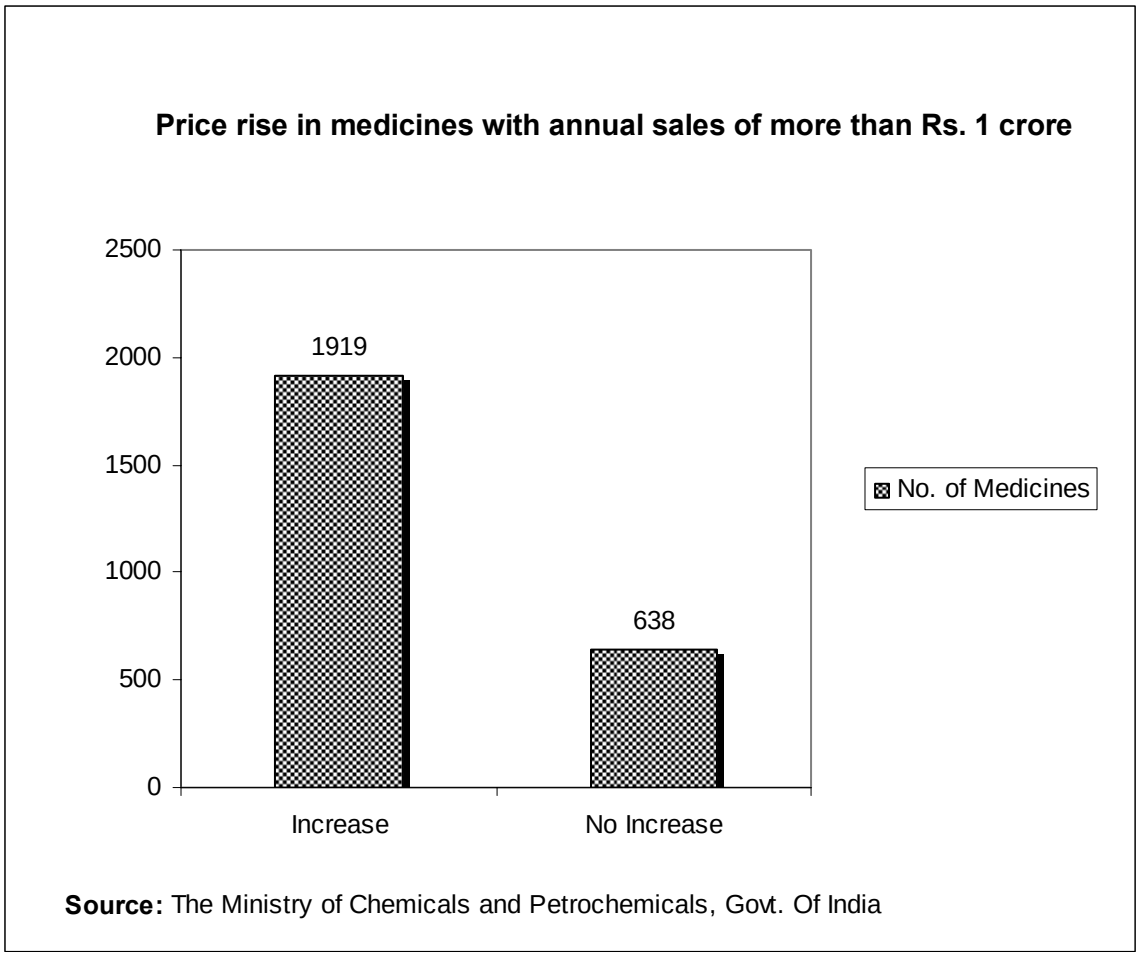
[40] R. A. Mashlekar, Current science, 81 (8) , 25 October 2001, p. 955

[41] *Integrating Intellectual property Rights and Development Policy* (London: Commission on Intellectual Property Rights, 2002)

The 1999 Human Development Report also states that the TRIPs agreement on IPR was drawn up with very little analysis of its likely economic impact and should be fully reviewed to create a system that does not exclude developing countries from knowledge or threaten indigenous knowledge or access to healthcare.

Price Control

The Ministry of Chemicals and Petrochemicals statistics point out that 75% of medicines (1919 out of 2557) having annual sales of more than Rs. 1 crore have seen increase in prices. In 38 medicines, the increase is over 100%. In 2000 – 01, the prices of 49% (1245 medicines) increased, while those of 42% (1080 medicines) remained stagnant and 9% medicines (232) prices decreased. In case of most generic, non-scheduled medicines, the retail trade margins range between 300% to as high as 1,000 with the average margins prevailing at about 500%. In spite of these price rises and huge profit margis, the number of drugs under price control has been steadily decreasing over the years owing to industry pressures. Only 33 drugs remain under price control as against the previous 75 drugs (with a total market share of 22% as against the previous 38%). [42]



Source: The Ministry of Chemicals and Petrochemicals, Govt. Of India

[42] Economic Times Mumbai, 7 September 2002

PHARMACEUTICAL POLICY 2002 – A CASE STUDY

Orientation

"The drug and pharmaceutical industry in the country today faces new challenges on account of: 1) liberalization 2) globalisation 3) new obligations undertaken by India under the WTO Agreements". ***(Pharmaceutical Policy 2002 Document)***

The policy begins by acknowledging that these are issues, that need to be addressed. People are being affected and will be further affected by these macro-economic policies. So, how does the policy address these issues? By making the industry more viable. There is no mention anywhere about the needs of the common people who are being affected by these changes. The new pharmaceutical policy is basically a industry oriented document. This admission is made in the policy document itself, which states: "These challenges (referring to the above) require a change in emphasis in the current pharmaceutical policy and the need for new initiatives beyond those enumerated in the Drug Policy 1986, as modified in 1994, so that policy inputs are directed more towards 1) promoting accelerated growth of the pharmaceutical industry and 2) towards making it more internationally competitive". These lines set the tone for the entire policy.

Growth of Pharmaceutical Sector

The logic for the government to indulge in a massive decontrol exercise "to promote accelerated growth and improve competitiveness" defeats logic because pharmaceutical stocks, even during the slowdown in rest of industry (except for the automobile sector), were the healthiest in the last quarter of 2001 and 2002. With the announcement of the pharma policy, the pharmaceutical stocks, in particular those of multinational corporations (MNCs), have further shot up. The box item (Fig. 1) gives the details of the Indian Pharmaceutical Industry, as described by the Indian drug manufacturers themselves.

Indian Pharmaceutical Industry Overview *

The Indian Pharmaceutical Industry today is in the front rank of India's science-based industries with wide ranging capabilities in the complex field of drug manufacture and technology. A highly organized sector, the Indian Pharma Industry is estimated to be worth $ 4.5 billion, growing at about 8 to 9 percent annually.

It ranks very high in the third world, in terms of technology, quality and range of medicines manufactured. From simple headache pills to sophisticated antibiotics and complex cardiac compounds, almost every type of medicine is now made indigenously.

Playing a key role in promoting and sustaining development in the vital field of medicines, Indian Pharma Industry boasts of quality producers and many units approved by regulatory authorities in USA and UK. International companies associated with this sector have stimulated, assisted and spearheaded this dynamic development in the past 53 years and helped to put India on the pharmaceutical map of the world.

The Indian Pharmaceutical sector is highly fragmented with more than 20,000 registered units. It has expanded drastically in the last two decades. The leading 250 pharmaceutical companies control 70% of the market with market leader holding nearly 7% of the market share. It is an extremely fragmented market with severe price competition and government price control.

The pharmaceutical industry in India meets around 70% of the country's demand for bulk drugs, drug intermediates, pharmaceutical formulations, chemicals, tablets, capsules, orals and injectibles. There are about 250 large units and about 8000 Small Scale Units, which form the core of the pharmaceutical industry in India (including 5 Central Public Sector Units). These units produce the complete range of pharmaceutical formulations, i.e., medicines ready for consumption by patients and about 350 bulk drugs, i.e., chemicals having therapeutic value and used for production of pharmaceutical formulations.

Following the de-licensing of the pharmaceutical industry, industrial licensing for most of the drugs and pharmaceutical products has been done away with. Manufacturers are free to produce any drug duly approved by the Drug Control Authority. Technologically strong and totally self-reliant, the pharmaceutical industry in India has low costs of production, low R&D costs, innovative scientific manpower, strength of national laboratories and an increasing balance of trade. The Pharmaceutical Industry, with its rich scientific talents and research capabilities, supported by Intellectual Property Protection regime is well set to take on the international market.

THE GROWTH SCENARIO

India's US$ 3.1 billion pharmaceutical industry is growing at the rate of 14 percent per year. It is one of the largest and most advanced among the developing countries.

Over 20,000 registered pharmaceutical manufacturers exist in the country. The domestic pharmaceuticals industry output is expected to exceed Rs260 billion in the financial year 2002, which accounts for merely 1.3% of the global pharmaceutical sector. Of this, bulk drugs will account for Rs. 54 billion (21%) and formulations, the remaining Rs. 210 billion (79%). In financial year 2001, imports were Rs. 20 billion while exports were Rs. 87 billion.

* ***http://www.pharmaceutical-drug-manufacturers.com/***

Fig. 1

Indian Drug Industry Fact sheet [43]

	1973	1999
Investment in Indian Pharmaceutical Industry	Rs. 225 crores	Rs. 2500 crores

	1969-1970	1999-2000
Pharmaceuticals units	2,257	20,059

	1965-1966	1999- 2000
Production of bulk drugs	Rs. 18 crores	Rs. 3777 crores
Formulations	Rs. 150 crores	Rs. 16,000 crores
Exports	Rs. 3.05 crores	Rs. 6631 crores
Imports	Rs. 8.2 crores	Rs. 3441 crores
R & D	Rs. 3 crores	Rs. 320 crores

Average profitability of industry	**1969-70**	15.47% of sales
	1991-92	6.1% of sales
	1994-95	1% of sales
	1998-99	8% of sales

Annual per-capita consumption of drugs	**Japan**	$ 412
	Germany	$ 222
	USA	$ 191
	India	$ 3

Fig. 2

[43] Source: Drugs and Pharmaceuticals Industry Highlights: Published by National Information Centre for Drugs and Pharmaceuticals, Central Drug Research Institute, Lucknow

	Type of drugs	%
Sale of Pharmaceuticals in Developing Country Markets	***Anti-infectives***	24
	Vitamins and nutrients.	15
	Alimentary tract diseases	11.5
	Analgesics	9
	Cough and cold	7.4
	Cardio-vascular	6.4
	Dermatogicals	5.7
	Central Nervous System drugs	4.1
	Anti-TB drugs	3.2
	Others	13.7

Fig. 3

Pharmaceutical vs. Health

Since medicines are an integral part of the health services package, it is expected that the Pharmaceutical Policy would be linked to the health policy. But our Pharmaceutical Policy preceded the new health policy, which was only declared later. The pharmaceutical policy comes under the Department of Chemicals and Petrochemicals. According to a press statement issued by the Federation of Medical and Sales Representatives' Association of India (FMRAI), the Ministry of Chemicals and Petrochemicals (MoCF) had earlier circulated secretly a document, Pharmaceutical Policy, 2001, which has now got the Cabinet's approval. Incidentally they have described the new policy as a "major assault on people's access to essential drugs".

Over-ruling Good Sense

The Drugs Price Control Review Committee (DPCRC) had recommended that in the absence of health cover for majority of the population in the country, price controls should be continued till the government expenditure on health rises to a substantial level and the availability of essential drugs is improved. Neither of these has been achieved, yet the Pharmaceutical Policy 2002 has recommended that price controls should be reduced. By reducing the span of price control, the Pharmaceutical Policy 2002 overrules the suggestion of the DPCRC of 1999.

Policy in Data Vacuum

Any Govt. policy is expected to be formulated based on information collected from independent, and the most objective sources. However, the Pharmaceutical Policy 2002 confesses that no reliable data exist to ascertain mass consumption and the absence of sufficient competition in respect of a particular bulk drug - the two criteria which are used for the selection of controlled drugs. The document says that, in the absence of any exhaustive and comprehensive information, the ORG-MARG data are the best available. Hence the policy has been formed in a data vacuum.

TRIPs and Pharmaceuticals

Two major apprehensions of adopting the TRIPS Agreement in the pharmaceutical sector were regarding the higher prices of the patented products and their accessibility. By providing a blanket exemption from price control, the government is making the access to drugs difficult.

Price Control

It is interesting to quote from the background note circulated by the government to the Drug Price Control Review Committee (DPCRC)[44] set up under the chairpersonship of the Secretary, Department of Chemicals and Petrochemicals prior to its deliberations. It said, "The Drug Price Control Order (DPCO) is used as one of the essential instruments to achieve the objective of essential medicines of good quality, at reasonable prices, for the required health care of the masses. It has been an evolutionary process, which has been taking cognisance of ever-emerging new factors".

The "ever-emerging new factors" mentioned were:

- Inadequate machinery to administer the price control orders,
- Industry's demands to do away with price control. The document states: "... The industry, keen to get rid of price controls altogether, has time and again questioned these working principles... However the industry has not been forthcoming in providing data to substantiate their claims."

So, there is no mechanism to administer price controls, and also there is no data to support industry's claims that price controls are detrimental to the consumer, to the economy and to the industry, and that decontrol would actually help R&D.

[44]Background Note on Pharmaceutical paper 2002: Government of India, 2001

Consequences of Decontrol

An analysis carried out by the Delhi Science Forum (DSF) on the impact of the 1995 decontrol throws up some interesting facts about the "market behaviour". The price movement of 28 essential drugs - eight under price control and 20 outside it - showed that out of the eight controlled drugs there was a decrease in six of them. On the other hand, the prices of the 20 drugs showed an increase in excess of 10 per cent and in some cases in excess of 20 per cent. More interestingly, the DSF analysis showed that in all segments there were wide variations in the prices of different brands of a given formulation and the top-selling brand in any formulation is not the cheapest one, sometimes twice as expensive. This is proof enough that the market mechanism does not stabilise drug prices and the market share of a brand is not dependent on its price. In fact, the very reason for putting in place a price control mechanism was this atypical market behavior in the case of pharmaceuticals. [45]

Need for Price Control

Analysis in the increase in prices of 50 top-selling drugs between February 1996 and October 1998.[46] It showed that the average increase in the case of brands under price control was 0.1 per cent whereas that in the case of brands outside price control was 15 per cent. It was also found that the price rise was not a one-time increase owing to an escalation in raw material costs but was indicative of a trend of continual increase in the prices of decontrolled drugs.

Market Mechanism & Price Stability

There are wide variations in the prices of different brands of a given formulation. The top-selling brand in any formulation is not the cheapest one, and is sometimes twice as expensive. This is proof enough that the market mechanism does not stabilise drug prices and the market share of a brand is not dependent on its price. In fact, the very reason for putting in place a price control mechanism was this atypical market behaviour in the case of pharmaceuticals.

Drug Price Control Order

When it was argued that the change in the Patents Act would result in an increase in prices, the government said that it would use the mechanism of Drug Price Control

[45] A. S. Gupta, Analysis of Pharmaceutical Policy 2002 quoted in FMRAI, *Access to Essential Medicine* (Kolkata: FMRAI, 1986)

[46] *ibid*

Order to keep the prices in check. Now that the Patents Act has been amended, the TRIPS argument is being used to dismantle the DPCO. So, ultimately the industry, supported by the Govt., wins at the cost of the poor.

Formulations at the Cost of Bulk Drugs

In addition to making higher profit margins for the manufacturer possible, the policy has done away with the **ceiling on profitability on formulations** that existed until now (through the Third Schedule of DPCO 1995). In case of bulk drugs, the manufacturer has been allowed a 4 per cent higher rate of return over the existing 14 per cent on net worth or 22 per cent on the capital employed.

- Considering that more and more manufacturers are moving away from bulk drug manufacture to formulations, this provides an additional windfall.
- With no restriction on imports, pharmaceutical imports (which is largely of bulk drugs) have been rising at the rate of 29.3 per cent while exports (which are mainly of formulations) have been increasing at the rate of 18 per cent, according to the data of the Centre for Monitoring of Indian Economy (CMIE).[47]

Policy Implementation

The Policy uses the Moving Annual Total (MAT) value and market share to determine whether a drug should come under price control. However the companies are known to break up production figures through various means.

Market Forces vs. People's Health Needs

The selection of drugs for price control should be based on health need - namely, the list of essential drugs - and not on market behaviour, which, in the case of drugs, does not follow the norms of other consumables. But this has been the problem with the Indian drug policy over the past four decades, in which the inputs of the health sector are never reflected in the policy articulated by the Department of Chemicals and Petrochemicals, which in turn is influenced by the industry lobby. The policy does not offer any justification as to the final set of criteria that has the effect of keeping three-fourths of the drugs in the market out of price control.

[47] CMIE: Pharmaceutical Industry data 2001

Pharmaceutical Policy 2002 And *Swaraj*

Medical vs. Health

When examined from an ethical framework of '*swaraj*', as presented in this paper, the policy falters on the first premise itself when it views drugs as a pharmaceutical industry and medical issue and not as 'health and well being' concern. The very fact that the Ministry of chemical and Petrochemicals formulates the pharmaceuticals policy is a grim reminder to this fact.

Self Rule and Self Restraint

The second premise of self rule and self restraint in *swaraj* also contradicts with the Policy where 'accelerated growth' and 'competitiveness' are the key words. Through the two sets of values are not inherently contradictory, the purpose behind each of these concepts places them at loggerheads with each other. While the former is intended to control oneself and benefit others, the latter is intended to benefit oneself and control others.

Egalitarian Concept

The third premise of *swaraj* is an 'egalitarian society', with positive discrimination towards the marginalised. A policy, which does not address the issue of access of essential drugs and services for all, goes against the basic tenets of *swaraj*.

Provision of Basic Amenities

The fourth premise of *swaraj* is the provision of basic amenities, which in pharmaceutical and healthcare terms would translate into availability of accessible, affordable and quality health service. However the policy does not address any of these three key issues.

Truth and Ahimsa

The fifth premise of *swaraj*, which is also the means of achieving it, is that of truth and *ahimsa*. A policy, which bases its assumptions on reports, which are produced and funded by vested interests and players who have a stake in the policy, is far away from the truth. The concept of *ahimsa* calls for pro-active contribution to the well-being of society and its upliftment. A policy which is explicitly for the well heeded and formed to comply with international norms and industry demands, while totally neglecting the needs of majority of the population is actively against *ahimsa*. The points in the policy which imposes TRIPs compliant conditions while reducing the medicines in the price control list is a case in point.

V CONCLUSION

The twenty-fifth anniversary of the historic Alma Ata Declaration went by quietly in 2003 with the promise of 'health for all' remaining a pipe-dream for majority of the people in the country. The situation has changed a lot since 1978, when the declaration was made. Today, neo-liberal policies of the State coupled with Structural Adjustment Policies dictated by multilateral financial organisations has led to liberalisation of the economy and privatisation of public sector bodies and public services including health.

The Draft Tenth Five Year Plan of the Planning Commission of India shows that the cost of private health care is more than 19 times the cost of what is provided by the State. [48] Studies across the country have shown that health–related expenditure is among the leading causes of impoverishment and rural indebtedness. However, the total expenditure on health as % of GDP has gradually fallen to 5.1 while the general government expenditure on health as % of total government expenditure has been cut to 3.1 per cent. As the Government shirks its responsibility of providing health for all its people as a right, more and more people are sinking into debt, poverty and ill-health. Today, about 50% Of Indian children are under-weight while the number is much higher among marginalised groups.

The Supreme Court of India in its various judgements has made it clear that the 'Right to Life' enshrined in the Constitution indicates a 'Right to Life with dignity', which also implies provision of basic services to sustain a life with dignity. A 'Right to Healthcare' Campaign in India is exploring various means to extend this interpretation to its logical conclusion and obtain 'Right to Healthcare' as an enforceable right for all citizens. Determined Political Will coupled with adequate financial allocation will help in making this Right a reality for all people everywhere.

In spite of all these rights and progressive judgements, adequate financial allocation, political will, awareness of these rights among people and strong political mobilization will be required to realize the right to healthcare.

[48] *Draft Tenth Five Year Plan,Vol. II, Planning Commission* quoted in Social Watch India, 2003.

Right to Healthcare

The 'Right to Life' (Article 21) is enshrined in the Indian Constitution. In addition there are Directive Principles regarding Nutrition, Standard of living and Health in Article 47 of the Indian Constitution. These provisions along with the various Supreme Court judgments in favour of emergency and occupational health care, illustrate that the case for basic healthcare to be provided to all citizens as their right, is strong in India. The 93rd amendment in the Constitution accepting Education as a fundamental right has strengthened the case of basic social services to be accepted as people's right. The International Covenant on Economic, Social and Cultural Rights, in its Article 12 clearly recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and creation of conditions which would assure to all medical service and medical attention in the event of sickness. The Alma Ata declaration of 'Health for all by 2000' signed in 1978 is yet another declaration which the government endorses.[49]

Drugs and Pharmaceuticals

A major culprit in pushing up costs has been the systematic deregulation of the pricing of drugs which gathered momentum in the recent years. At the time of the introduction of Drug Price Control Order, in 1970, all drugs were kept under price control. Now, the Pharmaceutical Policy of 2002 has reduced it further to 35 drugs.

Year	1970	1979	1987	1995	2002
Drugs kept under price control	All drugs	347	163	76	35

In 1995, the amendment of the Drug Price Control Order of 1987 (which had kept 163 drugs under price control) deregulated the drugs market leaving only 76 drugs under price control mechanism. An analysis of its impact by the Delhi Science Forum (DSF) showed that out of a set of 28 essential drugs (8 under price control and 20 outside it)—whose price movement was studied—'prices of 6 of the 8 controlled drugs decreased; on the other hand, the prices of the 20 drugs outside DPCO mechanism showed an increase in excess of 10 per cent and in some cases in excess of 20 per cent.' 'The DSF also analysed the increase in prices of 50 top-

[49] Source: *A brief report of the 'Right to Health Care Seminar, Asian Social Forum, Hyderabad*

selling drugs between February 1996 and October 1998. It showed that the average increase in case of brands under price control was 0.1 per cent, whereas that in the case of brands outside price control was 15 per cent. It was also found that the price-rise was not a one-time increase owing to an escalation in raw material costs but was indicative of a trend of a continual increase in the prices of decontrolled drugs.[50]

As seen above, the Pharmaceutical Policy 2002, which was created in a data vacuum, contradicts with the existing ground requirements, and fails to address the need of providing access to essential drugs for the entire population. As the policy document admits the policy inputs were directed towards: 1) promoting accelerated growth of pharmaceutical industry and 2) towards making it more internationally competitive.

Policy Fails Judicial Scrutiny

The Karnataka High Court on Tuesday declared that the Pharmaceutical Policy - 2002 formulated by the Central Government was arbitrary, unreasonable and violative of the Constitution and Essential Commodities Act. Chief Justice N.K. Jaina and V.G. Sabhahit delivered judgment on a writ petition filed by Lt. Col K.S. Gopinath and Dr B.V. Bhaskar of Bangalore, challenging the legality of the National Pharmaceutical Policy - 2002 published in February 15.

The petitioners contended that the Policy had been framed like business policy and if it were allowed to be enforced, it would take away life-saving and essential drugs out of the ambit of Drug Price Control which is highly detrimental to public interest. On detailed consideration of rival contentions, the Bench held that it found the Policy was indeed arbitrary, unreasonable and that it violated the Essential Commodities Act (1955) and Articles 14 and 21 of the Constitution. The violation was to the extent of the price control mechanism adopted in the Policy to determine drugs under price control, as it defeats the entire purpose of equitable distribution and availability of essential drugs in the basket of drugs under the policy.

Accordingly, the court directed the respondents including the National Pharmaceutical Pricing Authority to consider and formulate appropriate criteria so as to ensure that essential and life-saving drugs do not fall out of price control. The court further directed to review drugs which are essential and life-saving in nature in

[50] R Ramachandran (2002); 'Unhealthy Policy', *Frontline*, 15 March 2002

consultation with the Union Ministry of Health and Family Welfare. Until a list of such drugs is prepared and are brought into the basket of essential drugs, the respondents were directed not to implement the Policy with regard to Essential and Life Saving drugs for formulation of price control mechanism.

Recommendations to Improve Pharmaceutical Policy 2002

1) **A Broad–Based Policy:** A major shortcoming of the Policy has been in its undue emphasis on the development of the Pharmaceutical Industry over all other concerns. The Policy document states that, *".....policy inputs are directed more towards 1) promoting accelerated growth of the pharmaceutical industry and 2) towards making it more internationally competitive*". It is a shame that with a $6 billion pharmaceutical industry in the country, India ranks with the Least Developed Countries of the World in terms of Access to Essential Drugs.

The first recommendation is regarding the orientation of the Policy. The Pharmaceutical Policy of a country with "Very Low Access to Essential Drugs" should be geared towards setting right the problem of access to essential drugs for majority of its population, with no access to drugs.

2) **Ownership of Policy:** In India the Pharmaceutical Policy-2002, is framed by the Department of Chemicals and Petrochemicals. The rationale for this approach is that, the Department of Chemicals and Petrochemicals is responsible for the industrial development in this sector. As long as this practice continues, there will not be any hope for the health concerns of the population to be addressed in the health policy.

The formulation of the Pharmaceutical Policy should be handed over to the Health Ministry.

3) **Convergence:** The National Health Policy-2001 was announced a few months earlier to the Pharmaceutical Policy-2002. However, there are hardly any serious references in the National Health Policy on the role of drugs in reducing morbidity and mortality, resulting from preventable diseases. The Pharmaceutical Policy-2002 too has no links with the National Health Policy - 2001 and does not make any efforts to support the targets set in the National Health Policy. Ideally the Policy should have fashioned its projections on drug needs, to meet the goals set in the National Health Policy.

There needs to be a convergence in the goals and targets set in the Health Policy and the Pharmaceutical Policy of the country as they are intrinsically linked and one cannot achieve its objectives without the support of the other.

4) **Price Control:** The Drugs Price Control Review Committee (DPCRC) had recommended in 1999, that in the absence of health cover for majority of the population in the country, price controls should be continued till the government expenditure on health rises to a substantial level and the availability of essential drugs is improved. However the Pharmaceutical Policy has over-ridden the recommendations of the Committee and reduced the number of drugs under Drug Price Control Order (DPCO) to 35.

The Pharmaceutical Policy must adhere to the recommendations of DPCRC and all essential drugs brought under DPCO with immediate effect.

5) **Intellectual Property Rights:** The Patent Act of 1970 provided for only process and not product patents in pharmaceutical, food and chemicals. Indian research institutes utilised this provision to reverse engineer technologies, build indigenous capabilities in them, and disseminate them cheaply to industry. This helped the growth of Indian Pharmaceutical Industry, thereby achieving near self-sufficiency in production of bulk drugs.

   In compliance with WTO agreements and TRIPs provisions, Government passed the Patents (Second) Amendment Act on 14th May, 2002. Two major apprehensions of adopting the Act in the pharmaceutical sector were regarding the higher prices of the patented products and their accessibility. By providing a blanket exemption from price control, the government is making the access to drugs difficult.

In light of the introduction of the Patents (Second) Amendment Act, the Pharmaceutical Policy must provide for a new Drugs Price Control Review Committee (DPCRC) involving consumer groups, pharmaceutical industry representatives and health department officials to keep a watch on the rise of prices and introduce Price Control Orders on drugs which get beyond the reach of common people.

6) **Compulsory Licensing (CL):** The Patents (Second) Amendment Act passed on 14th May, 2002 has made the process of granting compulsory licences, highly rigid and restrictive, thereby giving patentees very wide control of the procedure for grant of CLs and for delaying and obstructing third parties from using CLs effectively. [51]

Article 31 of the TRIPS agreement does not prescribe or restrict the scope of compulsory licenses to any particular grounds. Instead, the refusal by right holder to allow use of reasonable commercial terms and conditions 'within reasonable period' is adequate justification for the issue of compulsory licenses.

The Pharmaceutical Policy should take advantage of the TRIPs provision and lay down provisions for granting of Compulsory Licenses in drugs in case of national need.

7) **Irrational Combination Drugs:** The pharmaceutical market in the country has about 80,000 formulations in the market, a sizeable percentage of which is considered to be irrational combination drugs. This is in the place of 452 drugs (279 that appear on the National Essential Drug List 1996 and 173 considered important by the Ministry of Health and Family Welfare). Failure to examine the therapeutical contribution of a product before allowing entry in the market is the reasons for the mushrooming growth of irrational combinations in the country. [52] The Pharmaceutical Policy 2002 fails to address this issue, thereby leaving the consumers to be duped by pharmaceutical companies marketing irrational combination drugs.

The Pharmaceutical Policy should take the issue of irrational combination drugs seriously and provide for adequate guidelines to examine the therapeutical value of a pharmaceutical product before allowing its entry in the market. The Policy should prioritise the setting up of labs for this purpose on a war-footing.

8) **Essential Drug List:** It has been found that irrational combination drugs are procured and distributed by government hospitals too, and essential drugs are often in short supply. This is due to lax implementation of Essential Drug List.

[51] Abrol D. (2002), Over-riding the Indian interest - A critique of the Patents (2nd Amendment) Bill, indiatogether.org
[52] Lalitha N. (2002): Drug Policy 2002: Prescription for Symptoms, Economic and Political Weekly, July 27

Thus, poor people who should normally have got medicines free of cost, buy them from the open market at high costs. The Policy fails to address this crucial issue too. [53]

The Pharmaceutical Policy should include provisions for making the use of Essential Drug List compulsory, first in the government health care system and later to the rest of the health care system. The Policy should also recommend steps to ensure adequate supply of essential drugs in the country.

9) **Research and Development (R & D):** There are about 24,000 pharmaceutical units in the country. [54] However less than 100 have R & D facilities. This shows that continued price reductions over the years have had very little impact on increasing the R & D facilities in the country. The Pharmaceutical Policy however, uses this logic to withdraw price controls.

The Pharmaceutical Policy should specify concrete steps for collaboration between the pharmaceutical industry and government owned research laboratories. Incentives like tax benefits and extension of research grants for developing new products and chemical entities must be provided for the Indian pharmaceutical industry.

10) **Bulk drug under price regulation:** The Policy states that besides the list of drugs under DPCO, a bulk drug will be under price regulation if: (a) the total moving annual total (MAT) sales value of any bulk drug is more than Rs 25 crore and the formulators' percentage share is 50 % or (b) the MAT value of a bulk drug is between Rs 10 and 25 crore, and the formulators' percentage share is 90 % or more. These cut-off figures are purely arbitrary. It is a known fact that the subsidiaries of large companies are commonly used to split the production and sales of the parent firm to escape from such ceilings fixed by the government. [55]

The Pharmaceutical Policy should remove these arbitrary conditions and bring all essential drugs under effective price control. In addition, companies producing good quality essential drugs should be given incentives like tax benefits.

[53] *ibid.*
[54] GITCO (2000): 'Industrial Status, Sickness Level and WTO Impact Study: Drugs and Pharmaceutical Sector', Gujarat, August.
[55] Lalitha N. (2002): Drug Policy 2002: Prescription for Symptoms, Economic and Political Weekly, July 27

The Last Word

As globalisation increases, and market forces overtake every system of life, it is essential that existing social safety nets be strengthened and new ones be put in place to hold those falling out of the mainstream due to the adverse impacts of globalisation. This is to be done, not as a favour to those who get pushed out of the race, but because they have been wronged and providing safety nets are only ways to prevent further harm. However, new policies like the Pharmaceutical Policy 2002, are taking away even the little self reliance and self sufficiency that was built up over the years. Fifty-five years after India attained freedom, it is on its way to losing its '*swaraj*', by playing into the hands of few vested, powerful interests. As the value base erodes, so does our '*swaraj*'.

The need of the hour is not narrowly defined nationalism, but an all-inclusive value base, which will provide the basis for governance and citizenship. Health of the citizens would be at the centre of such a value base. All policies would be directed towards achieving 'Health for All'. This is the goal and means of achieving *swaraj*. The dream of achieving 'Health for All' through *swaraj* will become a reality only when every, citizen takes it on as his/her responsibility achieve it and says in the words of Lokamanya Balagangadhar Tilak, that 'Swaraj is my birth right, and I shall have it'.

SUMMARY OF RECOMMENDATIONS FOR PHARMACEUTICAL POLICY 2002

1. **The Policy of a country with "Very Low Access to Essential Drugs" should be geared towards setting right the problem of access to essential drugs for majority of its population, with no access to drugs.**
2. **The formulation of the Pharmaceutical Policy should be handed over to the Health Ministry.**
3. **There needs to be a convergence in the goals and targets set in the Health Policy and the Pharmaceutical Policy of the country as they are intrinsically linked and one cannot achieve its objectives without the support of the other.**
4. **The Policy must adhere to the recommendations of Drugs Price Control Review Committee (DPCRC) and all essential drugs brought under Drug Price Control Order (DPCO) with immediate effect.**
5. **In light of the introduction of the Patents (Second) Amendment Act, the Policy must provide for a new Drugs Price Control Review Committee (DPCRC) involving consumer groups, pharmaceutical industry representatives and health department officials to keep a watch on the rise of prices and introduce Price Control Orders on drugs which get beyond the reach of common people.**
6. **The Policy should take advantage of the TRIPs provision and lay down provisions for granting of Compulsory Licenses in drugs in case of national need.**
7. **The Policy should take the issue of irrational combination drugs seriously and provide for adequate guidelines to examine the therapeutical value of a pharmaceutical product before allowing its entry in the market. The Policy should prioritise the setting up of labs for this purpose on a war-footing.**
8. **The Policy should include provisions for making the use of Essential Drug List compulsory, first in the government health care system and later to the rest of the health care system. The Policy should also recommend steps to ensure adequate supply of essential drugs in the country.**
9. **The Policy should specify concrete steps for collaboration between the pharmaceutical industry and government research laboratories. Incentives like tax benefits and extension of research grants for developing new products and chemical entities must be provided for the pharmaceutical industry.**
10. **The Policy must bring all essential drugs under effective price control. In addition, companies producing good quality essential drugs should be given incentives like tax benefits.**

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Volume 25, No. 5, May 2002
Volume 25, No. 7, July 2002
Volume 25, No. 6, June 2002
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PHARMACEUTICAL POLICY-2002

INTRODUCTION

The basic objectives of Government's Policy relating to the drugs and pharmaceutical sector were enumerated in the Drug Policy of 1986. These basic objectives still remain largely valid. However, the drug and pharmaceutical industry in the country today faces new challenges on account of liberalization of the Indian economy, the globalization of the world economy and on account of new obligations undertaken by India under the WTO Agreements. These challenges require a change in emphasis in the current pharmaceutical policy and the need for new initiatives beyond those enumerated in the Drug Policy 1986, as modified in 1994, so that policy inputs are directed more towards promoting accelerated growth of the pharmaceutical industry and towards making it more internationally competitive. The need for radically improving the policy framework for knowledge-based industry has also been acknowledged by the Government. The Prime Minister's Advisory Council on Trade and Industry has made important recommendations regarding knowledge-based industry. The pharmaceutical industry has been identified as one of the most important knowledge based industries in which India has a comparative advantage.

2. The process of liberalization set in motion in 1991, has considerably reduced the scope of industrial licensing and demolished many non-tariff barriers to imports. Important steps already taken in this regard are: -

- Industrial licensing for the manufacture of all drugs and pharmaceuticals has been abolished except for bulk drugs produced by the use of recombinant DNA technology, bulk drugs requiring in-vivo use of nucleic acids, and specific cell/tissue targeted formulations.
- Reservation of 5 drugs for manufacture by the public sector only was abolished in Feb.1999, thus opening them up for manufacture by the private sector also.
- Foreign investment through automatic route was raised from 51% to 74% in March, 2000 and the same has been raised to 100%.
- Automatic approval for Foreign Technology Agreements is being given in the case of all bulk drugs, their intermediates and
- formulations except those produced by the use of recombinant DNA technology, for which the procedure prescribed by the Government would be followed.
- Drugs and pharmaceuticals manufacturing units in the public sector are being allowed to face competition including competition from imports. Wherever possible, these units are being privatized.
- Extending the facility of weighted deductions of 150% of the expenditure on in-house research and development to cover as eligible expenditure, the expenditure on filing patents, obtaining regulatory approvals and clinical trials besides R&D in biotechnology.
- Introduction of the Patents (Second Amendment) bill in the Parliament. It, inter-alia, provides for the extension in the life of a patent to 20 years.

3. The impact of the policies enunciated, from time to time, by the Government has been salutary. It has enabled the pharmaceutical industry to meet almost entirely the country's demand for formulations and substantially for bulk drugs. In the process the pharmaceutical industry in India has achieved global recognition as a low cost producer and supplier of quality bulk drugs and formulations to the world. In 1999-2000, drugs and pharmaceutical exports were Rs.6631 crores out of a total production of Rs.19,737 crores. However, two major issues have surfaced on account of globalization and implementation of our obligations under TRIPs which impact on long-term competitiveness of Indian industry. These have been addressed in the Pharmaceutical Policy-2002. A reorientation of the objectives of the current policy has also become necessary on account of these issues:-

a. The essentiality of improving incentives for research and development in the Indian pharmaceutical industry, to enable the industry to achieve sustainable growth particularly in view of anticipated changes in the Patent Law; and

b. The need for reducing further the rigours of price control particularly in view of the ongoing process of liberalization.

4. It is against this backdrop, that Pharmaceutical Policy-2002 is being enunciated.

OBJECTIVES

5. The main objectives of this policy are:-

a. Ensuring abundant availability at reasonable prices within the country of good quality essential pharmaceuticals of mass consumption.
b. Strengthening the indigenous capability for cost effective quality production and exports of pharmaceuticals by reducing barriers to trade in the pharmaceutical sector.
c. Strengthening the system of quality control over drug and pharmaceutical production and distribution to make quality an essential attribute of the Indian pharmaceutical industry and promoting rational use of pharmaceuticals.
d. Encouraging R&D in the pharmaceutical sector in a manner compatible with the country's needs and with particular focus on diseases endemic or relevant to India by creating an environment conducive to channelising a higher level of investment into R&D in pharmaceuticals in India.
e. Creating an incentive framework for the pharmaceutical industry which promotes new investment into pharmaceutical industry and encourages the introduction of new technologies and new drugs.

APPROACH ADOPTED IN THE REVIEW

6. In order to strengthen the pharmaceutical industry's research and development capabilities and to identify the support required by Indian pharmaceutical companies to undertake domestic R&D, a Committee was set up in 1999 by this Department by the name of Pharmaceutical Research and Development Committee (PRDC) under the Chairmanship of Director General of CSIR.

7. To qualify as R&D intensive company in India, the PRDC has suggested following conditions (gold standards) :-

- Invest at least 5% of its turnover per annum in R&D,
- Invest at least Rs.10 Crore per annum in innovative research including new drug development, new delivery systems etc. in India,
- Employ at least 100 research scientists in R&D in India,
- Has been granted at least 10 patents for research done in India,
- Own and operate manufacturing facilities in India.

8. The recommendations of the PRDC in so far as they relate to the Pharmaceutical Policy have been taken into account while formulating the proposals on pricing aspects.

9. The Pharmaceutical Research & Development Committee has recommended in its report, submitted inter-alia, the setting up of a Drug Development Promotion Foundation (DDPF) and a Pharmaceutical Research & Development Support Fund (PRDSF). Necessary action in this regard has been initiated.

10. As far as the question of price control is concerned, the span of control has been gradually reduced since 1979. Presently, under DPCO, 1995 there are 74 bulk drugs and their formulations under price control covering approximately 40% of the total market. The functioning of the Drugs (Price Control) Order, 1995, has brought to light some problems in the administration of the price control mechanism for drugs and pharmaceuticals. In order to review the current drug price control mechanism, with the objective, inter-alia, of reducing the rigours of price control, where they have become counter-productive, a committee, called the Drugs Price Control Review Committee (DPCRC), under the Chairmanship of Secretary, Department of Chemicals & Petrochemicals was set up in 1999, which has given its report.

The recommendations of DPCRC have been examined and taken into account while formulating the "Pharmaceutical Policy - 2002".

11. It has emerged that the domestic drugs and pharmaceuticals industry needs reorientation in order to meet the challenges and harness opportunities arising out of the liberalisation of the economy and the impending advent of the product patent regime. It has been decided that the span of price control over drugs and pharmaceuticals would be reduced substantially. However, keeping in view the interest of the weaker sections of the society, it is proposed that the Government will retain the power to intervene comprehensively in cases where prices behave abnormally.

12. In view of the steps already taken and in the light of the approach indicated in the foregoing paragraphs, the decisions of the Government are detailed below :-

I. Industrial Licensing

Industrial licensing for all bulk drugs cleared by Drug Controller General (India), all their intermediates and formulations will be abolished, subject to stipulations laid down from time to time in the Industrial Policy, except in the cases of

i. bulk drugs produced by the use of recombinant DNA technology,
ii. bulk drugs requiring in-vivo use of nucleic acids as the active principles, and
iii. specific cell/tissue targetted formulations.

II. Foreign Investment

Foreign investment upto 100% will be permitted, subject to stipulations laid down from time to time in the Industrial Policy, through the automatic route in the case of all bulk drugs cleared by Drug Controller General (India), all their intermediates and formulations, except those, referred to in para 12.I above, kept under industrial licensing.

III. Foreign Technology Agreements

Automatic approval for Foreign Technology Agreements will be available in the case of all bulk drugs cleared by Drug Controller General (India), all their intermediates and formulations, except those, referred to in para 12.I above, kept under industrial licensing for which a special procedure prescribed by the Government would be followed.

IV. Imports

Imports of drugs and pharmaceuticals will be as per EXIM policy in force. A centralized system of registration will be introduced under the Drugs and Cosmetics Act and Rules made thereunder. Ministry of Health and Family Welfare will enforce strict regulatory processes for import of bulk drugs and formulations.

V. ENCOURAGEMENT TO RESEARCH AND DEVELOPMENT (R&D)

(a) In principle approval to the establishment of the Pharmaceutical Research and Development Support Fund (PRDSF) under the administrative control of the Department of Science and Technology, which will also constitute a Drug Development Promotion Board (DDPB) on the lines of the Technology Development Board to administer the utilization of the PRDSF.

(b) With a view to encouraging generation of intellectual property and facilitating indigenous endeavours in pharma R&D, appropriate fiscal incentives would be provided.

VI. PRICING

(a) Span of Price Control

The guiding principle for identification of specific bulk drugs for price regulation should continue, as per DPCRC's recommendation, to be: (a) mass consumption nature of the drug and (b) absence of sufficient competition in such drugs. However, the DPCRC's recommendation regarding the new criteria for ascertaining the mass consumption nature of a bulk drug on the basis of the top selling brand is not acceptable as it gives rise to anomalies.

In this context, it may be noted that there is no tailor made data available for the purpose of ascertaining the mass consumption nature and absence of sufficient competition with reference to a particular bulk drug. There is only one source namely, "Retail Store Audit for Pharmaceutical Market in India" published by ORG-MARG, which lists out all major brands and their sale estimates on All India basis. This publication contains data for single ingredient as well as multi-ingredient formulations. However, it does not give complete description of all the ingredients of the pharmaceutical product listed therein.

Hence, there is need to obtain information in regard to composition of each brand, dosage form wise and pack wise, from various other publications / sources, viz.,

(a) Indian Pharmaceutical Guide (IPG)

a. Current Index of Medical Specialities (CIMS),
b. Monthly Index of Medical Specialities (MIMS),
c. Drug Today
d. Information provided by some manufacturers
e. Label composition as indicated on market samples.

Though none of these sources can be said to be exhaustive and comprehensive in regard to market information, yet under the given circumstances, these are the best available. It has also been noted that the sale value of any combination formulation is not directly relatable to a single particular bulk drug forming part of the combination formulation. Combination formulations involve too many variables, viz., strength of a particular bulk drug and its proportion with respect to other bulk drugs used in the combination formulation, price difference between bulk drugs used in combination formulation, pack sizes, dosage forms etc. In view of these facts, ORG-MARG sales data for combination formulations does not yield information in regard to mass consumption nature and absence of sufficient competition with reference to a particular bulk drug. Also, it is to be borne in mind that processing of such data, which requires cross-checking with other publications and sources of information in regard to composition of each brand, dosage form-wise and pack-wise may involve instances of omission / commission.

In view of above, it would be logical to conclude that although ORG-MARG sale estimates available in regard to all single-ingredient formulations of a particular bulk drug would not yield the sale value of that bulk drug in the form of all its formulations, yet it would adequately reflect the mass consumption nature of that bulk drug in the form of single ingredient formulations, which may be used as a practical indicator for formulating the policy.

The Department through NPPA, with the help of NIPER has developed the desired database for single ingredient formulations from the retail store audit data as published by ORG-MARG. On this basis, the Department proposes to undertake the exercise of identifying the bulk drugs of mass consumption nature and having absence of sufficient competition according to the following methodology: -

i. The 279 items appearing in the alphabetical list of Essential Drugs in the National Essential Drug List (1996) of the Ministry of Health and Family Welfare and the 173 items, which are considered important by that Ministry from the point of view of their use in various Health Programmes, in emergency care etc., with the exclusion., as in the past, therefrom of sera & vaccines, blood products, combinations etc. should form

the total basket out of which selection of bulk drugs be made for price regulation.

ii. The ORG-MARG data of March 2001 would form the basis for determining the span of price control as suggested by DPCRC.

iii. The Moving Annual Total (MAT) value for any formulator in respect of any bulk drug will be arrived at by adding the MAT values of all his single-ingredient formulations of that bulk drug, its salts, esters, stereo-isomers and derivatives, covering all the strengths, dosage forms and pack sizes listed against that formulator in all groups / categories of the ORG-MARG (March 2001).

iv. The MAT value for all the formulators, as defined in sub-para (iii) above, in respect of a particular bulk drug will be added to arrive at the total MAT value in the retail trade.

v. The MAT value for an individual formulator, in respect of any bulk drug, as arrived at in sub-para (iii) above, will be the basis for calculating the percentage share of that formulator in the total MAT value arrived at as in sub-para (iv) above, in respect of that bulk drug.

vi. Bulk Drugs will be kept under price regulation if:-

(a) The total MAT value, arrived at as in sub-para (iv) above, in respect of any particular bulk drug is more than Rs.2500 lakhs (Rs.25 Crore) and the percentage share, as defined in sub-para (v) above, of any of the formulators is 50% or more.

(b) The total MAT value, arrived at as in sub-para (iv) above, in respect of any particular bulk drug is less than Rs.2500 lakhs (Rs.25 Crore) but more than Rs.1000 lakhs (Rs.10 Crore) and the percentage share, as defined in sub-para (v) above, of any of the formulators is 90% or more.

vii. All formulations containing a bulk drug as identified above, either individually or in combination with other bulk drugs, including those not identified for price control as bulk drug, will be under price control. The Government shall, however, retain the following over-riding power:-

In cases of drugs/formulations listed by the Ministry of Health and Family Welfare, mentioned in sub-para (i) above, and those presently under price control, having significant MAT value as per ORG-MARG but not covered under the criteria in sub-para (vi) above, as a result of this proposal, the NPPA would specially monitor intensively their price movement and consumption pattern. If any unusual movement of prices is observed or brought to the notice of the NPPA, the Authority would work out the price in accordance with the relevant provisions of the price control order.

(b) Maximum Allowable Post-manufacturing Expenses (MAPE)

Maximum Allowable Post-manufacturing Expenses (MAPE) will be 100% for indigenously manufactured formulations.

(c) Margin for Imported Formulations

For imported formulations, the margin to cover selling and distribution expenses including interest and importer's profit shall not exceed fifty percent of the landed cost.

(d) Pricing of Formulations

(i) For Scheduled formulations, prices shall be determined as per the present practice. The time frame for granting price approvals will be two months from the date of the receipt of the complete prescribed information.

(ii) The present stipulation that a manufacturer, distributor or wholesaler shall sell a formulation to a retailer, unless otherwise permitted under the provisions of Drugs (Prices Control) Order or any other order made thereunder, at a price equal to the retail price, as specified by an order or notified by the Government, (excluding excise duty, if any) minus sixteen percent thereof in case of Scheduled drugs, will continue.

(iii) The present provision of limiting profitability of pharmaceutical companies, as per the Third Schedule of the present Drugs (Prices Control) Order, 1995, would be done away with. However, if necessary so to do in public interest, price of any formulation including a non-Scheduled formulation would be fixed or revised by the Government.

(e) Ceiling prices

Ceiling prices may be fixed for any formulation, from time to time, and it would be obligatory for all, including small scale units or those marketing under generic name, to follow the price so fixed.

(f) Exemptions

(i) A manufacturer producing a new drug patented under the Indian Patent Act, 1970, and not produced elsewhere, if developed through indigenous R&D, would be eligible for exemption from price control in respect of that drug for a period of 15 years from the date of the commencement of its commercial production in the country.

(ii) A manufacturer producing a drug in the country by a process developed through indigenous R&D and patented under the Indian Patent Act, 1970, would be eligible for exemption from price control in respect of that drug till the expiry of the patent from the date of the commencement of its commercial production in the country by the new patented process.

(iii) A formulation involving a new delivery system developed through indigenous R&D and patented under the Indian Patent Act, 1970, for process patent for formulation involving new delivery system would be eligible for exemption from price control in favour of the patent holder formulator from the date of the commencement of its commercial production in the country till the expiry of the patent.

(iv) The DPCRC has suggested that the low cost drugs measured in terms of "cost per day per medicine" may be taken out of price control. Any formulator can represent to NPPA with proof of per day cost to consumer-patient. NPPA will be authorised to exempt such formulation from price control if its cost to consumer-patient does not exceed Rs. 2/- per day, under intimation to the Government. All orders passed by the NPPA will be prospective in operation. Whenever the concerned formulator wishes to revise the price, he, before effecting any change in price, would be bound to inform NPPA and seek fresh exemption and in case the cost to consumer-patient, on the basis of the proposed revised price, exceeds beyond the limit of Rs. 2/- per day, obtain the necessary price approval.

(g) Pricing of Scheduled Bulk Drugs

i. For a Scheduled bulk drug, the rate of return in case of basic manufacture would be higher by 4 per cent over the existing 14 per cent on net worth or 22 per cent on capital employed. The time frame for granting price approvals will be 4 months from the date of the receipt of the complete prescribed information.
ii. The Government shall, however, retain the overriding power of fixing the maximum sale price of any bulk drug, in public interest.

(h) Monitoring

(i) The DPCRC's recommendations to have effective monitoring and enforcement system and to move away from the "controlled regime" to a "monitoring regime" is in the present context an extremely important recommendation as imports will increasingly compete with local drugs and pharmaceuticals in the domestic market. A new system based on solely market prices data is required to be evolved and controls applied selectively only to cases where, either profiteering or monopoly profit seeking is noticed. The National Pharmaceutical Pricing Authority, set up in August, 1997, would need to be revamped and reoriented for this purpose. It will continue to be entrusted with the task of price fixation / price revision and other related matters, and would be empowered to take final decisions. It would also monitor the prices of decontrolled drugs and formulations and over-see the implementation of the drug prices

control orders. The Government would have the power of review of the price fixation/and price revision orders/notifications of NPPA.

(ii) Although the prices of some bulk drugs have been steadily decreasing, yet the same do not get reflected in the retail price of non-Scheduled formulations. Also, there is need to check high margin/commission offered to the trade by printing high prices on the labels of medicines to the detriment of the consumers. It is, therefore, proposed to strengthen the National Pharmaceutical Pricing Authority by providing appropriate powers under the DPCO which would make it mandatory for the manufacturer to furnish all information as called for by NPPA and also to regulate such prices, wherever, required.

(iii) The other recommendations of DPCRC like giving powers to drug control authorities to dispose of small and petty offences etc., will require an amendment to the Essential Commodities Act. This suggestion is considered not practicable. Monitoring price movement of drugs sold in the country as well as that of imported formulations will require developing appropriate mechanism in the NPPA.

(i) Drug Price Equalization Account (DPEA)

Provision would be made in the new Drugs (Prices Control) Order (DPCO) to ensure that amounts which have already accrued to the DPEA and those which are likely to accrue as a result of action in the past, are protected and used for the purpose stipulated in the existing DPCO.

VII. QUALITY ASPECTS

The Ministry of Health & Family Welfare would

(i) progressively benchmark the regulatory standards against the international standards for manufacturing,

(ii) progressively harmonize standards for clinical testing with international practices,

(iii) streamline the procedures and steps for quick evaluation and clearance of new drug applications, developed in India through indigenous R&D, and

(iv) set up a world class Central Drug Standard Control Organisation (CDSCO) by modernizing, restructuring and reforming the existing system and establish an effective net work of drugs standards enforcement administrations in the States with the CDSCO as a nodal center, to ensure high standards of quality, safety and efficacy of drugs and pharmaceuticals.

VIII. PHARMA EDUCATION AND TRAINING

The National Institute of Pharmaceutical Education and Research (NIPER) has been set up by the Government of India as an institute of "national importance" to achieve excellence in pharmaceutical sciences and technologies, education and training. Through this institute, Government's endeavor will be to upgrade the standards of pharmacy education and R&D. Besides tackling problems of human resources development for academia and the indigenous pharmaceutical industry, the institute will make efforts to maximize collaborative research with the industry and other technical institutes in the area of drug discovery and pharma technology development.

HEALTH RELATED INDICATORS - INDIA AT A GLANCE [56]

Indicators	Estimate	Year	Source
Population (millions)	1027	2001	Census of India, 2001
Population growth (1991-2001)	21.34	2001	Census of India, 2001
Annual Population Growth (percent)	1.8	1992-2002	World Health Report, 2003
Population Density (per sq.km)	324	2001	Census of India, 2001
Sex Ratio (females per 1,000 males)	933	2001	Census of India, 2001
Crude Birth Rate (per 1000 population)	25	1999	UNPOP
Crude Death Rate	9	1999	UNPOP
Total Fertility Rate	3	2000 - 2005	Human Development Report - 2003
Infant Mortality (per 1000)	67	2001	Human Development Report - 2003
Maternal Mortality Rate	540	2001	Human Development Report - 2003
Human Development Index Ranking	127	2003	Human Development Report - 2003
Literacy (Total)	65.38	2001	Census of India, 2001
- Males	75.85	2001	Census of India, 2001
- Females	54.16	2001	Census of India, 2001
Increase in literacy	13.75	1991 - 2001	Census of India, 2001
People below poverty line (%)	28.6	2000	Human Development Report - 2003
Urban Population (%)	27.9	2001	Human Development Report - 2003
Growth of Urban population (annual)	2.2	1990 - 1998	World Bank
Life expectancy	63.9	2000	Human Development Report - 2003
Probability 0f Dying (per 1000) –Under age 5 Years (Male)	87	2002	World Health report 2003
Probability 0f Dying (per 1000) –Under age 5 Years (Female)	95	2002	World Health report 2003
Per capita GNP (US $)	440	1999	UNPOP
Population with access to proper sanitation (%)	28	2000	Human Development Report - 2003
Population with access to improved water sources (%)	84	2000	Human Development Report - 2003
Health Expenditure-Public (% of GDP)	0.9	2000	Human Development Report - 2003
Health Expenditure - Private (% of GDP)	4	2000	Human Development Report - 2003
Physicians per 100,000 population	48	1990 - 2002	Human Development Report - 2003
Population with Access to Essential Drugs (%)	0-49 [57]	1999	Human Development Report - 2003

[56] **Source:** http://www.youandaids.org/AsiaPacific/India.asp
[57] Very Low Access to Essential Drugs

Panel Discussion on WTO Issues

Conducted by CREAT, 1st Sep 2003, Ramanashree Comforts, Bangalore

The meeting was attended by about 25 people, mainly from academic institutions like IIMB, IIPM, NLSIU, etc., consumer organisations and kannada media. It was inaugurated by Sri. M. Veerappa Moily, Ex-Chief Minister of Karnataka and the Chairperson of Taxation Reforms Committee. The co-ordinator of CREAT, Mr. Y. G. Muralidhar chaired the sessions.

Mr. Veerappa Moily – Keynote address

- We need to take a balanced view of trade and WTO issues.
- Necessary to encourage potential to increase trade
- NO clarity on trade issues at many levels
- Developing countries must lobby for abolishment of agri subsidies at all levels and should not stand the unequal partnership existing at WTO
- Developing countries should be able to impose Quantitative Restrictions
- All negotiations and multilateral agreements must be based on the guiding principles of 'Right to Food'. There must first be a multilateral agreement on this
- Don't open up Indian market under pressure, which is 'extortion', but only on the basis of 'reciprocity'.
- If we work closely with China, we could be a strong force
- The disastrous effects of WTO are being felt. Economic and social sovereignty has been lost. "**By freeing the economy, we have caged ourselves**".
- "Is WTO integrating the World Economy? No, they are disintegrating the world's economy".
- Example from South Kanara district in Karnataka (Shri. Moily's constituency) shows that bidi and silk trade has been affected because some of "our own" social activists bring up issues like child labour, exploitation, etc. which helps the western markets reject our imports. We need self-regulation to curb this.
- We are not adequately utilising the existing safeguards in these agreements
- "Globalisation is destroying people's power and democracy".
- MNC's are destroying people's powers through "our own national corporations"
- The US is ready to phase out 'amber box subsidies', but not 'blue and green boxes'
- We need to introspect on 'what kind of globalisation we require', and not 'whether we require globalisation', globalisation is an inevitable reality
- Consumer groups are not fully prepared or equippe to effectively intervene in issues relating to international trade, WTO, etc. Hence awareness raising meetings such as this and workshops are required.

Shri Gopal Naik, IIMB – Agriculture and WTO

- When agriculture was brought into the purview of GATT, the idea was to freeze subsidies at the existing levels and to reduce it within a fixed time frame. The formula was worked out that developing countries would have to reduce only about two thirds of what the developed countries were doing (*this point was not clear to me and needs to be clarified*- Naveen).
- Single commodity exporting countries were badly hit by this and could not engage in international trade.
- However developed countries did not honestly reduce the committed subsidy levels
- It is unfair that developed countries are not reducing their subsidies while not allowing developing countries to increase theirs.
- Main issues required to create a level playing field are
    1. Do away with export subsidies completely
    2. Reduce domestic subsidies substantially
    3. Do away with amber, blue and green box concepts

Rupa Chanda, Associate Prof. IIMB – GATS and India

- US was pushed by the telecom and financial sector majors to include services into GATT (which was initially only a product trade agreement)
- Structure of services agreement (GATS) is different from the rest of the WTO stucture
- GATS structure is loose and flexible mainly because he Indian negotiators at that time were very strong and smart
- The conceptualisation of 'services ' as 'trade' was different, so even the agreement had to be different. Mainly through 4 modes – Cross Border, Consumption Abroad, Commercial Presence and Movement of Natural Persons.
- GATS agrrements can either be sectorally (like telecom, health etc.) or horizontally (i.e. across all sectors). Its 2 main components are: 1) Extent of allowances (like allowing partial/ full FDI and conditions therein) and 2) Extent of National Treatment (conditions imposed on foreign investors differently from those imposed on Indian companies)
- 161 activities in 12 sectors come under the GATS purview. It is a 'request-offer' kind of agreement.
- India is already way ahead of its commitments in GATS, for instance we have already allowed 26% FDI in Insurance and 74% in telecom.
- There is asymmetry in what we have attained in mode 3 and mode 4., with mode 3 being the highest utilised
- Till 1995, India was very defensive and offered very little in the Uruguay round in 1994, but now we have an offensive strategy in GATS.
- India has offers to open up many sectors. However there are indications that India will only commit to opening up the accountancy sector with some restrictions.
- US and EU is asking India to commit in various sectors atleast how much ever they have already opened in reality.
- Cancun meeting is mainly related to agriculture and IPR.
- "Opening the sectors will raise standards and bring in accountability".
- Problems with GATS agreement does not lie in opening up per-se, bt not having proper domestic regulations and monitoring structures.

Damodaran, Indian Institute of Plantation Management – TRIPS

- Article 27.3 is the most tricky article in TRIPS
- TRIPS 27.3b deals with rights of plant variety (either through patent or/and plant breeder's rights). US has patents and began giving patenets as early as 1930s.
- India in 2001 passed the Plant Varieties and Farmer's Rights Act, which gives recognition to plant breeders and farmers who have conserved varieties, but not patents.
- Issue in Cancun: from 2005, micoorganisms will also have to be recognised.
- India and Africa have a lot in common and are together opposing the microorganisms bit, but it seems like a "lost case"
- Under the flexible provisions of TRIPS, developing countries have two options: compulsory licensing and parallel imports.
- The agreement on flexible provisions of TRIPS which was recentlty clinched comes with a caveat that the size, shape, packaging, etc must be different for drugs produced under compulsory licensing.
- Indian drug manufacturers are not happy since investment required to make different shapes and different packaging will wipe out the margins thus making the flexible provisions less effective.
- Cancun negotiations very important in terms of livelihood and food security.
- In India lot of congruence between producer and consumer, therefore it is in the interest of poor people for consumer organisations to support the producer.

Meeting with Dr. Rupa Chanda, Associate Professor, IIMB
17 September 2003, Bangalore

- Dr. Rupa Chanda teaches Macroeconomics and Trade at IIMB and has worked extensively on WTO, GATS and Macroeconomics policies, including Trade in Health Services.
- My Background reading for this meeting included Dr. Chanda's ICRIER Report on Privatisation and 'The Health Care Policy Process' by Carol Baker.
- We discussed on efficiency and feasibility of regulations in India, USA and Canada. However Dr. Chanda agreed that replicating other models would not necessarily work.
- She suggested that professional bodies and association needed to be roped in to agree to voluntary regulations from an 'equity' perspective.
- She did not concur with the view that private sector's sole motive was 'profits and profits alone'.
- She gave instances from Cuba where money gained through health tourism was being used in promoting public health.
- Her two-pronged solution was in regulation (self imposed and by decree of law) and astute financial planning where profits from the private sector could be used to finance public sector.
- She also opined that ideally private sector should take care of the interests of those who pay and public sector of the rest.
- It was pointed out that this was not possible, and an example of the Karnataka Health Project was given, where the state did not see issues of urban poor as priority, since enough facilities were available (it did not matter that they were available in the private sector and the poor could not access it).
- She also said that as long as the working environment could not be improved in the public sector, services also could not be improved.
- Harnessing Corporate Social Responsibility (CSR) was another solution she suggested. She suggested that I meet Dr. Vasanti Srinivasan from IIMB who has worked on C.S.R.
- Using non-health related industries donations to build corpus for social insurances was another idea.
- As a first step to ensuring better regulation and identifying gaps, she suggested studying the existing legislations and enforcement of laws related to health sector. (Both private and public).
- Sharing her experience with the Ministry of Health while writing the position paper on 'Trade in Health Services' , Dr. Chanda said that she was appalled at their opposition to opening up the health sector and for not thinkng about " how do we compete and co-exist".
- She agreed to be a part of any future meeting we organised, including 'Right to Healthcare'.

Annexure 8

Report on All-India Drug Action Revival Meet Held on September 7, 2003

II Floor, Hall YMCA, Mumbai Central, Mumbai, 10 a.m. – 5.30 p.m.
(hosted by Forum for Medical Ethics)

- An informal chat with Dr.Dinesh Singh, Human Rights Law Network, Lucknow Before the meeting revealed that they had filed a PIL in the High court on quality of care in sterilization camps in U.P based on a study they conducted. Colin Gonsalves was representing them.
- Also met Chinu of Locost who gave copies of the 'prayers' in the drug price control case and the AIDS Drugs case. He has promised to send the full petition by mail.(it has already been sent to CHC and copies made).
- Locost has also become a party to the case and are fighting against the Government which is challenging the Karanataka High Court order stating that 'essential drug list is necessary and price control on these is essential? The next hearing of the case is on October 9 2003.
- Anant Phadke gave an overview of the meeting and AIDAN.
- Amit Sengupta said that India s a peculiar case with respect to pharma because India pharma companies were relatively successful while 80% of Indian did not have access to modern medicine.
- He said that the belief of Indian drugs being cheaper was a myth, as patented drugs were cheaper. On the issue of pricing he said that in 1978-343 drugs were under price control. 1987 – 166, 1994 – 73 and about 25-30 were expected now.
- And the profitability limits which were about 45% has been increased to 100 and more.
- The dependence on imports were increasing as many companies had moved from manufacturing to trading. Large cos. Have closed down their manufacturing units.
- The idea of essential drugs list in India predates WHO, but official Government list came only in 1996, 18 years after WHO.
- Amit feel that the problem of hazardous drugs was relatively minor and there were other priority issues including irrational use of drugs which were related to prescription practices and irrational combition of drugs, being produced.
- With Quantitative restrictions being lifted under WTO. The small scale sector was closing down.
- TRIPS in the long term would provide an enabling environment for the foreign sector there by making a dent in the Indian market.
- Amitava Guha said that only 2 out of the 45 MNC pharma cos. Are manufacturing in India, while the rest are importing from their parent cos.
- Therefore production is a big problem-therefore imports increases. Therefore it affects availability.
- 32 bulk drug in the essential list are being imported (This is shocking !!!!).
- Dumping in bulk drugs is also happening.
- The prices between branded and generics for the same drug varies upto 2000%. Therefore there is tremendous scope for price reduction. Often when drugs are banned, the orders stipulate that the ban will come into

effect after 2 years. If something is banned, it needs to be immediate and this delay in starting date defies logic.

- Action (A note on the history of AIDAN will be circulated by the old AIDAN members. Amit will write about EP. Force and SC case. Anand, Amit, Mira and others on Genesis CPMU will put it all together).
- The statutory bodies in drugs include:
    a) Drug consultative committee and (DCC)- not much powers, - all state drug controllers and commissionaires.
    b) Drug technical Advisory Board (DTAB) – highest body – by nomination
- Different organisations took up responsibilities to work on different aspects relating to drugs.
- CHC along with DSF and FMRAI (Amit Sengupta) agreed to work on WTO /TRIPS /GATS and its links to health policy.
- It was decided that Gopal Dabade would be the co-ordinator of the different groups. And within 6 months a formal AIDAN meeting would be called where organisational issues would be sorted out.
- Prasanna, CHC agreed to start an e-group for the group.

CHC Action Points

These points were discussed and finalised in a one- to one meeting with Amit.

1. A bibliography of relevant TRIPS /GATS/ WTO and health related does would be prepared by CHC. Amit would send relevant files. Also see http://www.delhiscienceforum.org
2. Based on the above, a training/ awareness module for JSA activists would be prepared, which could be translated into different languages.
3. If time permits, draft JSA position paper on the above issues would be prepared by June 2003 and circulated to all JSA members.

Annexure 9

Report of 'Book Release on Child Rights'

British Council Library, II Floor C wing, Mittal Towers, Mumbai
8 September 2003

- The author Asha Bajpai, was my Law Professor at TISS. I had worked with her on 'child and courts' – a project of TISS and Mumbai High Court during my summer vacation at TISS. She invited me to attend the book release.
- Justice A.K. Shah, the sitting judge of Mumbai high court, Mr. Satish Sahner, Ex-police comminission Mumbai and Ms. Alpa Vohra, child activities were the special guests.
- The book 'Child Rights in India' was released by Jus Shah, who called it the most comprehensive book on child right and issues.
- The other gusts also shared the same view
- Some aspects of the book were highlighted.
    - All-inclusive nature (child health, nutrition, education, prostitution, labour, culture, etc).
    - It has exposed mystery of 'hazardous labour' for children because how can we define 'hazardous' for a child.
    - Need for uniformity in the define of age of a child.
    - Bridges gap between academic and activist world.
    - Need for ' child focussed culture' was stressed.
- An interesting question from the book was read out. It is by a Brazilian writer / activist 'A Juvenile delinquent is a child caught red-handed in the fight for survival'.
- Having worked with juvenile delinquent in Umeskadi Observation Home. (Probably the largest such home in South Asia) at the beginning of my professional social work career, I can vouch for the above statement.
- During the discussions, I raised the point about 'Children in Emergency Situations'. And gave two examples.
    1) Children caught in riots / genocide in Gujarat. There was hardly any reference to their needs / rights either during the violence or after.
    2) Children in drought hit states of Rajasthan, and Gujarat. Certain regions in both state have been reeling under drought for the past 5 years. The children born / who are small during these 5 years would have received hardly any nutritious food resulting in reduced physical and mental growth? Child rights are hardly even mentioned in these contexts.
- If we are a society / nation which care about its children (our constitutions and agreements and declarations say that we do care) , then we need to do something about it .
- The author agreed that least work had been done on the about topic and promised to work on the issue in the future.

Annexure 10

WORKSHOP REPORT -"CAPACITY BUILDING ON BUDGET ANALYSIS" ORGANIZED BY ASTHA, THE BUDGET ANALYSIS RAJASTHAN CENTRE AND SAVE THE CHILDREN (UK), JAIPUR OFFICE, FEBRUARY 5-7, 2004

Introductory Session		
	(a) Welcome	
	(b) Contextual Background to the Concern About Budget Analysis	
	(c) Questions, Concerns and Expectations Participants Brought to the Workshop About Budget Analysis	
Why We Have To Understand The Budget		
	"Why Do We Need Budget Analysis: Disha's Experiences-Concepts and Utility"	
Definition and Classification of the Budget by Major and Minor Heads		
	Definitions	
	System of Accounting and Classification of Budget Expenditure by "Heads"	
	The Numerical Coding System of the Budget Heads	
		1. Major Head Social Services Major Heads and Accounting Code Numbers Economic Services Major Heads and Accounting Code Numbers Grants-In-Aid and Contributions Major Heads and Accounting Code Numbers
		2. Sub-Major Head
		3. Minor Head Codes and Common Nomenclature
Group Exercise		
More Information About Understanding Budgets		
	(a) The Process of Budget Decision-Making	
	(b) How Budgets Are Prepared	
	(c) How to Read Big Numbers	
Group Exercise		
Budgets and Advocacy – How NGOs Can Use the Budget		
	(a) Concerns	
	(b) Strategies and Insights	
Budget and Panchayats		
Budget and Education		
How to Get Information About the Government, From the Government		
Suggestions		
	About Future Budget Workshops	
	About Budget Analysis	
Conclusion		

"CAPACITY BUILDING ON BUDGET ANALYSIS"

The Budget Analysis Rajasthan Centre was established in 2002, and Save the Children (UK) has been supporting the Centre from the beginning. Save the Children, with its focus on Child Rights, Child Labour, Education, Health, Nutrition has also used the data of the Centre in its advocacy work. So, when BARC was approached by Save the Children with the request to organize a workshop for some of its partner organizations, some staff of Save the Children and other donor agencies active in the field of child rights and welfare, some government officers who work on child issues, and other NGOs from Rajasthan, the request was readily agreed to.

The Objectives of the Workshop were:

- To introduce the participants to the basics of State Budget Analysis, such that they can interpret it for programming purposes

- To provide the participants with knowledge on how analysis of the State Budget is closely linked with Development Issues, and how it could make a difference to the lives of marginalized communities

- To provide inputs on the role that civil societies and the community at large could play in the State Budget development process

In order to strengthen the training team of the Budget Analysis Rajasthan Centre, BARC contacted the team associated with the DISHA-Patheya BIAS Budget Analysis Centre in Ahmedabad, Gujarat, who readily agreed to be part of the Workshop training group. Dates were fixed so that the most senior budget analyst from Ahmedabad, Mr. M.D. Mistry, could attend.

There were 37 persons who attended the Workshop, and there were participants from the Save the Children partner groups, donor organizations, Rajasthan NGOs, and government officials – although the government officials were very few . Participants came from Gujarat, U.P., Uttaranchal and Rajathan. A list of participants is attached to this Report as Appendix No. 1.

Introductory Session

(a) Welcome

On behalf of the BARC and DISHA training teams, and on behalf of Save the Children (UK), Dr. Ginny Shrivastava welcomed the participants to the Workshop. After the introductions by each participant, she outlined the Objectives of the Workshop, and hoped that in the 3 days of working together, all would grow in understanding about the importance of using budget data to strengthen the advocacy work being done with and on behalf of the vulnerable and marginalized people with whom we work.

(b) Contextual Background to the Concern About Budget Analysis

She pointed out that the Rajasthan Budget Centre had been formed by Astha as part of the follow-up activities to a 10-District study that was done in 1996-98 in Rajasthan, to monitor the impact on the poor in the state of the economic policies of Globalization, Privatization and Liberalization. At that time, the data showed that in terms of amounts of loans taken by the poor for survival expenditures, the number of days of employment in a year, the family income, the consumption of food items, the number of children dropping out of school to join the workforce, that conditions for the poor were worsening as a result of these globalized economic policies. Today too, we see the effects of this "jobless growth" with migrant labour numbers increasing, rural health services deteriorating, private schools springing up all over in response to poor government schools. The policy of "privatization" is that the government must pull back from providing services that could, they say, be better done by the "private sector".

Working with the poor, we are concerned that the poor may not be able to pay for education for their children, for health services for their families, for basic foodgrains on the

open market, for private tankers to supply water, for tubewells to irrigate their fields, etc. By understanding the budget figures related to education, health, food security, drinking water, irrigation, etc. with the poor we can raise loud voices about government policies and provisions. And a look at the Departmental totals may not be enough – the Education budget may look quite large, but in looking at what that budget is spent on, we find that over 90% of the budget is spent on salaries. What is left for educational materials, school repair, school libraries, etc.? It is in this context -- that the larger or macro policies affect what is happening at the micro level, in the villages and towns in which we work -- that the Workshop has been organized.

(e) Questions, Concerns and Expectations Participants Brought to the Workshop About Budget Analysis

The chairperson then asked the participants to speak about concerns or expectations they had about budget analysis, and which they had brought to this workshop.

The first to speak was the Rajasthan State Labour and Employment Commissioner, Mr. Rajendra Bhanawat, who shared some of his concerns which he brought to the Workshop about budget analysis. One point he made was that while the state budget talks about income and expenditure of the state, there are also other expenditures made by the state which come from the Central Government, from donor agencies, international lending agencies, etc. The budget is for the state, but it does not show either all the income, nor all the expenditures since it does not include the details about the non-state sources of income and the expenditures of that money.

His second concern about the budget analysis, was that one could determine how much money had been budgeted and spent, but the budgets did not reveal the *outcome of the expenditures* – the *quality* of the work done, the *effectiveness* of the work done, on which expenditures were made. He made a plea that Impact Studies must be a part of Budget Analysis. He used as an example, Child Labour. There are about 20-25 laws made about Child Labour, but only making laws does not decrease child labour. There is no concerted programme of either the state or central government about Child Labour. He appealed to some NGOs or People's Organizations to take up this cause.

Mr. Dharmender Sharma, of PLAN India, also shared the concern about the need to evaluate the quality of the work done by the government. He was worried about education, and pointed out that in the last 5 years, the government of Rajasthan had opened about 23,000 Rajiv Gandhi Swaran Jayanti Schools throughout the state, but up to now, needed educational materials were not supplied and there had not been quality training to the teachers. The teachers' salaries were being paid, but there needed to be an evaluation of the educational experience of the children involved. He added that government schools spend about 90% on salaries and 10% on educational materials, training, buildings, etc. NGOs spend about 80% and 20% respectively. Some kinds of studies are needed to assess the input–output cost effectiveness to guide the government budgeting processes for education budgets.

From CUTS (Consumer Unity Trust Society), Mr. R.K. Sharma voiced the concern that the government gives out lots of data, but the difference between the data and the ground reality was often very great. There is a lot of talk about the growth and health of the economy of India, of how things are improving for all Indians. But Mr. Sharma said that things for the poor 70% of the population living in rural areas, is as it was 20 years ago. What is happening is that the rich are getting richer, and the poor poorer. He felt that budget analysis was one way to get some solid data that would expose the conditions of the poor.

Mr. Sanjay Awasthi of CARE said that it is absolutely right to join "budget" and "policy", and through budget analysis, one could see the efficacy of the policy.

Mr. Ramayan Yadav of Vigyan Foundation, Lucknow, stated that budget making should be done from the ground up. Gram Panchayats decide on needed expenditures at the ground level. When budgets for Blocks, Districts and then the State are done, those involved in making the budget should just add up all the demands originating from the needs of the

people in the local communities. He further stated that field related people must be involved in the process of making the state budget so that the budgets reflected the needs of all communities, including the poor.

Mr. Ramayan Yadav also had a question: "Why is Budget one thing, and Expenditure another?"

Everyone present affirmed the fact that in the present scenario, the study and understanding of the budget was necessary for those who are working with the poor.

Why We Have To Understand The Budget

Mr. Bipin Thakker, Research Officer (Budget and Policy) of the DISHA-Patheya team, started by sharing their own experience of how they got interested in the State Budget.

1986-1988 was a period of severe drought in Gujarat (in India as a whole too!), and DISHA advocated to the Government of Gujarat, that

- Minimum Wages must be given for Drought Relief Work (the government wanted to see drought relief work as "relief" and not as "work", and so the drought relief work payments were less than the Minimum Wage Act amount at that time).
- There must be an Employment Guarantee for a stipulated number of days of labour work per year for the poor

The Government of Gujarat refused, and the reason that they gave for refusing was that there was not enough money in the State Budget to cover the implications of these demands. Soon after that, the same state Government increased the salaries and dearness allowances of government employees! They could not pay more for poor unorganized labour, but there was money for government employees.

They started by wanting to analyse the Tribal Sub-Plan. Then they went to other budget books, and with all budget books, they faced a big problem – all the budget books are in "code". It took them a long time to understand the codes, but they succeeded, and now, every year, they study and analyse the budget books. They feed the data they pull out of those books to elected representatives, newspaper reporters, the media generally, intellectuals and academics and to the general public.

"Besides this, Gujarat government was coming out with information on how much money they spent on tribals and in tribal areas. Against the money spent, we hardly observed the 'change' in infrastructure and in the condition of the tribals. We were helpless, as we did not know how to monitor the spending. We decided that we **must** know and find out about the 'finances' of the state. We then tried to find out the budget of the Tribal Area Sub Plan. We got the budget document from the govt. book shop after some time. We studied the budget manuals and classified the data according to the departments from various budgets. We compared the spending in the **tribal areas** by various departments against the spending in the **non-tribal areas**. We published a write-up titled: "**It is nothing but an injustice to the tribals of the eastern belt by the govt. of Gujarat**" and sent it to govt.'s elected representatives, opposition parties, press and other media, public-cause advocates, etc. It created ripples among the decision makers! Next, we published about the **injustice** in distribution for irrigation, and **displacement** of tribals due to building of major and medium dams which led to **migration** from tribal areas to non-tribal areas."[58]

From these experiences, DISHA-Patheya started analysing the budgets of the state.

The Patheya team went on to say that through Budget Analysis, it is possible to see for which communities the government is spending money, what regions are selected and what regions are neglected. For example, in the Central Government budget, *the amount of money allocated for the National Commission for Women is only 30 lakhs for one year!*

[58] The material in quotation marks, is taken from the Power Point Presentation prepared by DISHA-Patheya BIAS on "Why Budget Analysis"

Women are a neglected area of the budget. In Gujarat, there are 4 labour inspectors budgeted for one large area – how can these few inspectors take many cases of less payment of wages, or other labour law violations? They cannot – so employers are relatively free to exploit labour in that area.

We work with the poor, and *hope* things go well. NGO workers usually do not want to go into budget figures – we are comfortable with slogans and meetings! But Industries hold meetings with the Finance Minister and advocate the policies they would like to see put in place. How can the voices of the poor get into the budget making process? We NGO social activists have to take the voices of the poor into the process. When we understand the budget making process, then we can negotiate. Who are the budget makers? The elected representatives can protest budget provisions, can make corrections. Departmental Committee Members of the Legislature and the Parliament have a lot of influence on the budgets of their department. We need to keep feeding MLAs and MPs, and keep informed about who are in the democratic structures of our governing decision-making bodies.

Another reason that we have to understand the budgets, and make them work for the masses of the poor, is that the main source of income for states comes from Sales Tax, and everyone pays Sales Tax. Therefore, the money the state government is spending is *our money*, which we pay to the government when we purchase matches, beedis, kerosene, petrol, soap, etc. etc. When the poor people pay into the government coffers, they are really only demanding that the money be spent in their best interest – it is their right to do so.

After these general remarks, and general comments by the participants, the DISHA-Patheya team led the group through a Power Point presentation about the need for an understanding of the state budget.

"Why Do We Need Budget Analysis : [59]
Disha's Experiences-Concepts & Utility

The state budget is the most solid expression of the Government's priorities, performances, decisions and intentions. The state as well as the Government with its various organs like the legislature, the executive and the bureaucracy seek their continued existence through the budget.

It is claimed and taken for granted, that the state as well as the Government exist for the welfare of the people. Again, the budget expresses and spells out that welfare.

And yet, it remains the most neglected document of the Government.

It is equally neglected as a procedure, or even as a ritual. It is the Bible that nobody reads, including the legislators, journalists, activists or most of the academics. As a Gujarati devotional song (bhajan) says, it is the blade of grass that hides a mountain - which nobody sees !

It would be obvious to any activist that vague, emotional, generalised complaints about injustice and deprivation is merely rhetoric that cannot be effective beyond public meetings. When dealing with the bureaucracy and the political leadership, or questioning the Government in the legislature or the serious and prestigious press, it is only facts and figures that count. And what better facts and figures than the Government's very own ones, given in the budget ?

[59] This material has been written for the Power Point presentation by DISHA-Patheya BIAS, Ahmedabad

Thus the utility of budget analysis is obviously strengthening:

(a) The claims of the poor in the state's resources, and
(b) Our understanding of the working of the state machinery.

The following is an account of our experience of the process of:
(a) Learning the science and the art of budget analysis,
(b) Making our fund of information public, and
(c) Influencing the political and non-political climate of opinion, as well as the decision-makers in the State

Public argument is the most effective means of involving citizens and NGOs in more responsive and responsible govt.

Effective public argument is based on verifiable information, constitutional validity, a cohesive socio-political perspectives and moral authority. (Information is power.)

Budgets reflect the policies and programmes of the government. So, for any realistic understanding of public policies one needs corresponding budgetary information.

Policy argument substantiated with budgetary information will be far more credible and effective. Budget analysis thus provides critical value addition to public advocacy initiatives.

The budget is an articulation of the existing power relations in society

Budgetary information and analysis in the local language, published in the form of readable booklets, has helped people see the budget as part of the reality of their lives.

It is no wonder then, that the budget needs demystifying, so that ordinary people can participate in the process, questioning and changing the budget in favour of the most deprived.

Budget Analysis Can Serve Three Functions

1. *The creation of public argument for policy change –*
   - *An effective public argument would go beyond a particular policy and would impact the entire ecology of that policy. Such a public argument derives its strength and vitality from the power of information and the power of people or of public opinion*
   - *Strategic use of budgetary information can be made to influence public perception and opinion. The success of a public argument should not be seen merely in terms of targeted policy change, but also in terms of attitudinal change among the people*
2. *Pre-budget lobbying to ensure a more equitable distribution of resources*
3. *An increase in the bargaining power of social action groups*
   - *Social Action Groups have neither electoral power nor money power. Most of these groups are too scattered to make any cohesive or far-reaching impact on political systems.*
   - *While many of them are effective at the micro-level, their bargaining power at the macro-level is very low.*
   - *But many micro-level organizations with an adequate mass base and strong information base on macro-level policies and other indicators, have proved that they can have substantial bargaining power at the macro level, particularly in influencing state-level policies*

Budget analysis was an interaction of the power of information with people's power (Disha's experience)

Budgetary information in a socio-political or ideological perspective becomes a source of budgetary knowledge. And knowledge is power.

The budget should not escape the scrutiny of the people. Unlocking the budget and opening the floodgates of information is the historical and political task of action groups.

Budget Analysis –

A means towards transparent and accountable governance."

Having stated that "unlocking the budget and opening the floodgates of information is the task of action groups", the DISHA-Patheya team next moved on to the session in which they explained about the codes and classification of the income and expenditure of the budgets of the state. They reported from their experience:

"The accounting codes, from major head, minor head, sub minor head and detailed head, the study of Finance Commission's reports to understand the devolution of financial resources and the business rules to conduct proceedings in the state assembly, gave us lot of ***confidence*** *and helped understand the state's income and expenditure."* [60]

Definition and Classification of the Budget by Major and Minor Heads

The training team explained the codes used in understanding what information was in the Budget Books, and how to find out data that one might want. They started with some of the basic definitions, and used Power Point presentations to make clear the code names, numbers, progression, and inter-relationships.

Definitions

1. ***"Annual Financial Statement"*** or ***"Budget"*** means a statement of estimated receipts and expenditures of the state in respect of a financial year, laid before the legislature under Article 202 of the Constitution.
2. ***"Consolidated Fund"*** is the fund formed under Article 206 of the Constitution comprising all revenue received by the government, all loans and ways and means advances raised or received by it and all moneys received by it in the payment of loans. The disbursements made out of these receipts are shown on the expenditure side of the fund. The expenditures are summarized according to headings, from Major Head to Object Head.
3. ***"Major Head"*** means the main unit of account for the purpose of recording and classifying the receipts and expenditure of the state according to various functions of government. Example – education, agriculture, health, etc.
4. ***"Sub-Major Head"*** means an intermediate head of account introduced between a a Major Head and a Minor Head under it, when the Minor heads are numerous and can conveniently be grouped together under such intermediate heads.
5. ***"Minor Head"*** means a head sub-ordinate to a Major Head or a sub-Major Head. It identifies the "programme" undertaken to achieve the objectives of the functions under Plan/Non-Plan programme.

[60] Taken from the Power Point presentation "Why Budget Analysis", prepared by the DISHA-Patheya team.

6. ***"Sub-Head"*** means an unit of account, next sub-ordinate to a minor head, which indicates a scheme or activity undertaken as a part of the programme represented by the Minor Head. In regard to non-development or administrative expenditure, it denotes an organization or a particular wing of administration.

7. ***"Detailed Head"*** or ***"Object Head"*** means the smallest accounting unit subordinate to the sub-head indicating object of expenditure such as salaries, travel expenses, etc.

8. ***"Budget Estimates"*** are the detailed estimates of the receipts and expenditures included in the budget for a financial year. It is the estimated budget amount needed for the item in that financial year, and appears on the charts as "BE".

9. ***"Revised Estimate"*** is an estimate made after 6 months of the financial year (around September or October) of more accurate estimates of the probable receipts or expenditure for the remaining months of the financial year. It is summarized in the budget charts as "RE"

10. ***"Charged Expenditure"*** means such expenditure as is not subject to the vote of Legislature and is declared to be charged on the Consolidated Fund of the State under Article 202(3) of the Constitution of India. E.g. expenditures on the President of India, the Election Commission

11. ***"Revenue and Capital Expenditure"*** – Expenditure is classified under two headings, revenue and capital.
    a) Revenue Expenditures – are "current" expenditure
    b) Capital Expenditures – corresponds to expenditure on investment

12. ***Development and Non-Development Expenditures" --*** All expenditures incurred for creating new assets or services are "development expenditures", while that incurred for administrative purposes or for collection of taxes etc. is "non-development expenditure."

13. ***Plan and Non-Plan Expenditure" –*** Plan expenditure is that which is provided for in the Five-Year Plans. Plan expenditure has to be utilized within the time period set by the Plan. If however, the scheme/programme extends beyond the time provided for in the Plan, then the further expenditure to be incurred on the project will be categorized as non-Plan expenditure. Plan expenditure may be either revenue or capital expenditure.

For the purposes of our budget analysis, we can start with the

Consolidated Fund of the State

into which **Revenue** comes, and out of which **Expenditures** are made

Revenue	**Expenditure**
a) Tax Revenue	a) General Services
b) Non-Tax Revenue	b) Social Services
c) Grants-in-Aid and Contributions	c) Economic Services
d) Public Debt	d) Grants-in-Aid and Contributions
e) Loans and Advances	e) Loans and Advances

Revenue

A. Tax Revenue
   a) Taxes on Income and Expenditure
   b) Taxes on Property and Capital Expenditure
   c) Taxes on Commodities and Services

B. Non-Tax Revenue
   a) Fiscal Services
   b) Interest Receipts, Dividends, and Profits
   c) Other Non-Tax Revenue
      i) General Services
      ii) Social Services
      iii) Economic Services

Expenditure

A. General Services

a) Organs of the State

b) Fiscal Services

i) Collection of Taxes on Income and Expenditure

ii) Collection of Taxes on property and Capital Transactions

iii) Collection of Taxes on Commodities and Services

iv) Other Fiscal Services

c) Interest Payment and Servicing of Debt

d) Administrative Services

e) Pensions and Miscellaneous General Services

f) Other

B. Social Services

a) Education, Sports, Art and Culture

b) Health and Family Welfare

c) Water Supply, Sanitation, Housing and Urban Development

d) Information and Broadcasting

e) Welfare of SCs, STs and OBCs

f) Labour and Labour Welfare

g) Social Welfare and Nutrition

h) Others

C. Economic Services

a) Agriculture and Allied Activities

b) Rural Development

c) Special Area Programmes

d) Irrigation and Flood Control

e) Energy

f) Industry and Minerals

g) Transport

h) Communications

i) Science, Technology and Environment

j) General Economic Services

D. Grants-in-Aid and Contributions

a) Grants-in-Aid to Panchayats

E. Public Debt

a) Internal debt of state government

b) Loans and Advances from Central Government

F. Loans and Advances

a) Loans and Advances for programmes or projects under different Sub-Sectors

The System of Accounting and Classification of the Budget Expenditure by "Heads"

Accounting Head	Description
Major Head	Functions or Major Divisions of Sub-Sectors of Services, such as Technical Education, Family Welfare, etc.
Sub-Major Heads	Sub-Functions or components of functions clubbed under Major Head
Minor Heads	Programmes undertaken under each Function such as Training, TASP, Welfare of SC/ST/OBC, etc.
Sub Heads	Schemes under each programme such as Assistance to SC/ST Students for Books, Health Education, etc.
Object Heads	Inputs of different schemes such as salaries, purchase of materials, grant-in-aid, etc.

The Numerical Coding System of the Budget Heads

(1) Major Head A 4-Digit Code. Revenue Receipts Start with "0"
Revenue Expenditures Start with "2" or "3"
Capital Expenditure Starts with "4" or "5"
Loans and Advances Start with "6" or"7"
Code starting with "8" represents Contingency Fund or Public Account

Example of Major Heads

0210 – Revenue Receipt Head of "Medical & Public Health"

2210 – Revenue Expenditure Head of "Medical & Public Health

4210 – Capital Expenditure Head of "Medical & Public Health

6210 – Loans for "Medical and Public Health"

SOCIAL SERVICES

MAJOR HEADS AND ACCOUNTING CODE NUMBERS

(a) Education , Social , Art and Culture

2202. General Education
2203. Technical Education
2204. Sports and Youth Services
2205. Art and culture

(b) Health and Family Welfare

2210. Medical and Public Health
2211. Family Welfare

(c) Water Supply , Sanitation , Housing and Urban Development

2215. Water Supply and Sanitation
2216. Housing
2217. Urban Development

(d) Information and Broadcasting

2220. Information and Publicity
2221. Broadcasting

(e) Welfare of Scheduled Castes , Scheduled Tribes and Other Backward Classes

2225. Welfare of Scheduled Castes , Scheduled Tribes and Other Backward classes

(f) Labour and Labour Welfare

2230. Labour and Employment

(g) Social Welfare and Nutrition

2235. Social Security and Welfare
2236. Nutrition
2245. Relief on account of Natural Calamities

(h) Others

2251. Secretariat-Social Services
2252. Other Social Services

ECONOMIC SERVICES

MAJOR HEADS AND ACCOUNTING CODE NUMBERS

(a) Agriculture and Allied Activities

2401. Crop Husbandry
2402. Soil and Water Conservation
2403. Animal Husbandry
2404. Dairy Development
2405. Fisheries
2406. Forestry and Wild Life
2407. Plantations
2408. Food Storage and Warehousing
2415. Agricultural Research and Education
2416. Agricultural Financial Institutions
2425. Co-operation
2435. Other Agriculture Programme

(b) Rural Development

2501. Special Programme for Rural Development
2505. Rural Employment
2506. Land Reforms
2515. Other Rural Development Programme

(c) Special Areas Programme

2551. Hill Areas
2552. North Eastern Areas
2575. Other Special Areas Programme

(d) Irrigation and Flood Control

2701. Major and Medium Irrigation
2702. Minor Irrigation
2705. Command Area Development
2711. Flood Control and Drainage

(e) Energy

2801. Power
2802. Petroleum
2803. Coal and Lignite
2810. Non-Conventional Sources of Energy

(f) Industry and Minerals

2851. Village and Small Industries
2852. Industries
2853. Non-ferrous Mining and Metallurgical Industries
2875. Other Industries
2885. Other Outlays on Industries and Minerals

g) Transport

3001. Indian Railways-Policy Formulation , Direction , Research and other Miscellaneous Organisation
3002. Indian Railways-Commercial Lines-Working Expenses
3003. Indian Railways-Strategic Lines-Working Expenses
3004. Indian Railways-Open Line Works (Revenues)
3005. Payments to General Revenues
3006. Appropriation from Railway Surplus
3007. Repayment of Loans taken from General Revenue
3025. Payment towards amortisation of over capitalistion
3051. Ports and Light Houses
3052. Shipping
3053. Civil Aviation
3054. Roads and Bridges
3055. Road Transport
3056. Inward Water Transport
3075. Other Transport Services

(h) Communications

3201. Postal Services
3225. Telecommunication Services
3230. Dividends to General Revenues
3231. Appropriations from Telecommunications
3232. Repayment of Loans taken from General Revenue by Telecommunications
3252. Satellite Systems
3275. Other Communication Services

(i) Science Technology and Environment

3401. Atomic Energy Research
3402. Space Research
3403. Oceanographic Research
3425. Other Scientific Research
3435. Ecology and Environment

(j) General Economics Services

3451. Secretariat-Economic Services
3452. Tourism
3453 Foreign Trade and Export Promotion
3454. Census Surveys and Statistics
3455. Meteorology
3456. Civil Supplies
3465. General Financial and Trading Institutions
3466. International Financial Institutions
3475. Other General Economic Services

GRANTS-IN-AID AND CONTRIBUTIONS

MAJOR HEADS AND ACCOUNTING CODE NUMBERS

3601. Grants-in-aid to State Governments
3602. Grants-in-aid to Union Territory Governments
3603. Payment to States share of Union Excise Duties
3604. Compensation and Assignments to Local Bodies and Panchayati Raj Institutions
3605. Technical and Economic Co-operation with other countries
3606. Aid Materials and Equipment

2. Sub-Major Head A 2-Digit Code They start with "01". "General" has been allotted code "80" which is the last Sub-Major Head
Its place is right under the Major Head
If there is no Sub-Major Head, the Major Head is followed by the Minor Head Directly.

3. Minor Head A 3-Digit Code Standard Codes 001 – 100
750 – 900
Non-Standard Codes
i) 101 – 200 Revenue Expenditure Series
ii) 201 –onwards. Capital and Loan Series

001 – Always "Direction and Administration
800 – "Other Expenditure"

Minor Heads

Minor Heads having common nomenclature under various Major/Sub-Major Heads, have same 3-digit code, as given below:

Code	**Common Nomenclature**
001 -	Direction & Administration
003 -	Training
004 -	Research/Research & Development
005 -	Investigation
050 -	Land
051 -	Construction
052 -	Machinery & Equipment
190 -	Assist. to Pubic Sector Undertakings
501 -	Services and Service Fees
791 -	Loss by Exchange/Gain by Exchange
792 -	Irrecoverable Loans Written Off
793 -	Special Central Assistance for SC Comp. Plan
794 -	Special .Central Assistance for Tribal Sub Plan
796 -	Tribal Area Sub Plan
797 -	Transfer .to/from Reserve Funds/Deposits
798 -	International Co-operation

Note: After having said all this, it was mentioned that Budget patterns vary from state to state. What is being quoted above is the Central Government system, which is more or less followed by the states. However, there is a need to press for the Central Government system of headings and code numbers to be adopted uniformly by all state governments.

Group Exercise

After all the explanations had been made about the Budget Heads, numbering systems, etc., Budget Books were distributed around the room, and 2-3 participants each took a book and tried to find the amounts budgeted for designated budget heads. They had a chance to search out a Major Head, a Sub-Major Head, a Minor Head, and Sub-Heads. Most participants were able to do the exercise with a little help from training team members.

It was pointed out that there is a Manual, which lists the Major and Minor Heads of Account. The title of the book is:

"List of Major and Minor Heads of Account of Union and State Governments."

Reprint of Fourth Edition, Vol. I and Vol. II

Issued by the Ministry of Finance

Department of Expenditure

Controller General of Accounts.

2001.

More Information About Understanding Budgets

Mr. M.D. Mistry, the Managing Trustee of DISHA, Ahmedabad, spent the whole day with the participants, sharing his insights into work on Budget Analysis from his long experience of work on budgets in DISHA, and from the insights he had gained recently from being a Member of Parliament. It was a rich experience to have him as a resource person in the training programme.

He reminded us in the beginning, that the country's policies are not going in favour of the poor, and those of us who work with the poor, have to get rid of our allergy to working on money issues. The country is boasting 7-8% growth rate, but all around us we see that employment is down, "jobless growth" – there is no "trickle down" happening. The policies are the cause of these results. We who work with the poor, must equip ourselves with the technical skills and knowledge to advocate on their behalf.

(a) The Process of Budget Decision-Making

He then began by explaining to the participants, some of the technical terms, which had not come the day before:

"Revenue Expenditure" – Revenue Expenditure is for the normal running of the government Departments, and various services, interest charges on debt incurred by the Government, subsidies, etc. Broadly speaking, expenditure, which does not result in creation of assets, is treated as revenue expenditure. It can be either "Plan" or "Non-Plan."

"Voted Expenditures" and "Charged Expenditures".

"Voted Expenditures" –The Assembly has to vote on the proposed expenditure

"Charged Expenditure" – no Assembly or Legislature voting is necessary.

The Finance Minister -- All the changes in the Budget that are wanted, have to come through the Finance Minister**.**

"**Cut Motion** " -- Opposition MLAs can put a "Cut Motion" in the Assembly, which means that the MLA wants to decrease or increase a budget head. These motions come while the Assembly is in session, and during the days of discussion on the Budget, which the ruling party has put before all the MLAs in the Legislature.

"**Interim Budget**" – A question was asked by a participant, what was an Interim Budget. The Rajasthan Government had just introduced an Interim Budget in the Assembly a few days before the Workshop. The entire Budget was put in the Legislative Assembly, and then quickly, a request for a vote on an "Interim Budget" – 4 months of expenditures – was put up by the ruling party, and passed, and then the Assembly was dissolved until after the Central Government elections. Mr. Mistry said that an "Interim Budget" is just that, that a portion of the total budget is passed as the House does not have the time to debate the entire budget, due to some emergency or another. He felt that in the Rajasthan case, there was no need for an Interim Budget – there was no Emergency facing the government. He speculated that there must be some new taxes, or budget cuts in the full budget, and if the people knew about those, they would feel unhappy with the ruling party at the state level – which might affect some votes from Rajasthan in the forthcoming Parliamentary elections.

"**Finance Commission**" – There is a Finance Commission at the Centre, and Finance Commissions art the State level. The Finance Commission members have a major role to play in determining what comes in or does not come in the Budget. The Constitution says that the Commission must be re-constituted every 5 years. Every State puts its demands to the Finance Commission at the Centre, pleading its case for Desert Development, numbers of BPL families, etc. At the State level, the Departments and Ministries put their cases to the State Finance Commission.

The members of the Finance Commission select the formulae for allocation of money – percentages are allotted according to population, or backwardness, or how well the department or state had managed its earlier finances, etc. However, he felt that the Chairman of the Planning Commission could influence the character, bias or "tilt" of the budget more than the Finance Commission.

The above structures and funds are all related to the knowledge we need when we want to make a strategy to advocate for increases in budget allocations, or decreases in others, on behalf of the poor and marginalized. Who are the decision-makers, what are the channels, which kinds of changes can be made by which structures. Mr. Mistry did not spell out advocacy strategies – that came later – but he did introduce the participants to the decision-making bodies and processes above.

(b) How Budgets Are Prepared

The Constitution of India outlines how budgets of the state are to be prepared. What is detailed in the Constitution, is that:

- The Gram Panchayat comes to agreement on what development and other resources are needed at the Gram Panchayat level. Then they pass on their demands and requirements to…..

- The Panchayat Samiti or the Block, where the elected representatives and the government staff consolidate all the requirements of all the Gram Panchayats in the Block, and send them on to ……

- The District Level Zila Parishad, where, with the help of the state government and central government officers in charge of the various departments, sort all the requirements of the Blocks into the various Departmental programmes and provisions, and send the District-wide requirements to …….

- The State Level where all the District financial requirements are put together into

the State Budget of requirements for the coming year. These ones are sent to the state Finance Minister. For some of the requirements, the resources of the State will be used, and for some, Central Government assistance will be available, and so whatever is needed "to go on up", will be sent to the Central Government for consideration and consolidation with the requirements of other states, ending up in the office of the Central Government Finance Minister..

However, although this is the procedure outlined in the Constitution, it is seldom or never followed. The senior government officials and elected representatives, committees of the Legislature, officers in the Budget Department, make the budgets, and do not ask or consult the people at the Gram Panchayat and Block levels about their needs. They make the budgets based on their own understanding of what is needed. This is very frustrating and demoralizing for those meeting in the Gram Panchayats and the Gram Sabhas at the grassroots level. It is also very un-constitutional!

There is another major problem with the "budget making system", and that is in relation to the Revised Estimates, which are done 6 months into the financial year. Departmental officials and probably a few elected representatives, make decisions in September and October to revise the budget estimates that had been submitted in the Legislature for discussion in the previous March. The budgets are revised, but the revisions are not public knowledge, until they come out in the budget books for the next financial year, the following March. In the interest of budget transparency, and the Right to Information, the Revised Budget process should be both more participative and more transparent. At present, it is totally an internal process, and the figures are not even put in the Assembly. This is a matter that needs to be taken up.

(c) How to Read the Big Numbers

The previous day, the participants had looked in the budget books, and found the Major Heads, Minor Heads, and taken a look at the figures beside those Heads. But actually reading the big figures, and comparing them, and understanding them, and putting them in a way that others can understand them, also needs to be learned.

The DISHA-Patheya team had handed out budget sheets the night before, and in this session, the participants tried to understand the numbers. For the purpose of explaining what was learned, 1 Major Head is reproduced below, from the sheet "Child Welfare Schemes – Government of Rajasthan, Year: 2001-02 to 2003-04"

Major Head "2202 General Education" Budget Figures for 2002-03 to 2003-04

(Rs. in thousands)

Year	Non-Plan Rs.	Plan Rs.	CSS * Rs.	Total Rs.
2001-02 Account	14164751	2274783	150899	16590433
2002-03 B.E.**	17873301	645905	155494	18674700
2002-03 R.E.***	16738437	809929	1308382	18856748
2003-04 B.E.	17482072	1619624	2251277	21352973

- CSS – Central Sponsored Scheme

** B.E. – Budget Estimate

*** R.E. – Revised Estimate

Now, first of all, all these figures are *in thousands of Rupees!* That means, that in getting the

true figure, it is necessary to add 3 zeros onto the number. E.g. Total money spent on General Education in Rajasthan in 2001-02 is Rs. 16590433000. When we put commas in that figure, we get Rs. 16,59,04,33,000. Now, it is possible to say: 16 arabh, 59 crore, 4 lakh, 33 thousand rupees, but people do not relate to that very well. And they do not relate to the big figure standing with 11 digits either. So, in putting the figure before the public, MLAs, the press, it is more meaningful (not more correct – all are correct), but more meaningful to say Rs. 1,659 crores and 4.33 lakh were spent on General Education in 2001-02. Then we can see that the Budget Estimate for General Education for the financial year 2003-04 is a total of Rs. 21352973000, or Rs. 2,135 crore, 29.73 lakhs.

From this table, it is also possible to see that between the Budget Estimate, and 6 months later, the Revised Estimate for 2002-03, both the Non-Plan and Plan Estimates went down, but the Centrally Sponsored Scheme Estimate went up, from the Budget Estimate of Rs. 15 crore, 54.94 lakh to Rs. 130 crore 83.82 lakh. To find out on which programme or for which purpose in General Education the increase from the Centre was intended, it would be necessary to go back to the budget books and look in the Minor Heads of General Education.

As Appendix No. 3 of this Report, please find another table of Budget Estimates and Actual Expenditures on the issue of Child Labour. Here, the figures are not big, they are small, but raise some serious questions for those working in the field of Child Rights. The title of the Table is: "Rajasthan State Revenue Expenditure on Child Labour Welfare Programmes in the Financial Years 1998-99 to 2002-03".

Group Exercise

In the Workshop, the participants were divided into groups of 4-5 persons, and each group was given a budget book. Exercises in finding the Heads and reading the numbers were given to the groups. The training teams of DISHA-Patheya and BARC helped, and Mr. Mistry himself joined in to help groups that were having some trouble. Everyone felt more confident after having gone through these exercises.

Budgets and Advocacy – How NGOs Can Use the Budget

> *"The Government Exists for the Welfare of The People"*
>
> -- Check the Budget --

(a) Concerns

In reading through the list of Major Heads, the reach of the Government is very wide – almost everything comes under its purview. The state is controlling or managing the society, and we can understand what is happening by understanding the finances.[61]

Again, it was highlighted that the source of income of the revenue is from the people – Income Tax accounts for hardly 1% of the total Budget. Sales Tax was discussed earlier. Even Non-Tax Income has a significant share of the money of the poor -–police fines, forestry and wildlife fines, forest produce income earned from the labour of the poor, mining income from the labour of the poor. Whatever is done with the public money of the state, it must improve conditions of the poor at large.

With prestigious highway projects making fast, four-lane highways with limited access roads and toll booths, the economy of the rural people is changing. Gone are the tea and

[61] It is not possible to get information about Military and Security expenditures. For Defence, in Rajasthan, it will be helpful to look in Desert Development in Border Areas to get a part of the picture of defence expenditures.

snack small shops, the village people selling guavas, *sita phul* and *jamoon.* Aside from that, the difference between the "ordinary roads" and the "fast track roads" is very large – the pot holes remain – symbolic of the priorities of the government in this age of "globalization".

Aside from Prime Ministers' Highways, changes are taking place which affect us all, and the poor particularly:

- High per capita income does not correlate with low infant mortality – increased prosperity is not leading to better quality of life. In Gujarat, the per capita income is higher than the national average, and the infant mortality is also higher than the national average. What is going on here?
- Interest rates in Banks are steadily dropping, so that people will put their money in mutual funds and stocks of industry, where the returns are said to be higher. Do the poor enter the stock market?
- Rs. 67,000 crores are spent on Defense – how much is spent on Women and Children?

Social workers and social activists have to participate actively in advocacy, and use the power that budget analysis will add to that. M.D. Mistry talked from experience, about some of the strategies and insights that he wanted to share.

(b) Strategies and Insights

"We highlight the Poor, Dalit and Tribal – we say we are un-biased, but we are not. We are biased in what information we choose. "

How to choose what to pull out of the budget and highlight, and what is of no use for the causes we are working for? M.D. Mistry advised:

> "Dive into the budget with a question – you need a
>
> lot of activist experience to make all the linkages.
>
> But questions help."

Perception of "the poor", of "the people" needs to be clear. There needs to be *consistency in that perception.*

"The way to get the most out of this budget analysis, is if you have your own analysis of society."

"Whatever documents are produced and made public, make sure that the sources are clear, and that the figures are accurate. The whole exercise can have a reverse effect if there are mistakes. "

With these insights as background, he shared several strategies that could be done by those doing advocacy work with and on behalf of the poor –

- The DISHA-Pateya team analyses the budget as soon as they can get a copy, and while the budget debate in the Assembly is going on, they write, on a daily

basis, 3-4 pages about the budget, highlighting some data which is not pro-people/pro-poor. These short notes are delivered in envelopes in the night to the MLAs during the Budget Session in the Assembly, with a stamp on the envelope "Important for Budget Discussion". The MLAs read these dispatches, because they are short, because they do not understand much about the budget on their own, and if they are in the Opposition, because they can get some data to speak in the Assembly and be recognized. This has been an effective strategy for getting public debate on matters affecting the poor.

- In addition, the DISHA-Patheya team formulate questions to be asked in the Assembly, and give these questions to selected MLAs who are often of the Opposition Party, and so debate on issues affecting the poor come into the Legislature, and into the press – into the public arena.

- There is a need to correlate the figures data from the budget sheets and budget books with other data of the state – like the number of children going to school, the child mortality rates, etc. Sometimes this data is available in documents and reports of the government departments, sometimes it is not. If it is not, doing sample survey impact studies or surveys, getting defendable data, would be a way to highlight the inadequacies of the budget amounts.

- Another kind of survey research would be to do micro studies to check out the claims of the policy makers, when they say that their policies are being implemented on the ground.

- Some knowledge of the budget will help when framing advocacy strategies, so that the people advocating the change will be ready with the replies of the government. And example is: Many women's groups in Rajasthan are advocating for the closure of liquor shops, for taking liquor contractors out of the tribal areas – *"Daru pina bund kero! Daru baijna bund kero!"* However, to know that the Government of Rajasthan gets Rs. 1,214 crores per year as income from the Excise of the liquor contracts means that the government will not easily listen to the shouted demands of the women. Country liquor contract royalties net Rs. 539 crores, Indian Made Foreign Liquor earns Rs. 507 crores, Spirits Rs. 120 crores, and Rs. 1.5 crores miscellaneous. The anti-liquor movement will have to be ready with an answer to the government. The Government will undoubtedly say they cannot afford to do without the liquor income. What will the women say?

- Establishing arguments for increases in expenditures in tribal areas could be done by calculating the amount of money that is earned by the state as Income from tribal areas, and calculating how much Expenditure is made by the state in tribal areas. Since the income will be more than the expenditure, the figures added to the advocacy demands will strengthen the case.

- Sit with the budgets and with Policy Documents, and see if the Policies match the budgets. Do the policies have a chance of being implemented with the finances budgeted? e.g. The policy of the Centre is that 33% of all budgets will be for implementing the Women's Development Policy, but the Central Allocation for Women is only 7% of the budget resources!

- Use the democratic structures, documents, and channels established to monitor the budget expenditures and the performance of the government:
    1. Write to the Estimates Committee for a public hearing on suggestions for revision of the budget
    2. Write to the chairperson of the Vigilance Commission asking him/her whether things have been done or not – irrigation, road building, etc. The District Monitoring and Vigilance Committee chairperson is the sitting MP. Central Government Officers, and related state officers, all MLAs, the

Chairperson of the Zila Parishad are members. The Chairperson nominates an NGO, a woman, and 2 more persons for membership in the Committee.

3. Get a copy of the Performance Budget of the state, which is a public document, to monitor the budget
4. Go through your local MLA to get information about what has been done against what was budgeted.

- The Budget Analysis Team also go to the Gram Panchayat level, Block Level and District Level, and talk with people, informing them about budget issues that affect their lives, and encourage them to pressure the government to provide what is budgeted.

- Aside from the Consolidated Fund money, there are also other government funds that can be spent at the local level. Those are the funds that the MPs and MLAs have to spend at their discretion in the area of their constituency. MPs have Rs. 2 crore per year; MLAs have Rs. 60 lakhs per year; and at theDistrict level, Zila Pramuks have Rs. 5 lakhs per year. The applications are channeled through the District Collector, and after the proposal is sanctioned, the MLA or MP is informed. Then, it is good if the MLA or MP sits with the people in the area where the project will be implemented, and the people understand the budget of the project so they can monitor it at the local level. Activists and people of the area can find out what happened to that money through the office of the Collector.

- M.D. Mistry pointed out that in many countries of the world, Labour Unions formed Labour Parties and entered the political field to go into the Parliaments and Assemblies to make the decisions that they wanted to see happen. One strategy for social activists working with the poor, would be to enter politics and fight from the "inside", by either standing for election, or forming a new political party.

One of the participants noted that election time is a good time to advocate for more resources to go to the people from the government budgets. She suggested that since the Parliamentary elections were coming up, that the Rajasthan organizations should lobby that the amount spent on the Mid-Day Meal Scheme for children in schools, to be raised from 50 paisa per child per day, to Rs. 2 per child per day. Karnataka is already spending Rs. 1 per day per child on the Mid-Day Meal. Since many of the NGOs present from the 4 states work on issues of children, they said they would discuss the issue with others after returning home.

Budget and Panchayats

The Panchayati Raj System is a 3-Tier System – Gram Panchayat, Block, District. The Rajasthan State's First and Second Finance Commission financially and economically empowered the Panchayati Raj structures, but in fact, in this present time, but Panchayats have no financial powers, and they only implement what is handed down to them from the State Level.

What resources have been channeled into the PRI from the state, can be found in the offices of the Block and District bodies. Although the 73rd and 74th Amendments of the Constitution intended to give more powers to the Panchayati Raj bodies, the financial powers are yet to be seen. The PRIs have no taxing power. The state is very reluctant to give up such powers.

The budgets for the Blocks in a District, can be found at the office of the Block

Development Officer. The District also has Block-wise Budgets. The District Budgets are available at the Zila Parishad offices.

The State Finance Commission gives 23.33% of the budget to the Panchayats. There are only 3-4 Budget Heads on which there is spending by the Panchayati Raj Structures – General Education, Command Area Development Programmes, Other Rural Development Programmes, and a bit on Water Supply and Sanitation.

Major Headwise Grant-in-Aid and Loans to Panchayats in Rajasthan[62]

(Rs. in thousands)

Account Head	2002-03 Budge Estimates		2003-04 Budget Estimates	
	Grant to Panchayats	% of grant to total state exp.	Grant to Panchayats	% of grant to total state exp.
2202 – General Education	8994237	24.61%	8711054	21.93%
2215 – Water supply & sanitation	153201	2.07%	153201	2.09%
2515 – Other rural development programmes	4375058	97.09%	4778976	93.79%
2705 – Command Area Development Programmes	69691	8.30%	71078	11.66%

The Grants to Gram Panchayats are made on the basis of need, and the formula to determine the need for resources, is:

80% on the basis of population
10% for backward areas
5% for number of BPL families
5% for more illiterate areas

The data about which Districts are most backward, and therefore, receiving the most funds, can be found in the State Finance Commission Report. However, it must be remembered that of the total budget for the Panchayati Raj Institutions, 70% is spent on salaries, and 30% on Development.

DRDA (District Rural Development Agency) funds and other government funds are given to the Block offices. Local funds go to the Gram Panchayats, but since they have no taxing powers, their local funds are made up of things like the sale of papayas from the trees growing on the Gram Panchayat land!! There is provision for the Central Government to give up to 25% if the Gram Panchayats raise 25%, but the local bodies do not. Their sources of income is less; they could impose a tax, but they do not.

The Gram Pachayats and Gram Sabhas have the powers to identify beneficiaries for development programmes, but no planning powers. What comes from higher levels is

[62] Table prepared by DISHA-Patheya, Ahmedabad, Gujarat.

implemented at the lower levels. The Gram Panchayats pass resolutions and give them to the Block structures. However, the structures are weak.

NGOs have to make the elected representatives of the 3 tier structures aware of the roles, powers, limitations, possibilities – the Sarpanches of the Gram Panchayats need information about the budget provisions.

The Mining Department has the ruling that the Royalties from Mines and Minerals go back to the Districts rich in minerals. In Rajasthan, that means that Bhilwara, Chittor and Udaipur will benefit.

In spite of all the shortcomings, it was advised by the training team to do training of Panchayati Raj Elected Representatives, making the men and women at the local level aware of what funds are in the budgets for them. People can understand things that they can see and which affect their lives. Even out of the 30% development funds that go into the PRIs, and the departmental works that go on at the local level, there is a lot of corruption. If the people are aware of budgets, and make sure that the full value of the budgeted money is indeed coming into their area, and being spent carefully, they will gain confidence in monitoring the funds. They will also begin to ask "From where do these funds come?" And so, the local people will become involved in budget analysis at their local levels. If this were to happen, democracy would be strengthened.

Budget and Education

Vijay Goyal of the BARC training team shared some work on Education that had been done by the Budget Analysis Rajasthan Centre on Education and Dropouts from Primary and Upper Primary levels.

The number and percentages of children in school are increasing, but the budget increases are not keeping up with the percentage increases in enrollment. From 1951, until 2003, there are now 23 times more schools, but the budgets have not increased by 2300%.

Enrollment data

- Overall Primary Education Enrollment in the past 8 years had increased by 47% (both boys and girls). Of this, the girls enrollment had increased by 80%.
- Overall Upper Primary Education Enrollment in the past 8 years had increased by 41% in total. Girls Upper Primary enrollment had increased by 85%.
- Scheduled Caste (SC) children's Primary Education enrollment had increased by 77%. SC Girls' enrollment had increased 100% (earlier, if there were 100 girls, now there are 200).
- Scheduled Caste children's Upper Primary enrollment had increased by 38%. SC Girls enrollment had increased by 150%.
- Scheduled Tribe children's Primary School enrollment had increased by 107%, while Scheduled Tribe girls' enrollment had increased by 100%.
- Scheduled Tribe children's Upper Primary enrollment had increased by 75%. Tribal girls Upper Primary enrollment had increased by 100%.

However, with all this increase in girls going to Primary and Upper Primary schools, the number of female teachers decreased in the last 8 years, and there has been an increase of only 4,000 more male teachers in this time period. At the Primary level, in 1995-96, the teacher-pupil ratio was 1:62. In 2002-03, the teacher-pupil ratio is 1:88.

Upper Primary teacher-student ratios for the same periods were 1:41 and 1:45.

In the age group 6 – 14, 80% of all children in the state of Rajasthan are enrolled in school. Of all girls enrolled in this age group, 70% are In school. In the age group 11 – 14

(grades 6-8), the increase in girls' enrollment has been from 26% in 1995-96 to 36% in 2002-03. For boys in the corresponding age group and time period, the increase has been from 48% of all boys in school in 1995-96 to 53% of all boys in school in 2002-03.

Drop-Outs

However – the Drop-Out figures are still very high. Although the Education Policy in 1992-93 stated that drop-outs by 2002-03 would be only 20%, the drop-outs are still much higher – 2001-2002 Drop-out figures show that 59% of the boys enrolled dropped out, and 66% of the girls enrolled in Primary Schools dropped out. The average drop-out rate over the last 8 years is about 60%.

What is the reason for the continuing high drop-out figures?

There may be a number of factors – the need for children to enter the workforce to help poor families earn a survival family income. On the other hand, poor families can see that the number of unskilled labour jobs are much less than they used to be, so there is a perception that children need to be better educated than they were before.

The quality of education – a concern voiced by the participants who were Save the Children partners in the first session of this Workshop – is one of the reasons too. And to see what the state is thinking about quality education, it was necessary to look at the budget.

Budget Provisions for Education

In 1998-99, General Education was 55% of the total Social Services budget provisions. In 2003-04, it had dropped to 54% - although the numbers of students have increased dramatically!.

The 1992 Education Policy Statement had also declared that General Education would be 6% of the GDP. In 1998-99, in Rajasthan, General Education was 3.7% of the GDP, and in 2003-04, it was 3.95% of the GDP. Primary Education in 1998-99 was 2.04% of the GDP, and in 2003-2004, the Budget Estimate was for 2.75% of the GDP.

Of the money available for education, Salaries for Primary School staff in government schools are 99.02% of all funds available. .06% is for Sports. We can see how much is available for science equipment, charts, libraries, study tours, cultural programmes, etc.!

Is the state not spending enough? That too is hard to say. When the amount of the Primary Education budget is divided by the number of all children in Rajasthan in the age group 6-11, the per child budgeted amount is Rs. 2,200. After subtracting out those children attending private schools, the per child budget provision is still Rs. 2,900. However, when we calculate that 60% of the children drop-out of school, and only 40% continue, then the amount of money the Government of Rajasthan provides for each child in school is even higher. In 1998-99, it was Rs. 4,365 per student, and in 2002-03 it was Rs. 5,526 per child.

The plea of the Workshop participants for *quality education*, for studies to compare the quality of education and budgets of non-governmental schools with government schools, to try to identify critical inputs to quality education for large numbers of children, seems sound. Something is still wrong with the Primary and Upper Primary education in Rajasthan, and it seems that spending money only on teachers' salaries is not the answer to vibrant education results.

And yet, when the policy has already been made to spend 6% of the GDP on General Education, and Rajasthan is still spending less than 4%, one can ask *"Why doesn't the government allocate more funds for education? Then there would be funds for libraries, science equipment, etc."* That provision is obvious. ***What*** *to spend the increased money on*

could be a dialogue between civil society actors working in the field of Child Rights and Education, and the government.

Overhead Projector transparencies were used in this presentation, and they, along with another BARC analysis of the Rajasthan Education budgets, are with the supplementary materials submitted along with this Report.

How to Get Information About the Government, From the Government

"I am ready to give you the information, but you must get the permission of my senior officer, please…."
"Come after 5 days, and you will get the information…." and after 5 days, only half of the information needed is supplied….
"I'm sorry, that information is not available; I am unable to give you the information you seek…."
"I have tried to use the Right to Information law, but still I don't get the information from the government offices…."
"I have never tried to get information from a government office….."

The DISHA-Pathey team and the BARC team reported that getting information and data from government offices was one of the biggest problems in this work! The DISHA team's experience, is that the local MLA is the best contact for information. MLAs and MPs get a lot of material about the performance of the government, and they cannot/do not use it all. Also, a word from the MLA can open the doors to access to information in government offices.

If the information is really hard to get, then one way to get it is to get an MLA to ask a question on the floor of the Assembly, and the reply will then have to be made in the Assembly, and the information automatically will become public.

It was also pointed out that it was a good idea to tell the government officer for what purpose you want the information. "For academic purposes" or "For study purposes" sounds harmless.

If you, or someone whom you take with you, know the officer from whom you are seeking information, then matters become much more simple.

It is also helpful to know the offices of the Government, from where data on budgets, policies, performance of the government, are available. The training team pointed the participants to:

- The Budget Department in the State Secretariat
- The Directorate of Economics and Statistics – they make many helpful documents, some of them free, and some of them priced publications
- Accountant General Office – state government accounts and audit reports will be available here
- District Statistical Officer –at the District headquarters. Progress reports on government programmes in the District
- District Accounts Officer will have data about expenditures and budgets of the District. District Rural Development Agency will have data on some rural development programmes and budgets. The District Planning Officer and the Chairperson of the Zila

Parishad's District Development Committee will have some data

- The Government Library, at the State Level. At the District Level, the Library is usually in the Information Centre (Soochna Kendra)
- The Census Office at the state level
- Government Book Depots (in Rajasthan, Kishore Book Depot opposite the Government Press carries government publications)
- The office of the Comptroller and Auditor General (CAG) of India has a lot of information, and publishes Reports yearly. Tribal expenditures in all states are available from that office.
- At the state level, the Tribal Development Commissioner's office keeps data about government programmes implemented in the tribal areas of the state. Likewise, the office of the SC Commission should have data about Dalits and government programmes for Dalits.

An excellent suggestions was made on how to get information, and that was – when you write to the District Education Officer, asking for some data about Primary Education, for example, then put at the bottom of the letter:

cc. Education Secretary
Minister of Education
M.L.A. for the area

Suggestions

About Future Budget Workshops

- Now that some of the basic information about reading and understanding the budget has been covered, Sector-wise exercises would be most useful – that is to say, call participants working on Health, working on Education, working on Women, Children, etc.
- The small-group exercises of digging into the budget books were very helpful. More time should have been given to really getting a feel of working with the budget books
- If the budget book exercises had been done with participants working on similar issues, we could have gotten some more details about the area of our concern
- 3 days is too short – more time is needed to understand the art of budget analysis
- Officials from the Government Departments in charge of programmes with which we work, would have been helpful. e.g. Secretary or Director Women Children Development
- Hold such workshops at the District level, so that District budgets could be worked on by those NGOs working in the District. Future action planning could then be done at the same time
- Such a workshop should be organized in U.P. and Uttaranchal
- District Budgets and Block Budgets as examples should be included in the resource material in the next workshop

About Budget Analysis

In the course of the 3 days, some points were made by participants and the training team, which pointed to matters that need to be included in analysis and action plans. Some of these were:

- To get a fuller picture of the expenditures of and by the government, information needs to be fed into the analysis process about incomes and expenditures from donor agencies to the government, from international lending agencies to the government, from the Central Government.
- Impact studies *must* be a part of budget analysis – just looking at the budget figures alone is not enough to understand what the ground reality is.
- Studies are needed to assess input-output cost effectiveness, and these studies might be joint ventures between government and non-government agencies.
- The process of doing the Revised Estimates of the state budget has to be made more participative and transparent, and the information about what the revised estimate is must be available to MLAs and to the public.
- Persons who work closely with the poor, with women, with tribals must be involved in the budget-making process.
- The constitutional provision that budgets must be made from "the bottom up", from Gram Panchayats, to Blocks, to Districts, to the State, must be examined again – the persons who framed the Constitution were not wrong in directing the country to this process

Conclusion

Dr. Ginny Shrivastava, on behalf of Astha and the Budget Analysis Rajasthan Centre, thanked everyone for coming and participating so attentively. She reflected the views of the training teams, that when the participants want to learn, have good insights and good questions, then the training programme comes alive. Although "Budget" may seem to be a dull and dry subject, the interest of all made the 3 days an "alive" learning experience for everyone.

She wanted to particularly thank Save the Children (UK) for making the workshop possible. Nidhi Pundhir of the Jaipur office of Save the Children has been an active partner in guiding and promoting the use of budget analysis in advocacy. It was too bad that other commitments prevented her from attending .

A special thank-you was extended to the members of the DISHA-Patheya training team, for all their hard work in the preparation for the workshop. Although they were from Gujarat, they had prepared many materials especially for this Workshop, highlighting various aspects of the Rajasthan budget. Their experience of having used the budget data analysed was useful to all participants, in actually understanding what to do. The presence in the Workshop of Mr. M.D. Mistry was an important factor in the success of the Workshop.

With these remarks, the Workshop concluded.